

**CHILDREN'S ATTACHMENTS WITHIN CHILD AND ADOLESCENT
INPATIENT MENTAL HEALTH UNIT**

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CHILDREN'S ATTACHMENTS WITHIN CHILD AND ADOLESCENT INPATIENT
MENTAL HEALTH UNIT

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Abstract

Despite differences in presenting complaints, backgrounds, and diagnostic status amongst children and adolescents within hospital mental health inpatient units, common deficits exist in many patients' abilities to form meaningful and trusting relationships. Young patients suffering from mental illness have also been found to have unsatisfied attachment needs. With research on attachment remaining relatively new, gaps and fragmentations within hospital policies and treatment plans continue to exist. Such gaps have consequently led to a noted lack of mastery amongst many hospital staff in successfully providing services to patients. This is particularly true when navigating complex scenarios such as when dependent relationships between staff and patients form. Based on a thorough literature review, a set of guidelines and a concise checklist that foster consistency, sensitivity, and increased felt competency was developed to guide the actions of mental health staff when patients develop dependent relationships to the unit and staff members.

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Chapter One: Project Overview

To begin this chapter, a brief background to the project is presented followed by an overview of the research question: When dependent relationships are formed between insecurely attached patients and mental health staff, how do staff avoid contributing to the cycle sustaining emotional detachment experienced by patients? Evidence supporting the purpose and value behind this project is provided through a discussion of relevant literature before moving into an explanation of the underlying personal motivation catalyzing this project. Concluding this chapter is a brief summary outlining suggested benefits of the presented guidelines and a glossary of definitions of terms utilized throughout the project.

Background

According to Alberta Health Services (2017a) over 80,000 children and adolescents within Alberta suffer from mental illnesses, some which pose lifelong effects including continual symptom management. With such prevalent numbers, research endeavours strive to improve mental health services and interventions with the ultimate goal of positively impacting the wellbeing and mental health of children and youth within the province (Alberta Health Services, 2017c).

Amidst the mental health services provided within Alberta are Child and Adolescent Mental Health Inpatient Services. Three such service locations are located within the City of Calgary, specifically at the Alberta Children's Hospital, Foothills Medical Centre, and South Health Campus. Utilizing a family centred approach, all three service locations offer assessment and treatment of children and adolescents, between

ages of 4 to 17 who present with serious behavioural, emotional, or psychiatric problems (Alberta Health Services, 2017b).

With an increasing prevalence of psychiatric hospitalization of children and adolescents, Irwin, Kline, and Gordon (1991) proposed the use of milieu therapy, with its focus on interpersonal relatedness and identified an increased need for “viable models, which can serve as a basis for program design and therapeutic intervention” (p. 193). This approach can help children use relationships with staff to develop adaptive behaviours while in hospital. The acute care approach aligns with what has been cited by researchers as being the most vital determinant of treatment success, the “therapeutic alliance” or the relationship between a helper and helpee (Ablon, n.d.; Green, 2006; McCabe & Priebe, 2004). The emphasis on fostering discriminate interpersonal attachment is currently being adopted by many acute inpatient settings (Delaney, 2006b; Sergeant, 2009) including the Alberta Children’s Hospital in Calgary, Alberta. Although dated, Irwin et al.’s (1991) description of milieu therapy as being a vehicle of change in child and adolescent behaviours through the use of the therapeutic alliance remains relevant. However, despite differences in presenting complaints, backgrounds, and diagnostic status of children and adolescents presenting to inpatient units, research has shown common deficits in many presenting patients' abilities to form meaningful and trusting relationships (Irwin et al., 1991; Moses, 2000). As referenced by Berry and Drake (2010), a significant portion of individuals suffering from mental illness have also been found to suffer from insecure attachment styles.

Continual growth in knowledge regarding attachment theory offers mental health staff a new understanding of why certain maladaptive behaviours encountered within

inpatient settings occur (Sergeant, 2009). This knowledge, in turn, provides staff with an understanding of the challenges that may arise when building therapeutic alliances between staff and patients as insecurely attached children and adolescents, through experience, have learnt to distrust caregivers (Keller, 2013). As noted by Keller (2013), it is important for staff to be knowledgeable in how attachment develops and how staff can intervene appropriately when patients present with symptoms of unhealthy or insecure attachments. Attachment theory was not originally designed by Bowlby (1969, as cited by Moses, 2000) to be utilized as a guide for therapeutic interventions. He believed attachment injuries remained stable across a lifespan but the theory has since evolved. Although a slow process (Irwin et al., 1991; Keller, 2013), research demonstrates that under the right conditions insecurely attached children and adolescents are able to form secure attachments with nonfamily caregivers such as mental health staff (Berry & Drake, 2010; Howes & Spieker, 2016; Schuengel, Oosterman, & Sterkenburg, 2009). While securely formed attachments between staff and patients act as a secure base to expand the attachment network of the child or adolescent (Schuengel et al., 2009), there are times where mental health staff may be the only significant attachment figure in some patients' lives (Berry & Drake, 2010).

The teaching of attachment theory within inpatient units has been thought to provide inpatient staff with chances to intervene in ways that begin a corrective or growth experience for patients (Delaney, 2006b; Moses, 2000). Strong therapeutic alliances or formation of secure attachments are encouraged between staff and patients within the boundaries established by hospital guidelines and prevalent literature. Such boundaries are set in place to prevent over-involvement from occurring (Berry & Drake, 2010) or

dependent relationships from forming (Sergeant, 2009). Surprisingly, within relevant literature there appears to be a lack of consensus regarding what is meant by appropriate boundaries. These boundaries are said to be, at times, elusive or difficult to maintain (Moses, 2000). Interviews with inpatient mental health staff conducted by Moses (2000) demonstrated the confusion staff faced when they received mixed messages regarding their main role within the agency and the “blurred lines” of what appropriate staff-patient attachments involve. As suggested by Adshead (1998), some administrators may unwittingly encourage staff to implement certain treatment or support but fail to provide staff with the appropriate guidelines to do so. Ultimately, learning to balance the multi-faceted nature of the staff-patient relationship within inpatient settings is complex. With this said, within inpatient care settings with young patients, powerful attachments to unit and staff are not uncommon and dependent relationships can still form despite preventative measures (Sergeant, 2009).

Consequently, escalations and difficulties, especially as discharge approaches, often occur when dependent relationships to unit and staff are formed (Sergeant, 2009). Therefore, as acknowledged by Kane (2008), further consideration needs to be given to the impact of relationships between young patients and inpatient staff, in particular around the issues of transition and discharge in order to provide clarity in appropriate staff actions, which has led to the development of the question posed in this project.

Question

The intention of this project is to address the following question: When dependent relationships are formed between insecurely attached patients and mental health staff, how do staff avoid contributing to the cycle sustaining emotional detachment experienced

by patients? Principles of attachment theory will be used in this project as a guideline in addressing this question and in providing guidelines to those working in Child and Adolescent Mental Health Inpatient Services.

Purpose and Value

Based on a thorough literature review, a set of guidelines was developed to recommend appropriate course of actions that mental health staff can take when patients develop dependent relationships to unit and staff. Such guidelines can encourage consistency and sensitivity to the needs of young patients, and will hopefully increase personal feelings of competency amongst staff. The created guidelines, along with this completed project are intended to be gifted to the Child and Adolescent Mental Health Inpatient Services at the Alberta Children's Hospital, Foothills Medical Centre, and South Health Campus for potential use. Although this project is intended for use specifically within the Alberta Children's Hospital, wider applications could be possible including other facilities, for example, schools, children's mental health centres, and counseling service serving the needs of children and adolescents.

Alberta is one of four provinces out of ten that has developed policies and plans that explicitly address pediatric mental health; however, gaps in such policies continue to exist (The Canadian Association of Pediatric Health Centres, The National Infant Child and Youth Mental Health Consortium Advisory, & The Provincial Centre of Excellence for Child and Youth Mental Health at CHEO, 2010). Emerging evidence highlights the fragmentation and struggle of mental health services across Canada in meeting the mental health needs and expectations of young patients (Sergeant, 2009; The Canadian Association of Pediatric Health Centres et al., 2010). Contributing to this experienced

struggle is the noted lack of mastery felt amongst staff, which is experienced to various degrees in successfully providing services to all patients. This is especially true when navigating complex scenarios such as when dependent relationships between staff and patients form (Moses, 2000). Because research on attachment is relatively new, the value of and importance of healthy attachments continues to be undervalued and misunderstood by professionals across various fields including psychology and medicine (Keller, 2013). As suggested, staff's sense of competence and active role in patients' learning is fundamental to attachment-promoting transactions, which are in turn, determinant of treatment success (Moses, 2000). Within the literature there is supporting evidence of the existence of the basic psychological need to form attachment to others with at least one relationship being founded on trust and ability for dependency (Ma, 2007). Consequently, the development of meaningful relationships has been continually shown to be a vital component within recovery processes of patients (McCabe & Priebe, 2004). These meaningful relationships direct efforts at contradicting client's deep-rooted negative expectations of self and others (Moses, 2000). During patient interviews, it has been shown that child and adolescent patients regularly discuss the closeness they feel to certain staff members and identify how such strong attachments can create challenges with the termination of these relationships, especially when transitioning out of inpatient care (Gill, Butler, & Pistrang, 2016). As suggested by Kane (2008), young patients need continuity as they transition out of hospital care to enable successful coping during this important time of change. If improperly handled, separation from staff attachment figures can create distress for young patients and cause disruptions in patient success including successful transitions back into the community (Berry & Drake, 2010; Kane, 2008). With

each experienced loss, the capacity for the child or adolescent to trust diminishes (Keller, 2013) and the relationships formed assume the same quality of rejection that has been reinforced within previous experiences of the most insecurely attached young patients (Berry & Drake, 2010; Irwin et al., 1991; Moses, 2000).

With reported increases in hospital service use for children and adolescents with mental health illness (Canadian Institute for Health Information, 2015), the significant need for guidelines for staff across all professional backgrounds including nurses, psychosocial rehabilitation assistance, family counsellors, doctors, and managers in how to appropriately implement attachment sensitive practices is highlighted. Such guidelines are suggested to parallel the concept of Individual Program Plans (IPP) within the education system. A team who is consistent in their therapeutic message avoids overloading young patients, and prevents further distress to not only patients but also other caregivers and fellow staff members.

Personal Interest

My interest in the topic of attachment of children and adolescents in inpatient mental health settings derives from experiencing mixed messages expressed by inpatient mental health staff in contrast to relevant literature regarding the multi-faceted relationship between staff and patients. As a Psychosocial Rehabilitation Assistant on the Child and Adolescent Mental Health Inpatient Unit at the Alberta Children's Hospital, attendance to milieu management and sensitivity to patient's attachment needs are facets of the job. However, while attachment sensitivity is strongly encouraged, certain relational boundaries that have been suggested by managers have been met with confusion due to perceived contradictions regarding appropriate therapeutic responses.

For example, when a dependent relationship has formed between patient and staff, that patient may find it difficult to work with other various staff members or find it difficult during periods of staff absence. Experienced difficulties may cause patients to experience distress, which, in turn, contribute to the expression of maladaptive behaviours. Previous directives personally received have been to create a distance between patient and myself and allow fellow co-workers to work through the patient's experienced difficulties and potential uprising of negative emotions. While this course of action may solidify boundaries or attempt to counteract dependency, it also enhances the message to the patient that words of reassurance are often followed by a sense of loss. As depicted by Keller (2013), "'I care about you' is followed by 'I am leaving you'" (p. 194). In the process of assisting young patients to "let go and move on," how inpatient staff and patient relationships are managed, both pre and post discharge, is imperative (Kane, 2008).

Summary

It is my belief that with a set of guidelines, mental health staff of the Alberta Children's Hospital will be able to better serve the child and adolescent patients within the Mental Health Inpatient unit. Aligning with Keller (2013), learning how to better serve these patients is important as unattended attachment injuries can interfere or even halt the development and wellness of young patients. While the created guidelines will derive from a thorough literature review, the creation of the proposed guidelines will, in extension, utilize knowledge and research skills gained from the Master of Counselling Program.

Definitions of Terms

As attachment theory continues to gain scholarly interest, the complexity of attachment itself is exemplified through the overabundance of terms being utilized to describe the various components within. As a result, this can create significant confusion in research and in practice. For the purpose of this project, a list of definitions of terms as utilized within this project is provided to offer clarity and prevent potential confusion.

Attachment theory. A psychological model advanced by the theoretical efforts of Bowlby (1958) and Ainsworth (1989). Attachment theory studies the functional dynamics of relationships formed within individuals lives, particularly focusing on relationships formed early in life (i.e., mother and child), and the impact of formed attachments on personal development.

Attachment bond/affectional bond. An affectional tie developed within a relationship when one individual views the other as unique and irreplaceable.

Confirmation bias. A predisposition to seek and interpret evidence in a way that confirms one's existing beliefs or theories.

Dependency. When a child or adolescent views an adult as a safe base and depends on that adult to act as an external regulator until the child or adolescent is able regulate for him or herself.

Insecure attachment. Umbrella term for Ainsworth's (1969) three insecure attachment styles, insecure-anxious (i.e., insecure ambivalent/resistant), insecure-avoidant, and insecure-disorganized/disoriented.

Insecure-anxious (insecure ambivalent/resistant). When a child or adolescent displays clingy and desperate behaviour in order to get their needs met as a

result of inconsistent attunement of their primary caregiver(s) since birth.

Insecure-avoidant. When a child or adolescent suppresses natural desires to seek comfort from caregivers when frightened, distressed or in pain, due to early life experiences in which his or her needs were disregarded and ignored by primary attachment figures.

Insecure-disorganized/disoriented. When a child or adolescent displays disorganized behaviours in order to have his or her needs met as a result of unpredictable behaviours of his or her primary attachment figure(s), often eliciting feelings of fear and insecurity for the child or adolescent.

Over-dependency. When a child's or adolescent's independent growth regresses or is minimized due to adult contact.

Primary attachment figures/caregivers. Individuals most involved in rapidly responding to a child's needs, often parents (adoptive or biological), grandparents, or other family members.

Secure attachment. A beneficial relationship between a child and attachment figure (often parent-child relationship), wherein a safe base is formed and the child exhibits assurance that their needs will be met. Overt displays of distress during periods of separation of child and caregiver and relief upon reuniting accompany this attachment style.

Surrogate figures. Individuals cast into a "parental mold" by a child or adolescent.

Under-dependency. A defensive-self reliance as a result of learnt defenses within the internal working model of insecurely attached children or adolescents.

Chapter Two: Review of Related Literature

In this chapter an overview of the literature related to the research question is presented. In addressing the question, when dependent relationships are formed between insecurely attached patients and mental health staff, how do staff avoid contributing to the cycle sustaining emotional detachment experienced by patients, a variety of topics were explored. A foundation of knowledge is provided through brief introductions to the following topics: (a) attachment theory, (b) attachment within inpatient settings, (c) internal working models of insecurely attached patients, and (d) over-dependent relationship formation. Following these sections is an in-depth exploration into patient experiences within inpatient settings, ethical considerations of current interventions, and the necessity for the presented guidelines. Concluding this chapter is an exploration of literature that helps build a foundation for the presented guidelines.

Attachment Theory

Attachment theory was first proposed through the work of John Bowlby (1958) and later expanded upon by researcher Mary Ainsworth (1969). The theory began with Bowlby's observations of a mother-infant relationship where he argued the relationship acted as an important precursor for a child's later functioning in life in addition to current life functioning (Cassidy, 2016). Further exploration uncovered the protective factors naturally developed within secure mother-infant relationships including protection during times of distress, illness, increased anxiety, adverse events, and so forth (Hooper, Tomek, & Newman, 2011). In order to test these protective factors, and further classify attachment relationships, Ainsworth formulated a procedure known as the "Strange Situation" (Keller, 2013). The results of this procedure demonstrated various styles of

attachment between infant and mother leading Ainsworth to develop taxonomy of what was referred to as insecure attachments (Keller, 2013). The two classifications included insecure-avoidant; and insecure-anxious, also referred to as insecure-ambivalent or resistant (Ainsworth, Blehar, Waters, & Wall, 1978). A third insecure attachment was later proposed by Main and Solomon (1986) referred to as insecure-disorganized or disoriented. Each classification of attachment described particular behaviours displayed by an infant in relation to their attachment to their mother when experiencing emotional distress or when separated from their mother (Collins & Feeney, 2000). The introduction of attachment theory not only provided insight into the attachment (care-seeking) system but presented vital information regarding the caregiving system (Collins & Feeney, 2000), an essential component of the attachment bond is also known as the *affectional bond* (Ainsworth, 1989, p. 711; Schuengel & Van Ijzendoorn, 2001, p. 308).

Ainsworth (1989) described an attachment bond as an affectional tie developed within a relationship when one individual views the other as unique, and never wholly replaceable or interchangeable with another person (Funakoshi et al., 2016, p. 4; Schuengel & Van Ijzendoorn, 2001, p. 308). Unlike other relationships, attachment bonds are said to be depicted by a desire to maintain close proximity to the attachment figure which includes experiencing pleasure and joy when reunited with the attachment figure after periods of separation; experiencing distress when separated from the attachment figure for short periods of time; and experiencing grief and loss with permanent termination of the relationship with the attachment figure (Ainsworth, 1989).

Attachment is not limited to parent-child relationships; multiple attachment bonds exist throughout the life cycle of an individual (Ainsworth, 1989). Included in the various

types of attachment bonds are the bonds created with what Ainsworth termed, *surrogate figures* (Ainsworth, 1989, p. 711). Ainsworth (1989) used the term surrogate figure to describe individuals cast into a “parental mold” by a child. These individuals often provide a sense of security for children who are unable to attain safety with their own parents (Ainsworth, 1989). Such surrogates might include, but are not limited to, teachers, counsellors, hospital staff, coaches, older siblings, and other relatives. Scholars began to learn that attachment bonds were a shared dyadic programme in which the actions and responses of caregivers and care seekers influenced one another (Collins & Feeney, 2000; Rees, 2007). Subsequently, the importance of sensitive and responsive actions by caregivers to a child’s expressed needs was highlighted, setting the stage for further research and intervention considerations (Collins & Feeney, 2000).

Although supplementary attachments differ from primary attachments (i.e. parents) in regards to relationship longevity, the influences of such bonds often continue after the relationship itself has ceased (Ainsworth, 1989). Therefore, representational models of relationships with surrogate figures continue to persist (Ainsworth, 1989).

Attachment in Inpatient Settings

When admitted to Mental Health Inpatient Services, children and adolescents face a degree of separation from primary caregivers (or attachment figures), and although temporary, separation can often last for extended periods of time (Berry & Drake, 2010; Schuengel & Van Ijzendoorn, 2001). However, it has been suggested that the impact on patients caused by separation from attachment figures depends on various factors (Schuengel & Van Ijzendoorn, 2001). These factors include pre-existing attachment representations, experienced stress within the institution, experiences during separation,

and availability of alternative secure base support (Schuengel & Van Ijzendoorn, 2001). For some patients, separation can cause a felt sense of loss and insecurity, in turn, activating attachment needs (Berry & Drake, 2010; Field, 1996; Funakoshi, Tanaka, Hattori, & Arima, 2016; Schuengel & Van Ijzendoorn, 2001). For others, “interpersonal difficulties, distressing symptoms and repeated admissions to hospital may lead to a breakdown in primary attachment relationships” (Berry & Drake, 2010, p. 309) and ensue disorganization of patients attachment behavioural systems (Bowlby, 1980 as cited in Schuengel & Van Ijzendoorn, 2001). This finding parallels similar observations made years ago by Adshead (1998).

As articulated by Schuengel and Van Ijzendoorn (2001) and echoed by the World Health Organization (2004), separation between patients and their primary caregivers does not necessarily have to be long-term or permanent to stimulate a patient’s search for temporary attachment figures or for changes in patient attachment behaviours to occur. During periods of separation from attachment figures, patients are left to rely on self-regulatory capacities which can often be immature or few in numbers for many patients, especially at young ages (Schuengel et al., 2009). Therefore, patient-staff attachments may be utilized as a protective factor against incidental damage by acting as a substitute secure base of support when a patient feels “cut off” from his or her primary attachment network and is unable to cope with the stressors on his or her own (Schuengel & Van Ijzendoorn, 2001). As noted, stability within patient-staff relationships holds grave importance due to the emotional costs associated with experienced separation and loss (Hooper et al., 2011; Schuengel & Van Ijzendoorn, 2001).

Surprisingly, evidence has shown that patients who demonstrate insecure attachment patterns can also experience a sense of loss and insecurity upon admission to inpatient services (Schuengel et al., 2009). Bowlby (1973, as cited in Keller, 2013) and Malekpour (2007) explained that unhealthy forms of attachment can occur between a child and a caregiver with whom the child perceives as being able to “better cope with the world” and provides short-term nurturance or protection while simultaneously causing harm to the child. While inpatient services provide greater physical security to patients who have suffered from neglect or abuse, upon admission some of these patients lose the only source of security and comfort they have experienced, despite how unhealthy or limited it was (Keller, 2013; Schuengel et al., 2009). However, it is important to note that not all patients who display insecure attachments experience such distress. For patients who have suffered multiple attachment injuries, (i.e., emotional wounds caused by unhealthy attachments that build on one another to form insecure attachment), and who lack confidence in the availability of attachment figures, the establishment of stable, secure, bonds with staff members within inpatient care may constitute an entirely new experience for patients (Kobak, Little, Race, & Acosta, 2001; Moses, 2000). Insecure attachments gradually become the internal working model of intimacy for the child or adolescent (Furnivall, 2011; Hooper et al., 2011; Kobak, Zajac, & Madsen, 2016). Consequently, prolonged reliance on unhealthy attachment systems can contribute to patient’s maladaptive development (Keller, 2013; Kobak et al., 2016; Schuengel et al., 2009).

Attachment within relationships is perceived as contributing to an individual’s ability to thrive through adversity (Feeney & Collins, 2015). Therefore, echoing fellow

authors such as Ma (2007), Feeney and Collins (2015) argued that dependency on others is normative and, in fact, plays a crucial role in an individual's development across a lifespan. This belief is supported by the work of Bowlby (1997, as cited in De La Rey, 2005) who wrote about the advantages and essentialness of having ready access to sources of support and protection. Many authors have argued that in institutions, there needs to be an acknowledgement of the importance of attachment and for the provision of secure base support when caring for individuals who are removed from attachment networks including those who are unable to, or find difficulty in, coping with the accompanying stress of being admitted to inpatient services or for individuals who present with no prior secure attachment networks (Dozier & Tyrrell, 1997). As new caregivers, hospital staff members have a heavy task of rebuilding or correcting patients' hindered confidence in the availability of attachment figures (Keller, 2013; Schuengel & Van Ijzendoorn, 2001). However, when patient attachments to primary caregivers are insecure, this rebuilding becomes increasingly more difficult (Schuengel & Van Ijzendoorn, 2001).

Internal Working Models of Attachments

Within hospital settings, the vitality of a strong staff-patient relationship cannot be overstated because without such relationships effective treatment cannot take place (Cookson, Daffern, & Foley, 2012; Delaney, 2006c; Hooper et al., 2011; Venta, Sharp, & Newlin, 2015). Furthermore, understanding patient attachment styles may enhance positive therapeutic encounters and, in turn, improve treatment outcomes (Hooper et al., 2011; Ma, 2007; Ontario Network of Child and Adolescent Inpatient Psychiatry Services, 2015; Tan, Zimmermann, & Rodin, 2005). For example, Hooper et al. (2011) and

Cookson et al. (2012) argued that attachment styles affect patients' health seeking behaviours and capacities to be soothed, or even to accept help from health care professionals. Therefore, many researchers have identified that attachment styles can be used as one source in classifying relationships between patients and health care providers (Adshead, 1998; Ciechanowski et al., 2010; Delaney, 2006c). Patients with insecure attachment patterns are either reluctant to develop close relationships with hospital staff due to mistrust of adults or are often most at risk for developing an over-dependent relationship with particular staff members (Furnivall, 2011; Schuengel & Van Ijzendoorn, 2001; Sergeant, 2009). Additionally, to intervene effectively and to successfully support patients through maladjusted behaviours, inpatient staff must begin by understanding the patient's internal working models of attachment and the regulation issues underneath antecedent behaviours (Berry & Drake, 2010; Delaney, 2006a; Irwin et al., 1991; Keller, 2013; Sergeant, 2009). The internal working model can be understood as a cognitive schema that is predictive of behaviours displayed by self and others during times of felt threat, which are then utilized to enact appropriate behavioural responses (Adshead, 1998; Hunter & Maunder, 2001). According to Moses (2000), in attempting to understand the source or meaning of patient's challenging behaviours, staff members themselves become more tolerant; thus, paralleling Bowlby's idea of the "therapeutic principle of approaching a client's defensive behavior by examining the ways in which it derives from earlier experiences" (Moses, 2000, p. 483).

While the purpose of this project is concerned with development of over-dependent relationships, it is also important to understand why certain insecure attachment patterns pose less risk for the development of over-dependency. Therefore, in

the following sections the inner working models of Ainsworth's three insecure attachment patterns will be discussed: (a) insecure-anxious, (b) insecure-avoidant, and (c) insecure-disorganized, in addition to secure attachment pattern (Ainsworth, Blehar, Waters, & Wall, 2015). Through a review of the literature, what differentiates healthy dependency from over-dependency will also be explained.

Insecure-anxious. Ainsworth and Bell (1970) defined insecure-anxious pattern of attachment as a set of behaviours displayed by children who have adopted an ambivalent behavioural style towards their attachment figure due to unmet feelings of security caused by unpredictability of the caregiver. Within Ainsworth's Strange Situation experiment, these children exhibited dependent and clingy behaviour when separation attempts from caregivers were made, displaying a great deal of distress when attachment figures finally departed (Ainsworth & Bell, 1970). Upon the return of the attachment figures the children engaged in either rejecting or helpless behaviours (Ainsworth & Bell, 1970).

What may appear to be an "out-of-control" child is often a child who is attempting to gain control over an overwhelming emotion (Delaney, 2006c). Evidence shows that previous experiences of inadequate care can greatly diminish a child or adolescent's capacity to emotionally regulate (Venta et al., 2015). In the case of anxiously attached patients, patients appear to maintain little faith in their own ability to cope and manage independently (Hunter & Maunder, 2001).

As De La Rey (2005) explained, an essential part of healthy attachments and a healthy process of individuation include the natural development and tolerance of separation. With experienced availability and sensitivity of primary attachment figures,

children and adolescents transition through different phases in life where natural dependency on primary attachment figures gradually gives way to a substantial degree of independence (Ainsworth, 1969). Through the process of feedback and experience, secure children and adolescents learn that physical absence of caregivers does not mean abandonment (De La Rey, 2005). Consequently, separation is no longer perceived as a threat and becomes less anxiety provoking (De La Rey, 2005).

However, when a child or adolescent's primary attachment figure behaves inconsistently the development of a secure base, which promotes independence and security, is disrupted. As a result, separations from primary attachment figures become less tolerable and often elicit extreme feelings of distress and anxiety (De La Rey, 2005; Funakoshi et al., 2016; Irwin et al., 1991). Due to the inconsistency of provided care, these children and adolescents become victims of neglect (Belsky & Simpson, 2016) and learn to experience caregivers as only being helpful if the *signal* of neediness is maintained (Hunter & Maunder, 2001). Belsky and Simpson (2016) described this "...demanding nature as an ecologically contingent strategy designed to obtain, retain, or improve greater parental attention and care" (p. 98) in order to promote survival. Therefore, with little trust in the availability and security of attachment figures, it is often unknown to anxiously attached children or adolescents if separation will mean abandonment forcing sudden reliance on one-self (Belsky & Simpson, 2016; De La Rey, 2005; Hunter & Maunder, 2001). As a result, anxiously attached children and adolescents present as extremely needy, impulsive, anxious, fragile, and cling to attachment figures in fear of losing them (Cross, 2004; Furnivall, 2011; Hunter & Maunder, 2001; Schuengel & Van Ijzendoorn, 2001).

When a child or adolescent's functioning becomes severely impaired due to separation from an attachment figure, healthy dependency becomes *over-dependency* (Sroufe, Fox, & Pancake, 1983). Within mental health inpatient settings anxiously attached children and adolescents are the patients who present as being soothed by the presence of particular staff members but display an inability to maintain this calm upon the staff member leaving (Hunter & Maunder, 2001). As briefly explained in Chapter One, over-dependent relationships become a catalyst for what is referred to as patient maladaptive behaviours. However, not all children and adolescents who experience maltreatment at the hands of their caregiver will continue to seek support.

Insecure-avoidant. An insecure-avoidant pattern of attachment is representative of unemotional and unresponsive behaviour displayed by infants towards their primary caregivers, despite short periods of separation (Ainsworth et al., 2015). As exemplified in Ainsworth's Strange Situation experiment, upon reuniting with their mothers after being left momentarily in an unfamiliar room, infants displaying insecure-avoidant attachments proceeded to turn away from their approaching mothers and ignore attempts for interaction (Ainsworth et al., 2015). Although heart rate monitoring provided evidence of experienced distress of infants during separation from their mothers, the infants displayed no visual signs of such distress (Ainsworth et al., 2015). According to Ainsworth's student Mary Main, such infant behaviours resulted from conditioning marked by consistent unresponsiveness of caregivers to the needs of the infants (Ainsworth et al., 2015).

When continual mistrust occurs due to unreliable care, often associated with physical or emotional abuse, some children and adolescents become resistant to support

even during times of distress (Furnivall, 2011; Hunter & Maunder, 2001; Kobak et al., 2016). Ainsworth (1979, as cited in Belsky & Simpson, 2016) categorized these individuals as insecure-avoidant. While children and adolescents who are categorized as avoidant may experience distress upon separation from attachment figures, these feelings of distress are rarely shown, acknowledged, or resolved (Belsky & Simpson, 2016; De La Rey, 2005).

The development of avoidant behaviours for these children and adolescents has evolved to overcome deficiencies in caregiving depicted by high distress and hostility (Belsky & Simpson, 2016). To these children and adolescents, attachment figures are viewed as unreliable due to an increasing lack of confidence in the perceived sensitivity and availability of such figures. This view can result in self-reliance to meet personal needs in order to avoid dependency on caregivers who are thought to inevitably let them down (Belsky & Simpson, 2016; Hunter & Maunder, 2001). Consequently, children and adolescents displaying avoidant attachment patterns present as rejecting, cold, and distant (De La Rey, 2005; Hunter & Maunder, 2001).

The ability to be emotionally vulnerable is often difficult as the thought of the inaccessibility and rejecting demeanor of caregivers becomes incapacitating for these children and adolescents (Belsky & Simpson, 2016; Cross, 2004; Delaney, 2006c; Irwin et al., 1991; Venta et al., 2015). Therefore, unlike patients who display anxious attachments, patients with avoidant attachment patterns may perceive close attention from mental health practitioners as threatening and, as a result, deny assistance (Belsky & Simpson, 2016; Cross, 2004; Hunter & Maunder, 2001). As a result, these patients are often viewed as non-problematic by care teams (Hunter & Maunder, 2001).

Insecure-disorganized. The classification of Insecure-Disorganized arose from challenges faced by Ainsworth and colleagues in successfully fitting all infant behaviours observed in the Strange Situation experiment into three main categories (Main & Solomon, 1990). Eventually, a fourth classification was added by Main, which categorized contradictory behaviours displayed by infants within the experiment (Main & Solomon, 1990). Such behaviours included, but were not limited to, overt displays of fear, misdirected or jerky movements, and freezing with apparent dissociation (Main & Solomon, 1990).

Children and adolescents with disorganized attachment styles are said to have experiences with primary attachment caregivers that are erratically hurtful or abusive (Hunter & Maunder, 2001). Children and adolescents who experience such maltreatment at the hands of their caregiver are placed in a dilemma of seeking safety from the very person who is the main catalyst for their distress (Furnivall, 2011). In response to this dilemma children and adolescents tend to behave inconsistently, and engage in contradictory behaviours with caregivers due to an internal working model that is insufficiently organized to provide reliable strategies to cope and react effectively (Belsky & Simpson, 2016; Howe, 2011; Hunter & Maunder, 2001; Sergeant, 2009). Therefore, disorganized children and adolescents often present as difficult, unorganized, confused, and “hard to sort out” (Howe, 2011; Hunter & Maunder, 2001; Solomon & George, 2016). Patients who display disorganized style patterns often engage in *push pull* relationships consisting of the simultaneous interaction between help seeking and rejecting behaviours (Hunter & Maunder, 2001; Moses, 2000). While these children and adolescents may desire staff to respond in a reliable and effective manner, they have

minimal trust in the abilities of any caregiver to do so (Hunter & Maunder, 2001). Subsequently, separation from staff members may elicit a fluctuation of feelings for these patients (i.e., angry rejection to strong desire to re-engage; Belsky & Simpson, 2016; De La Rey, 2005). Moses (2000) argued that, paradoxically, a patient's distancing behaviour may actually signal a desire for connection, which often goes unnoticed. In extreme cases, staff may find themselves at the core of three conflicting roles within the attachment system for a patient: (a) the bearer of all attachment needs (forming dependency), (b) inadequate attachment figure (eliciting anger), and (c) a predatory threat (eliciting mistrust and avoidance; Hunter & Maunder, 2001).

Secure-attachment. Secure-Attachment was a classification utilized by Ainsworth and colleagues to categorize children who willfully explored their surroundings and would engage in interactions with strangers while primary caregivers were present (Ainsworth, 1969). However, when primary caregivers would leave the room, securely attached children ceased all exploration, interaction, and became visibly upset until the caregivers returned (Ainsworth, 1969). Upon the caregivers return the children were easily comforted and often resumed to play happily with their caregivers (Ainsworth, 1969).

When children and adolescents experience mutually reinforcing relationships where primary attachment caregivers are attuned to the needs of the child, an internal working model is developed where the availability of support is trusted (Hooper et al., 2011). Through the experience of a healthy attachment, children and adolescents develop a sense of self-worth (Hooper et al., 2011; Keller, 2013; Rees, 2007), emotional safety, self-confidence, and self-reliance (Allen & Tan, 2016; Keller, 2013). Within the inpatient

mental health care setting these patients often develop the most effective and beneficial relationships with staff (Hooper et al., 2011). A developed sense of self-worth provides secure patients with the reassurance that they are worthy of care when needed while a developed sense of emotional safety provides a level of trust that adequate and appropriate health care will be received when required (Hooper et al., 2011). Schuengel and Van Ijzendoorn (2001) argued that patients' secure mental representations of attachment act as stimulants for confident interactions with subordinate attachment figures such as mental health staff members. Although secure patients face the challenge of being separated from secure attachment figures when admitted to hospital, *person permanence* promotes continued felt safety for secure patients despite the absence of any attachment figure (Schuengel & Van Ijzendoorn, 2001). Therefore, secure patients have little need to seek alternative attachment from staff members resulting in decreased risk in forming dependent staff-patient relationships (Schuengel & Van Ijzendoorn, 2001).

Summary

Through their experience with caregivers, insecurely attached children and adolescents learn to distrust adults as a safe base. Consequently, insecurely attached patients repeatedly display dysfunctional emotional understanding, are emotional reactive, and require emotional management (Venta et al., 2015). Unlike children with secure internal working models, children with insecure internal models often struggle with communicating attachment needs and seeking comfort and protection from alternative caregivers (Kobak et al., 2016). As a result, as patients, these children and adolescents may seek help from mental health members in ways that are perceived as inappropriate or dependent (Schuengel & Van Ijzendoorn, 2001). For example, the

inability to self-regulate often leaves patients to perceive life events as being stressful and can cause patients to feel a host of negative emotions including shame, defeat, and guilt (Delaney, 2006c). Insecure internal working models disrupt not only a child or adolescent's confident expectancies and emotional self-efficacy but hinder his or her ability to understand and cope with sources of disruptions in attachments (Kobak et al., 2016). Thus, patients suffering from multiple attachment injuries often question their ability to be loved and cared for (Keller, 2013).

Over-Dependent Relationship Formation

Deciphering the difference among the terms dependency, over-dependency, and under-dependency can become quite confusing due to common overlap and interchangeable usage of the terms. As a result, this following section will provide further clarification of the terms.

Dependency. Patients react differently to diverse staff members because of differing attachments formed and can lead to various displays of interpersonal boundaries by patients (Schuengel & Van Ijzendoorn, 2001). When mental health staff provide comfort, emotional reassurance, and convey acceptance and understanding during times of experienced negative emotions, a refuge for patients is created (Feeney & Collins, 2015). After providing such refuge, the supports given assist patients in *rebuilding* (i.e., reframing and redefining their internal working models; Feeney & Collins, 2015; Moses, 2000). A part of ensuring success in the rebuilding process is the utilization of a staff member as a secure base or as a safe haven (Berry & Drake, 2010; Feeney & Collins, 2015; Keller, 2013; Schuengel & Van Ijzendoorn, 2001). As a patient begins to view a staff member as safe, trusting, sensitive, available, consistent, and reliable, even when the

patient repeatedly acts out, staff members begin to take on that role as a secure base (Adshead, 1998; Gill et al., 2016; Moses, 2000). Patients begin to display behaviours that are corresponding to attachment behaviours including seeking comfort, seeking support, seeking proximity, or social referencing (Adshead, 1998; Schuengel & Van Ijzendoorn, 2001; Venta et al., 2015). Dating back to earlier psychological research by Dickstein, Thompson, Estes, Malkin, and Lamb (1984), social referencing referred to the active search of cues from others in unknown situations to determine appropriate appraisal of events. However, not all authors attribute social referencing to attachment behaviours (Stenberg & Hagekull, 2007).

As explained by Rees (2007), Schuengel and Van Ijzendoorn (2001), and Sergeant (2009), attachment representations remain subjective to experiences; therefore, revisions of insecure attachments can be stimulated through new attachment-related experiences. Once a secure base has been established, to further the success of treatment and the successful reorganization of insecure attachments amongst patients, staff members are encouraged to develop healthy attachment relationships with patients (Cookson et al., 2012; Funakoshi et al., 2016; Sergeant, 2009). However, as noted by Delaney (2006c), forging connections with hospitalized children and adolescents demands close attention to how these patients respond to adults, therefore, reinforcing the validity of mental health staff members understanding patient attachment styles. As demonstrated through the literature on attachment, and reiterated in this project, patients with insecure-anxious attachment styles are predisposed to develop dependency when experiencing feelings of attachment for a caregiver (Sroufe et al., 1983).

Due to insecure internal working models, many patients inappropriately displace patterns of behaviour and emotional reactions related to significant primary attachment figures onto current mental health staff members (Schuengel & Van Ijzendoorn, 2001; Varcarolis, 2005). This process is referred to as transference (Schuengel & Van Ijzendoorn, 2001; Varcarolis, 2005). Common forms of transference may include, but are not limited to, fear of abandonment, desire for affection, desire for respect, and desire for the gratification of dependency needs including regulation (Varcarolis, 2005). Therefore, staff must acknowledge that attachment relationships often accompany working through feelings of transference with patients in order for the relationship to offer a corrective experience for patients (Hooper et al., 2011; Hunter & Maunder, 2001; Schuengel & Van Ijzendoorn, 2001). Moreover, as explained within attachment theory, patients with insecure attachment patterns are not often capable of emotionally regulating themselves; thus, unlike securely attached individuals, an external source of regulation is needed (Hooper et al., 2011). Lacking this understanding as professionals in hospital settings as well as in other settings (e.g., schools) can lead to expectations being placed on a child or adolescent that extend beyond his or her current capabilities (Wotherspoon, 2013). Under such circumstances, when expectations are not met it is not due to the child or adolescent being unwilling to do what is asked, but simply he or she is unable to meet the set expectations due to a lack of important early foundational skills including social, cognitive, and emotional skills (Wotherspoon, 2013). Delaney (2006c) argued, “How staffing intervene at that point, when coping is failing and disorganization is mounting is critical to helping children remain in control” (p. 198).

Over-dependency. Surprisingly, there remain minimal training opportunities for

mental health staff members to learn how to effectively act as a secure base and support patients with highly insecure attachment representations (Moses, 2000; Ontario Network of Child and Adolescent Inpatient Psychiatry Services, 2015; Schuengel & Van Ijzendoorn, 2001). If not taught how to handle transference effectively, staff members are placed at risk for becoming overly involved with patients and may find themselves involved in a conflicted relationship (Schuengel & Van Ijzendoorn, 2001). The blurring of patient-staff boundaries is often viewed to be the fault of staff in response to evoked feelings of countertransference where staff members reciprocate in ways that no longer meet the needs of patients, but instead, meet their own needs (Feeney & Collins, 2015; Varcarolis, 2005). It is at this point that over-dependence is promoted within the patient-staff relationship (Feeney & Collins, 2015; Sergeant, 2009; Varcarolis, 2005).

The overlapping of the concepts of dependency and attachment (Ainsworth, 1969) can create great difficulty in deciphering if relationships with patients have become over-dependent. In the simplest of descriptions, over-dependence is depicted by the regression or minimization of patient's independent growth due to staff contact (Adshead, 1998; Sroufe et al., 1983; Varcarolis, 2005). This can be exemplified by a staff member's need to rescue a patient. Rescuing may lead to continual assistance during times when patient independence can be achieved. The patient can inadvertently adopt a helpless role in absence of the staff member (Hunter & Maunder, 2001; Varcarolis, 2005). Under such circumstances, inpatient environments can reinforce a patient's dependency on others and deteriorate feelings of confidence in managing successfully without staff support (Gill et al., 2016). Patients who receive mental health services and who show little desire to be discharged from hospital can experience severe anxiety resulting from over-dependent

attachments (Gordon & Groth, 1961). In some instances, this over-dependency is so strong that if discharged, patients will act in ways that cause them to be re-admitted to hospital (Gordon & Groth, 1961). While countertransference can elicit strong positive reactions towards patients by staff members, countertransference can also work in the opposite direction where patients provoke strong negative reactions for staff (Varcarolis, 2005).

Under-dependency. As many mental health staff members can attest, challenging patients can often evoke negative feelings including frustration and annoyance. These are normal feelings that can occur for staff members when facing difficulties with patients (Moses, 2000; Varcarolis, 2005). Moreover, Furnivall (2011) explained that difficult behaviours presented by certain patients can activate self-defense mechanisms in staff members, similar to what is experienced by the patient (Berry & Drake, 2010; Moses, 2000). However, when staff members begin to display behaviours characterized as unresponsive or insensitive, patients with insecure attachment styles can resort back to their learnt defenses within their internal working model (Feeney & Collins, 2015; Moses, 2000). Hunter and Maunder (2001) explained that if an insecure-anxious patient were made aware that staff members viewed him or her as clingy and needy then this patient's sense of distrust and anxiety would be re-solidified. Furthermore, insecurely attached patients may perceive distancing of staff members as a threat to the relationship and, in response, patients could react with anger, violence, or self-harming behaviours (Adshead, 1998). Underdependence is a term used by Feeney and Collins (2015) to represent children and adolescents' reliance on defensive coping in response to environments in which caregivers are viewed as insensitive or rejecting. As a

result, *defensive-self reliance* is said to ensue (Feeney & Collins, 2015, p. 121). Patients who are the most emotionally guarded and experience the most difficulty, that is, the most in need, are often the patients that are likely to receive the least amount of sensitive care (Hunter & Maunder, 2001).

Patient Experiences

Attachments to staff parallel that of attachments to parents (Adshead, 1998; Gill et al., 2016; Irwin et al., 1991; Moses, 2000; Schuengel & Van Ijzendoorn, 2001; World Health Organization, 2004), although patient-staff relationships are not considered to be as persistent as primary attachments due to their temporary nature (Adshead, 1998; Gill et al., 2016; Irwin et al., 1991; Moses, 2000; Schuengel & Van Ijzendoorn, 2001; World Health Organization, 2004). However, even though staff-patient relationships are often brief and temporary, these same relationships may be substantial and important to many patients (Gill et al., 2016; Varcarolis, 2005).

A qualitative study conducted by Gill et al. (2016) demonstrated that for many children and adolescents seeking mental health services, the strong relationships formed with staff members and fellow co-patients play a vital role in inpatient experiences, with some patients referring to these formed attachments as a *life saver* (p. 60). Where patients whose childhood experiences are marked by inadequate caregiving, inpatient staff often become a hub for the support and care desperately desired; thus, contrasting previous experiences of felt isolation prior to admission (Gill et al., 2016; Kane, 2008; World Health Organization, 2004). Something as simple as mental health members displaying genuine concern, positive regard, and empathy for patients can have a powerful impact on that patient's life (Varcarolis, 2005). With inpatient mental health staff conducting similar

tasks to that of parents or primary caregivers (Funakoshi et al., 2016; Gill et al., 2016; Moses, 2000), it comes as no surprise that to some patients, staff with whom they have developed an attachment bond are experienced as akin to a family (Gill et al., 2016). Consequently, with the formation of such strongly felt attachments to staff, separations and disruptions in these relationships can be extremely challenging as well as distressing for patients, a point strongly supported within the relevant literature (Adshead, 1998; Berry & Drake, 2010; Furnivall, 2011; Gill et al., 2016; Hooper et al., 2011; Hunter & Maunder, 2001; Irwin et al., 1991; Kane, 2008; Moses, 2000; Varcarolis, 2005).

As explained by Varcarolis (2005), when clients have unresolved feelings of loneliness or abandonment in addition to unresolved feelings of being rejected or unwanted, these same feelings may be reawakened during the inevitable termination of the staff-patient relationship at discharge. Moreover, the insecure internal working models of patients may also elicit difficult feelings for patients when mental health staff members are absent for long periods of time (Berry & Drake, 2010). Therefore, abrupt or insensitive terminations of relationships formed with staff on the inpatient unit can be harmful, anxiety provoking, and painful for patients (Furnivall, 2011; Varcarolis, 2005). Such endings can be thought of as disruptions of an attachment (Furnivall, 2011). Furthermore, without proper termination and effectively addressing patients' distressed feelings, the staff-patient relationship is likely to remain incomplete for many patients as no closure is received (Varcarolis, 2005).

Ethical Considerations

When the termination of staff-patient relationships arouses feelings of guilt for mental health staff members, it is often thought that these feelings are misplaced feelings

of responsibility (i.e., countertransference), and any actions taken are thought to be in response to the needs of the staff member opposed to the patient themselves (Varcarolis, 2005). However, given the information presented in this project, it is argued that by responding to formed dependency and over-dependency with avoidance or distancing, is similar to terminating a relationship abruptly as well as insensitively which can cause harm to patients. With this said, it is essential that the termination or distancing of staff-patient relationships is done with sensitivity to avoid feeding into patients' insecure internal working models. Instead termination is concluded in direct response to patient needs.

Unarguably, working with children and adolescents in a mental health inpatient setting can be a rewarding and demanding experience. As Koocher and Keith-Spiegel (1990) stated, working with a child and adolescent demographic can be riddled with more acceptances of responsibility, confusions, and potential ambiguities. However, professionals within caregiving professions are bound by ethical codes that govern their behaviours and course of actions. For example, counsellors are guided by the Canadian Code of Ethics for Psychologists (Canadian Psychological Association, 2017), teachers are guided by codes of ethics established by each province, and hospital staff are guided by established provincial codes of ethics. Within each professional code of ethics, the ethical responsibilities of professionals are outlined to ensure members act in the best interest of clients, including the delivery of competent services (Alberta Health Services, 2015; Koocher & Keith-Spiegel, 1990). Mental health staff members are no exception. Under the Alberta Health Service Code of Conduct seventh value of performance, Alberta Health staff members have the responsibility as individuals and as a team to

measure the impact of their actions and decisions on patients, families, and communities (Alberta Health Services, 2015, p. 25). Hospital staff members who fail to recognize the importance and influence of the staff-patient relationship relative to therapeutic encounters are at risk for providing less than optimal care (Cox, Smith, Brown, & Fitzpatrick, 2008; Hooper et al., 2011; Miller, 2008).

Like any other individual, *good-byes* are difficult for patients, some good-byes evoking memories of other difficult good-byes they have had to say (Varcarolis, 2005). As Berry and Drake (2010) argued, patients with insecure attachment styles "... require adults who strive to understand their feelings and thoughts rather than just react to their behaviours. Developing a reflective and responsive culture among both staff and residents is an essential component of attachment-informed care" (p. 311). As noted by Delaney (2006c), during hospitalization, mental health staff members can help shape patient-staff interactions so that adults come to be experienced as useful and for the termination of attachments to be a learning experience in which patients learn that they are worthy of being cared for (Varcarolis, 2005). It remains important for staff members to ensure the therapeutic relationships with patients do not "slip" into social or intimate relationships. Although inpatient mental health staff members assume multiple roles on the unit, the main goal remains keeping the relationship continuously focused on the client's problems and needs (Varcarolis, 2005).

Guidelines Needed

Now the question remains, where do we go from here? While authors indicate that although progress has been made in child and youth mental health in Canada, there is still a significant amount of work that needs to be done (Canadian Institute for Health

Information, 2015). As stated by the Ontario Network of Child and Adolescent Inpatient Psychiatry Services (2015), the lack of available research and guides outlining preferable inpatient interventions across all scenarios has led to inpatient units utilizing different treatment models. From personal experiences, this information appears to remain relevant today. Greenham and Persi (2014) explained that without further research and standardization, mental health inpatient units will continue to utilize their own models of care, leading to inconsistency in care. Furthermore, the absence of concrete guidelines not only leads to inconsistencies across inpatient units in hospital settings, but can also lead to inconsistency in interventions utilized amongst the same staffing team.

According to Delaney (2006c), when developing interventions aimed at helping children and adolescents understand their affective world, patients' emotional understanding should be considered. As a result, interventions need to be aimed at the level of a patient's emotional understanding which is often distorted or low for patients presenting with insecure attachment styles (Delaney, 2006c). Therefore, the following section will present a review of information that will be utilized as a foundation in the development of presented guidelines that will help answer the research question: How do mental health staff members avoid contributing to the cycle sustaining emotional detachment as experienced by patients?

Guideline Foundations

As mental health staff members begin to understand patient attachment styles and consequent insecure internal working models, they must recognize signs of transference and be willing to work with patients in sorting through the emotional aspects brought forth by the staff-patient relationship (Hooper et al., 2011). In doing so, it is vital for staff

members to take patients and their experiences of felt attachment seriously (Moses, 2000; Varcarolis, 2005). This approach requires staff members to be reflective rather than reactive in responding to patients' maladaptive behaviours derived from over-dependency. Staff must remain sensitive and responsive to the needs of the patient (Furnivall, 2011).

Within an institutional culture, one of the leading causes for premature termination of staff-patient relationships involves staff misunderstandings of the vulnerabilities behind patients' acting-out behaviours (Harris, & Pien-Wong, 2010). Therefore, escalating behaviours should be managed by using interventions that promote regulation and soothing versus interventions that promote forced containment (Delaney, 2006c). Within her work, Delaney (2006c) encouraged staff members to become aware of signals that indicate a failure in a patient's coping and to intervene before the mounting of overwhelming patient distress is experienced.

As an external regulator for patients, staff members who have become a dependent source of safety for patients must be reliable, consistent, and concerned while refraining from giving into urges of counter transference that result in avoidance or rejecting behaviours towards the patient (Hunter & Maunder, 2001; Irwin et al., 1991). Multiple authors advocate that in order for the process to be a corrective experience for patients. The staff member at the source of the patient's distress must work with the patient in exploring the buildup of emotions and bring awareness to feelings and reactions the patient may be experiencing related to separation (temporary or permanently) from the staff who has become an attachment figure (Berry & Drake, 2010; Irwin et al., 1991; Kane, 2008; Moses, 2000; Schuengel & Van Ijzendoorn, 2001; Varcarolis, 2005). By

helping the child or adolescent cope with emotional turmoil or anger, it can be beneficial for the patient to learn that he or she can be accepted and cared for even when engaging in misbehaviours; those individuals the patient is most close to will not always abandon them (Irwin et al., 1991). When the patient begins to experience the possibility of change in relationships, the stage for hope is set (Irwin et al., 1991). If a patient works through difficulties with an adult (i.e., a staff member whom they feel close to), this experience may provide the patient with further evidence that perhaps relationships with others are not impossible to repair (Irwin et al., 1991). Varcarolis (2005) argued that this experience should be viewed as an opportunity to work with patients in developing personal resources and actualize more of the patient's potential and capabilities to thrive.

While there is no doubt that boundaries to prevent over-reliance on staff members should remain in place as highlighted through this project, cases of over-dependency can still occur. This increased reliance and dependency on staff can create a source of difficulty for both staff and patients. However, to avoid further damage, it is vital that there is a set of guidelines in the form of easily accessible step-by-step procedures, to assist hospital staff in handling such instances in a therapeutic manner so as to minimize harm. As professional health care providers, it is our duty to protect patients from harm. As Keller (2013) suggested, attachment injuries left unattended can interfere and even halt development or wellness of a child or adolescent. To help a child reinvent their cycle of attachment injuries and contribute to the child's unlearning, a worker must realize that this can only be achieved through healing experiences and not through words (Keller, 2013).

Chapter 3: Methodology

The intent of this project was to provide frontline staff within Mental Health Inpatient settings with attachment sensitive guidelines to effectively manage maladaptive behaviours driven by formed over-dependency within staff-patient relationships. Therefore, the literature review was used to answer the following question: When dependent relationships are formed between insecurely attached patients and mental health staff, how do staff avoid contributing to the cycle sustaining emotional detachment experienced by patients? In the following section, the process utilized to complete the literature review and presented guidelines are outlined. This includes descriptions of the databases and search terms utilized, inclusion criteria of resources, inclusion criteria for guidelines, and ethical considerations followed.

Literature Review

Guided by the research question, selected based on a perceived need through experience, Google Scholar was utilized as a “jumping off point” within the systematic review. Further in-depth research was then collected through the utilization of subject specific databases provided by the University of Lethbridge. The following databases provided the literature for the searched terms and phrases: Google Scholar, Alberta Health Services, Academia, Sage Journals Online, ProQuest (Nursing & Allied Health Database), Summon, The National Center for Biotechnology Information (NCBI) Online, PsycNet, and Wiley Online Library.

The aim of the literature review was to provide peer-reviewed resources to assist efforts in the development of practical guidelines for improving patient care in Child and Adolescent Inpatient Mental Health Care settings. Limited resources relevant to the

presented research question posed a challenge throughout the literature review demanding extensive use of search terms and search term phrases. Additional methods utilized to overcome limited search results included journal articles provided from the Alberta Children's Hospital, relevant academic books and textbooks obtained through educational courses, and cited references found within relevant literature. Cited references discovered in relevant literature were located and read in full. If deemed relevant, the resources were utilized. The following search terms and phrases, with additional variations, guided the literature search for this project:

- Attachment – Separation
- Dependency – Child Development
- Psychiatric staff as attachment figures
- Benchmarking inpatient psychiatry
- Attachment styles medical settings
- Insecure attachment in child inpatient settings
- Attachment in Mental Health Inpatient Settings
- Attachment theory within a modern framework
- Children's mental health in Alberta today
- Attachment in Inpatient Units
- Children Inpatient attachment with nurses
- Attachment theory in psychiatric rehabilitation
- Mental health patients wanting to stay in hospital
- Therapeutic relationship between staff and child patients in inpatient unit

- Experience of adolescent Inpatient care and the anticipated transition to community
- Effects on children of termination of child-caregiver attachments
- Attachment relationships with staff and patients in child mental health unit
- Attachment theory and physician patient relationships
- Emotional behavioural communication problems in children
- How to handle attachments as staff on inpatient child units
- Transitions in inpatient mental health care settings
- Managing transitions from adolescent psychiatric in-patient care
- Managing transitions in mental health
- Termination procedure for inpatient care for children with attachment injuries
- Patient-nurse attachment relationships in inpatient care

To better understand attachment within inpatient settings, my initial exploration began with the following questions:

- Do attachment relationships develop within staff-patient relationships in inpatient settings?
- How do these attachments differ from primary caregiver attachments?
- How do these attachments develop? and
- If not handled properly, how will this impact the patient?

Once the literature review began, it became apparent that a gap within the literature existed. Due to the acknowledged literature gap regarding attachment in Child and Adolescent Inpatient Mental Health settings, inclusion criteria were broadened to find pertinent literature. The following inclusion criteria were undertaken within the

systematic literature review, relevant to the topic and peer reviewed. While the age of material was considered, the limited selection of articles made this difficult.

Consequently, dated material was only selected if deemed extremely valuable to the project and was duly noted as being dated.

In regard to the first two questions, there was a consensus within the discovered literature regarding attachment formations occurring between inpatient staff and patients. However, there was a lack of consensus regarding the “type” and “strength” of attachments formed with staff. To better understand the attachments formed within inpatient settings, I studied key articles and publications on this subject. Two specific articles authored by Funakoshi et al., (2016) and Schuengel and Van Ijzendoorn (2001) were the primary focus.

Interestingly, the promotion and impact of formed attachments within inpatient settings appeared contradictory within the literature. While a majority of the literature appeared to argue the positive benefits of formed staff-patient attachments within inpatient settings, others argued the importance of boundary setting and discouragement of such attachments. With further exploration, there was inconsistency in the usage of the following terms: attachment, dependency, and over-dependency. Therefore, a search was conducted using the search terms and phrases:

- attachment versus dependency,
- difference between healthy dependency in attachment, and
- over dependency in attachment.

While multiple resources were utilized in clarification of the terms, an article by Schuengel and Van Ijzendoorn (2001) provided the initial clarification and acted as a

guide through the confusion. While there was evidence suggesting severe consequences on a patient's well-being as a result of insensitive handling of formed dependency, guidelines as to how to handle maladaptive behaviours when dependent relationships were formed were a rarity.

Development of Guidelines

The formulation of the suggested guidelines began with noting emerging themes within relevant articles. These themes included:

- trust as reliable external regulators,
- discussion of experienced feelings and concerns,
- debriefing incident as a team,
- pre-planning anticipated behaviours by providing consistency and predictability, and
- tapering dependency when appropriate.

While the created guidelines were derived from a thorough literature review, the creation of the proposed guidelines utilized personal knowledge gained from the Master of Counselling Program and from personal experiences as a Psychosocial Rehabilitation Assistant.

Ethical Considerations

The collection, reviewing, and synthesizing of the collected data was an independent task, where I alone completed each step. Information was obtained lawfully in addition to being reported accurately. All conclusions were derived from peer-reviewed articles; however, personal interpretations based on work and education experiences were incorporated and noted. Consequently, these guidelines were not

empirically validated. As a result, a disclaimer of the guidelines usefulness prefaced the content. This project was founded upon the synthesizing of preexisting literature; therefore, no participants or human subjects were required. All utilized references were appropriately recorded and credited to the authors.

Chapter Four: Suggested Guidelines

As emphasized by Kane (2008) and highlighted through this project, children and adolescents within inpatient mental health units, like all other children and adolescents, need to be heard and recognized, and to have their needs supported. The well-being of young patients experiencing inevitable disruptions and termination of attachment relationships within inpatient settings should be an area of concern for all inpatient health care providers (Kane, 2008; Ontario Centre of Excellence for Child and Youth Mental Health, 2012).

How patients perceive and manage the termination of staff-patient relationships via transitioning out of hospital or disruption to relationships within (e.g., staff shift changes, staff holidays, staff sickness) is impacted by the young person's history of attachment and current attachments to hospital staff (Hooper et al., 2011; Kane, 2008). With the history of many patients and their families fraught with intergenerational trauma, mental health staff members are uniquely challenged with providing appropriate stability, support, and reliability that is often lacking within the lives of these patients and their families (Many, 2009). As product of chaotic, disorganized, abusive, and or neglectful environments, many insecurely attached patients view change as unpredictable and the termination and disruption of relationships can be traumatic (Many, 2009; Schuengel & Van Ijzendoorn, 2001). If executed sensitively, the termination or disruption within patient-staff relationships can provide patients with their first experience of non-traumatic loss and provide the experience of an emotionally supportive termination phase that is a fundamental component to effective intervention (Many, 2009; Schuengel & Van Ijzendoorn, 2001; Varcarolis, 2005).

Providing attachment-informed care within inpatient settings requires cultural and political shifts to be made to increase the recognition and value of the healing process occurring within staff-patient attachment bonds (Furnivall, 2011). To assist in implementing sensitive separations and terminations within staff-patient relationships, clear guidelines are vital (Berry & Drake, 2010). Therefore, to help close the gap within the literature (Delaney, 2006a; Many, 2009; Ontario Centre of Excellence for Child and Youth Mental Health, 2012) the following guidelines have been created to help direct inpatient mental health staff in the proper handling of disruptions and terminations of staff-patient relationships when dependency or over-dependency has been formed. The proposed guidelines increase staff knowledge, awareness, consistency, structure, and sensitivity surrounding patient attachment within inpatient settings. The guidelines have the potential to prevent unintentional contributions to maladaptive cycles sustaining emotional detachment of insecurely attached patients (Miller, 2008). However, it should be noted, before guidelines are implemented, cultural sensitivity should be considered. This refers to ensuring the guidelines and interventions suggested are culturally appropriate for the particular client.

Establishing Trust

It is important for mental health care providers to understand that attachment interventions are not put in place to minimize a patient's past experiences with felt losses of primary attachment figures (Keller, 2013), but to acknowledge such past trauma and work on rebuilding the patient's trust in adults and others. The rebuilding of trust involves the creation and maintenance of an atmosphere in which trust can flourish (Varcarolis, 2005). To achieve this, it is important to understand that patients'

maladaptive behaviours and rudimentary assumptions regarding relationships and the world around them are often defensive and driven by unconscious motivations outside of patient awareness (Varcarolis, 2005; Ziegler, n.d.). Consequently, as preexisting attachment wounds are awakened within staff-patient relationships, patients are often unable to change resulting behaviours at will and are reliant on staff to act as external regulators until independent skills and self-confidence are developed and as a safe base as high levels of personal distress are experienced (Hunter & Maunder, 2001; Irwin et al., 1991; Varcarolis, 2005).

Insecure-anxious. Hunter and Maunder (2001) referred to a linear model explaining the expression of affect and affect modulation (Figure 1). Insecure-anxious patients are positioned at the furthest left of the continuum. This means that insecure-anxious patients often display intense emotional expression due to poor affect regulation (Hunter & Maunder, 2001). When in distress, these patients are often reliant on staff members with whom they have built a dependable relationship to provide a temporary secure (i.e., midline) internal working model for them (Hunter & Maunder, 2001). However, despite the formation of an attachment bond with a particular staff member, the ability of a staff member to be trusted and relied upon will be tested repeatedly by a patient (Hunter & Maunder, 2001; Keller, 2013).

Due to past experiences, patients come to develop expectancies that fit their working models of themselves and others (Adshead, 1998; Hooper et al., 2011; Moses, 2000; Venta et al., 2015; Ziegler, n.d.). Therefore, insecurely attached patients often have an unconscious drive to seek evidence that proves their defensive outlook as rational and accurate, paralleling confirmation bias. Confirmation bias is defined as a tendency to seek

and interpret evidence in a way that confirms one's existing beliefs or theories (Heshmat, 2015). While the development of trust varies in length (Varcarolis, 2005), the stipulation for trust to be earned on behalf of a staff member remains consistent (Keller, 2013).

When maladaptive behaviours occur as a result of a staff-patient relationship disruption or termination (short-term or long-term), it is vital for the staff member with whom the child is close to remain present with the child or adolescent and facilitate problem resolution (Feeney & Collins, 2015; Irwin et al., 1991). It is acknowledged personally that this approach may be surprising and may be met with some resistance, as explained below.

It is not unusual to hold the belief that by remaining with a patient through maladaptive behaviours reinforces the exact patient behaviours that are undesired and dysfunctional. To some professionals, such patient behaviours may be viewed with the negative connotation of attention-seeking. To ensure responses are not derived from countertransference, it is important for staff to be aware of negative and positive personal feelings and reactions towards a patient (Varcarolis, 2005). To help determine if a course of action is furthering patient dependency and contributing to over-dependency, one question to consider is, "Does the presented distress exceed the patient's current cognitive and behavioural coping/regulation abilities, or can the patient be expected to regulate and cope successfully on their own?" (Schuengel & Van Ijzendoorn, 2001).

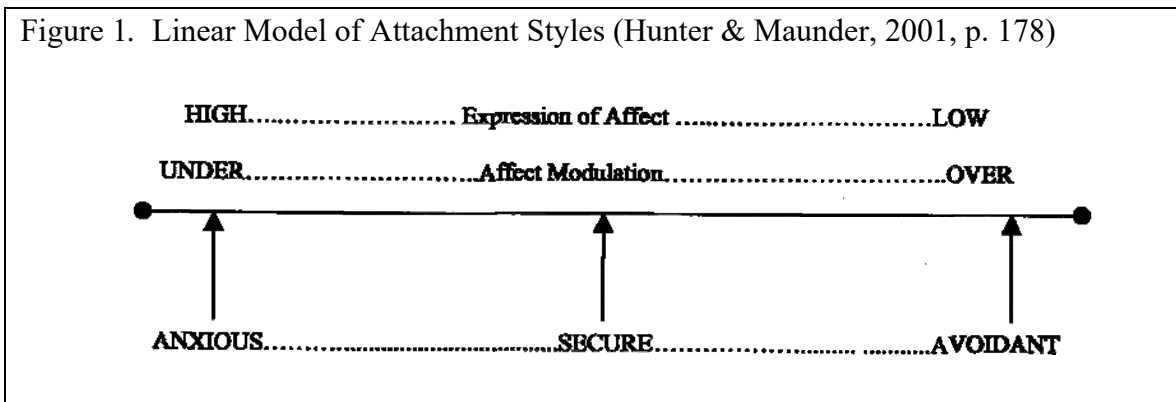
Past experiences have hindered the proper development of self-regulation abilities for many patients (Schuengel et al., 2009); therefore, until insecure-anxious patients receive the proper support necessary to help develop their capacity to self-regulate, they are reliant on external supports (Gill et al., 2016; Schuengel et al., 2009). Although

initially reliant on a specific staff member, through the relationship staff can work with the patient on expanding the patient's circle of trust, expanding the attachment network of the child, and easing transitions between caregivers (Schuengel et al., 2009). Paralleling James' (1994, as cited in Ziegler, n.d.) *Building Blocks of Treating Emotional Disturbance*, relationships to other mental health staff members will not form until feelings of safety, acceptance, and trust are fostered with those members. Similarly to working with children with autism (Hume, 2008), transitions with insecure patients must also be sensitively paced to ensure patient readiness (Ontario Centre of Excellence for Child and Youth Mental Health, 2012; Varcarolis, 2005).

Similar to Irwin et al.'s (1991) argument, minimizing the number of staff a patient is expected to connect to reduces "... the risk that transient contact with multiple mental health professionals will further disillusion children who already lack trustworthy relationships" (p. 199). Moses (2000) supported this argument in his work too. The relationships that patients develop with a few trusted staff provides a critical foundation for staff to assist patients in developing the necessary skills to regulate independently and to recognize and give appropriate expression of their needs (Delaney, 2006c; Irwin et al., 1991). Maintaining these strong relationships is vital to the therapeutic process (McCabe & Priebe, 2004). For patients to begin confronting and discussing painful personal experiences and private thoughts, trust and stability must be established and staff must be viewed as reliable (Schuengel & Van Ijzendoorn, 2001; Varcarolis, 2005). When provided with a strong working relationship, patients are able to experience increased levels of distress and demonstrate dysfunctional behaviours within a safe setting, but unlike other relationships, patients are provided a supportive foundation to explore new

adaptive coping behaviours and are provided with valuable feedback (Schuengel et al., 2009; Varcarolis, 2005).

Similar to the natural development of most relationships, trust within a staff-patient relationship is nourished through the demonstration of staff empathy, genuineness, developed positive regard, displayed consistency, and continued assistance in alleviating felt pain (Varcarolis, 2005). Through the working relationship staff should strive to provide patients with the experience of being responded to, respected, and understood (Delaney, 2006c). By accepting a patient's need for dependency and remaining a constant source of support and security, staff members with whom the patient has formed an attachment bond can assist the patient in developing stronger initiative, self-trust, and competency (Hooper et al., 2011; Moses, 2000). As a patient forms trust that a staff member will respect his or her needs and ensure his or her safety, the young patient's confidence will rise improving the patient's ability to tolerate transitions within the staff-patient relationship (Many, 2009). Over time, as a patient's independence is fostered and attachments to primary caregivers are reestablished, the attachment with the staff member will loosen and move into the background without negative consequences (Many, 2009; Schuengel et al., 2009; Sergeant, 2009). The success of a therapeutic staff-patient relationship can be influenced by the empathic response of staff members to the specific needs of the patient (Children's Mental Health Ontario, 2013; Tan et al., 2005).



Insecure-disorganized. Unlike their insecure counterparts, insecure-disorganized patients are unable to maintain a stable pattern of relatedness in the short term (Hunter & Maunder, 2001). Therefore, the therapeutic aim for these patients is not about moving them towards the secure middle of the continuum but limiting the degree to which patients disorganize treatment teams, and allow inpatient staff members to work together in maintaining effectiveness as an external regulator (Hunter & Maunder, 2001). While limiting the number of inpatient staff with whom these patients work with is ideal, it is often less manageable, as the emotional burden of care may need to be shared (Hunter & Maunder, 2001). During these cases it is extremely important for staff members to practice continual self-awareness to avoid slipping into countertransference urges including rejection of the patients, which can lead to punitive, premature discharges, or over-investigation, which can often lead to prolonged admission (Hunter & Maunder, 2001).

Establishing Discussion

When maladaptive behaviours occur for patients as a response to disruptions within, or terminations of, an attached relationship with a staff member, it is vital to remember that such behaviours are often triggered by underlying maladaptive thought

processes. These negative thought processes are derived from insecure internal working models (Moses, 2000) such as “they are abandoning me” or “they do not care about me.” Therefore, it is important for the staff member who is considered to be the catalyst for the behaviour as a result of formed dependency, to open up a safe space for the patient, when appropriate, where emerging feelings can be discussed as well as acknowledged (Berry & Drake, 2010).

Even when staff members are absent for short periods of time, it is important to recognize the difficult and painful feelings this might evoke for a patient (Berry & Drake, 2010; Furnivall, 2011). Sensitive handling of little losses caused by short staff absences can gradually assist the child in developing the skills to cope with the inevitable termination through discharge (Many, 2009).

As patients are provided with the opportunity to recognize, share, and discuss aroused feelings with the staff member, the patient learns that it is alright to feel sad when someone they care about leaves (Varcarolis, 2005). This process provides patients with an opportunity to discover and express unresolved feelings, for example, feelings of abandonment and rejection for the very first time (Varcarolis, 2005). When providing patients with the space to talk, the staff member should be actively listening, attending to underlying messages, and acting as an advisor for patient concerns (Varcarolis, 2005).

Staff members are encouraged to provide patients with suitable reassurance, which may include reassurance of the staff member's return but only under the conditions that this can be met, or letting the patient know that the patient will be on the staff member's mind when away (Furnivall, 2011). Niimura, Tanoue, and Nakanishi (2016) argued that by failing to provide opportunity and space for patients to disclose and reflect

on experiences, patients felt rejection will be reinforced and inadvertently cause patients to shut down and close off from staff. As Hunter and Maunder (2001) eloquently stated, “References to concepts such as self-reliance, a wish for trust and security, and the need for reassurance, are not pejorative and are meaningful to all parties, regardless of their knowledge of any particular theory of human behaviour” (p. 182).

As patient care is eventually transferred to another staff member after the effective restoration of an attached child's felt security, the new staff member is encouraged to maintain an open space for continued discussion of resulting feelings in response to the absence of the primary staff member (Berry & Drake, 2010). An opportunity is created for the new staff member to act as another surrogate external regulator when the primary staff member is unavailable (Hunter & Maunder, 2001).

Although staff members are encouraged to discuss the inevitable termination of the staff-patient relationship with patients at least two weeks in advance of discharge (Berry & Drake, 2010), it is not uncommon for patients to engage in defensive behaviours in response to felt anxiety revolving around the preemptive loss (Varcarolis, 2005). This reaction may be exemplified through patient withdrawal, outward hostility, denial of emotions, and regression in progress (Berry & Drake, 2010; Varcarolis, 2005). It is important for the staff member with whom the patient has formed an attachment bond, to work with the patient to shed light on feelings and reactions the patient may be experiencing in relation to separations (Varcarolis, 2005). Figure 2 below provides suggested responses for staff when responding to defensive patient behaviours. Traumatized children and adolescents often know no other way to express personal feelings of anger, fear, and sadness regarding perceived abandonment than to

behaviourally express their feelings through maladaptive behaviours (Many, 2009). Helping patients develop a vocabulary to express their feelings towards felt losses is important. In addition to the presented examples of responses, utilization of Kenney-Noziska's (2008), "*Feelings Hide-and-Seek*," activity can assist staff members in targeting communication by providing opportunities for patients to identify, communicate, and process their emotions. This activity can be found in Kenney-Noziska's (2008) book, *Techniques-Techniques-Techniques: Play-Based Activities for Children, Adolescents, & Families*, or online through Lowenstein's (2010) work, *Favorite Therapeutic Activities for Children, Adolescence, and Families: Practitioners Share Their Most Effective Interventions*.

Figure 2. Examples of Responses to Explore Patient Defensive Behaviours

- "Good-byes are never easy. Often they remind us of other good-byes. Tell me about a time where you have had to say good-bye in your past."
- "People may feel angry when they have to say good-bye to someone. Sometimes people feel angry with the person who is going away. How do you feel about me going away?"
- "Good-byes can be hard. Even thinking about having to say good-bye to someone we care about can make our bodies react funny. For some people they get stomachaches. Can you think of a time this has happened to you? As we talk about good-byes right now what is happening in your body? What thoughts are going through your head?"
- "Good-byes can cause people to feel a lot of emotions. This can include feeling sad, mad, and scared. What do you think about this? What other emotions might someone feel? What emotions do you feel when you say good-byes? What emotions come up for you now when you think about saying good-bye to me?"
- "Just like it was coming in here to the inpatient unit, leaving the unit can also be hard. What might make it challenging for you to leave here?"
- "Did you know that saying good-bye is not always hard with just people? Saying good-bye to places can be equally as difficult. What might make it difficult for you to say good-bye to the unit?"

Figure 2. The first two responses are based on presented questions within the work of Varcarolis (2005). The last two responses acknowledge potential difficulties transitioning from formed attachments to the hospital itself.

Although most health care providers are encouraged to refrain from self-disclosing with patients, self-disclosing personal feelings regarding the termination of the staff-patient relationship, if done professionally, can be appropriate. Disclosing genuine feelings of sadness towards the termination of the relationship allows the staff member to share the termination experience with the client in which genuine caring for the patient can be demonstrated (Varcarolis, 2005). Consequently, utilization of the termination of the staff-patient relationship can be a method of intervention (Many, 2009). The termination process can prove to be a learning experience for many patients as maladaptive thoughts regarding self-worth and importance are challenged by evidence displayed in the termination process with the staff member (Varcarolis, 2005).

Debriefing

Admittedly, demonstrating availability, stability, and reliability by seeing through maladaptive behaviours with patients can be quite exhausting for staff members. Passing off patient care to other staff members may often appear to be reasonable, especially during scheduled breaks or changing shifts, with the belief that it will help the patient work through experienced distress with other staff. However, switching staff when a patient is not ready can cause mistrust and hinder the trust necessary for the patient to explore difficult emotions and dysfunctional beliefs in a felt safe environment.

While acknowledging the difficulty this may place on staffing, it is not only important to ensure that debriefing is conducted with patients but also that debriefing is conducted between staff directly involved in addition to the nurse in charge. Debriefing with staff should include how the situation was handled (what went well, what did not go well), how the patient responded (patient readiness), and how to move forward (when

future incidents arise). Debriefing, especially with the charged nurse, is a time where staff can practice self-awareness and explore any feelings of countertransference that may occur or to address signs of potential burnout (Varcarolis, 2005).

Young patients are often able to sense when staff members have checked out or unavailable, often hampering the development of a positive relationship (Varcarolis, 2005). Thus, it is vital for mental health staff members to practice continual self-awareness and conduct mandatory debriefings after incidents. The nurturance of trust can appear to be a slow moving process (Varcarolis, 2005); however, it is vital that an atmosphere of trust be maintained, as it is required for the healing process to continue.

Establishing Pre-Planning

With a greater understanding of the functioning of a patient's maladaptive behaviours, the anticipation of such behaviours are more readily foreseeable and should be planned for, resulting in an increased capacity to support patients (Berry & Drake, 2010). Being aware of the specific times that elicit extreme feelings of distress for a patient, for example, when a staff member leaves the patient to tend to another patient, can assist staff members in intervening effectively. When a patient begins to display signs of becoming overwhelmed, staff must accept their role as an external regulator (Varcarolis, 2005), acknowledge the presenting signs, and step in to act as early warning to mounting distress (Delaney, 2006c). However, in tandem with the role of an external regulator is the role of a teacher. Accompanying this role is the responsibility to help develop the patient's self-soothing skills, develop the patient's ability to anticipate circumstances leading to emotional flooding, and develop the patient's problem solving skills (Delaney, 2006c).

Consistency. Being an optimal regulator for patients requires staff to not only display genuine concern for patients while remaining composed, but to also demonstrate reliability and consistency (Hunter & Maunder, 2001). Staff must show up on time for work, stay with patients for agreed upon periods of time, and avoid giving in to countertransference urges to avoid patients in times of distress (Hunter & Maunder, 2001). While maintaining consistency is not always easily achieved in inpatient settings, it remains vitally important to a patient's felt sense of safety (Furnivall, 2011). Continual displays of consistency provide patients with evidence that stability within caregiving relationships is possible (Schuengel & Van Ijzendoorn, 2001). This emphasizes the need for staff member's continual vigilance of personal actions and displayed behaviours. Following through declared courses of action, for example, checking in on patients when promised, are vital, with the recognition and acknowledgement of mistakes proving to be essential in the continued maintenance and growth of the relationship. Acknowledgment of personal mistakes not only signifies respect for patients but can also provide an exemplar of the repairing process within disrupted relationships and problem solving development.

Finally, it is critical that mental health staff aim to achieve consistency in utilized approaches (Sergeant, 2009). Unfortunately, although appearing simplistic in theory, this task proves to be much more challenging in the real world. Presented challenges will be discussed further within the limitations section. However, despite presented challenges, displays of resiliency amongst team members can heighten consistency in application of treatment. Sergeant (2009) explained that resilient team members often encourage others to adapt a more positive position when facing challenging situations, including caring

for patients despite presented maladaptive behaviours.

Predictability. For most insecurely attached patients when dependency is formed, transitions in caregivers, for example, as a result of staff breaks or shift changes, can often be a source of upset. In order to ease transitions, warnings of upcoming transitions should be utilized to increase predictability for patients (Furnivall, 2011; Many, 2009). Although periodic reminders (5 minute intervals) are recommended to be implemented 15 minutes prior to transitions (Many, 2009), personal experiences have demonstrated that effective timing varies with each patient. For certain patients, shorter warning times, e.g., 5 minutes or less, are required to prevent heightened anxiety levels caused by anticipation. Furthermore, for many younger patients (approximately five years and younger), 15 minutes exceeds their attention span; therefore, shorter warning times may also be more appropriate. However, at the other end of the spectrum an initial warning at 15 minutes may be viewed by other patients as insufficient. Through trial and error, with 15 minutes providing a beginning point, efficient warning time for patients can be established. Alternatively, when appropriate (those patients that are cognitively capable and able to demonstrate effective decision making), patients can be permitted to set preferred warning times. Many (2009) suggested that, when possible, to integrate patients into the treatment planning. Furthermore, continual check-ins, approximately every 30 minutes or less depending on patient's level of need by staff members, can provide patients with needed reassurances that reinforces the idea that support will be provided to the patient regardless if the patient has maladaptive behaviours or not (Hunter & Maunder, 2001). Warnings for the termination of the staff-patient relationship should occur, at minimum, two weeks before the patient's discharge date (Berry & Drake, 2010).

However, it is strongly suggested that through one's work with a patient, eventual termination should be raised and discussed (Varcarolis, 2005).

Establishing Tapering

Tapering has been proven to be an effective strategy in counselling families with experienced issues of abandonment (Hunter & Maunder, 2001; Many, 2009); this same technique may prove beneficial within inpatient settings. As patients begin to display improvements in developmental norms, self-regulation skills, and developmentally appropriate methods of expression, and discharge nears, if not already done so, staff should slowly begin to establish tapering or the fading out process (Many, 2009). To clarify, this does not mean that staff should begin to avoid patients or become dismissive of future distress signals. This simply means providing patients with the space necessary (e.g., meeting less frequently with the patient) to further develop their independent growth and continue to exert control over felt dependency. Continual, although less frequent, check-ins are encouraged to continue to provide patients with the opportunity to discuss feelings regarding the upcoming discharge. If met with maladaptive behaviours, please refer back to the section, *Establishing Discussion*. Before discharge from the hospital, it is vital to ensure the patient's needs, concerns, and available resources are identified (Ontario Centre of Excellence for Child and Youth Mental Health, 2012).

As the termination phase begins, the goals and objectives that have been achieved within the staff-patient relationship should be discussed as part of the termination process (Varcarolis, 2005). Staff members are encouraged to help provide reminders of how the patient can incorporate learnt coping strategies into daily living outside the hospital (Varcarolis, 2005). Furthermore, to honour the bond that was developed with the patient,

it is important for staff to provide opportunity to discuss time spent together (Varcarolis, 2005). This discussion will help validate experiences for patients, and facilitate the closure of that relationship (Varcarolis, 2005). To acknowledge the patient's past history with difficult losses or separations, during the final meeting a small object may be given to the patient to be utilized through transition (Furnivall, 2011; Many, 2009). This object may be a photograph of the staff member and the patient together, a rock with a meaningful handwritten message or symbol, or a drawn representation of the staff members' hospital identification (ID) badge which can be created beforehand or together (see Appendix A for blank ID template). During the passing of the object, the staff member can indicate to the patient that the object can act as a reminder for the patient of their time spent together (D. McBride, personal communication, November 4, 2017). However, if the item becomes lost it can be explained to the patient that this will signify that it is time for the patient to let go and continue moving forward (D. McBride, personal communication, November 4, 2017). Patients and their families should be welcomed to come back to visit the unit and staff in order to help ease transitioning out (Many, 2009). Furthermore, patients and their families should also be welcomed to check-in with staff members through the unit line while staff members are on shift (Many, 2009). Even if patients choose not to check-in after discharge, simply knowing they have the ability to check-in can often provide patients with necessary emotional support to move forward on their own (Many, 2009).

Chapter Five: Synthesis of Guidelines

Overview

The subject matter presented within the guidelines was intended to assist frontline staff in effectively, sensitively, and consistently handling maladaptive behaviours resulting from dependent attachments formed within staff-patient relationships. The need for guidelines became apparent through personal experiences as an employee within a Child and Adolescent Inpatient Mental Health unit and was further emphasized by an acknowledged gap within the literature. Effectively dealing with maladaptive behaviours is quite complex in isolation, but when adding the additional complexity of insecure attachments the situation is, as described by Aggie, a Family Counsellor at the Alberta Children's Hospital, even further muddied (personal communication, August 30, 2017). Understanding that inpatient units are high paced environments, where frontline staff are often required to act quickly and proficiently, the guidelines are required to be concise, easy to follow, and easy to implement in order to be effective. Therefore, the Quick Guideline Checklist (Appendix B) is a resource created for easy use for frontline staff when on shift and dealing with a maladaptive behaviour. Specifically, the checklist consists of the guidelines formulated into steps and presented as bullet points, creating a quick guide for staff.

The Checklist is formatted specifically so it can be printed, laminated, and attached to staff members' lanyards with their ID badge for easy access. Further instructions and explanations of the presented guidelines are provided to frontline staff within The Quick Guideline Checklist: Extended Version (Appendix C) which is created to be kept within the nursing station for frontline staff to view before shift. This extended

version can also be sent electronically by managers to ensure it is viewed amongst staff to increase consistent use. Finally, the guidelines presented within the project itself are written primarily with managers in mind as it provides supporting evidence for the practices suggested. All guidelines are presented in an ordered fashion for ease of understanding and execution.

Benefits

The presented guidelines have the potential to assist in guiding frontline staff in appropriately managing maladaptive behaviours resulting from dependent relationships. Furthermore, the following guidelines have been created with the purpose of ensuring such behaviours are responded to sensitively in order to prevent further harm to insecure patients by exacerbating preexisting attachment injuries. As a result, confidence in staff member's ability to effectively manage maladaptive behaviours could increase and patient care could improve. Adoption of the presented guidelines by mental health staff members and organizations has the potential to improve consistency in interventions utilized by frontline staff within the same unit as well as frontline staff across Child and Adolescent Inpatient Mental Health settings. By increasing the consistent use of sensitive interventions, it may decrease admission length and decrease patient readmission. In the long-term this may prove to be financially beneficial for hospitals.

Limitations

A major limitation of these guidelines includes presented limits that affect the dynamics between staff-patient interactions (Gross & Goldin, 2008). Factors such as high client-staff ratio and regimented schedules tend to lessen opportunities for providing patients with individual attention as daily contacts between patients and staff members

are often shortened due to frequent separation caused by competing duties or shift change (Adshead, 1998; Gross & Goldin, 2008; Moses, 2000; Schuengel & Van Ijzendoorn, 2001; World Health Organization, 2004). Consequently, patients' needs for stable connection with staff, as alternative attachment figures and external regulators, are often frustrated (World Health Organization, 2004). However, in spite of attachment relationships forming, many staff members continue to operate under practices that encourage the establishment of power differentials between young patients and staff (Moses, 2000). Under such circumstances, the presented guidelines may be met with resistance and provide a further inconsistency to treatment interventions across staff members (Moses, 2000). Deemphasizing individual attention as a result of emphasizing healthy boundary setting may be common practice; it remains uncondusive to the development of optimal staff-patient attachments and attachment injury healing (Moses, 2000).

Despite the hope that these guidelines can create change with frontline practices, establishment of change on a larger scale will prove challenging. Continual budget cuts within the health care system often leads to stricter policies regarding claimed overtime which affects frontline staff. Unfortunately, with an inability to claim overtime many staff members are discouraged from following through with maladaptive behaviours upon shift change. Lack of support for staff at a managerial and financial level inadvertently reduces the hospital's capacity to respond sensitively and appropriately to patients' needs (Adshead, 1998). For these guidelines to prove most effective, the organizational system must place patient care as the top priority.

Finally, although cultural sensitivity is noted, the creation of the proposed

guidelines did not expand to include potential differences that may be found across cultures. How patients communicate and seek assistance in times of distress may, in part, be dependent on one's cultural identification (Department of Health and Human Services, 2001). Although dated, evidence provided by Tronick et al. (1992, as cited in Field, 1996) demonstrated an example of cultural variation in human attachment behaviour. Further research in this area is recommended.

Summary

The intention of this project was to address the following question: When dependent relationships are formed between insecurely attached patients and mental health staff, how do staff avoid contributing to the cycle sustaining emotional detachment experienced by patients? Principles of attachment theory were used in this project as a guideline in addressing this question and in providing guidelines to those working in Child and Adolescent Mental Health Inpatient Services.

The importance of holding child and youth mental health organizations accountable to high standards requires the planning and managing of vital transitions (Ontario Centre of Excellence for Child and Youth Mental Health, 2012). However, a lack of provincial standards fails to guide organizations in good practice and fails to hold organizations responsible (Ontario Centre of Excellence for Child and Youth Mental Health, 2012).

An understanding of attachment theory provides both professionals and organizations with valuable insight into behaviours displayed by children and adolescents who have been subjected to attachment injuries during their lifetime. Furthermore, the understanding of attachment and attachment styles provides awareness of the potential

harm caused if treatment and care provided to insecurely attached children and adolescents are not handled with great sensitivity. Thus, through this project, the importance for professionals to learn to identify, prevent and treat attachment injuries is demonstrated and highlighted. As Bowlby (1969, as cited by Moses, 2000) argued, caretakers need to begin to direct their efforts in providing patients with evidence that works against patient's entrenched negative expectations of self and others. In order to do so, mental health staff members need to be available to patients, to respond sensitively, and to be nonpunitive with patients despite the occurrence of maladaptive behaviours (Moses, 2000).

In response to a vital need of improvement in implemented practices, the Quick Guideline Checklist is designed for fast and efficient use by frontline staff while on the floor and in need of reference. Therefore, although small in size, the resource is considered to be more useful than a larger sized manual within busy hospital settings. In combination, the three presented resources are aimed at making changes on the floor of Inpatient Mental Health units and also in making changes in policy within the larger hospital entity. In addition, it is acknowledged that hospital settings are not the only places in which knowledge regarding attachment is relevant and important. Therefore, the presented information and resources within this project can be adapted to fit a variety of settings including schools, children's mental health centres, and counseling services. Although limitations may exist, this project is one push forward to regaining patient centered care.

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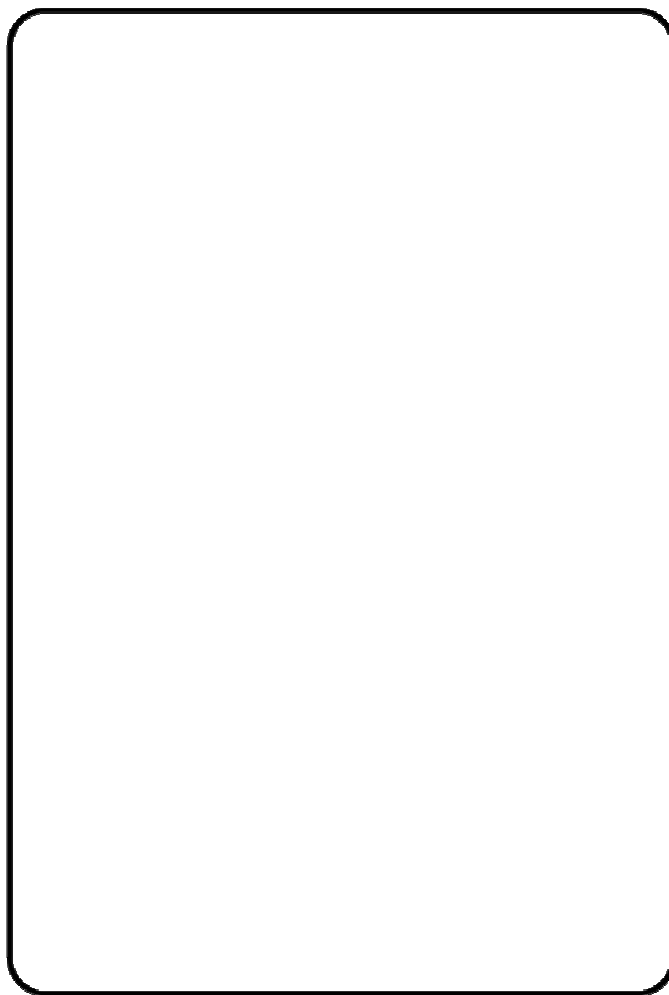
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Appendix A
Blank Identification Template



Appendix B

Quick Guideline Checklist

Quick Guideline Checklist

- 1) Ensure Safety
- 2) Establish Trust
 - Provide External Regulation
- 3) Establish Discussion
- 4) Offer Snack & Refreshment
- 5) Debrief With Team
- 6) Establish Pre-Planning
 - Consistency
 - Predictability
- 7) Establish Tapering

Appendix C

Quick Guideline Checklist: Extended Version

Quick Guideline Checklist

Extended Version


Use of Guide:

This guide is intended for the use of frontline staff within mental health inpatient settings when managing maladaptive behaviours occurring as a result of staff-patient dependent relationships.

1) Ensuring Safety

- ✓ When escalations occur it is easiest to direct co-patients away from the scene. Co-patients can be sent to their rooms (doors closed) or directed to another secure location with staff assistance. It is important to remember that escalations are not only upsetting for the patient involved but can be quite triggering for those around them. Thus, it is vital that staff ensure check-ins are conducted with each co-patient. Discussions involving concerns or experienced distress should be followed through.

Who should be present with the patient at this time?

-  Dependent Staff Member
-  One or two assisting staff members

- ✓ If the patient is unable to harm self or staff in the current settings it is preferable to refrain from directing the patient to their room or another location as experiencing heightened levels of distress makes it difficult for patients to be able to follow through with directions. The first priority is to regulate the patient. However, as the staff member with whom the child or adolescent is dependent upon works on calming the patient, one staff member should be directed in slowly, and discreetly, removing any objects within the area that could be used to harm the patient/others or cause damage.

Ensuring Safety of the Following Individuals

- Of Patient Escalating
- Of Yourself
- Of Co-Patients
- Of Fellow Staff Members
- Of Bystanders

Ensuring Safety

- ✓ Use of restraints pharmacologic, mechanical, physical, and environmental should ***only*** be used when ***all*** other methods and resources have been exhausted and a patient continues to be a danger to self or others. Please refer to Restraint as a Last Resort – Addiction and Mental Health – Inpatient Policy (Document # HCS-176-06) effective February 1st, 2018.
- ✓ The use of secure rooms found on inpatient units (smaller rooms that are bare and can often lock from the outside) are encouraged to be utilized as a ***last*** resort. These rooms should ***only*** be utilized if the patient is posing a severe risk to others or to self. At no point should the use of secure rooms be utilized as threat by staff. Utilization of coercion can be associated with harm to patients (National Collaborating Centre for Mental Health, 2015). Although appearing to be, at times, the easiest route, it is vital for staff to remember that many patients have experienced trauma. Therefore, it is vital that staff refrain from causing further trauma to the patient.
- ✓ If a secure room is required, patient should be directed to walk self if compliant. If patient is not compliant, dependent staff along with a co-staff (if required) should assist patient. Security should be only utilized if a threat to safety is present.

If Placed in Secure Room:

The door should remain open (if safe to do so). If not safe to do so initially, provide patient with reassurance that the door will be opened once safe to do so.

- “Hey (Name of patient), I am right here with you. Once it is safe for me to do so I will come in there and sit with you. Until then I will be right here by this door.”

Praise should be given to the patient when showing signs of regaining regulation or when utilizing coping strategies.

- “Good job breathing (name of patient)”
- “(Name of patient), you are doing an awesome job regulating yourself. I can see your body is starting to tell me you are just about ready for me to come in.”

2) Establishing Trust

- ✓ Providing evidence of reliability and dependability is vital. Therefore, dependent staff must see the maladaptive behaviour through and refrain from passing care over to other staff. Remember breaks can be rescheduled! Discussion with charged nurses before beginning of shifts regarding flexibility of breaks is encouraged to ensure self-care time can be taken.
- ✓ Establishing trust with a patient requires demonstrating reliability as an external regulator when patients do not have the capacity to self-regulate.
 - ✚ Remain calm
 - ✚ Remain composed
 - ✚ Slow movements
 - ✚ Limit word use – Too much talking when in distress can heighten escalations
 - ✚ Slow pace of speech
 - ✚ Calm tone of voice
 - ✚ Utilization of grounding techniques
 - Deep breathing
 - Notice breathing
 - 5, 4, 3, 2, 1
 - Ice chips
 - Deep pressure (only if appropriate and patient is okay with touch. Must be very careful with this.)
 - Distraction

Instructions for 5, 4, 3, 2, 1

- 5 – List five things that you can see
- 4 – List four things that you can touch
- 3 – List three things you can hear
- 2 – List two things you can smell
- 1 – List two things you can taste

Deep Pressure

Extreme caution must be used. Please avoid using unless discussion with entire team has occurred and effectiveness of technique for a patient has been determined. To ensure appropriateness of touch, staff should focus on only applying deep pressure to patient's shoulders, arms, and hands. Deep pressure should only be applied in the presence of other staff members.

3) Establishing Discussion

- ✓ When maladaptive behaviours occur as a response to disruptions within, or terminations, of an attached relationship with a staff member, it is vital to remember that these patient behaviours are often triggered by underlying maladaptive thought processes derived from insecure internal working models (Moses, 2000), e.g., “they are abandoning me,” “they do not care about me.” Therefore, it is important for the staff member who is considered to be the “catalyst” for the behaviour as a result of formed dependency to open up a safe space for the patient, when appropriate. Emerging feelings can be discussed as well as acknowledged (Berry & Drake, 2010).
- ✓ However, before discussion can begin, staff members must check patient readiness. If discussions occur prematurely escalations can worsen.

Check Patient Readiness

Non-verbal Cues

- ✚ Breathing slowed
- ✚ Loosening of tensed muscles (e.g., clenched fists, clenched jaw, raised shoulders)
- ✚ Calmed movements (e.g., sitting still, no longer pacing)

Verbal Cues

- ✚ Lowered tone of voice
- ✚ Slowed rate of speech
- ✚ Less use of profanity
- ✚ Verbalizing readiness to talk

Establishing Discussion

Staff Role in Discussion

- ✚ Implement active listening
- ✚ Attend to underlying messages
- ✚ Validate and normalize feelings
- ✚ Act as sounding board
- ✚ Provide reassurance
 - Short Disruptions
 - i. State time of return
 - ii. Thoughts are with patient
 - iii. Create ritual (if desired)
 - Termination
 - i. Encourage visits
 - ii. Encourage phone calls to unit

- ✓ It is important for the staff member with whom the patient has formed an attachment bond, to work with the patient to shed light on feelings and reactions the patient may be experiencing in relation to separations (Varcarolis, 2005). Traumatized children and adolescents often know no other way to express personal feelings of anger, fear, and sadness regarding perceived abandonment than to behaviourally express their feelings through maladaptive behaviours (Many, 2009).

Examples of Responses to Explore Patient Defensive Behaviours

- “Good-byes are never easy. Often they remind us of other good-byes. Tell me about a time where you have had to say good-bye in your past.”
- “People may feel angry when they have to say good-bye to someone. Sometimes people feel angry with the person who is going away. How do you feel about me going away?”
- “Good-byes can be hard. Even thinking about having to say good-bye to someone we care about can make our bodies react funny. For some people they get stomachaches. Can you think of a time this has happened to you? As we talk about good-byes right now what is happening in your body? What thoughts are going through your head?”
- “Good-byes can cause people to feel a lot of emotions. This can include feeling sad, mad, and scared. What do you think about this? What other emotions might

someone feel? What emotions do you feel when you say good-byes? What emotions come up for you now when you think about saying good-bye to me?"

- “Just like it was coming in here to the inpatient unit, leaving the unit can also be hard. What might make it challenging for you to leave here?”
- “Did you know that saying good-bye is not always hard with just people? Saying good-bye to places can be equally as difficult. What might make it difficult for you to say good-bye to the unit?”

4) Offer Snack and Refreshment

- ✓ Just like it is for staff, escalations for patients can be exhausting! Within escalations patients heightened distress levels utilize a large amount of energy. Therefore, it is important that staff offer patients a snack and refreshment afterwards. This offering not only ensures patient's electrolytes are replenished but also begins the repairing process within the relationship.

5) Debriefing

- ✓ While acknowledging the difficulty this may place on staffing, it is not only important to ensure that debriefing is conducted with patients but that debriefing is also conducted between staff directly involved and the charged nurse. Debriefing with staff should include how the situation was handled (what went well, what did not go well), how the patient responded (patient readiness), and how to move forward (when future incidents arise). Furthermore, debriefing, especially with the charged nurse, is a time where staff can practice self-awareness and explore any feelings of countertransference.

6) Establishing Pre-Planning

- ✓ With a greater understanding of the functioning of a patient's maladaptive behaviours, the anticipation of such behaviours are more readily foreseeable and should be planned for; thus, resulting in an increased capacity to support patients (Berry & Drake, 2010).
- ✓ Staff members also have a responsibility to help develop the patient's self-soothing skills, develop the patient's ability to anticipate circumstances leading to emotional flooding, and develop the patient's problem solving skills (Delaney, 2006b).

Pre-Planning: Consistency

What it entails:

- ✚ Showing up on time for work.
- ✚ Staying with patients for agreed upon duration of time.
- ✚ Avoid rejecting clients during times of distress.
- ✚ Check in on patient as promised.
- ✚ Acknowledge and admit to mistakes.
- ✚ Remain consistent in approaches with fellow staff members.
- ✚ Maintain a resilient attitude.

Pre-Planning: Predictability

What it entails:

- ✚ Provide warnings for transitions in care:

Although periodic reminders (5 minute intervals) are recommended to be implemented 15 minutes prior to transitions (Many, 2009), personal experiences have demonstrated that effective timing varies with each patient. Through trial and error, with 15 minutes providing a beginning point, efficient warning time for patients can be established. Alternatively, when appropriate (cognitively capable and able to demonstrate effective decision making) patients can be permitted to set preferred warning times.

- ✚ Continual check-ins:

Approximately every 30 minutes or less (depending on patient's level of need) by staff members, can provide patients with needed reassurances that reinforce the idea that support will be provided to the patient regardless if the patient has maladaptive behaviours or not (Hunter & Maunder, 2001). The length of time between check-ins can be gradually, and appropriately lengthened, as the patient requires less frequent reassurance.

What it entails:

- ✚ Provide warnings for termination/discharge:

Warnings for the termination of the staff-patient relationship should occur, at minimum, two weeks before the patient's discharge date (Berry & Drake, 2010). However, it is strongly suggested that through one's work with a patient, when appropriate, the fact of eventual termination should be raised and discussed (Varcarolis, 2005).

7) Establishing Tapering

- ✓ As patients begin to display improvements in developmental norms, self-regulation skills, and developmentally appropriate methods of expression, and discharge nears, if not already done so, staff should slowly begin to establish tapering or the fading out process (Many, 2009). To clarify, this does not mean that staff should begin to avoid patients or become dismissive of future distress signals. This simply means, providing patients with the space necessary (e.g., meeting less frequently with the patient) to further develop their independent growth and continue to exert control over felt dependency.

- ✚ Continual, although less frequent, check-ins
- ✚ Encouragement to practice self-regulation skills

- ✓ If met with maladaptive behaviours please refer back to step 3 (Establishing Discussion).

Termination Process:

- ✓ Before discharge from the hospital, it is vital to ensure patient's needs, concerns, and available resources are identified (Ontario Centre of Excellence for Child and Youth Mental Health, 2012).
- ✓ Goals and objectives that have been achieved within the staff-patient relationship should be discussed (Varcarolis, 2005).
- ✓ Help provide reminders of how the patient can incorporate learnt coping strategies into daily living outside the hospital (Varcarolis, 2005).
- ✓ Provide opportunities to discuss time spent together (Varcarolis, 2005).
- ✓ During the final meeting, a small object may be given to the patient to be utilized through transition (Furnivall, 2011; Many, 2009). During the passing of the object the staff member can indicate to the patient that the object can act as a reminder for the patient of their time spent together. However, if the item becomes lost it can be explained to the patient that this will signify that it is time for the patient to let go and continue moving forward.

- ✚ Photograph of staff member and patient

- ✚ A rock with a meaningful handwritten message or symbol
 - ✚ A drawn “representation” of the staff members hospital identification (ID) badge which can be created beforehand or together
- ✓ Patients and their families should be welcomed to come back to visit the unit and staff in order to help ease transitioning out (Many, 2009). Furthermore, patients and their families should also be welcomed to check-in with staff members through the unit line while staff members are on shift (Many, 2009).

Our Values With Albert Health Services

(Alberta Health Services, 2016, p. 5)

Compassion

“We show kindness and empathy for all in our care, and for each other.”

Accountability

“We are honest, principled and transparent.”

Respect

“We treat others with respect and dignity.”

Excellence

“We strive to be our best and give our best.”

Safety

“We place safety and quality improvement at the centre of all our decisions.”

Appendix D

Checklist: Extended Version References

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