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How does attachment state of mind affect the nurse-woman caregiving relationship?

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under the supervision of

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CERTIFICATE OF ORIGINAL AUTHORSHIP

I, Frances Chavasse, declare that this thesis, is submitted in fulfilment of the requirements for the award of PhD Nursing, in the School of Nursing and Midwifery, Faculty of Health at the University of Technology Sydney.

This thesis is wholly my own work unless otherwise referenced or acknowledged. In addition, I certify that all information sources and literature used are indicated in the thesis.

This document has not been submitted for qualifications at any other academic institution.

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DEDICATION

This work is dedicated to all the nurse "wounded healers" affected by childhood attachment trauma and whose time has come to be acknowledged and healed.

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LIST OF ABBREVIATIONS

AAI	Adult Attachment Interview
ACE-Q	The Adverse Childhood Experiences Questionnaire
ACEs	Adverse Childhood Experiences
ASQ	Attachment Styles Questionnaire
CASP	Critical Appraisal Skills Programme
CFH	Child and Family Health
ECRS	Experiences in Close Relationships Scales
ECRS-R	Experiences in Close Relationship Scale-Revised
EE	Emotional Expression
EOI	Emotional Overinvolvement
EPDS	Edinburgh Postnatal Depression Scale
FPM	Family Partnership Model
IWM	Internal Working Model
NPCRI-N	Nurse-Patient Caregiving Relationship Interview, Nurse
NPCRI-P	Nurse-Patient Caregiving Relationship Interview, Patient
PAM	Psychosis Attachment Measure
PND	Postnatal Depression
PTSD	Post-Traumatic Stress Disorder
RPS	Residential Parenting Services
RQ	Relationship Questionnaire
RSQ	Relationship Style Questionnaire
TIC	Trauma-informed Care

ABSTRACT

The quality of the care provided to a client has been central to the essence of nursing and clinical practice since Florence Nightingale. The nurse-client caregiving relationship is a significant component of all healthcare interactions, and research has found that quality care is linked to positive client outcomes. More recently, Attachment theory has been used in psychological research to understand the link between therapists' adult attachment states of mind and the type of caregiving relationships they develop with their clients. Specifically, it explores how attachment states of mind affect the caregiving provided to clients. This research aimed to explore how the attachment states of mind of 12 child and family health nurses and the attachment states of mind of 13 women affected their caregiving and care-receiving relationship during the woman's stay in a Residential Parenting Service.

The data collected in this theory-building case study were the Adult Attachment Interview used to classify the child and family health (CFH) nurses and women's attachment state of mind, a short semi-structured interview called the Nurse-Client Caregiving Relationship Interview (Nurse and Client versions) administered to understand the caregiving and care-receiving relationship, the Adverse Childhood Experiences questionnaire to score the nurse and women's exposures to adverse childhood experiences and demographic data of both nurses and women. The Adult Attachment Interview was analysed using the Adult Attachment Interview Scoring and Classification System and Adverse Childhood Experiences questionnaire; the Nurse-Client Caregiving Relationship Interview was analysed using narrative analysis.

Results showed that this sample had higher frequencies than a normative community sample of insecure attachment classifications. This included a higher frequency of unresolved/cannot classify sorts, not generally found in community samples. In addition, there was higher exposure than community norms to Adverse Childhood Experiences in some categories of the Adverse Childhood Experiences questionnaire.

Results also showed that insecure attachment states of mind were associated with less sensitive and responsive nurse caregiving. A secure state of mind was associated with more sensitive and responsive nurse caregiving. An unresolved/cannot classify state of mind was associated with nursing care lacking a coherent caregiving strategy.

This case study has drawn attention to the powerful influence of the CFH nurse and woman's attachment state of mind and the potential to either enrich or disrupt the nurse-client caregiving relationship. The CFH nurses with unresolved childhood trauma are understood to have an unconscious motivation to help clients with troubled pasts and are described as wounded healers. To address this problem for the CFH nurses and the women in their care, the implementation of an organisational trauma-informed model of care may raise awareness for nurses of ACEs and subsequent trauma. A trauma informed model of care may develop strategies to address susceptibility to workplace re-traumatisation through prevention and supportive intervention.

Several limitations must be considered when interpreting the results of this case study. This small, purposive sample was chosen for deep analysis of the four case studies. The characteristics of the CFH nurses and women and their reasons and interests for volunteering to participate in this particular study cannot be known, leaving the sample open to selection bias. Additionally, the small sample size reduces the transferability of the findings. In future studies, larger sample size may be more instructive. Other limitations were that all the women had English as their first language, all were Caucasian except one Aboriginal woman, and all were middle class and had at least 12 years of education.

Further research, using a larger sample of nurses, would enable a deeper understanding of how nurses' attachment state of mind affects the nurse-client caregiving relationship. Additionally, the impact of the complex interplay of the nurses' attachment state of mind, early childhood attachment trauma and the cumulative effects of their ACEs on the nurse-client caregiving relationship requires further examination.

Chapter 1: ATTACHMENT AND THE NURSE-WOMAN CAREGIVING RELATIONSHIP

A central accepted concept of attachment theory is that a person constructs their internal representational model of themselves and others through the moment-by-moment early experiences with their primary attachment figure (Main, Kaplan & Cassidy 1985). These recurring and engrained "..event-based.." (p. 75) interactions of the self and the attachment figure, once structured, tend to guide our behaviour, attention, reasoning, and language (Bretherton & Waters 1985; Main, Kaplan & Cassidy 1985). In due course, our adult attachment state of mind, the internal representations of our thoughts, feelings and beliefs about ourselves and our closest relationships are shown through language rather than behaviour (Main, Goldwyn & Hesse 2003; Main, Hesse & Goldwyn 2008; Steele & Steele 2008b). Evidence suggests that adult attachment state of mind can unconsciously guide parenting and caregiving behaviours (Hesse & Main 1999; Van Ijzendoorn 1992; van IJzendoorn 1995).

Caregiving is not only a principal role of nursing but also an essential quality of nursing. On occasion, the nurse-client [1] (Grant, Mitchell & Cuthbertson 2017) caregiving relationship may not always proceed smoothly due to multiple factors such as a nurse's feelings of low self-esteem, personal attitudes towards families (Kokkonen et al. 2014), expectations of the nurse from the family (Ghadery-Sefat et al. 2016), the nurse's decision-making skills (Halama & Pitel 2016) and even the nurse's own potential for burnout (Barr et al. 2014; Gama, Barbosa & Vieira 2014). Nurses with a history of childhood trauma from their primary attachment figure may also experience ruptures in their nurse-client relationship with the potential for subsequent unfavourable outcomes (Hiles Howard et al. 2013). Nurses who have experienced childhood trauma are sometimes unaware of the rupture of the relationship because of an involuntary need to downplay their own and the woman's distress (Maunder et al. 2010; Murphy et al. 2014). Other nurses may lack empathy, have an intrusive style of

[1] The correct terminology for the child & family health nurse caregiving relationship with the family he/she works with is nurse-client. "Client" in the National Standards of Practice for Maternal, Child and Family Nurses in Australia refers to mother, father, child and family.

caregiving or become over-involved with the women they are caring for (Borelli & David 2003; Dozier, Cue & Barnett 1994; Hiles Howard et al. 2013).

My enduring interest and scholarship in the attachment field motivated me to learn if attachment state of mind affected nurses' caregiving in my speciality, child and family health (CFH) nursing. I asked myself whether secure and insecure attachment states of mind in the CFH nurses affect their caregiving when working with women and their infants admitted to Residential Parenting Services (RPS). Additionally, I wondered whether secure and insecure women's (that is, mothers') attachment states of mind affect how they perceive the care they receive from CFH nurses.

Furthermore, the women and men admitted to RPS who experience difficulties with parenting have often experienced childhood trauma and/or loss through the death of an attachment figure, thus requiring additional support and education from the CFH nurses and the multidisciplinary team. Substantial research shows both trauma and loss affects attachment state of mind with the potential to affect the CFH nurses' caregiving (Hesse & Main 1999; Lyons-Ruth & Block 1996; Schoenmaker et al. 2015; Van Ijzendoorn 1992; van IJzendoorn 1995; van Ijzendoorn, Juffer & Duyvesteyn 1995). My research aims to acknowledge and understand the CFH nurses' and women's state of mind regarding trauma in the form of physical and/or sexual abuse and loss through the death of an attachment figure and how these significant traumatic events affect the nurse-client caregiving relationship.

This chapter introduces the research and describes attachment theory, the central concept that underpins this study. Attachment theory was chosen for this study because of the equivalency to the nursing concern for close human relationships and caregiving. Attachment theory is an evolutionary theory that describes two human motivational systems; the child's powerful tie to their primary caregiver and the reciprocal caregiving system that ensures the infant's survival (Bowlby 1969/1982, 1973/1998, 1980/1998). Mary Ainsworth's longitudinal observational studies of mother-infant interactions characterised maternal caregiving behaviours into a spectrum of sensitive to insensitive, psychologically and emotionally available to unavailable (Ainsworth 1969). Succeeding this, her laboratory test, the Strange Situation Procedure (Ainsworth et al. 1978/2009) categorised different caregiver-infant interaction strategies into the binary categories secure and insecure.

Main, Kaplan & Cassidy (1985) shifted attention to studying the internal attachment representations of the adult attachment system using Mary Ainsworth's secure and insecure classifications and applying these to adults. An interview and its coding system, the Adult Attachment Interview, was developed and revised to capture the state of mind of the adult speaker and offer an indication of the type of caregiving the parent may provide to their child (George, Kaplan & Main 1996; Main, Goldwyn & Hesse 2003).

From an evolutionary perspective, the nurse could also be seen as a caregiver, someone her vulnerable and often distressed client seeks help from. Attachment theory addresses this evolutionary situation for both CFH nurses and clients. The question is, does the nurse's adult attachment state of mind indicate the type of caregiving she will provide her client, and will the nurse's caregiving exhibit behaviours similar to Mary Ainsworth's maternal caregiving behaviours, and how will the women clients respond?

Attachment researchers have continued to provide robust evidence over the ensuing six decades to support the notion that the early parent-child attachment relationship has an impact across the lifespan (Berthelot et al. 2015; Brown 2019; Coan 2018; Dozier et al. 2018; Granqvist et al. 2017; Hesse, Main & Goldwyn 2008; Slade et al. 2020; Wittenborn 2012). The premise of this research is to apply attachment theory to explore the nurse-client caregiving relationship. The proposed intent is to offer deeper insights into the unseen and unconscious behaviours of the nurses' caregiving and the clients' care-receiving behaviours.

The following chapter offers a brief overview of the study's context, followed by central concepts of the nurse-client caregiving relationship – as they relate to attachment theory – and the significance of the research for the nursing profession. The study's aims and the research questions are then presented, and the chapter ends with an outline of the thesis structure.

ATTACHMENT THEORY

THEORETICAL BACKGROUND

John Bowlby (1973/1998) conceived and developed attachment theory to explain a child's instinctive and strong motivation to seek and maintain proximity to a discriminated and preferred attachment figure, who is perceived as available and responsive to help the child cope with a separation or a potentially menacing situation (Bowlby 1969/1982, 1988c). The "child's tie to his mother" (p. 177) or attachment figure is understood to be an instinctive motivation to seek and maintain proximity, which is demonstrated by behaviours children direct towards their attachment figure in response to separation from them (Bowlby 1969/1982, p. 177).

When infants and children are separated from their caregivers, they use two groups of specific attachment orientational behaviours, signalling and approach, to restore and maintain proximity to their caregiver (Bowlby 1969/1982, p. 244). Before they are capable of locomotion, the child will use signalling behaviours such as calling, smiling, and crying to gain their caregiver's care and attention. Once the child is mobile, they continue to use signalling and add approach behaviours such as seeking, searching for and following their caregiver. By three years of age, attachment behaviours are less intense as children have developed more complex and competent abilities to gain and maintain proximity to the caregiver.

Bowlby's formulation included that the child's attachment and attachment behaviour is organised around their relationship with their caregiver; this consists of the quality of the caregiver's affiliative responses to the child's attachment behaviour and the ability to balance the child's need to explore their environment. Central to Bowlby's (1988b, p. 11) theory is the "secure base-safe haven" concept, defined as the primary caregiver's ability to provide a secure base or place from where the child may venture out, explore, play and discover their outside world, knowing that they will be welcomed back to the haven of their secure base, to be emotionally reassured protected and comforted when frightened, distressed or physically hurt. The secure caregiver provides a balanced, secure base and encourages the infant to explore, play, and socialise within proximity of crying or calling distance. When their child becomes frightened or distressed, their attachment system, which comprises the signalling and approach behaviours, is set in motion. The secure caregiver welcomes and encourages

the infant to freely return to the safe haven for reassurance and support. On the other hand, when the insecure caregiver's infant is distressed, they tend to be less flexible when responding to safe haven approaches. These caregivers may only offer their infant unpredictable access or actively block access to their safe haven (Ainsworth et al. 1978/2009; Bowlby 1969/1982, 1988a; Main, Kaplan & Cassidy 1985).

By the end of the first year, the child can organise their behaviour to recognise, withdraw and move away from any person or thing perceived as strange and fear-inducing and move towards the safe haven (Ainsworth et al. 1978/2009; Bowlby 1969/1982, 1980/1998; Sroufe & Waters 1977). At this point, the child and their caregiver have generally developed characteristic patterns of interaction. The child has internalised a working model of how they expect themselves to behave in relationship with their caregiver/s and how the caregiver is expected to behave towards the child (Ainsworth et al. 1978/2009; Bowlby 1969/1982; Bretherton 1990).

Bowlby (1988g, p. 129) explains that both members of the dyad have expectations about how the other behaves and cannot avoid responding to the anticipated behaviour of the other, regardless of whether the behaviour is expected to be satisfying or unsatisfying. No matter what patterns of behaviour the dyad have developed, the child internalises the interactions and constructs an Internal Working Model (IWM) of the caregiving relationship in the environment in which they live. The IWM guides the child to anticipate how the caregiver will treat them and helps guide their behaviour towards the caregiver (Bowlby 1988g).

Mary Ainsworth (1978/2009), a close colleague of John Bowlby, provided the first empirical evidence to support Bowlby's theory. Ainsworth developed a systematic laboratory condition to observe a caregiver and their 12 to 18-month-old infant in a stressful 20-minute "strange" situation that included two brief separations where the child is firstly left with a stranger and then on their own, with a reunion after each separation. This procedure is called the Strange Situation Procedure (SSP) (Ainsworth 1991; Ainsworth et al. 1978/2009). The procedure is designed to understand the individual responses of the caregiver and child to their reunion after a stressful experience.

The observation of an infant's behavioural responses to a specific caregiver at separation and reunion enabled Ainsworth and her colleagues to classify infant attachment in 12 to 18-month infants into

three organised categories, secure (B), insecure-avoidant (A) and insecure resistant or ambivalent (C). A fourth infant classification disorganised was later identified by Main and colleagues (Hesse & Main 2000). Ainsworth's laboratory SSP demonstrated that the infants' IWM were, in most cases, generally organised at 18 months of age (Ainsworth et al. 1978/2009; Main, Kaplan & Cassidy 1985) (Table 1.1). Ainsworth's empirical research supported Bowlby's (1988c) theory that the child's need for proximity to their caregiver constructs the child's IWM or representation of their caregiver. Ainsworth's central hypothesis that maternal sensitivity was a significant predictor of secure attachment was added to the IWM construct (Ainsworth et al. 1978/2009).

Table 1.1 also provides Mary Main et al.'s (2003) three organised adult attachment classifications, secure (F), insecure dismissing (Ds), insecure preoccupied (E) and the unresolved-disorganised (U) classification. Both child and adult attachment classifications include a rarer cannot classify for children's behaviours in the SSP and adult attachment interviews that do not fit any single classification (Hesse 1996; Hesse & Main 2006; Hesse & Van Ijzendoorn 1999b; Main & Hesse 1990).

Table 1.1: Adult Attachment Interview and infant 'Strange Situation' classifications (adapted from HHesse (1999)

Adult state of mind with respect to attachment*	**Infant 'strange situation' classifications**
Secure/autonomous (F)[2] Values attachment; coherent and collaborative discourse; balanced evaluation of relationship even if unfavourable; consistent description of experiences – not contradictory.	**Secure (B)** Child happy to explore room in the presence of caregiver. Shows they miss caregiver when they leave. More distressed when caregiver leaves a second time but seeks soothing quickly. Easily soothed on reunion and able to return to play and exploration.
Dismissing (Ds)	**Avoidant (A)**

[2] Each attachment classification is abbreviated with a single letter. Mary Ainsworth's infant classifications are A,B,C and Mary Main's adult classifications are D, E, F. The disorganised (D) unresolved (U) and cannot classify are abbreviated with their first letter

Dismisses, downplays, or denigrates attachment related experiences or relationships. Actively contradicts experiences when recalling memories. Poor memory for childhood. May idealise own parents. ult Attachment Interview may be very brief and not coherent.	Does not show they miss their caregiver. Has a paucity of play. Doesn't greet caregiver on their return and may actively turn away and focus on toys and environment. Does not reach for caregiver or make contact. Does not show distress.
Preoccupied (E) AAI may be very long and not coherent. May be angry, passive or even fearfully preoccupied with past and present attachment relationship and experiences. Uses long tangled, ungrammatical sentences. Very vague or has fearful intrusions throughout the interview	**Resistant or ambivalent (C)** Preoccupied with caregiver throughout the 'strange situation'. May be reluctant to leave the caregiver at all. Cries on separation, but hard to settle on reunion and unable to take comfort from caregiver. May seem angry or passive at caregivers attempts to engage child. Does not take an interest in toys or environment, as focussed on caregiver.
Unresolved/disorganised (U) Lapses in monitoring of reason, discourse or behaviour occur in speech, only when speaking about loss through death of a loved one, abuse or trauma. The individual will also have an organised category F, Ds or E.	**Disorganised (D)** Infant displays odd, brief, disoriented behaviour on reunion with a parent after a separation. May freeze, fall to the floor, back away or hide behind a chair. The infant will also have an organised category B, A or C.
Cannot Classify (CC) CC is used if there is no clear F, Ds or E organised patterns apparent across the AAI transcript. There appears to be two mental states represented e.g., Ds and E. Additionally there may be U, Ds and E. This is deemed a low coherence state of mind transcript	**Cannot Classify (CC)** For infants that do not fit the four 'strange situation' classifications. The infant may show a mix of organised patterns or exhibit an absence of organised patterns.

Both Bowlby and Ainsworth believed that when the caregiver is perceived to be consistently and predictably accessible and responsive to the child's communications and attachment behaviours, a mutual balance in the caregiver-child dyad is created (Ainsworth et al. 1978/2009; Bowlby 1988j). Further, when the child internalises the caregiver as helpful, loving, sensitive and cooperative, they will be confident to seek the caregiver's help.

Main, Kaplan & Cassidy (1985) followed up a cohort of 40 six-year-old children and their parents who had previously participated in an SSP study. The study aimed to compare differences between non-verbal attachment behaviours that signified early security or insecurity and the shift the six-year-old child with reasonable language skills had made to an internal representation of their secure or insecure attachment to their parent's (Main, Kaplan & Cassidy 1985). In this study, the children's representations of their attachment relationship with their parents were assessed using seven observational and discourse or language measures. The internal representations of the six-year-olds language skills were elicited during the administration of the Klagsbrun-Bowlby adaption of The Hansburg Separation Anxiety Test (Klagsbrun & Bowlby 1976). This test consists of a series of six photographs showing children undergoing mild to severe separations from their parents. The photographs were presented to the children, and they were asked to describe what each of the children in the photos was feeling and what they would do about the separation, using prearranged prompts to help the child if necessary (Klagsbrun & Bowlby 1976; Main, Kaplan & Cassidy 1985).

The results showed the children who were classified as secure during infancy were able to find ways to deal with the separation actively, had internalised their attachment figure as available and a self-representation as worthy of help and love and were confident to ask for help when needed, indicating an ongoing secure attachment to their attachment figure(s) (Bowlby 1988e; Bretherton 1990; Main, Kaplan & Cassidy 1985).

The children with insecure attachment were less able to manage the separation actively or did not know how to manage it at all. These children had internalised declining levels of availability in the attachment figure (Main, Kaplan & Cassidy 1985). When a caregiver is inconsistently available, unpredictably responsive, and insensitive to the child's attachment needs and is unable to find comfort in contact with their caregiver, the child is at risk of forming an insecure attachment. If this interaction pattern persists, the child constructs a self-representation as less worthy of help and less confident of their caregiver's availability and responsiveness when help is needed. Main et al (1985) concluded that the assessment of the six-year-old child's self-representation within the caregiving relationship determined whether they had an insecure-avoidant or ambivalent attachment classification. When insecurely attached children were asked to respond to experiences in which they were separated from their caregiver, their answers indicated they may have experienced rejection,

helplessness, excessive attention to feelings or downplayed feelings. A proportion of children had no clear response patterns or incoherent, negative, avoidant, hostile, or confused responses, suggesting a disorganised pattern of attachment (Bretherton 1990; Main 2000). Secure, insecure and disorganised self-representations or IWM's function at an unconscious level, are thought to be relatively stable but are open to change by either favourable or unfavourable experiences occurring throughout the ensuing year's (Bowlby 1969/1982, 1988d, 1988g; Bretherton 1999; Main, Kaplan & Cassidy 1985).

THE INTERNAL WORKING MODEL (IWM) CONCEPT

Over the first three years of the child's life, their IWM continues to be constructed within primary attachment relationships. Once the IWM is established, interactions tend to persist unless the caregiver adjusts or changes (either positively or negatively) their sensitivity, responsivity or psychological or emotional availability (Ainsworth et al. 1978/2009; Bowlby 1988g; Main, Kaplan & Cassidy 1985). As the child grows older and interacts with caregivers, their IWM becomes increasingly complex and generalised. Bowlby (1988g, p. 127) notes that the child's developing IWM belongs to both the child and their attachment figure for the first two to three years. After this time, the child's IWM gradually becomes their own. However, their ongoing interactions with their attachment figure continue to shape and update their IWM and form expectations of future relationships, such as relationships with teachers, close friends, and romantic partners (Bowlby 1969/1982, 1988j; Bretherton 2006; Bretherton & Munholland 2008).

Each of the three organised infant attachment patterns has a system of interaction that is readily identifiable in a research setting. The secure attachment pattern has a clearly recognisable pattern of behaviour, but insecure attachment has several patterns. In the SSP, certain caregivers were observed to allow their infants unrestricted physical and emotional access to themselves; their infants approached and explored as needed. This enabled the dyad to develop the ability to work in what Bowlby (1969/1982, p. 355) termed a "goal-corrected partnership". In such a partnership, the dyad is mutually adapted to see the other's point of view, collaborate on their goals and mutually negotiate their conflicts. This reciprocal self-other relationship promotes emotional understanding, empathy, social competence, and perspective-taking. The interactions are elaborated on, and the IWM is updated accordingly (Bowlby 1969/1982; Bretherton & Munholland 2008; Crowell, Treboux & Waters

2002). If no unfavourable events occur, the child will continue to flexibly revise and update their IWM and enjoy mutually satisfying relationships.

On the other hand, insecure caregivers tend to restrict their infant's physical and emotional access to them; for example, the avoidant infant does not approach their caregiver after an absence and attends to their environment rather than their caregiver. An ambivalent infant, in contrast, focuses intently on the caregiver but finds no consolation in the caregiver's attempts at soothing. Unlike a secure attachment, these relationships are generally not goal-corrected and have minimal reciprocity, collaboration or perspective-taking (Hesse 2016; Hesse, Main & Goldwyn 2008; Main 1991; Main 2000).

It was Bowlby's notion that the IWM develops from past experiences to predict future scenarios and possible behaviours. At different developmental stages, the child or adult draws on, interprets and evaluates experiences of their relationships and builds them into a model of current and anticipated relationships (Bretherton & Waters 1985; Main, Kaplan & Cassidy 1985). Primarily, in an attachment relationship, these representations of the self and other function outside of the individual's conscious awareness (Bretherton 2006; Bretherton & Munholland 2016; Bretherton & Waters 1985). These multiple sources of single event representations of the self and caregiver are gradually consolidated and generalised to other relationships (Main, Kaplan & Cassidy 1985). If these patterns persist into adulthood, the IWM becomes less amenable to revision and updating (Bowlby 1973/1998; Bretherton & Waters 1985; Treboux, Crowell & Waters 2004). In due course, anything incompatible with an existing IWM may be obstructed and defensively excluded from awareness. The person may become inflexible regarding their own or other people's emotional needs, cognitions, perspectives, and attachment needs (Bowlby 1988g; Bretherton & Munholland 2008; Fonargy et al. 2016; Steele & Steele 2008b).

Thus, an individual's IWM revises, rejects or assimilates new attachment-related information to the existing model, this guides reciprocal interactions in the present, and the revised attachment-related information anticipates future relationship interactions (Bretherton & Munholland 2016). Bowlby (1969/1982) explains that to be useful; the IWM must be continually consciously and unconsciously revised, modified and flexibly updated as the person reflects on past and current experiences. Ideally, the revised IWM is extended to existing and new experiences, interactions, feelings and events

related to significant people and the environment. This enables an individual to envision how future relationships can be enriched (Bretherton & Munholland 2008; Crowell, Treboux, Gao, et al. 2002).

As suggested by Main et al. (1985) these were event representations or single relationship experiences occurring multiple times from multiple types of interactions. These event representations formed the general IWM of how the child and primary attachment figure interact in their relationship. The child continues to actively create representational models of themself and their attachment figure in relationship to each other. The IWM is active when the child is with the caregiver and when the caregiver is absent. Thus, the child formulates representational rules for the organisation of their memory and attention to their attachment figure, self and the environment. These rules will allow or restrict access to an understanding of the self, their attachment figure, and their relationship. In the adult, the rules of their IWM are evident in how they organise and structure their thinking about attachment figures and their relationship experiences (van IJzendoorn 1995). The Adult Attachment Interview (AAI) (Main, Goldwyn & Hesse 2003) examines the spoken language of adults to determine the state of mind or internal representation concerning attachment.

The notion of IWMs being constructed through attachment experiences and changing over time with ongoing close relationship experiences reconceptualises attachment as an internal representation of attachment relationships and not merely a behaviour with related feelings; IWMs then involve memory, attention, and cognition. These representations also relate to individual patterns in language and how the mind has structured a model of relationships. Koren-Karie (2000) points out that there is no unequivocal association between childhood experiences and an adult's cognitive representations of these events. This is because the representation is a current state of mind regarding attachment experiences.

ATTACHMENT THEORY: A CRITIQUE OF THE RESEARCH FRAMEWORK

Attachment theory is suggested by Slade (2008) as informing clinical work rather than determining how it is carried out. Similarly, attachment theory is now recognised as a framework of preference for social work, psychiatry, neuroscience, social and developmental psychology, and animal sciences. Attachment theory informs research such as animal-human attachment, trauma, adverse childhood experiences, reflective functioning, risk and resilience, maternal neurobiology, neurobiology of infant attachment, and infant sleep (Adshead 2018; Arrazola & Merkies 2020; Bai, Crosby & Teti 2021; Bai

et al. 2022; Berthelot et al. 2015; Feldman 2016; Fonagy et al. 1994; Fonagy et al. 1991; Kim 2016; Moran et al. 2008; Murphy et al. 2015; Murphy et al. 2014; Schwartz 2015; Slade et al. 2005; Steele 2003; Thomson & Jaque 2017b; Witte et al. 2021). The wealth of research across these disciplines suggests that attachment theory offers a developmental perspective on the origins of an individual's well-being, risk, resilience, illness and disorder throughout the lifespan (Adshead 2018). Following the approach of other disciplines, attachment theory is well-suited to inform nursing research to expand knowledge and further enrich the nurse-client caregiving relationship.

During the 1960s, John Bowlby's attachment theory was not initially well-received and unsympathetically critiqued by his peers in the psychoanalytic community. He was criticised for abandoning Freud's theories and thought to be reductionist and mechanistic for placing the social bond between the attachment figure and child as the primary biological need (Fonagy 2001; Slater 2007). Vicedo's (2017) critique of "putting attachment in its place" focuses on Bowlby's early work from 1960 to the 1980s and disregards all subsequent attachment research and associated evidence generated over the last 40 years. Duschinsky et al. (2020) rightly points out that some of Bowlby's early work was wide of the mark, such as child-care being harmful, but Bowlby later corrected this earlier assumption as evidence to the contrary emerged (Friedman 2008; NICHD 2001). Despite this, Bowlby's theory laid the foundation for the empirical work of Mary Ainsworth's (1978/2009) Strange Situation Procedure and the instrument used in this research, the Adult Attachment Interview (George, Kaplan & Main 1996; Main, Kaplan & Cassidy 1985). Over the following decades, attachment research has multiplied, and many exploratory and innovative studies have been carried out. In the early years, these usually had small sample sizes that often demonstrated very impressive findings that would later show less significance. Critics of attachment theory have seized on this as a reason to dismiss the import of the earliest strong findings in Mary Ainsworth's (1978/2009) innovative Baltimore study of 26 families and Mary Main's (1985) ground-breaking Berkeley study of 32 families (Van Ijzendoorn & Bakermans-Kranenburg 2021). However, critiques do not consider that these same studies have been replicated thousands of times over the ensuing 40 years (Bakermans-Kranenburg & van IJzendoorn 2009). The analyses and meta-analyses carried out since have provided strong effect sizes to show the power of prediction for the intergenerational transmission of attachment, how parental unresolved trauma and loss places the child at risk of disorganised attachment, and the

effects of attachment on parental caregiving (Hesse & Main 1999; Lyons-Ruth & Block 1996; Van Ijzendoorn 1992; van IJzendoorn 1995; van IJzendoorn & Bakermans-Kranenburg 2008).

Attachment theory is a prominent and formidable theory and unavoidably open to critique often by those with inexact understanding. Sroufe (2021) submits that the theory is often oversimplified, misused or misrepresented, such as “attachment parenting”, with little meaningful advance. Attachment theory maintains its standing because it helps make sense of the fundamental importance of human relationships and the need for safety when confronted with a fearful situation. It remains an open theory, able to be revised and refined in light of new evidence.

ADULT ATTACHMENT RELATIONSHIPS

Attachment bonds continue throughout the lifespan; as Bowlby stated, “...from the cradle to the grave...” (1979/2010; 1988e, p. 82). In adulthood, love and support are often sought from a romantic partner (Feeney 2007; Feeney & Collins 2015). Adults form romantic attachments which are specific to a person and often enduring. In adults, attachment behaviour is usually active at lower intensity levels and not as prominent (Bowlby 1969/1982). Nevertheless, the need to gain proximity, love, and reassurance when anxious and distressed continues throughout the lifespan.

The IWM or representations of self with attachment figures, organised in childhood, stabilise over time and continue into adulthood (Crowell & Treboux 1995; Crowell, Treboux & Waters 2002). However, key features of attachment are common to each adult within the romantic partnership. Each partner seeks a safe haven when distressed and offers a potential secure base to “explore” new opportunities. Separation, divorce, and loss through death cause grief, protest and despair (Ainsworth 1991; Feeney 2004; Weiss 1991). In healthy romantic relationships, neither partner is perceived as stronger and wiser, although power imbalances may arise in the circumstances such as ill-health (Bowlby 1969/1982; Collins & Feeney 2000; Feeney & Collins 2004; Weiss 1991; Zeifman & Hazan 2008).

Individual differences in how adults respond to each other in relationships correspond to adults’ IWMs developed in infancy. Bowlby (1980/1998) pointed out that “personality” development is non-linear and interactional. Through childhood, adolescence and adulthood, the construction of internal

representations is influenced by new experiences encountered in relationships and the broader social environment. Memories, beliefs and expectations are perpetually being transformed, reinforced, re-interpreted and even blocked (Bretherton 1999; Collins, Ford & Guichard 2006; Crowell, Fraley & Shaver 2008; Main, Kaplan & Cassidy 1985).

Similarly to children, adults are understood to have either secure or insecure attachments. Unlike children, however, an adult's attachment may be harder to determine from their behaviour during a structured series of separation and reunion episodes such as the Strange Situation Procedure. Therefore, studies of adult attachment have focused less on observable separation behaviour and more on understanding individual differences in the adult's attachment state of mind.

MEASURING ADULT ATTACHMENT

Over the last 50 years, Bowlby's attachment theory has guided social and developmental psychology researchers to develop measures to categorise or dimensionalise adult attachment (Roisman 2009; Roisman et al. 2007). In 1985, Main, Kaplan and Cassidy (1985) undertook a study involving six-year-old children and their parents using a structured interview protocol called the Adult Attachment Interview (AAI) (Main & Goldwyn 1984). The AAI recorded parents' autobiographical memories of their early experiences; the transcripts were analysed using discourse analysis of their language, examining the internal representational level of speech and the inferred structures of the speaker's state of mind. After the first version of the AAI was developed in the 1980s, it was revised to the current edition (George, Kaplan & Main 1996; Main, Goldwyn & Hesse 2002, 2003). The current AAI scoring and classification system has been subjected to rigorous psychometric testing. Bakermans-Kranenburg and van IJzendoorn (1993) tested AAI reliability and discriminant validity by assessing whether the classifications were reliable across interviewers over two months. They also tested for factors unrelated to attachment, such as social desirability, autobiographical memory and intelligence quotient (IQ). The results showed that the AAI was stable and reliable over the two months and unaffected by the interviewer. Neither was the AAI affected by the non-attachment-related factors, IQ, autobiographical memory or social desirability, thus demonstrating good discriminant validity (Bakermans-Kranenburg & van IJzendoorn 1993; van IJzendoorn 1995). Further studies replicated, extended and supported the conclusions found in Bakermans-Kranenburg and van IJzendoorn (1993) initial study (Benoit & Parker 1994; Sagi et al. 1994).

Since it was introduced in the 1980s, the AAI continues to be a widely used, valid and reliable instrument to measure adult attachment state of mind. Bakermans-Kranenburg & van IJzendoorn (2009) reported on “The First 10,000 Adult Attachment Interviews: Distributions of Adult Attachment Representations in Clinical and Non-Clinical Groups”, and these interviews represented over 200 studies over the preceding 25 years. Hesse (2016) reported an additional 130 published studies comprising approximately 7800 AAIs between 2008 and 2015.

Finally, to use the AAI in research, a researcher must attend a two-week training institute with two certified trainers and ten or more participants. After this, the researcher must pass an 80% reliability check by coding 30 transcripts with agreement established by Mary Main and Erik Hesse.

The current AAI scoring system operationalises features of the speaker’s account (represented in the transcript): coherence, collaboration with the interviewer and overall coherence of mind. The scoring system thus provides the final indication of the speaker’s state of mind with respect to their attachment (Main, Goldwyn & Hesse 2003).

The AAI reflected developmental psychology's cultural constructs and methodological concerns and was the first scoring and classification system developed to measure adult attachment. Main and Goldwyn’s (1984) work on the AAI emerged directly from John Bowlby’s conceptualisation of IWMs (1969/1982) and Mary Ainsworth’s infant attachment classifications that emerged from the Strange Situation Procedure (Ainsworth et al.(1978/2009). The AAI is a 20-question semi-structured protocol intended to “surprise the unconscious” (Main 2000, p. 1077). The AAI takes approximately 45 to 90 minutes to administer in a non-clinical sample and longer in clinical samples. The AAI interview is recorded and transcribed verbatim. Certified coders then systematically analyse characteristics of each transcript, such as probable childhood experiences and state of mind with respect to attachment that allows assignment into one of the three main organised adult attachment categories and an alternate low-coherence-disorganised category if required. The three categories are ‘organised states of mind’ with respect to attachment – secure-autonomous, insecure-dismissing, and insecure-preoccupied. Two categories are ‘disorganised states of mind’ with respect to attachment – unresolved-disorganised (U) and cannot classify (C). The AAI scoring and classification system is the attachment measure used in this study and will be described more thoroughly in Chapter 4.

Alongside the narrative attachment measures such as the AAI, many self-report measures of adult attachment have been developed, which are quicker and cheaper to use in research. Both development and social-personality psychologists have emerged from shared theoretical traditions. However, both have measured attachment using differing methodological cultures (Roisman 2009). Social psychologists have developed attachment measures based on Ainsworth's secure and insecure classifications, conceptualising these as a two-factor construct consisting of avoidance and anxiety. This contrasts with Ainsworth's three-factor[3] classification system, Avoidant (A), secure (B) and ambivalent (C) (Mikulincer & Shaver 2010).

Self-report methods for measuring adult attachment had a different emphasis on studying adult attachment, which was dependent on social-personality researchers. Two different types of measures were developed, the three-category self-report (Hazan & Shaver 1987) and the four-category model (Bartholomew & Horowitz 1991a). These measures are intended to describe adult attachment behaviour, such as seeking comfort when distressed and confidently exploring the environment at other times; the effects of positive and negative self-perceptions and perceptions of others in relationships; attachment-related attitudes, memories and experiences in adult relationships (Mikulincer & Shaver 2010; Roisman 2009). Self-report measures are thought to provide a more contemporaneous understanding of a person's mental representations of their interactions within intimate relationships than the AAI. They measure adults' conscious evaluations of their closest adult attachment relationships while acknowledging that these conscious beliefs are grounded in unconscious thought processes (Crowell & Treboux 1995; Mikulincer & Shaver 2007a; Roisman et al. 2007). This method of measuring assigns individuals to categories or dimensions conceptualised as attachment styles.

Self-report instruments for measuring adult attachment have become increasingly sophisticated since the 1980s for assessing romantic, adolescent, therapist, health worker and managerial attachment relationships. For research purposes, self-report attachment assessments are often much easier and cheaper to administer than coded narratives such as the AAI. Recently, there has been an effort to

[3] Each attachment classification is abbreviated with a single letter. Mary Ainsworth's infant classifications are A,B,C and Mary Main's adult classifications are D, E, and F. The disorganised (D) unresolved (U) and cannot classify are abbreviated with their first letter

determine if some convergence exists between the AAI and self-report measures of attachment, but more work is required in this area (Roisman 2009; Roisman et al. 2007). In chapter three, self-reports of attachment are discussed and explained more thoroughly in the literature review. A complete discussion of three-category and four-category models and examples of self-report measures are provided.

The AAI was chosen for this research rather than a self-report measure because there is a substantial body of evidence to draw on when researching adult attachment state of mind; the AAI is understood to be the gold standard measure of adult attachment (Riem et al. 2012; Roisman, Fraley & Belsky 2007; Talia et al. 2019). Furthermore, the researcher must be a reliable coder of the AAI, establishing the research as reliable and valid.

The AAI was administered to all participants in this research. To administer and code the AAI, I was required to undergo certification. I gained four-way reliability in the system in 2015 after attending my first AAI institute in Minneapolis with Dr Sonia Gojman de Milan and Dr June Sroufe. I attended my second AAI Institute at the University of California, Berkeley, in 2018 with Dr Mary Main and Dr Erik Hesse (see Appendix 9). As a trained and reliable AAI coder, I scored and classified all 12 CFH nurses and the 13 women's transcripts. Eight of the 25 interviews in this research were second-coded by certified AAI instructor Dr Loyola McLean.

THE SIGNIFICANCE OF THIS RESEARCH TO NURSING

This research views the nurse-client caregiving relationship through the lens of attachment theory; in this instance, the nurse-woman relationship during admission to an RPS for a five-day stay. The investigation endeavours to address a gap in nursing knowledge by using Bowlby's concept of IWMs to systematically analyse the attachment state of mind of the CFH nurse and the woman in her care and how this affects their caregiving relationship.

Upon admission to the RPS, CFH nurses ask women to describe their life stories and ask questions regarding a history of childhood physical and/or sexual abuse, loss through death or divorce and their relationship with their mother. In many cases, the CFH nurses will listen to a woman's life history of attachment trauma and loss. Attachment researchers have proposed that the sensory, auditory and behavioural experience of being exposed to other's stories of trauma and loss has the potential to

trigger unconscious memories of their own and the woman's unresolved trauma and loss (Hesse & Main 2006; Kozlowska et al. 2015; Liotti 2006; Maunder et al. 2010). Evidence has shown that when an individual's attachment system is activated under moments of distress, they become disoriented or even frightened; if this occurs to a nurse, she may be unable to provide the sensitive and responsive type of caregiving the woman needs when she most needs it (Hesse et al. 2003; Solomon & George 2011). Under these circumstances, the woman may become fearful, and her attachment system activated so that she may become resistant to care, withdraw from the caregiving situation, or discharge herself early (George & West 1999; Liotti & Prunetti 2010). Recent research has found that the effect of an insecure and/or unresolved adult attachment state of mind of a helping professional is associated with a poor relationship with their client's (Hiles Howard et al. 2013; Murphy et al. 2014). More recently, nurses and psychologists have questioned whether nurses' attachment affects the nurse-client relationship and have used self-report attachment measures to investigate this possibility (Berry & Greenwood 2016; Hawkins, Howard & Oyebode 2007; Williams et al. 2017) (this will be addressed in the literature review Chapter 3). Nurses have consistently desired to improve nursing care, as the history of Florence Nightingale to the present will confirm. Each generation of nurses has taken the most appropriate new research evidence or theory and applied it to nursing practice to determine if nursing care can be improved. Currently, there is an explosion of research in medical, surgical, mental health, community, palliative care, child, adolescent and family nursing examining ways to ensure clients receive the best possible nursing care (Canli Özer et al. 2019; Christian 2019; Considine et al. 2017; Giménez-Díez et al. 2022; McMullen et al. 2017).

This research applies the accumulated evidence from the last 60 years of attachment theory research to examine the nursing practice of CFH nurses and the women that receive their care. The study intends to understand if their attachment state of mind affects their caregiving relationships. Like all good nursing research, the aim is to improve nursing care, subsequently improve the nurse-client relationship and ensure positive outcomes for the women and their children in their care.

AIMS OF THE RESEARCH AND THE RESEARCH QUESTIONS

This research aimed to describe the influence of nurses' attachment states of mind – and those of the women they care for – on nurse-caregiving relationships during a five-day residential stay at an RPS.

Six specific research questions were identified for this research:

1. Is there an association between a secure attachment state of mind and the quality of the caregiving and care-receiving relationship between the CFH nurse and the woman?
2. Is there an association between the CFH nurse's attachment state of mind and how she perceives her caregiving relationship with the woman?
3. Is there an association between the CFH nurse's attachment state of mind and how she provides care to the woman?
4. Is there an association between the woman's attachment state of mind and how she perceives her caregiving relationship with the CFH nurse?
5. Is there an association between an insecure attachment state of mind and the caregiving relationship between the CFH nurse and the woman?
6. Is there an association between 'disorganised' and/or 'cannot classify' attachment state of mind and the caregiving/care-receiving relationship between the CFH nurse and the woman?

THESIS OUTLINE

This chapter has presented an overview of attachment theory and the theoretical framework that guides this research. In the next chapter, to provide further context for this research, an account of nurse caregiving theory over the last 180 years is given and how Nursing has approached attachment theory. I also consider how the research presented here contributes to Nursing in greater detail. Chapter 3 reviews the literature addressing the association between nurses' attachment style and factors that may affect the nurse-client relationship or nurses' performance of the caregiving role.

This research is underpinned by a social constructionist epistemology which informed my choice of a qualitative methodology and a theory-building case study design for conducting this study. These choices are described in the Methods chapter (Chapter 4), along with the sampling approach, recruitment, ethical considerations and data collection and analysis procedures. The three instruments used in the research are then considered: the Adult Attachment Interview (AAI); the Nurse-Client Caregiving Relationship Interview, Nurse (NCCRI-N) and Client (NCCRI-P) versions; the Adverse Childhood Experiences Questionnaire (ACE-Q).

Results are presented in Chapters 5, 6 and 7. Chapter 5 details the distribution of AAI classifications, adverse childhood experiences (ACEs) and the demographics of the research participants. Comparison is made between the distribution of AAI classifications in this sample and the distributions in a published normative North American sample.

In Chapter 6, three illustrative case studies provide a deeper understanding of the AAI's secure and insecure classifications. The case studies are offered as exemplars of the effect of attachment state of mind on the caregiving relationship.

Chapter 7 presents the main case study, a CFH nurse and two women with whom she worked during their five-day residential stay. Each woman's story is featured, focusing on hearing the women's voices via excerpts from their narratives. This case study is presented to elucidate the effect of low-coherence state of mind on the nurse-woman caregiving relationship.

Chapter 8 discusses the findings, addressing the following issues: ACEs and trauma-informed care, unresolved loss from separation and divorce – perceived abandonment, low-coherence/cannot classify, implications of the three case studies for the nurse-client caregiving relationship, CFH nurses as wounded healers, implications, limitations and future research.

Chapter 9 reflects on the three stages of the research: early, middle and final.

Chapter 2: THE EVOLUTION OF THE NURSE-CLIENT CAREGIVING RELATIONSHIP AND ITS CONVERGENCE WITH ATTACHMENT THEORY

Nurses have traditionally been concerned with providing the best possible nursing care to individuals who need support when physically, mentally or psychologically unwell. This has been evident since Nightingale began her work in the Crimean war in the mid-19th century and continued into the 20th-century (Tourville 2003). More recently, health is viewed on a continuum of "states of well-being" (Eriksson, Ghazinour & Hammarström 2018). Throughout the 20th century, nurses developed theories of caregiving that incorporate the person being nursed, their health and well-being, the environment in which they are nursed and the nurse as an individual (Tourville 2003). These nursing theories place the nurse-client relationship as the central focus of improving the caregiving relationship (Henderson 1964; Johnson 1980; Leininger 1988; Peplau 1952/1991).

Similarly, attachment theory is primarily concerned with establishing a secure parent-child relationship to ensure that an individual's future relationships continue to be satisfying and productive (Bowlby 1969/1982, 1973/1998, 1980/1998). A sensitive, psychological, and emotionally available primary attachment figure promises a child a secure caregiving experience and a pleasurable relationship (Ainsworth 1969, 1985b).

Consequently, caregiving emerges as a central tenet of both nursing and attachment theory; accordingly, a convergence between the two theories could be said to exist. Both theories are primarily concerned with exploring ways to ensure the best possible caregiving relationship can be achieved between two people, generally one more vulnerable than the other.

Foth, Lange & Smith (2018) critique neoliberalism's recent emergence and its impact on quality nurse caregiving cannot be "...taken-for-granted..." (p. 2). Therefore, it is vital to be alert to the current realities and pressures on nurse caregiving, look to the past history of nurse caregiving and re-envisage how it can contribute to the present. This chapter will examine the history of nursing care from Florence Nightingale to the present, with the intent to understand how nurses have developed the caregiving relationship since Nightingale.

THE HISTORY OF THE NURSE-CLIENT CAREGIVING RELATIONSHIP

The emergence of modern nursing began with Florence Nightingale's early conceptualisation of nursing and the development of her 13 canons for nursing (Nightingale 1860, p. 12; Rahim 2013). Nightingale's 13 canons represent an environmental theory of nursing that has continued as the basis of nursing into the 21st century. Nightingale's Environmental Theory includes perceiving the client as a holistic being and manipulating the environment to provide the best possible conditions for health and well-being. For Nightingale, the nurse was a well-educated woman who provided quality nursing care rather than seeking to provide a cure. As this description of a nurse suggests, Nightingale believed nursing and medicine were distinct disciplines (Hegge 2013; McDonald 2018; Selanders 2010). As a result, the importance of environment and quality nursing care for the client is firmly embedded into nursing principles and practices; and nursing theory developed accordingly.

Nurse theorists continue to advance meaningful concepts of the nurse-client relationship, each grounded in a particular theoretical perspective (Henderson 1964; Leininger 2002; Peplau 1952; Travelbee 1971; Watson 1988). Following Florence Nightingale's lead, an early 20th-century nurse scholar Estrid Rodhe believed nursing was a calling and that women had an exceptional ability to care for and nurture their client's (Kangasniemi & Haho 2012). As a nurse educator, Effie Taylor (1934) described nursing as a science and an art. She believed nursing was more than simply curative or reparative, which was a physician's role. Taylor considered nurses to adopt a more holistic approach encompassing knowledge of human behaviour, social environments and preventative medicine. Jean Watson's influential nursing theory was expounded in her 1979 book, *Nursing: The Philosophy and Science of Caring* (Watson 1979/2008), which crossed all cultures. Like Nightingale, Watson believed nursing was primarily about caring rather than curing (McDonald 2018; Selanders 2010; Watson 1988). She developed a model of caring called *Caritas*, which included ten carative factors that cultivated sensitivity, a helping-trusting relationship, compassion, promotion of feelings, mutual decision-making and a supportive environment between the nurse and client (Cossette et al. 2005; Watson 1979/2008). Watson's model encompasses the essential qualities of a secure caregiver identified by Mary Ainsworth (1969; 1978/2009). Sensitivity, the recognition of feelings, support and trust, are all attributes that promote a secure parent-child relationship and the potential to establish the ideal nurse-client caregiving relationship.

In the 21st century, technology has profoundly affected how healthcare is delivered, but nurses continue to provide high-quality nursing care in both acute and community care settings. Clients' expectations of nurses are that nurses will have technical skills and expert clinical knowledge. Nurses in acute care settings demonstrate high-level technical skills by managing complex medical equipment to monitor clients. Nevertheless, they remain committed to their client as an individual (Benner, Tanner & Chesla 1992; Morrison & Symes 2011). Nurses understand that people with physical or psychosocial illnesses are frightened and expect their nurse to be comforting and an expert clinician. Travelbee (1963, p. 72) was very aware of the client's vulnerabilities when she wrote:

> *When the chips are down, however, and the patient is experiencing emotional problems and difficulties – is frightened, depressed, anxious or in despair – he will not be aware or care about our fine scientific concepts and principles, our beautifully performed nursing procedures ..., he will remember how we related to him during his crisis situation.*

Nevertheless, there is the potential for an overgeneralization and idealization of the nurse's role. A counterargument could be offered that some people with insecure attachment states of mind, may be fearful of, or hostile towards nurses out of exaggerated self-protection. Nurses should expect to encounter people with this fear.

Nurse theorists wrote extensively on the importance of establishing supportive nurse-client caregiving relationships, placing the client at the centre of the relationship, and identifying the attributes of a caring nurse (Henderson 1964; Orlando 1961/1990; Peplau 1952/1991). Virginia Henderson (1964) was also very aware of clients' vulnerabilities and the need for sensitive and responsive nurse caregiving and support when she introduced her theory, the universal concept of nursing, which had 14 components based on a person's basic needs. She recognised the need for psychosocial support and recommended that nurses try to get to know and understand their client and 'get into his skin' (1964, p. 67). Henderson advocated that nurses listen to their clients and their families constructively or therapeutically and, importantly, be available to their clients, again concepts echoing attachment theory and caregiving.

Hildegard Peplau's (1952) work, *Interpersonal Relations in Nursing: A Conceptual Frame of Reference for Psychodynamic Nursing,* characterised nursing based on her study of the nurse-client

caregiving relationship in the clinical setting, primarily in psychiatric facilities. A central feature of Peplau's theory is developing the nurse-client caregiving relationship with clients who have significant difficulties communicating and forming close relationships with others. Peplau theorised that clients expected nurses to fulfil six roles or functions in their caregiving relationship: stranger, resource person, teacher, leader, surrogate, and counsellor. Each role facilitated the nurse-client interpersonal relationship at both functional and psychosocial levels. The leadership role stands out in the contemporary context; Peplau termed it a "democratic role". Here the nurse-client relationship is one of collaboration and cooperation, sharing decision-making and participating in designing nursing plans. Peplau considered the nurse attributes required for this type of leadership to be respected for the dignity and worth of each individual.

Cheryl Forchuk (1994; 2001; 1998) investigated another facet of Peplau's theory of Interpersonal Relations, the four phases of the nurse-client caregiving relationship: orientation, identification, exploitation, and resolution. Forchuk (1994) examined the orientation phase where the nurse and client get to know each other. During this phase, the nurse gains trust listens, shows respect, provides dignity and responds unconditionally to the client's needs (Peplau 1952/1991, pp. 28-9). Forchuk's main finding was that both the nurse's and client's preconceptions of each other would determine how their caregiving relationship developed and eventually, the positive or negative outcomes of their hospital admission. Similarly to other nurse theorists, Peplau ascribes similar attributes to the nurse that Ainsworth noted in her longitudinal observations of mothers and their infant's (Ainsworth et al. 1978/2009)

Gwen Tudor (1952), a psychiatric nurse researcher, conducted fundamental participant-observation research in a psychiatric unit. Tudor wanted to understand how individuals integrated into social situations and maintained recurrent behaviour patterns when interacting with others. As a participant-observer, Tudor witnessed nursing staff (herself included) consistently avoiding a client with challenging behaviours. The client's difficult behaviours escalated in response to the nurse's avoidance, leading to further nurse avoidance. The ongoing cycle of nurse avoidance and escalating difficult client behaviour subsequently led to client neglect and isolation. The client withdrew from social situations, and their mental illness worsened. In this instance, the nurse's caregiving was rejecting and neglecting, evidence in attachment terms of insecure caregiving behaviours.

Tudor intended to investigate if she could alter the client's behaviour patterns and modes of participation in their caregiving relationship. She postulated that changed behaviour and improved involvement could increase the individual's sense of security, satisfaction, and self-esteem with positive outcomes for her mental health.

Being a participant-observer in the research was to observe and participate with the clients and nurses in the ward environment. While watching the nurse-client caregiving relationships, Tudor noticed that the nurses avoided a particular client who acted out, withdrawing from the nurses. When Tudor spoke with the client, she also experienced an inexplicable desire to keep her distance from the client. It was only through several discussion sessions with her supervisor that she understood why she avoided the client and could proceed with the research. If analysed from the perspective of attachment theory, Tudor was demonstrating her ability to reflect on practice and in attachment theory terms may indicate she had a secure attachment (Fonagy et al. 1998; Steele & Steele 2008a)

From this experience, Tudor made two discoveries. Firstly, she conjectured that the nurses might not be deliberately ignoring their clients; it was possible that collectively they had a pattern of responses to clients whose behaviour and emotional state they found socially challenging. Equally, the nurses may not have known they avoided very distressed clients they found difficult.

Her second more significant finding was the value of seeking reflective supervision to process her response patterns to clients and situations that challenged her ability to provide compassionate and supportive caregiving to her highly distressed client. Tudor recognised the importance of working through and understanding the reasons for her avoidance of the distressed client. With this knowledge, she supported the nurses on the unit to take the client's perspectives and guide them to provide more empathic and supportive caregiving to their clients. Reflective supervision is now considered best practice to support nurses in their clinical work and improve their capacity to identify emotions and motivations influencing the caregiving relationship. However, growth and discovery can only occur within a trusting relationship with an experienced supervisor.

NURSES AND ATTACHMENT THEORY IN PRACTICE

In the 1980s, nurse researchers began to explore maternal-infant attachment and ways to integrate this new theory into practice. In this early phase of attachment research, the interest was solely in the

mother and baby. Nurse scholars grounded their investigations into the mother-baby attachment relationship using nurse caregiving theories. Their study was done in parallel to the emerging works of Bowlby, who had published his three-volume *Attachment and* Loss series (Bowlby 1969/1982, 1973/1998, 1980/1998), the last volume of which was published at the beginning of the 1980s. Three examples of this early work are considered below.

Reva Rubin's (1976) four psychological tasks of pregnancy, most notably "binding in", was commonly cited to support the formation of maternal-infant attachment. Cranley (1981) developed a 24-item scale using Rubin's psychological tasks to measure maternal attachment in pregnancy. The results of Cranley's scale supported the existence of maternal-infant attachment behaviours towards the foetus; however, her findings based on the developmental tasks of pregnancy were difficult to interpret, and the scale had moderate validity. Based on Rubin's theory, Mercer and Ferketich (1994) used Cranley's scale to examine differences between experienced and inexperienced mothers' attachment from the second or third trimester to eight months postpartum. Mercer and Ferketich, too, had difficulty measuring attachment and finding differences between experienced and inexperienced mothers' attachment. Rubin's theory did not consider the nurse-client caregiving relationship. Nevertheless, this began nurses' exploration of attachment as a concept.

Goulet et al. (1998) undertook a concept analysis of parent-infant attachment to address a "lack of a clear definition of attachment". They noted that "very few factors have been singled out as significantly associated with the development of a strong link between parents and their baby" (p. 1072). This analysis drew predominantly on nursing literature as well as briefly citing Bowlby. From the research, Goulet et al. developed a conceptual model that defined the attributes of parent-infant attachments. These attributes are proximity, commitment and reciprocity and include antecedents and consequences of attachment. Goulet et al. concluded that nurses need "...to find new ways to envisage the concept..." of attachment (Goulet et al. 1998, p. 1079).

Johnson's (1980) Behavioural System Model for Nursing took the theoretical view of "...the client as a behavioural system..." (p. 207). Johnson's model shifted towards behavioural systems; the system includes seven functioning, self-maintaining subsystems that enable people to remain in balance and attain their goals. An imbalance in these subsystems creates a state in the individual that can be ameliorated by nursing care. Johnson asserted that the subsystems are genetically programmed and

emerge phylogenetically. The first, most critical, developmental subsystem to emerge is the attachment or affiliative subsystem. This subsystem fulfils the need for survival by, amongst other things, the formation of strong social bonds. Johnson credited this first subsystem to the work of Ainsworth (1964). The second subsystem, dependency, fulfils the need for assistance, approval, and protection. Johnson's other five subsystems, the aggression/protective subsystem, pertains to the self, so unrelated to attachment – and ingestive, eliminative restorative and sexual are not associated with the behavioural attachment system. Nevertheless, Johnson acknowledges attachment behaviour and the mother-child dyad as a growing area of research and appears to be the first nurse theorist to incorporate contemporary attachment theory. In summary, late 20th-century nurse theorists were hesitant to assimilate Bowlby's attachment theory into nurse-client relationship theories.

Moving into the 21st century, nurse scholars began turning away from nursing theory-based conceptualisations of attachment in nurse caregiving and clinical practice and toward Bowlby's theory of attachment. However, Rubin's "binding in" psychological concept remained popular, as Mercer and Walker (2006) demonstrated in their literature review. Rubin's theory remains popular because it raises awareness of women's psychological and emotional tasks during each trimester of her pregnancy. Over the last 20 years, a continued interest in studying mother-infant attachment has continued. Neonatal intensive care nurses have established a secure early mother-infant attachment for premature and very sick infants (Chen et al. 2019; Franklin 2006; Karl et al. 2006; Kim et al. 2019; Phianching, Chaimongkol & Pongjaturawit 2020; Walker 2013). Other nurse scholars have examined attachment through literature reviews (Brimble, Anstey & Davies 2019; Kearvell & Grant 2010; Mathews et al. 2019), offering models for clinical practice (Steelman 2019; Sullivan et al. 2013; Wheeler 2011) and continuing education articles (Hornor 2019).

More recently, nurses and psychologists have been growing interested in investigating nurse and client attachment styles using self-report attachment measures. These researchers have investigated how nurses' attachment may affect their capacity to empathise, regulate emotions, the potential for burnout, and communication skills, and how these factors impact on their nurse-client caring relationships (Aiyegbusi & Kelly 2015; Bar-Sela et al. 2018; Barr 2020; Golia et al. 2017; Harding et al. 2015; Kaya 2010; Lee & Song 2015; Leinweber et al. 2019; Salehi, Gholamzadeh & Javadi 2020).

The relationship between nurses' attachment styles and the nurse-client relationship is examined in greater depth in the narrative review presented in Chapter 3 of this thesis.

CHILD AND FAMILY HEALTH NURSES

The primary concern of child and family health (CFH) nurses is the well-being of children from birth to five years. They achieve this important work by working in partnership with parents, providing professional guidance and relationship-based caregiving to parents and their infants during the first five years of a child's life. CFH nurses are commonwealth registered nurses with a university bachelor's degree (or equivalent) and must have an additional postgraduate qualification in child and family health nursing. Most CFH nurses have another post-graduate certificate, diploma and/or master's qualifications in the following specialties: midwifery, adult or infant mental health, counselling, lactation consultancy and paediatrics (Dahlen et al. 2018; Grant, Mitchell & Cuthbertson 2017; Rossiter et al. 2017; Schmied et al. 2014).

CFH nurses have a long history of caring for women and infants in Australia (Briggs 2006-7; Grant 2013; Shepherd 2011). In the early 20th century, 'home visitors', predecessors of today's CFH nurses, visited women and babies in their homes to encourage breastfeeding and educate women in mothercraft skills, health and hygiene to reduce infant mortality (Armstrong 1939). Residential Parenting Services (RPS) were established in Australia in 1918 and continue into the 21st century. The RPS are government-funded tertiary-level health services providing five-day and four-night residential stays for parents, usually, the mother, infant, toddler or sometimes both children, who may attend (Fowler et al. 2016; Priddis et al. 2018; Rowe & Fisher 2010). The parents can self-refer to the RPS or be referred by their medical practitioner or community CFH nurse. A wide range of practical parenting and psycho-educational support programs are offered by a nurse-led team of CFH and enrolled nurses, a multidisciplinary team of social workers, psychologists and medical practitioners (Kohlhoff et al. 2020; Wightman, Hutton & Grant 2021). The. CFH nurses work as a team and care for the women together, carefully ensuring that they meet the women's needs as required. Each shift, the nurses meet up to discuss their concerns about the women and the women's triumphs. Team nursing is used rather than "patient assignment" because of nurse shortages. Thus, team nursing ensures all women get the care they need.

The parents who seek help and stay at RPS usually experience significant parenting challenges and generally present with an infant with dysregulated sleep patterns, feeding difficulties or persistent crying. Frequently women may also experience maternal exhaustion, sleep deprivation and mild to moderate postnatal depression and anxiety (Dahlen et al. 2019; Fowler et al. 2019; Fowler et al. 2016; Priddis et al. 2018). The CFH nurse spends approximately two hours with the woman and her infant when she arrives for her admission. Sometimes her partner stays for the admission as well. They tour the residential unit during this time, and the woman is shown her accommodation. The formal procedure includes a complete psychosocial history of the woman and her infant, an infant development check, and the CFH nurse will observe the woman feed her baby either a breast, formula or solid food when the baby is hungry. If the woman and baby feel ready, the nurse will carry out an NCAST Parent-Child Interaction feeding observation (Oxford & Findlay 2013) to determine the strengths the woman brings to her caregiving and suggestions the CFH nurses can make to enhance and support caregiving. The CFH nurse and woman will work out the goals of her stay and what she would like to achieve before discharge. These goals will be reviewed each day and modified as needed.

CFH nurses' roles have evolved to incorporate the psychosocial health needs of mothers and their infant's (Sims & Fowler 2018). In the 21st century, this role has been increasingly informed by attachment theory and the neuroscience of early brain development (Staples 2016). Embracing this knowledge has highlighted the urgent need, in some cases, for early intervention in the parent-infant relationship (Priddis et al. 2018; Priddis, Keedle & Dahlen 2018). Further, this knowledge has alerted CFH nurses to the psychosocial health needs of men as an emerging health issue (Fletcher et al. 2011; Psouni & Eichbichler 2020; Wells & Aronson 2021).

Currently, CFH nurses play a pivotal role in providing universal preventative health care to the community, such as well-baby health check centres, immunisation, school health and home visiting for new parents. CFH nurses also provide targeted health care to the parent-infant dyad in the community setting, including longer-term home-visiting programs and RPS (Dahlen et al. 2019; Schmied et al. 2014; Wightman, Hutton & Grant 2021). This work is essential and often complex, and CFH nurses bring specialist skills and knowledge to this role to achieve the best possible outcomes for the parent-infant dyads (Fowler et al. 2015; Fraser, Grant & Mannix 2016a; Wightman, Hutton &

Grant 2021). CFH nurses now recognise the importance of moving away from traditional practices by integrating attachment theory and the neuroscience of early brain development while continuing standard screening and surveillance, child development and perinatal and infant mental health screening (Priddis, Keedle & Dahlen 2018; Sims & Fowler 2018; Staples 2016). This shift in the CFH nursing knowledge base requires CFH nurses to obtain, assimilate and transfer to practice a vast body of new knowledge (Fowler et al. 2015; Grant, Mitchell & Cuthbertson 2017; Wightman, Hutton & Grant 2021).

THE FAMILY PARTNERSHIP MODEL

The concept of partnership to describe the nurse-client caregiving relationship has been systematically investigated by nurses over the last 30 years (Bayntun-Lees 1992; Hook 2006; Morse 1991a; Pembrey 1984). Nurses' conceptualisations of nurse-client partnership encompass multiple aspects, including the nurse's attributes and elements required for a successful partnership (Carol Ramos 1992; McQueen 2000; Shanley, Jubb & Latter 2003). Twenty years ago, CFH nurses recognised the concept of partnership and its relationship to the nurse-client caregiving relationship (Fowler, Rossiter, et al. 2012; Rossiter et al. 2011). Establishing a partnership may be particularly beneficial when working with women and their infants with psychosocial complexity and contributes an additional psychotherapeutic element to the nurse-client caregiving relationship (Davis & Day 2010; Kelly 2001; Rogers 1957; Rossiter et al. 2011). To address the needs of these families and enable the CFH nurses to work in a partnership caregiving model, the Family Partnership Model (FPM) (Davis & Day 2010) was introduced into CFH nursing practice (Keatinge, Fowler & Briggs 2007). CFH nurses who implemented the FPM model in their practice report found that establishing a trusting partnership with the family was the first step towards a positive caregiving relationship with parents (Fowler, Rossiter, et al. 2012; Hopwood & Nerland 2019; Rossiter et al. 2011). Establishing a positive, trusting caregiving relationship can improve care outcomes and embrace attributes of a secure caregiving (Ainsworth 1969; Berry et al. 2016; Fowler et al. 2019; Hopwood et al. 2013).

At first, when implementing FPM, many CFH nurses found it difficult to let go of being an "expert" who provides advice and all the answers (Bidmead, Davis & Day 2002; Keatinge, Fowler & Briggs 2007). Some nurses were reluctant to lose the inflexibility that comes with control, authority and power traditionally attached to their position (Fowler, Rossiter, et al. 2012; Ramjan 2004). Over time, FPM

has achieved greater acceptance in CFH nurses' practice. As the knowledge and skill required for working in partnership with parents evolve, the research examines how aspects of FPM are integrated into the practice (Fowler, Rossiter, et al. 2012; Fowler et al. 2016; Kardamanidis, Kemp & Schmied 2009; Rossiter et al. 2012). The FPM describes the caregiving relationship between the nurse, parent, and infant. The FPM is the nurse-client caregiving relationship conceptualised in another way and offers similar nurse attributes that nurse theorists have historically ascribed to.

The FPM offers another formulation of the nurse-client caregiving relationship, assuming a new body of knowledge and incorporating relationship and communication concepts from the psychology and psychotherapy (Kelly 1991; Rogers 1951). Bidmead, Davis and Day (2002), the originators of the FPM, characterise partnership using the terms "working in partnership" and "the Helping Process" (Davis & Day 2010, pp. 263-64). Contemporary CFH nurse researchers have offered alternative ways to describe the partnership, such as the "working relationship" (Shepherd 2011), "working relationships" (Dragon 2017; Fraser, Grant & Mannix 2016b), "trusting/trust relationship" (Clendon & Dignam 2010; Kardamanidis, Kemp & Schmied 2009), "relationship building" (Heaman et al. 2007) and "mother-nurse relationship" (Shepherd 2011). Again, all of these attempt to define the nurse-client caregiving relationship.

As nurse theorist has done over the past 180 years, Davis and Day (2010, p. 51) list the "good helper" characteristics: empathy, genuineness, and respect. These characteristics, a central feature of the FPM, derive from Carl Rogers (1951, 1957) necessary conditions for a therapist to help bring about personality change in a client. Rogers (1951) calls these attributes congruence, unconditional positive regard and empathy, yet again recalling the characteristics of a sensitive and available secure caregiver.

The FPM calls these necessary conditions 'helper characteristics'. Peplau (1952, 1992) interpreted the nurse-client caregiving relationship as an interpersonal process in which the nurse brings professional expertise, and the client brings knowledge of their own needs. Peplau further describes characteristics of the nurse, such as frustration, anger and aggression that may damage the caregiving relationship (D'Antonio et al. 2014). These consistent characteristics may be perceived through an attachment lens as insecure caregiving.

The FPM qualities, genuineness and humility are aspects of Rogers' congruence. Characteristics that relate to congruence can be found within nursing research. "Trust", or "building trust", are the most frequently used terms to describe developing the nurse-client relationship (Clendon & Dignam 2010; Dragon 2017; Fowler, Rossiter, et al. 2012; Fraser, Grant & Mannix 2016b; Heaman et al. 2007; Kardamanidis, Kemp & Schmied 2009; McQueen 2000; Rossiter et al. 2012; Shepherd 2011). Genuineness is mentioned less frequently, although it is part of the FPM terminology (Fraser, Grant & Mannix 2016b; Rossiter et al. 2012; Shepherd 2011); and reciprocity (McQueen 2000) and consistency (Rossiter et al. 2012; Shepherd 2011) have also been identified. The introduction of the FPM to contemporary CFH nurse practice has initiated considerable reflection on the nurse-client caregiving relationship and the attributes the CFH nurse brings to the relationship.

As the history of nurse caregiving has shown, an essential aspect of any nurse-client caregiving relationship is respect, and so it is with the FPM (Davis & Day 2010, p. 112). In Rogers' (1957) terminology, respect can be seen as equivalent to unconditional positive regard. Respect is conveyed by engaging with the client with warmth and non-judgemental acceptance of them and their experience. Peplau (1952, p. 28) discusses the importance of responding unconditionally to her clients during the orientation phase of her model. CFH nurses use the term "respect" to describe working in partnership (Dragon 2017; Fowler, Rossiter, et al. 2012; Heaman et al. 2007; Hopwood, Clerke & Nguyen 2018; McQueen 2000; Shepherd 2011) and warmth (McQueen 2000; Rossiter et al. 2012). Travelbee (1963) advocates that nurses take a non-judgemental approach, a term frequently found in FPM nursing research (Clendon & Dignam 2010; Fraser, Grant & Mannix 2016b; Hopwood, Clerke & Nguyen 2018; Kardamanidis, Kemp & Schmied 2009; Rossiter et al. 2012).

A fundamental component of a successful nurse-client caregiving relationship is showing empathic concern. The FPM includes empathy as "a fundamental requirement of helping" (Davis & Day 2010, p. 117). CFH nurses consider empathy an essential quality (Fägerskiöld & Ek 2003; Heaman et al. 2007; Kardamanidis, Kemp & Schmied 2009; McQueen 2000; Rossiter et al. 2012). Empathy involves the nurse being emotionally available to the client, as well as sensitive, responsive and compassionate to their difficulties while being fully aware that their own experiences are different to their client's (Clendon & Dignam 2010; Fowler, Lee, et al. 2012; Fraser, Grant & Mannix 2016b; Rossiter et al. 2012).

Empathy is identified by Travelbee (1964) as similar to rapport and advises nurses to build rapport when establishing their caregiving relationships. While Travelbee (1964), writing almost 60 years ago, used the term “sympathy” as we use the word “empathy” today, she associated sympathy with the nurse’s ability to show compassion for the client. Even though the FPM is firmly grounded in two psychological theories, Carl Rogers (1951) *Client-Centred Therapy* and George Kelly’s (1991) *The Psychology of Personal Constructs*, its association with the principal theories of the nurse-client caregiving relationship is evident.

As nurse-client caregiving relationship theories have evolved over the last 180 years, a convergence has occurred between distinguishing the qualities of the secure caregiver in a parent-child attachment relationship and the positive attributes of an enriching nurse-client relationship. Even though the child entirely depends upon the parent to form their attachment relationship, their relationship develops through the moment-by-moment caregiving interactions, the quality of those caregiver behaviours, and how the parent responds to their child’s distress (Ainsworth 1969; Bowlby 1988c; Main 2000). Bowlby emphasised that attachment behaviour is characteristic of all individuals from “the cradle to the grave” (1988e, p. 82). Thus, the infant, child and adult client is dependent and reliant on the nurse in moment-by-moment caregiving interactions. Secure caregiving attributes such as sensitivity, contingency, empathy, and psychological and emotional availability are the order of the day not only for children dependent on their parents but for adults who are less able to cope when they are physically, psychologically and/or emotionally unwell (Bowlby 1988j).

The major foundational nursing theory has been caregiving. Each generation of nurse theorists has embraced current research knowledge as it emerged and applied it to the nurse-client caregiving relationship. The pioneer of nursing and founder of modern nursing, Florence Nightingale, was the first nurse researcher. Using her environmental nursing theory, she advanced ground-breaking initiatives such as health promotion, hospital reforms, and improved nutrition and sanitation (Hegge 2013; McDonald 2018; Selanders 2010). Virginia Henderson’s (1980) Need Theory described nursing as both an art and science and proposed ways nurses could preserve the “essence of nursing” by caring for their client’s needs, providing emotional support and promoting independence. Importantly, Henderson’s theory acknowledged the advancing technological age, embraced the importance of

multiple sources of emerging scientific inquiry, and made decisions based on research findings (Henderson 1964, 1978/2006, 1980, 1982).

Jean Watson (1988, 2002) proposed a shift toward reclaiming the caring values of the nurse-client caregiving relationship and making caring central to nursing knowledge. Watson presented transpersonal caring, which she believed *"...attends to the human centre of both the one caring and the one being cared for..."* (1988). In developing her new theory of caring, Caritas, Watson used the concepts "intentionality" and intersubjectivity to describe focusing and centering on the client's dignity and humanity when offering caregiving (Watson 1988, 2002). Both concepts, intentionality and intersubjectivity, emerged from ethological, attachment and developmental psychological theories and described the development of social engagement and intentional sharing between the infant and caregiver (Emde et al. 1991; Feinfield et al. 1999; Mundy, Kasari & Sigman 1992; Shultz & Wells 1985; Trevarthen 2001).

Continuing the tradition of how nurses develop knowledge of nursing care, this research applies another psychological theory, attachment theory, to form a deeper understanding of the nurse-client caregiving relationship. This research focuses on discovering how the nurse's and woman's attachment state of mind affects their caregiving relationship during a five-day and four-night RPS residential stay. My research draws on attachment theory and merges it with 180 years of nursing research to further enrich nursing knowledge.

Chapter 3: A Narrative Review of Nurse Attachment Style and Caregiving Relationship

The quality of the nurse-client relationship has been a primary concern for the Nursing profession since Florence Nightingale wrote her seminal work, *Notes on Nursing* (1860). Nurses have always understood that the quality of their care has influenced client outcomes and the restoration of good health and well-being (Fowler et al. 2019; Guest, Bunce & Johnson 2006; Peplau 1952). Over the last 100 years, nurse scholars have advanced theories of nursing care that inform practice resulting in improved care outcomes (Benner 1984; Henderson, France & Blampied 2011; Henderson 1964; Leininger 1988; Peplau 1997; Rogers 1951; Travelbee 1971; Watson 2011).

Over the last 60 years, attachment theory (Ainsworth 1985b; Bowlby 1969/1982) has emerged as a central framework for guiding mental health and social service theory and practice. Credible evidence has emerged that suggests that an insecure or unresolved attachment state of mind renders adults more vulnerable to such difficulties as stress or burnout in the workplace, mental illness, a lack of empathy, are less likely to ask for help and poor coping strategies, with the potential to affect relationships (Barr 2020; Basharpoor, Narimani & Atadokht 2015; Berry & Greenwood 2016; Hawkins, Howard & Oyebode 2007; Kokkonen et al. 2014; Williams et al. 2017). Recently nurse researchers have begun to consider whether nurses' attachment state of mind may affect the nurse-client caregiving relationship (Golia et al. 2017; Halama & Pitel 2016; Harding et al. 2015; Salehi, Gholamzadeh & Javadi 2020).

As this research was a focused study of nurses, this literature review aimed to demonstrate that there was and is a significant gap in the literature to show nurses have infrequently initiated, taken the lead, and accomplished studies examining the effects of adult attachment state of mind on the nurse-client caregiving relationship. Therefore, only studies with nurses on the research team are included in the review.

This narrative review aims to examine whether nurses' attachment style is associated with factors that influence their caregiving relationships and the performance of their role.

The PICO method was used to clarify the research question to be addressed by this review. This method required the identification of the Population, Intervention, Comparison, Outcome (PICO) (Considine et al. 2017; Frandsen et al. 2020). These were:

P nurses

I attachment style affects

C secure or insecure

0 the caregiving relationship.

The research question for this review was: What is the association between nurses' attachment representations, measured by self-report and discourse attachment measures, and factors affecting the nurse-client caregiving relationship or the nurse's performance in their caregiving role? Clients were not included in the review as most studies focused solely on nurses' attachment style and potential impact on caregiving.

REVIEW METHODS

A "narrative review" methodology was used to guide the review of the selected articles (Dawson et al. 2013). This method principally uses language rather than statistical methods to explain and summarise the selected studies' findings (Dawson et al. 2013; Popay et al. 2006; Ryan & Group 2016). This method provides procedures for developing and ordering themes and identifying study patterns.

SEARCH STRATEGY

An initial search of the literature was conducted in the Scopus, CINAHL, Academic Search Complete and Google Scholar electronic databases using the initial key terms "child and family health nurse", "nurse home visitor", "mental health nurse", and "nursing", each combined with the AND operator. This search yielded very few journal articles. Broader search terms were applied, and the process was repeated using "nurse" and "attachment", and "nurse-patient" and "attachment", "caregiving", and "allied health", and "working alliance" once again combined with operator AND. This search retrieved 880 articles (see Figure 3.1 Search Strategy).

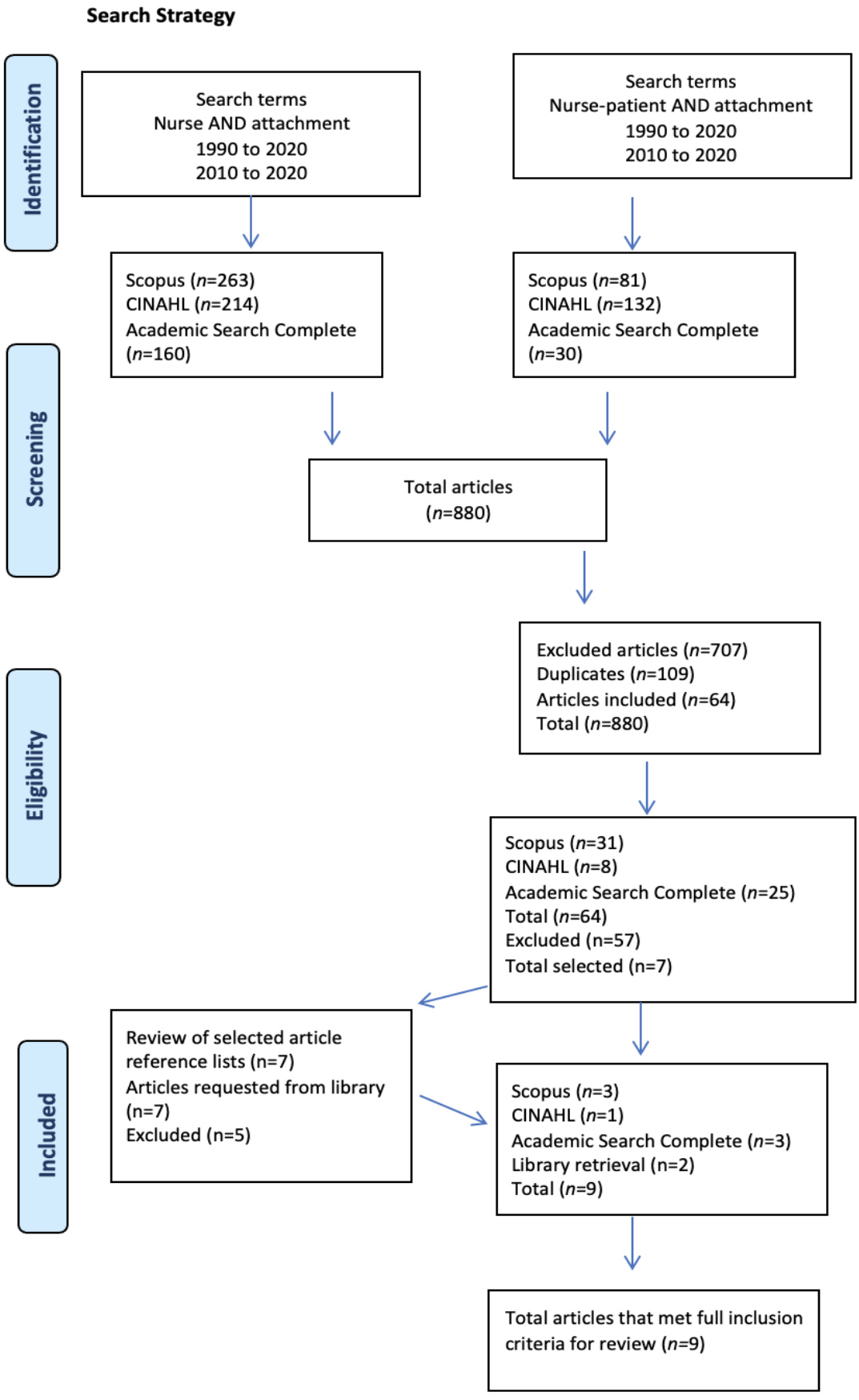


Figure 3.1: Search Strategy

INCLUSION CRITERIA

Criteria for inclusion of research in the review were:

1. conducted by nurses
2. addresses nurses' attachment style or attachment state of mind
3. addresses a nursing issue with the potential to impact the nurse-patient relationship or nurses' performance in their caregiving role
4. uses an adult attachment measure, either self-report or narrative-based
5. written in the English language

EXCLUSION CRITERIA

Criteria for exclusion of research in the review were:

1. research conducted by other health professionals
2. focused solely of the working alliance without including nurses' attachment
3. focus on mother-infant relationship only
4. explorations of nursing concepts using attachment theory
5. theoretical papers, scholarly articles and narrative reviews
6. study did not use a self-report or discourse analysis measure of attachment
7. when the Critical Appraisal Skills Programme (CASP) checklist tool was used, and the article was found to be of poor methodological quality

The four databases retrieved 880 articles from a wide range of nursing specialties, including maternal, child and family health, neonatal intensive care (NICU), midwifery, mental health nursing, and nurse practitioner practice. Research in psychology and medicine was also captured. In the first round of exclusions, the abstracts of the 880 articles were scrutinised to remove duplications or reports that did not fit the inclusion criteria. Another 64 articles were identified that both fully and partially met inclusion criteria, these were retrieved for closer examination to determine suitability for the review.

The first 12 articles to be excluded were research conducted by psychologists and nurses focusing solely on the working alliance without including nurses' attachment. Another 14 studies examined the mother-infant relationship during pregnancy, with premature infants, during the early postnatal period,

and in early infancy. These 14 studies were because the mother-infant attachment relationship was not the focus of this review. Another 13 articles were excluded because they explored a nursing concept such as trust or empathy using attachment theory as a framework. Seventeen articles were excluded because there were either theoretical, narrative reviews did not use a self-report or discourse attachment measure or when the Critical Appraisal Skills Programme (CASP) checklist tool was used, the article was found to be of poor methodological quality. Seven articles from the 64 remained for inclusion in the review.

A manual search of the reference lists in the seven articles was made to find other research suitable for inclusion in the review; two more relevant articles were identified, bringing the final number of articles to nine for this review. The remaining articles were reviewed using The Critical Appraisal Skills Programme (CASP) checklist and included in the table of evidence. The supervisory panel checked the reliability of the selection process against the inclusion and exclusion criteria.

QUALITY ASSESSMENT

The Critical Appraisal Skills Programme (CASP) checklist tool for Cohort Studies was used for appraising all nine studies in this review (CASP 2021; Chenail 2014; Hannes, Lockwood & Pearson 2010). Three broad issues are considered during the appraisal of the cohort studies: Are the results valid; What are the results? And will the results help locally? The CASP Cohort checklist does not have a scoring system; rather the 12 questions are designed to help the reviewer systematically think through three issues when appraising a study. These are: Are the results valid? What are the results? Will the results help locally? This guide the results of the review.

DATA EXTRACTION AND SYNTHESIS

A narrative review methodology was used to guide this review of nine studies. Each article was evaluated using the CASP checklist; an example of one CASP appraisal is included in Appendix 1: CASP Example. Each of the appraisals was reviewed by my supervisory panel. I then wrote discussions of the articles on which this literature review is based.

DESCRIPTIVE CHARACTERISTICS OF THE STUDIES

Psychologists led eight of the research projects described in the articles, with nurses included in the research teams (Basharpoor, Narimani & Atadokht 2015; Berry & Greenwood 2016; Berry et al. 2008;

Halama & Pitel 2016; Hawkins, Howard & Oyebode 2007; Khodabakhsh 2012; Kokkonen et al. 2014; Wainwright et al. 2021). One project was led by a paramedic (Williams et al. 2017).

One study was conducted in Australia (Williams et al. 2017), one in the Slovak Republic (Halama & Pitel 2016), two in Iran (Basharpoor, Narimani & Atadokht 2015; Khodabakhsh 2012) and five in the United Kingdom (Berry & Greenwood 2016; Berry et al. 2008; Hawkins, Howard & Oyebode 2007; Kokkonen et al. 2014; Wainwright et al. 2021). The studies were done in Iran, the United Kingdom and the Slovak Republic, which may reduce cultural bias.

The locations of the studies were hospital settings such as emergency centres (Basharpoor, Narimani & Atadokht 2015), psychiatric/mental health services (Berry & Greenwood 2016; Berry et al. 2008; Wainwright et al. 2021), palliative care (Hawkins, Howard & Oyebode 2007), paediatric unit in a general hospital (Halama & Pitel 2016), geriatric and palliative care centres (Kokkonen et al. 2014) and university nursing programs (Khodabakhsh 2012; Williams et al. 2017). In five of the eight studies, the majority of nurse participants were female and worked in paediatrics, geriatric care, hospice-palliative care and psychiatric care; in a study of student male and female nurses working in hospital medical units, and finally the majority of male nurses worked in the emergency centres and psychiatric services.

None of the studies was randomised controlled trials. The research designs used in the included studies were cohort, and cross-sectional design studies (Basharpoor, Narimani & Atadokht 2015; Hawkins, Howard & Oyebode 2007; Kokkonen et al. 2014; Williams et al. 2017) and Wainwright et al. (2021) used correlational regression analysis.

Table 3.1: Descriptive characteristics of the studies

Authors, year & country	Method	Sample & context	Study aims	Measures	Results & main findings
Basharpoor, Narimani & Atadokht (2015) **Iran**	Cross-sectional design	Emergency centres of hospitals major city, Iran 100 nurses Female (n=42) Male (n=54) Age (M=38.45)	The role of attachment styles in predicting PTSD in emergency nurses	ASQ[4] Global Mississippi PTSD-Q[5]	**CASP A:** study addressed a clearly focused issue and cohort recruited in acceptable way - yes **CASP C:** Results will help locally – yes for nursing practice **CASP B results:** • Attachment style means were secure 27.62; fearful 13.56; preoccupied 20.50; dismissive 15.37 • Nurses with fearful and dismissive attachment had statistically significant higher PTSD scores than the group of nurses with secure and preoccupied styles • Insecure attachment appears to be associated with PTSD
Berry et al. (2008) **UK**	Cohort design	15 Psychiatric nurses and 5 support workers Female (70%) 26 clients with psychosis Male (61.5%)	How nurse/ support worker attachment style is associated with client and nurse discrepancies in understanding of interpersonal problems and therapeutic relationships	SAM[6] Specific IIP-32[7] Psychological mindedness[8] FMSS[9]	**CASP A:** study addressed a clearly focused issue and cohort recruited in acceptable way - yes **CASP C:** Results will help locally – yes for nursing practice **CASP B results:** • Nurse/SW attachment avoidance positively associated with poorer staff psychological mindedness discrepancies in ratings of interpersonal problems between staff and clients

[4] Attachment Styles Questionnaire (Van Oudenhoven, Hofstra & Bakker 2003)
[5] Mississippi PTSD Questionnaire (Hagh-Shenas et al. 2005; Keane et al. 1988)
[6] Staff Attachment Style (Berry et al. 2007) specifically designed for research
[7] Inventory of Interpersonal problems -32(for key worker) (Startup 1998)
[8] Measure of psychological mindedness (Barrowclough, Gregg & Tarrier 2008)
[9] The Five-Minute Speech Sample (Magaña et al. 1986)

					• Nurse/SW avoidance was negatively correlated with psychological mindedness with Emotional Expression • Psychological mindedness negatively correlated with Nurse/SW anxious-attachment style • Nurse/SW who rated themselves as having positive relationships with clients had lower anxious attachment and avoidant attachment
Berry & Greenwood (2016) **UK**	Cohort design	24 nurses 9 Allied health professionals Male (59%) Age (M=25.9) 61 clients with psychosis	To investigate if professional anxious-avoidant attachment styles mediated by interpersonal characteristics would be associated with less positive therapeutic relationships	PAM[10] Specific WAI-S[11] TOS[12] AAPPQ[13] CMEI[14]	**CASP A:** study addressed a clearly focused issue and cohort recruited in acceptable way - yes **CASP C:** Results will help locally – yes for nursing practice **CASP B results:** • No significant association was found between avoidant attachment and therapeutic relationship • Care coordinators with greater levels of anxious attachment reported less positive therapeutic relationships • No association was found between caregiver attachment or job attitudes and the client's relationship rating
Halama & Pitel (2016) **Slovak Republic**	Correlational design	161 nurses Age (M=38.5) Female (n=158)	To investigate the relationship between attachment styles and decision-making styles in hospital nurses	RQ[15] Global SRS[16]	**CASP A:** study addressed a clearly focused issue and cohort recruited in acceptable way - yes

[10] Psychosis Attachment Measure (professional) (Berry et al. 2006)
[11] Working Alliance Inventory – Short (Tracey & Kokotovic 1989)
[12] Therapeutic Optimism Scale Augmented (Bruckner 1979; Byrne et al. 2004)
[13] Alcohol and Alcohol Problems perception Questionnaire (Cartwright 1980)
[14] Case Manager Expectancy Inventory (O'Connell & Stein 2011)
[15] Relationship Questionnaire (Bartholomew & Horowitz 1991b)
[16] Self-Regulation Scale (Diehl, Semegon & Schwarzer 2006)

		5 clinics in the Bratislava Children's University Hospital		MDMQ[17]	**CASP C:** Results will help locally – yes for nursing practice **CASP B results:** • Adaptive or vigilant decision-making styles were not correlated with any attachment styles • Fearful and anxious-preoccupied attachment styles correlated with maladaptive decision-making styles • Both fearful and anxious-preoccupied attachment styles were negatively associated with self-regulation ability, • Fearful and anxious-preoccupied attachment correlated with hypervigilance, buck-passing and procrastination • Hypothesis: self-regulation could be a link between attachment style and maladaptive coping
Hawkins, Howard & Oyebode (2007) **UK**	Cross-sectional design	84 hospice-palliative care nurses Female (99%) Age (M=46) 9 Hospice settings In client hospice Day hospice Community/home liaison teams	Investigates the potential impact of hospice nurse's attachment style on their experience of stress and coping Dismissing or fearful may cause vulnerability to stress and less likely to access help	ECR[18] Global NSS[19] GHQ-12[20] COPE[21]	**CASP A:** study addressed a clearly focused issue and cohort recruited in acceptable way - yes **CASP C:** Results will help locally – yes for nursing practice **CASP B results:** • Attachment styles: 52% secure, 18% preoccupied, 17% fearful & 13% dismissing • Insecure nurses at more risk of psychological ill-health than secure nurses

[17] Melbourne Decision-Making Questionnaire (Mann et al. 1997)
[18] Experience in Close Relationship scale (Brennan, Clark & Shaver 1998)
[19] The Nursing Stress Scale (Gray-Toft & Anderson 1981)
[20] General Health Questionnaire-12 (McCabe et al. 1996)
[21] COPE (Carver, Scheier & Kumari Weintraub 1989) Assessing Coping Strategies: A Theoretically Based Approach

					• Some insecure nurses (attachment style not specified) more at risk of developing psychiatric illness due to stress • Secure and preoccupied nurses were more likely to draw on emotional social support as a coping strategy than fearful or dismissing nurses
Khodabakhsh (2012) **Iran**	Correlational design	Convenience sample of 260 nursing students Females (n=130) Males (n=130) Age (M=21.6) Tehran University of Medical Sciences	To examine the relationship between attachment style and 4 components of empathy	ASQ[22] Global IRI[23]	**CASP A:** study addressed a clearly focused issue and cohort recruited in acceptable way - yes **CASP C:** Results will help locally – yes for nursing practice **CASP B results:** • Secure positive correlations with perspective taking empathic concern, fantasy and personal distress • Anxious negative correlation with perspective-taking, empathic concern, fantasy and personal distress • Avoidant negative correlation with perspective taking empathic concern, fantasy and personal distress
Kokkonen et al. (2014) **UK**	Cross-sectional design	Nurses (n=77)[24] Females (n=61) Male (n=16) An average 60% of clients had dementia	To examine the relationships between staff attachment style, geriatric nursing, self-efficacy, approaches to dementia, and burnout in paid caregivers for people with dementia	ECRS-R[25] Global ADQ[26] IGNS-E[27] MBI[28]	**CASP A:** study addressed a clearly focused issue and cohort recruited in acceptable way - yes **CASP C:** Results will help locally – yes for nursing practice **CASP B results:**

[22] Attachment Style Questionnaire (Feeney, Noller & Hanrahan 1994a)
[23] Interpersonal Reactivity Index (Davis 1983)
[24] Registered Nurse (n=32) Assistant Nurse (36) ward manager (n=5) other (n=4)
[25] Experiences Close Relationships Scale-Revised (Fraley, Waller & Brennan 2000)
[26] Approaches to Dementia care Questionnaire (Lintern 2001; Woods 2000)
[27] Inventory of Geriatric Nursing Self-Efficacy (Mackenzie & Peragine 2003)
[28] (Maslach, Leiter & Schaufeli 2009)

		Nine in client geriatric wards			• Anxious attachment associated with increased levels of emotional exhaustion and depersonalisation and decreased levels personal accomplishment. • Anxious attachment significantly negatively associated self-efficacy and person-centred attitudes; and negatively predicted personal accomplishment. • Avoidant attachment associated with high levels of emotional exhaustion and depersonalisation • Avoidant attachment not a significant predictor for burnout but vulnerable to burnout
Wainwright et al. (2021) **UK**	Cohort Correlational regression analysis Questionnaire-based, cross-sectional	50 nurse-client dyads. All >18 years old Male=29 (58%) Female=20 (40%) Acute mental health in-patient ward Mental health nurses clients known to each other for at least 7 days	To explore both client and nurse attachment, emotional regulation and the impact of these on the nurse-client alliances and client social functioning within acute mental health units.	PAM WAI[29] DERS[30] SBS[31] GHQ[32]	**CASP A:** study addressed a clearly focused issue and cohort recruited in acceptable way - yes **CASP C:** Results will help locally – yes for nursing practice **CASP B results:** • Nurse emotional regulation, nurse-rated working alliance and nurse anxious & avoidant attachment associated with higher levels of nurse distress
Williams et al. (2017) **Australia**	Cross-sectional design	Convenience sample (n=600) Paramedics (29%)	To identify attachment style and empathy levels in health science students as well as to explore	RSQ[33] Global JSE-HPS[34]	**CASP A:** study addressed a clearly focused issue and cohort recruited in acceptable way - yes

[29] Working Alliance Inventory (nurse version) (Hatcher & Gillaspy 2006)
[30] Difficulties in Emotional Regulation Scale (Gratz & Roemer 2008)
[31] Social Behavioural Scale (Wykes & Sturt 1986)
[32] General Health Questionnaire (Goldberg & Hillier 1979)
[33] The Relationship Scales Questionnaire (Griffin & Bartholomew 1994a; Griffin & Bartholomew 1994b)
[34] Jefferson Scale of Empathy Health Provider – student (Fields et al. 2011)

	Nurses (29.7%) Nurse-paramedics (11.3%) OTs (30%) Females (80.7%) Age (M=20) 1st year (64%) University students	attachment as a factor in students cognitive empathy levels	**CASP C:** Results will help locally – yes for nursing practice **CASP B results:** • Paramedics had highest secure attachment mean scores 22.1 • Nurses had lowest insecure dismissing attachment mean scores 22.1 • Nurses had the following highest insecure attachment mean scores: Fearful attachment 15.1; dismissing attachment 22.1; preoccupied attachment 14.6 • The paramedic/nursing students scored highest on empathy with mean scores 113.8 & nurses scored lowest on empathy with mean score of 109.9 • Nurses scored highest on the 3 insecure styles and lowest on empathy • Clinician's with dismissing attachment tend to be less empathic • The correlations between attachment and empathy were minimal in size & unlikely to have clinical impact

MEASURES USED IN THE REVIEW RESEARCH

SELF-REPORT ATTACHMENT MEASURES

All nine studies were conducted using self-report measures. Self-report measures of attachment conceptualise attachment as styles. Therefore styles will be the terminology used in this review (Brennan, Clark & Shaver 1998; Griffin & Bartholomew 1994b). Six studies used global or general measures of attachment, and three studies used attachment measures specific to health professionals. There were three types of measures used in this review. The continuous dimensional scales measure attachment on a continuum from avoidant at one end to anxious at the other. Security of attachment lies towards the middle of the continuum. Single sentence definitions or 'prototype' categories ask a person to choose the description that most represents them and, finally, a mixture of both measures in the one self-report.

The following four most commonly used approach was the global self-report measures including the Relationship Questionnaire (RQ) (Bartholomew & Horowitz 1991b), the Experiences in Close Relationships Scales (ECRS) (Brennan, Clark & Shaver 1998), Experiences in Close Relationship Scale – Revised (ECRS-R) (Fraley, Waller & Brennan 2000), and Relationship Style Questionnaire (RSQ) (Griffin & Bartholomew 1994b).

The four self-report attachment measures listed above are based on Bartholomew and Horowitz (1991b) four-category model of attachment measured by the RQ. Rather than a two-dimensional model of anxious and avoidant attachment, they distinguished between secure, preoccupied, dismissing- avoidant and fearful-avoidant. Their prototype model was later expanded to a questionnaire format that used the four prototype categories (Brennan, Clark & Shaver 1998; Griffin & Bartholomew 1994a).

Another self-report measure, the Attachment Styles Questionnaire (ASQ) (Mosterman & Hofstra 2014; Van Oudenhoven, Hofstra & Bakker 2003), is based on Bartholomew and Horowitz (1991b) four-category model and has 24 items with five-point rating scales. Mosterman and Hofstra (2014) caution that this can be a problematic scale to use and interpret as individuals may receive high or low scores on all four scales making validity questionable. This scale may theoretically make a person both securely and insecurely attached. The result can reduce the researcher's ability to establish a

dominant attachment style, affecting the validity of the scale and interpretation of results. Internal consistency (Cronbach's alpha) for each style was 0.75 for secure, 0.80 for preoccupied, 0.70 for fearful and 0.62 for dismissing. Finally, Khodabakhsh (2012) used the Attachment Style Questionnaire (ASQ) to measure adult attachment using a 40-item scale of Feeney, Noller and Hanrahan (1994a). Two measures used were specifically designed for therapists: the Staff Attachment Style for nurses (Berry et al. 2007); and the Psychosis Attachment Measure (PAM) for health professionals (Berry et al. 2006).

The self-report attachment measures used in these studies differ in how they are scored and analysed. Additionally, direct comparison between findings is difficult because the studies used either dimensional or categorical measures. Fraley and Waller (1998) suggest that a dimensional model best represents adult attachment. Griffin and Bartholomew (1994a; 1994b) advise that dimensional measures provide flexibility when using correlational data analysis methods.

SPECIFIC ATTACHMENT MEASURES

The first study by Berry et al. (2008) used a self-report measure purposely designed for their research, the Staff Attachment Style Questionnaire. This is a two-dimensional scale with higher scores denoting higher anxiety and avoidance. This attachment measure has concurrent validity with Berry and colleagues' previous attachment self-report measures, but they do not mention cross-validating with any other measure (Berry et al. 2007; Berry et al. 2006). Their second study measured professional attachment style using the PAM. Berry et al. (2006) report that the PAM has adequate Cronbach alpha internal consistency (avoidant r = 0.75) and anxious (anxious = r =0.72). Gumley et al. (2014) report Cronbach alpha coefficients for the avoidance dimension on the PAM to be 0.60 to 0.91 and anxiety dimension 0.70 to 0.86. This contrasted with their 2008 study, in which they did find avoidant attachment to be negatively associated with the working alliance. An examination of PAM's structure by Olbert et al. (2016) revealed an inconsistency in the two factors, anxious and avoidant attachment. Their exploratory factor analysis did not show a coherent factor structure. According to Olbert et al. (2016), the measure is valid for anxiety but not avoidance. Given this lack of agreement over the PAM's reliability, the study's results should be viewed with caution. In the current literature review, Wainwright (2021) reports that the alpha significance level was 0.86 for both anxious and avoidant subscales of the PAM.

Additional Measures Used in the Studies

Each of the eight studies explored whether nurses' attachment styles impacted one or more factors that affected their relationship with the client or the performance of their caregiving role. Each of the studies used a variety of measures to achieve this purpose. In all, 18 different measures were used to investigate Post Traumatic Stress Disorder (PTSD), burnout, work-related stress, nurse empathy and the effect of nurses' attachment and interpersonal characteristics on the nurse-client caregiving relationship.

Table 3. 1: Additional measures used in the studies

Post-Traumatic Stress Disorder (PTSD), burnout, and work-related stress		
Name of measure	**Description of measure**	**Reference**
Approaches to Dementia Care Questionnaire (ADQ)	Evaluating nurses' attitudes, behaviour, hopefulness and person-centred care	(Lintern 2001) (Woods 2000)
Mississippi PTSD Questionnaire (MPTSD-Q)	A 35-item Likert scale that uses a sample of PTSD domain items from the *Diagnostic and Statistical Manual of Mental Disorders-III.* It also includes other features frequently associated with PTSD	(Keane, Caddell & Taylor 1988) (Hagh-Shenas et al. 2005)
Maslach's Burnout Inventory (MBI)	Measuring nurses' emotional exhaustion, depersonalisation, and personal accomplishment	(Maslach & Jackson 1981)
COPE scale	Measures 13 individual ways of coping that either impede or help adaptive coping	(Carver, Scheier & Kumari Weintraub 1989)
The Nursing Stress Scale (NSS)	Measuring sources of nurses' stress that occur when providing care such death and dying; conflict with physicians; lack of support; conflict with other nurses and workload	(Gray-Toft & Anderson 1981)
GHQ-12	Screening nurses' mental health for psychological distress and personal characteristics	(McCabe et al. 1996)
Inventory of Geriatric Nursing (IGNS-E)	Measuring workplace stresses that effect nurses' caregiving self-efficacy. Measured how nurses managed interpersonal conflicts with colleagues, challenging clients and clients' families	(Mackenzie & Peragine 2003)
Empathy measures		
Interpersonal Reactivity Index (IRI)	Measuring four different components of nurses' empathy: perspective taking, empathic concern, fantasy and personal distress	(Davis 1983)
Jefferson Scale of Empathy Health Provider – Student (JSE-HPS)	Measuring nurses' cognitive empathy	(Fields et al. 2011)

Interpersonal characteristics that may affect the nurse-client caregiving relationship		
Case Manager Expectancy Inventory (CMEI)	Measure nurses' expectations of the ability of clients with chronic mental illness to do tasks associated with "normal" adult roles. Higher scores indicate greater positive expectations and valuing of clients	(O'Connell & Stein 2011)

Alcohol and Alcohol Problems Perception Questionnaire (AAPPQ)	Nursing attitudes, therapeutic commitment and empathy towards client, nurses expectations of client outcomes and role security	(Cartwright 1980)
Five Minute Speech Sample (FMMS)	Nurses' speech sample was recorded, coded, and rated for high or low Emotional Expression (EE). EE is associated with positive, neutral, or critical comments and Emotional Overinvolvement (EOI); the Nurses' FMSS was also scored with the Measure of Psychological Mindedness scale, which was scored on a scale one to three, with three being high psychological mindedness	(Magaña et al. 1986)
Inventory of Interpersonal Problems -32 (IIP-32)	Measures the level of the nurses' psychological self-awareness and understanding of nurse-client interpersonal relationships	(Barkham, Hardy & Startup 1996)
Self-Regulation Scale (SRS)	Measures the emotional and attentional aspects of self-regulation in nurses who are facing difficulties or trying to focus attention	(Diehl, Semegon & Schwarzer 2006)
Therapeutic Optimism Scale (TOS)	Measures nurses' optimism or pessimism regarding their personal ability to contribute and positively influence outcomes for their clients with mental health difficulties	(Bruckner 1979) (Byrne, Sullivan & Elsom 2006)
Melbourne Decision-Making Questionnaire (MDMQ)	Measures four decision-making styles: Vigilance, thought to be the style associated with secure attachment, and three maladaptive styles: hypervigilance, buck-passing and procrastination.	(Mann et al. 1997)
The Working Alliance Inventory – Short form (WAI-S)	Measured how the nurse worked with the client on the goals, tasks and bonds of the admission. The client did not participate	(Tracey & Kokotovic 1989)
Working Alliance Inventory (nurse version)	Measures how the nurse works with client, ten questions – four relating to bond with client, three related to goals of therapy and three relating to tasks of therapy	(Hatcher & Gillaspy 2006)
Difficulties in Emotional Regulation Scale	Measures six areas of emotional regulation: acceptance of emotional responses; difficulties engaging in goal-directed behaviour when upset; impulse control difficulties; lack of emotional awareness; limited access to affective emotional regulation strategies; and emotional understanding	(Gratz & Roemer 2004)
Social Behaviour Scale	Assess social functioning on four subscales: antisocial behaviour; depressed behaviour; social withdrawal and thought disturbance	(Wykes & Sturt 1986)
General Health Questionnaire	Measures current mental health status, including current levels of distress	(Goldberg & Hillier 1979)

RESULTS OF THE NINE STUDIES IN THE NARRATIVE REVIEW

Each of the nine studies focused on the nurses' attachment and distinctly different aspects and qualities of nurses that had the potential to interact with their attachment style to affect their caregiving. Therefore, the following section provides the results of each of the nine studies and a synthesis of the nine studies focusing on an attachment will follow in the findings.

Basharpoor, Narimani and Atadokht's (2015) correlational study of 100 emergency nurses attempted to determine the role of attachment style in predicting PTSD. Their results showed that the nurses with fearful-avoidant or dismissing attachment styles on the ASQ[35] had higher PTSD scores on the MPTSD-Q than nurses without PTSD. There was no significant difference between nurses with secure and preoccupied styles with high scores on the MPTSD-Q and those without PTSD. The results suggest that both fearful-avoidant and dismissing avoidant attachment may be associated with burnout. As this was a correlational study, no causation can be inferred. As previously cautioned, the ASQ attachment measure is difficult to use and interpret. Moreover, the authors did not mention if they had used the Persian (Farsi) version of the ASQ (Firoozabadi et al. 2014).

The IIP-32 and the FMSS were used by Berry et al. (2008) to understand if there was a difference between how the nurses perceived the clients' interpersonal problems and caregiving relationship. Additionally, they measured the nurses' psychological mindedness or self-awareness level. An avoidant attachment style was significantly positively correlated with nurses' ratings of nurse-client interpersonal problems and negatively correlated with nurse psychological mindedness. There was no evidence of an association between anxious attachment and interpersonal problems or psychological mindedness. Less convincing were the results for an association between staff attachment style and the working relationship using the FMSS. In this sample of approximately 20 nurses, there was no evidence of negative statements or relationships, critical comments or EOI, meaning no evidence of high EE.

Consequently, the researchers compared to staff with a positive nurse-client relationship to staff with neutral relationships. When they did this, they found that nurses with more positive relationships had

[35] Attachment Styles Questionnaire (Mosterman & Hofstra 2014; Van Oudenhoven, Hofstra & Bakker 2003)

a small positive association with lower levels of anxious attachment (r = 0.39). Nurses with neutral relationships showed higher levels of avoidant attachment (r = 0.47).

Berry and Greenwood (2016) examined the association between attachment and therapeutic relationships in anxiously and avoidantly attached nurses, allied health staff and clients with psychosis. In direct contrast to Berry et al. (2008), this study found a moderate association between anxious attachment and a less positive working alliance of staff with their clients, a finding similar to Wainwright et al.'s (2021) study. This was indirectly and partially mediated by lower role commitment, therapeutic optimism, and role security. These findings suggest that professionals with an anxious attachment may be more vulnerable to factors such as the need to have job security, feel less committed to their role and be less optimistic about people getting better.

Halama and Pitel's (2016) research explored whether nurses' adaptive or maladaptive decision-making styles were related to their attachment style, assuming that a nurse's self-regulation would mediate the relationship between their secure or insecure attachment style and decision-making abilities. The results revealed that no attachment style, either secure or insecure, showed any association with a vigilant decision-making style. Secure attachment only showed a significant small negative association with hypervigilance. Self-regulation was positively correlated with secure attachment and vigilance and negatively correlated with insecure attachment and maladaptive decision-making. The other significant finding was that fearful-avoidant and anxious-preoccupied attachment styles were positively associated with decision-making types, hypervigilance, buck-passing and procrastination. Fearful-avoidant and preoccupied attachment negatively predicted self-regulation ability and was inversely associated with maladaptive decision-making. The authors concluded that self-regulation could be a mediating factor between attachment and maladaptive decision-making.

In a cross-sectional study by Hawkins, Howard and Oyebode (2007), 84 hospice nurses were surveyed and asked about sources of work stress and the types of coping strategies they used that either impeded or helped them cope and adapt to their stressful work environments. This study provided percentages of attachment styles, with 52% secure, 18% preoccupied, 17% fearful and 13% dismissing. The results for the GHQ-12 appeared inconclusive. The authors advised that some insecurely attached nurses were more likely to be at risk of psychiatric disturbance due to high-stress

levels. However, they did not specify whether they had an avoidant or anxious attachment. The results supported the hypothesis that fearful-avoidant and dismissing-avoidant nurses would be less likely to seek emotional support in stressful situations. It replicated Kokkonen et al. (2014). Hawkins, Howard and Oyebode (2007) found that nurses with fearful-avoidant and dismissing-avoidant styles are more at risk of work-related stress and burnout because they did not seek social support, a protective factor in burnout. Additionally, the coping strategy of secure and insecure preoccupied nurses was associated with social and emotional support.

Khodabakhsh (2012) measured student nurses' attachment styles and their empathy using the IRI. Khodabakhsh reported, as expected that secure attachment was significantly positively correlated with empathic concern (r = 0.71). As expected, the nurses with insecure attachment styles showed significant to moderate negative correlations with empathic concern. Nurses with avoidant attachment showed moderate negative correlations for empathic concern -0.67. Nurse with anxious attachment styles showed a significant negative correlation for empathic concern -0.7. As with Basharpoor, Narimani and Atadokht (2015), these results should be viewed with caution. The ASQ used in this study is not referenced, but it appears to be, from its description, the Feeney, Noller and Hanrahan (1994b) ASQ. Khodabakhsh (2012) also intimates the ASQ has been translated into Persian, but there is no mention of retesting psychometrics, making the psychometric properties questionable.

Kokkonen et al. (2014) used the ECRS-R to determine the relationship between attachment style and self-efficacy, person-centred attitudes, emotional exhaustion, and depersonalisation in a sample of 77 nurses. Attachment was treated as a dimensional construct, anxious and avoidant. Avoidant attachment was associated with emotional exhaustion and depersonalisation but did not predict burnout. Anxious attachment was associated with burnout, and symptoms such as reduced perceived personal accomplishment, emotional exhaustion, and depersonalisation. According to the MBI, all four symptoms mentioned above are an indication of an increased risk of burnout. An anxious attachment was also associated with a reduced ability to provide person-centred care and use emotion-focussed strategies. The authors suggest that nurses with an anxious attachment style were likely to become particularly distressed in stressful situations. Finally, an anxious attachment style was associated with lower perceived self-efficacy in challenging caregiving situations with clients who had dementia.

Wainwright et al. (2021) used the PAM to examine 50 nurse-client dyads attachment and their emotional regulation to understand the effect these have on the nurse-client working relationship and client social functioning in an acute mental health unit. According to the results, anxious and avoidant nurse attachment, difficulties with emotional regulation and low-scoring nurse-rated working alliance were significantly associated with nurse distress. The authors suggest the clinical implication for the nurses who experience high levels of distress requires they have regular supervision to support their work. Additionally, offering interventions that enable nurses to become aware of their own attachment style in a therapeutic relationship may be helpful and develop improved self-regulation ability.

Williams et al. (2017) used the JSE-HPS and the RSQ to compare students' attachment styles and empathy by their professional degrees. They found that the two highest-scoring attachment styles were paramedic students with secure attachment styles (M = 22.1 SD 4.2) and nursing students with insecure dismissing styles (M = 21.1, SD 4.4); both were statistically significant. Indeed, the nursing students had the highest mean scores on all the insecure scales: fearful (M = 15.1 SD 4.5), dismissing (M = 21.1, SD 4.4) and preoccupied M = 14.6, SD 3.6). Regarding empathy combined paramedic and nursing students showed the highest empathy levels (M = 113.8). In tandem with high insecure attachment, the nursing students had the lowest mean empathy scores (M = 109.9). The study found that the nursing students' scores were statistically significantly higher for dismissing attachment than those of the paramedic/nursing, paramedic or occupational therapy students.

DISCUSSION

This narrative review demonstrated a wide range of results that shed light on the connection between nurses' attachment style and a range of factors that either directly or indirectly affected the nurse-client caregiving relationship, including coping style, empathy, self-regulation and particular personal attributes. Comparison of results from the review studies has been hampered by the fact that eight different attachment self-report measures were used (Shi, Wampler & Wampler 2014), and generalised conclusions should be drawn with caution. However, it can be concluded that nurses' insecure avoidant and anxious attachment styles negatively affected the nurse-client caregiving relationship. It should be noted that no discourse analysis studies were found, and the review is built on self-report research only.

Overall, the results of this review suggested that nurses with an insecure attachment style may have more interpersonal difficulties providing care to their clients because they tend to be inconsistent, unavailable, under- or over-involved and have lower levels of empathy, especially when their clients are distressed. They may also have more trouble coping with stress and more problems regulating their emotions. These characteristics potentially place the nurse with an insecure attachment at risk of difficulties with problem-solving and planning a workday, interpersonal issues with clients and peers, burnout and PTSD.

The final synthesis will maintain the primary thesis focus of attachment. The findings will be themed by the attachment dimensions, avoidant and anxious-preoccupied, and a section on secure attachment.

AVOIDANT ATTACHMENT

The findings of this literature review concerning nurses with avoidant attachment are consistent with previously published studies examining relationship behaviours of romantic couples with avoidant attachment (Brennan, Clark & Shaver 1998; Campbell et al. 2001; Collins & Feeney 2000; Jacobvitz, Curran & Moller 2002).

Two studies in this review (Khodabakhsh 2012; Williams et al. 2017) found that nurses with an avoidant attachment style tended to be less empathic. A similar phenomenon has been found in psychological therapists with an avoidant attachment style; they presented as distant, unavailable and less involved with clients (Bartholomew & Horowitz 1991a; Dozier, Cue & Barnett 1994; Rubino et al. 2000). Wei et al. (2011) observed that individuals with an avoidant attachment style maintained an emotional distance to avoid intimacy, leading to less empathy for others. Stern, Borelli and Smiley (2015) conjectured that suppressing feelings of empathy and trying to downplay or dismiss others' problems may be an attempt to escape the nurse's own pain.

Previous research sheds some light on possible underlying mechanisms for these findings. Two research teams in this review showed that nurses whose attachment styles were avoidant or dismissing tended to downplay feelings when distressed (Halama & Pitel 2016; Wainwright et al. 2021), a finding consistent with earlier studies (Hazan & Shaver 1987; Hazan & Shaver 1994; Shi, Wampler & Wampler 2014). Wei et al. (2011) found that people with avoidant attachment styles

tended to maintain an emotional distance and avoid intimacy, leading to the potential consequence of less empathy for others. Stern, Borelli and Smiley (2015) conjectured that suppressing feelings of empathy and trying to downplay or dismiss others' problems may be an attempt to escape psychological pain.

Dozier et al. (2001) suggested that individuals with an avoidant attachment may distance themselves from others when their attachment system is activated, leading them to manage emotional or personal issues by rejecting the client, distancing themselves or diverting the conversation. Rholes, Simpson and Oriña (1999) and Rubino et al. (2000) linked avoidant attachment with more hostile and rejecting interpersonal behaviours, particularly when distressed, consequently impacting the nurse-client caregiving relationship. In their study, Berry et al. (2008) reported attachment avoidance was negatively correlated with nurse psychological mind-mindedness and indicated the nurse's ability to take the perspective of her client was limited, thereby reducing the nurse's capacity to show empathy for the client.

The problem of burnout in nurses has been studied extensively. Three studies in this review examined if there is a correlation between nurse avoidant attachment and the potential to experience burnout (Basharpoor, Narimani & Atadokht 2015; Hawkins, Howard & Oyebode 2007; Kokkonen et al. 2014). The indication, that nurses with fearful-avoidant and dismissing-avoidant styles, are more at risk of work-related stress and burnout is supported by the research of Pines (2004) and Barr (2020) on nurses' attachment and burnout. Their research confirms that nurses with insecure attachment are at greater risk of burnout than nurses with secure attachment. Recognizing that insecure attachment may be a significant contributor to nurses experiencing burnout is an important step forward in addressing the problem (Dor, Mashiach Eizenberg & Halperin 2019; Ledingham et al. 2019; Lewis & Cunningham 2016).

Good quality caregiving requires nurses to be empathic, take the client's perspective, be psychologically available and reflect on practice. Such caregiving qualities are also associated with secure, responsive and sensitive parent-infant caregivers (Ainsworth et al. 1978/2009; Feeney & Collins 2001, 2003; Toth, Rogosch & Cicchetti 2008). These findings suggest that nurses with an insecure avoidant attachment are at risk of providing less than optimal care to their clients.

ANXIOUS-PREOCCUPIED ATTACHMENT

Four studies in this review found that nurses with an anxious-preoccupied attachment may experience significant distress (Halama & Pitel 2016; Hawkins, Howard & Oyebode 2007; Kokkonen et al. 2014; Wainwright et al. 2021). An anxious attachment was associated with much difficulty with self-regulation, less self-efficacy, a low personal accomplishment of nursing tasks and maladaptive coping and decision-making. Previous research has also shown similar results where therapists tend to show intense negative emotional responses, be controlling and vigilant to perceived criticism and show an overdependence on others (Brennan, Clark & Shaver 1998; Mikulincer & Shaver 2005; Mikulincer & Shaver 2007b; Simpson, Rholes & Nelligan 1992).

Two researchers in this review (Khodabakhsh 2012; Williams et al. 2017) found that nurses with anxious attachment experienced the nurse-client relationship less positively, and anxious attachment was associated with lower empathy. This finding has been identified in other research by psychologists, social workers, and psychotherapists who have an anxious attachment style and also show less empathy and tend to become overinvolved with their clients (Borelli & David 2003; Dozier, Cue & Barnett 1994; Petrowski et al. 2013; Rubino et al. 2000). Emotional competencies such as self-regulation are central to empathic responding and the ability to manage high levels of distress (Stern, Borelli and Smiley (2015). Nurses work in highly stressful environments and are vulnerable to stress and burnout. Kokkonen et al. (2014) findings in this review demonstrated attachment anxiety was associated with stress, emotional exhaustion, depersonalisation and negative person-centred attitudes. These findings are supported by previous researchers examining stress and burnout in the nurse's (Barr 2020; Gama, Barbosa & Vieira 2014; Golia et al. 2017). The nurse-client caregiving relationship is fundamental to positive therapeutic outcomes. Two studies in this review (Berry & Greenwood 2016; Wainwright et al. 2021) showed that nurses with an anxious attachment had less favourable self-rated working alliances with their clients. Therapists with anxious attachment styles have difficulty with emotional regulation and higher levels of distress, which can interfere with their ability to empathise and negatively impact their nurse-client caregiving relationships (Black et al. 2005; Slade 2008; Tyrell et al. 1999). When the nurse experiences a range of interpersonal difficulties, the nurse-client caregiving relationship is bound to suffer, with poorer therapeutic outcomes for the client (Bowlby 1988d; Bucci et al. 2016; Schauenburg et al. 2009).

SECURE ATTACHMENT

Finally, Williams et al. (2017) identified that paramedic/nursing students with secure attachment scored highest on empathy. Similarly, Hawkins, Howard & Oyebode (2007) found that nurses with secure attachment were more likely to draw on social support as a coping strategy. These two findings embody central concepts of attachment theory, denoting an empathic caregiver who can take the perspective of the other; and elements of the secure base, that is, seeking social support to cope with stressful situations (Ainsworth 1969; Bowlby 1988j; Slade 2005). A secure attachment enables an individual to form satisfying relationships, show emotional and cognitive empathy, self-regulate, take the perspectives of others, and enjoy satisfying relationships (Bowlby 1969/1982, 1988d; Fonagy et al. 2002). Ideally, when a nurse has a secure attachment, the nurse-client relationship will be more satisfying for both partners in the relationship (Bowlby 1982; Feeney 2004, 2007).

LIMITATIONS OF THIS NARRATIVE REVIEW

Although many of the papers retrieved and screened for this review included nurses, a number of these were rejected for not meeting the inclusion criteria, leaving nine papers for deeper analysis. Several limitations may reduce generalisability. Overall, the study's nurses were registered nurses in public hospitals, hospices or psychiatric facilities. Two studies looked at undergraduate nursing students at university nursing faculties or hospital placements. Community health nurses were not represented in the studies. Five of the studies had either small sample sizes or low response rates. The combination of these factors may make the studies less representative of the nursing population. About cultural representation, this review included two studies from Iran, and the search revealed several more from Iran and China that did not wholly meet the study criteria. All nine studies used different self-report attachment measures, which makes comparing results challenging.

Another limitation not explicitly addressed in the studies was factors that may have affected the nurses, such as personal difficulties outside of the workplace, previous trauma, cultural, psychosocial or workplace conflict.

Three researchers suggested that their research be followed up using an instrument that taps into unconscious attachment representations, such as the AAI (Berry & Greenwood 2016; Berry et al. 2008; Hawkins, Howard & Oyebode 2007). De Haas, Bakermans-Kranenburg and Van Ijzendoorn

(1994) advise that “attachment representations are not associated with attachment style”, and self-report attachment measures may need to be reconsidered if unconscious processes need to be identified. Self-report measures conscious constructs, and the AAI measures unconscious constructs so researchers need to be fully cognizant of the differences between the two measures when planning their research (Fortuna & Roisman 2008; Riggs et al. 2007; Roisman et al. 2007; Shaver, Belsky & Brennan 2000).

Bernier, Larose and Boivin (2007) caution that great care must be taken when choosing self-report instruments. Their study comparing the AAI and self-report scales found that information gathered from dismissing individuals may be biased due to defensive information-processing strategies. On the other hand, the AAI is understood to activate the attachment system and is associated with unconscious attachment representations, meaning the individual is not conscious of their responses to the interview questions and is unlikely to manipulate their answers (Maier et al. 2004).

Furthermore, despite searching for discourse studies such as the AAI, all the measures used in the identified studies were the self-report scales. This shows that the nursing research on nurse attachment and caregiving has focussed on self-report measures to date. There do not appear to have been any studies using the AAI to understand how the nurses’ attachment state of mind affects the nurse-client caregiving relationship.

Self-report measures are known to be open to social desirability response bias. Questions regarding coping under pressure, problem management and managing under pressure are everyday expectations of a “good” nurse, so a nurse will genuinely wish to give a positive impression (Perinelli & Gremigni 2016). Most importantly, nurses are acutely aware of their caregiving role and always desire to be perceived to be agreeable, kind, empathic, and genuine (Dalton & Ortegren 2011).

CLINICAL IMPLICATIONS OF THE REVIEW FINDINGS

The authors of all nine research papers acknowledged that nurse attachment and its effects on the nurse-client caregiving relationship is an under-researched area of nursing knowledge and requires further study. As these studies suggest, nurses with an insecure attachment may struggle in the workplace and be at greater risk of burnout and/or PTSD. Additionally, nurses with insecure avoidant or anxious attachments may have lower levels of empathy and may experience interpersonal

difficulties with colleagues, the clients' families and most importantly, clients. These difficulties potentially affect the nurse-client caregiving relationship and may result in adverse outcomes for the clients in their hospital stay or the provision of community interventions.

RESEARCH IMPLICATIONS

As this review has indicated, understanding the effects of the nurse's secure or insecure attachment on the nurse-client caregiving relationship remains an under-researched aspect of nursing scholarship. To date, it has only been studied with self-report attachment measures, but as several of the researchers in these studies suggested, a more in-depth investigation of the nurses' unconscious processes using a discourse analysis measure such as the AAI would prove valuable to this emerging field of nursing knowledge. In a semi-structured interview comprising 20 questions, the AAI activates the attachment system (Hesse 2016; Main, Hesse & Goldwyn 2008). This gives the researcher a glimpse of the unconscious individual differences in nurses' IWMs of attachment relationships that direct their feelings, behaviours, attention, memory and cognition. This enables the researcher to find explanations for differences in the nurses' caregiving behaviours and possible ways to address the difficulties identified in this literature review, such as burnout, stress, PTSD, low levels of empathy, high levels of distress and problems with self-regulation. This research provides pathways to enhance and enrich the nurse-client caregiving and care-receiving relationship.

CONCLUSION

The findings of this review regarding nurses' insecure attachment conform to those of published studies, but follow-up research is needed to build on the results. Nevertheless, the included studies form the vanguard in nursing knowledge in attachment theory. More specifically, how the nurses' attachment affects the nurse-client caregiving relationship, while the self-report measures used in the studies are simple, quick, cheap to use and require relatively little instruction, this may be problematic, as many researchers using them may not have the necessary deep knowledge of attachment theory, resulting in the inaccurate interpretation of the results.

This review of the literature identified two significant gaps in the nursing literature. Firstly, nurses must conduct and lead their attachment theory-based research to improve practice and support the emotional safety of the nurses and clients. Secondly, a reliable discourse instrument is needed to

examine nurses' and clients' attachment state of mind and their effects on the caregiving relationship. The AAI (Main, Goldwyn & Hesse 2003) is such an instrument and has a proven high level of reliability. This research has addressed both these critical gaps in nursing knowledge.

Chapter 4: METHODS

This chapter justifies this study's epistemological and theoretical foundations, design, methodology and methods. Beginning with a brief revisiting of the research's aims and research questions, the chapter then describes the research's theoretical framework, social constructionism, its importance to the study and its relation to the chosen qualitative methodology. Following this is a discussion of the study's research design, a 'theory-building case study.

RESEARCH AIMS

This research examined how the adult attachment state of mind of the CFH nurse and the woman she works with impacted the nurse-client caregiving relationship during a five-day residential stay at a Residential Parenting Service (RPS). The research answers these six questions:

7. Is there an association between a secure attachment state of mind and the quality of the caregiving and care-receiving relationship between the CFH nurse and the woman?
8. Is there an association between the CFH nurse's attachment state of mind and how she perceives her caregiving relationship with the woman?
9. Is there an association between the CFH nurse's attachment state of mind and how she provides care to the woman?
10. Is there an association between the woman's attachment state of mind and how she perceives her caregiving relationship with the CFH nurse?
11. Is there an association between an insecure attachment state of mind and the caregiving relationship between the CFH nurse and the woman?
12. Is there an association between 'disorganised' and/or 'cannot classify' attachment state of mind and the caregiving/care-receiving relationship between the CFH nurse and the woman?

Based on the aims of this research and specific research questions, the focus of my study is to understand through language and relationships the nurses' and the women's adult attachment state of mind, how they represent the nurse-client caregiving relationship and the ways their representations affected caregiving and care-receiving. My theoretical and structural choices, described below, are best suited to address the aims of the research, as I shall elaborate on throughout this chapter.

THE THEORETICAL FRAMEWORK FOR THIS RESEARCH

Justifying the research's epistemological and theoretical foundations is necessary to demonstrate that the choice of design and methodology is consistent with my understanding of how knowledge, beliefs and social action are constructed. Social constructionism is the underpinning epistemology of this research. The basis of social constructionism is that collectively, we construct knowledge of our worlds through human relationships and language fundamental to understanding and negotiating our worlds (Gergen 2015d; Gergen 2020). Gergen (2015a) suggests that metaphors or "what is there before" enable us to freely look at existing constructs, releasing the observer to consider new possibilities.

Under ordinary circumstances and in any healthcare setting, the nurse-client caregiving relationship comprises two (or more) individuals coming together to build a socially supportive connection that enables the client to regain optimal well-being. Many of the parents admitted to the RPS experience long or short-term emotional and psychological distress that affects the relationship with their infant. During the period of the client's physical, or psychological ill-health or disorder, both nurse and client assume socially constructed caregiver and care-receiver roles. Once this episode ends, their roles in the nurse-client relationship cease, and they both take socially constructed roles outside the health facility, within multiple other relationships. While in the healthcare facility, the client maintains different relationship roles such as the child of their parent, parent to their child; and the nurse assumes socially constructed roles with the client's family. From a social constructionist point of view, the common denominator of these roles is relational, the roles are performative, and language is used to confirm the construction of the nurse-client caregiving relationship (Camargo-Borges & McNamee 2020; Gergen 2015d; Gergen 2020; Gold 2020; Hechinger, Mayer & Fringer 2019).

The above description describes a traditional way of perceiving the nurse-client caregiving role. The traditional performance of the nurse-client relationship has been replicated since Nightingale (1860) and is perceived as an enduring truth. It has been historically and culturally situated within a tradition of 19th-century womanly attributes. Gergen (2015c) believes that when traditional ways of understanding are restrictive and limited, by reduced opportunities to gain new knowledge or an inability to reflect on practice, we are not free to construct alternatives. He explains that this understanding is a "taken-for-granted reality" (Gergen 2015d, p. 22). Social constructionists believe

there is no right, and no wrong, and multiple truths co-exist, providing opportunities to collaborate, generate knowledge and construct changes in the clinical practice (Camargo-Borges & McNamee 2020; Gergen 2015d). It follows that observers cannot be neutral or objective and able to put their values aside. It is, therefore, necessary to take opportunities to discover new truths (Camargo-Borges & McNamee 2020). In the process, the social constructionist researcher acknowledges their values and the influence of social processes and enters the research inspired by these values to make changes and challenge the dominant discourse (Gergen 2015b). Social constructionism considers people relational beings, and our language representative of past relationships. This aspect of constructionism accords well with the use of the AAI in this research. The AAI analyses an individual's language to determine their internal representation of their past attachment experiences (Main, Goldwyn & Hesse 2003). Social constructionism and attachment theory converge in the conceptual space that hypothesises former relationships leave traces in our lives as a relational history. In social constructionism terms, this condition has been called your "multibeing" Gergen (2015c) . Your "Multibeing" represents multiple experiences from your earliest and present relationships and how these influence whom you become. Gergen's relational theory is in keeping with Bowlby's (1988j) IWM concept.

A theory-building case study approach (Stiles 2005) has been selected for my research because this design accepts that theories are not truths. New knowledge can be gained through observations such as listening to a person's language and observing their behaviour (Stiles 2009). New knowledge permeates the theory and may modify, extend, and construct new additions to the theory (Stiles 2007). This elaboration makes it a living theory that continually infuses knowledge. Stiles (2005) theory-building case study design is consistent with a social constructionist approach as it focuses on understanding language and observation in a relational context, that is, in the therapeutic milieu (Stiles 2007). Social constructionism merges fittingly with the spirit of this research.

As laid out in previous chapters, attachment theory is the theoretical perspective used to understand the nurse-caregiving relationship. This theory is the research's driving force. Attachment theory opens up opportunities for new ways to support nurses challenged by their caregiving relationship with clients and who may not be coping within the prevailing nurse-client caregiving constructions. New ways of perceiving the multiple truths may be found through attachment theory.

RESEARCH DESIGN – THEORY-BUILDING CASE STUDY

This case study used Stiles (2009) theory-building case study research approach – informed by social constructionism – to gain a new understanding of the selected case. Theory-building case studies are ideal for clinical practice research. They offer the clinical researcher opportunities to observe people's experiences and "...see aspects of people that others seldom or never see..." (Stiles 2007, p. 122) to gain new and meaningful knowledge. Applying theory-building to the case study enables an inductive and deductive approach to the analysis (Stiles 2009). The deductive approach poses six research questions that explore aspects of known and established attachment theory. Data is collected through the AAI and NCCRI spoken narratives of the CFH nurses and women and screening of the ACE-Q. The research questions are not tested through quantitative statistical methods, such as correlation or regression. Instead, the narrative data were analysed by comparing the coded narratives against each other and making non-statistical inferences from the AAI classifications and coding system, Ainsworth's caregiving scales and adult attachment theory in theoretical terms. Once theoretical deductive inferences from the collected data have been made, the qualitative data from AAI and NCCRI spoken narrative data will be re-examined to explore patterns and develop emergent theory, thus taking an inductive approach to theory-building (Stiles 2005, 2010a). In both stages, the coding protocol of the AAI and analysis of the NCCRI will be used to identify patterns in the CFH nurse's and women's narrative and language usage, the CFH and women's nurses' experiences of caregiving and care-receiving to develop emergent theory (Eisenhardt & Graebner 2007; Stiles 2010b).

Stiles (2010a) proposes that impermeable theories are "scientifically dead". Hence, he uses the metaphor of diffusion to explain how living theories accommodate a continual infusion of new observations of language and relationships. He continues, that there is no single correct method (Stiles 2005) when using theory-building research. The researcher's responsibility is to explore ways to understand the research's ideas and questions while comparing each clinical research observation with attachment theory and deductively and inductively developing emergent theory (Stiles 2009). The observations of language and relationships must be systematic, thorough, and entirely relevant to the theory (Stiles 2003). The central proposition of a theory-building case study is how well the case study represents the theory. The researcher looks for enough observations that generalise to minor differences that can permeate the theory and generate a modification to the theory (Stiles 2007, 2009, 2010a). Attachment theory will be the theory used to guide the theory-building of this case study and

match existing theory regarding the U, CC and unresolved/cannot classify (U/CC) categories and the nurse-woman caregiving relationship. On the other hand, any observation in the data that may not converge with prevailing theory will be offered as an infusion and contribution to both attachment and nursing theory.

A QUALITATIVE METHODOLOGY

This research used a qualitative methodology. Qualitative research aims to understand and interpret the subtleties and complexities of an individual's or a group's social meanings and experiences in their natural settings (Braun & Clark 2013a; Cresswell & Cresswell 2018; Sandelowski & Barroso 2003).

To generate the best possible account from the CFH nurses and women participating in this study, I gathered multiple types of data in the form of in-depth interviews, reviewed case notes and made observations to gain an understanding of their current and childhood experiences, adverse childhood experiences, trauma and loss (Dube 2003; Gergen 1985; Stiles 2007). I understood that each participant had constructed their version of reality. These constructions had come from experiences within their multiple relationships, social situations and the contexts in which they had lived in the past and currently live (Gergen 2015c).

In qualitative research, the researcher generally collects the data themselves and may be seen as the "key instrument" (Cresswell & Cresswell 2018). In this research, I used the AAI, the Nurse-Client Caregiving Relationship Interview (NCCRI), behavioural observations during the interviews, the Adverse Childhood Experiences questionnaire and the women's case notes. These sources of evidence allowed me to search for relationships and insights relevant to the research question so as to either prove or disprove the research questions (Baxter & Jack 2008; Hodkinson & Hodkinson 2001; Yin 2014).

Qualitative research is concerned with language and the meaningful narratives that emerge from words, which provide "rich" descriptions of experiences or objects being studied (Braun & Clark 2013b). The accounts obtained from the multiple data sources enabled me to delve beneath the surface to provide meaningful insights into the constructions and meanings of the participant's experiences. Examining the structure of their spoken language or narrative in the two interview

instruments enabled me to gain an understanding of the participants' existing construct of relationships (Gergen 2015b; Stake 1978) or to conceptualise in attachment terms the CFH nurses' and women's attachment state of mind (Main, Goldwyn & Hesse 2003). As a qualitative researcher, I spoke directly to the CFH nurses and women while recording their language, observing behaviours and listening as they shared their complex stories (Braun & Clark 2013b; Stiles 2007).

This research aimed to explore whether there was an association between the attachment state of mind of the CFH nurse and the woman she cared, and if this affected their caregiving relationship during a stay in an RPS. As I am also a CFH nurse and work in the same RPS as the CFH nurses in the research, I am a member of the culture being studied and understand the prevailing nurse-client caregiving constructs (Gergen 2015c; Hechinger, Mayer & Fringer 2019). As a member, I know the CFH nurse's point of view because of a shared identity, language, and experience (Shepherd 2011). This knowledge enabled rapport and trust to be quickly established, which was critical to building the researcher-participant relationship (Asselin 2003; Plows 2008). When a researcher is studying their group (or, in this case, as a CFH nurse wanting to gain insight into the way my colleagues provided care and nursing), this is known as an "insider" or an "emic" approach (Asselin 2003; Leininger 1985; McFarland 2014; Nikkonen & Janhonen 1995). Jootun et.al. (2009) refers to the insider role as "the actual-practitioner-as-researcher". I also connect with the women in the study as a woman and mothers and understand what it is like to have a crying baby or a baby who does not sleep. When carrying out insider research, these shared experiences can be regarded "as the heart of the reality of the culture" Field (McFarland 2014, p. 96). In some cases, challenging and deeply personal experiences may not be shared with a researcher who is not a group member – an outsider or etic researcher (Dwyer & Buckle 2009).

Of course, being an insider researcher required a continuous cycle of reflexive examination throughout the research to understand how the experiences of being with the nurses and women were affected by – and affecting – my preconceptions, interpretations, understanding, judgements, beliefs, and knowledge (Frank 1997; Gearing 2004). Being a part of the culture had advantages and disadvantages, which required constant exploration and careful consideration of when I needed to be the "emic" or the "etic" researcher (Dwyer & Buckle 2009; Wegener 2014).

RESEARCH DESIGN

The research aimed to have four representative case studies. In each case study, none of the CFH nurses and women who participated in their caregiving and care-receiving pairs or triad was matched or assigned according to their AAI classification. The women's AAI classifications were only known after their residential stay was completed.

Three short case studies characterised the AAI secure adult attachment classifications, secure-autonomous, insecure-dismissing and insecure-preoccupied (Main 2000). The main case study was to represent the AAI unresolved classification. After the sampling was completed, a fifth rarer AAI classification, CC was coded (Hesse 1996). The CC classification was included in the fourth case study with the U classification.

Purposive theoretical sampling was employed in two stages to select a sample of CFH nurses and women whose attachment state of mind could provide insight into the theoretical differences and similarities between the five AAI classification. In the first stage, CFH nurses and women volunteered to participate in the research. Twelve nurses and 13 women were recruited and interviewed using the AAI and Nurse-Client Caregiving Relationship Interview (NCCRI). The 25 AAIs were then coded to determine the AAI classifications of the CFH nurses and women to proceed to the second stage of the purposive theoretical sampling.

In the second stage, three CFH nurse caregivers and three women care-receiver pairs were selected that represented the three organised AAI classifications, secure, insecure dismissing and insecure preoccupied.

In the main case study, the decision to have one nurse and two women were not previously planned. When I approached the women to participate in the research, they both expressed a strong desire to be a part of it, so I interviewed both women. When the coding was finished, the CFH nurse who provided caregiving to these two women all had the AAI classification, CC, so they were selected for the fourth case study. In Addition to CC, one of the women, and the CFH nurse had a U attachment classification. This unexpected instance of the three CC and two U classifications helped me understand how the co-construction of the interaction of the caregiving and care-receiving relationship between the CFH nurse and the two women.

The Adverse Childhood Experiences Questionnaire (ACE-Q) was also used to screen each AAI transcript. A semi-structured interview that I developed, entitled the Nurse-Client Caregiving Relationship Interview (NCCRI), Nurse and Client version, was administered to CFH nurses and women. Finally, the nurses answered some demographic information, the women's medical records were examined, and relevant information was included in the analysis. The AAI and NCCRI were collected simultaneously; subsequently, each nurse and woman's AAI, NCCRI and ACE-Q were scored, coded and analysed as a whole analysis. The results were then interpreted, and finally, a synthesis of the analysed results was undertaken to find and develop emergent theory and new knowledge as it arose.

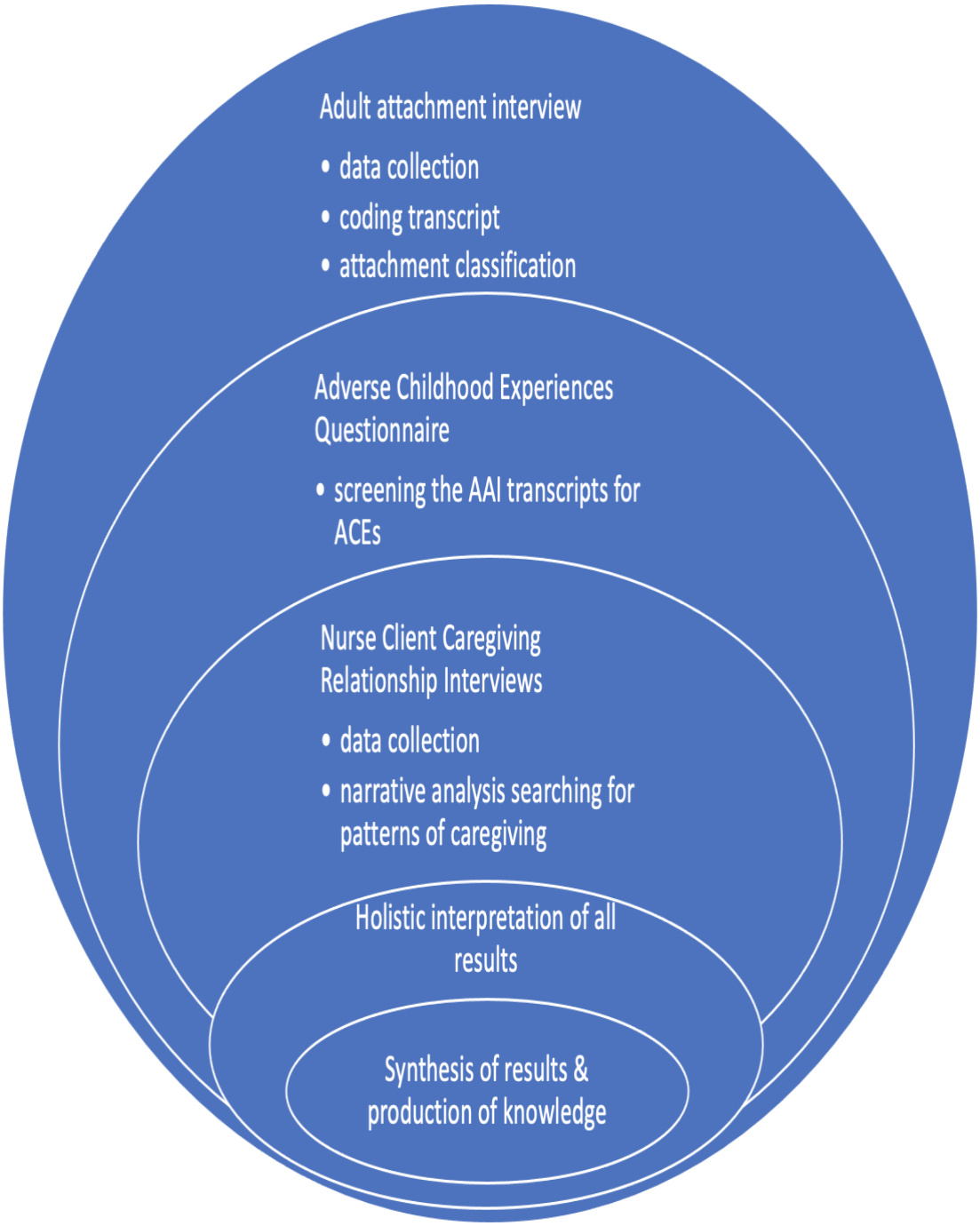


Figure 4. 1: Process of data collection

RESEARCH ETHICS

This research was approved by the NSW Health Human Research Ethics Committee (HRECs), Research Development Office, Royal Prince Alfred Hospital Camperdown, NSW, on the 15th of July 2015 (Protocol No: X15-0089&HREC/15/RPAH/121) (See Appendix 6). The University of Technology Sydney Human Research Ethics Committee ratified the ethics approval on 21st February 2016 (Reference number: ETH16-0305).

An application for an amendment to the research plan was made to the ethics committees as the plan to use independent interviewers could not be implemented. In the first interview protocol, an independent interviewer not employed by the parenting centre was thought more appropriate to do the interviews than I, whom the parenting centre employed. The rationale for this approach was that using an independent interviewer was necessary to protect the nurses' safety, confidentiality, and anonymity. An interviewer was recruited and trained to use the AAI protocol. Following ethics approval in July 2015, the interviewer was contacted, but she decided not to conduct the interviews. A second interviewer was recruited in mid-2016. She was trained in the AAI interview protocol and began interviewing. Two interviews were audiotaped for quality while she continued interviewing another six CFH nurses. The interviewer had not followed the AAI interview protocol in four interviews, so these could not be coded; therefore, these interviews would have to be redone. After these eight interviews, the interviewer also withdrew from the study.

In consultation with my supervisory panel, we requested an amendment to my ethics approval to enable me to conduct the CFH nurse's AAIs. I approached six newly recruited CFH nurses and the four CFH nurses who required another interview and asked if they would mind if I interviewed them. All 10 CFH nurses were completely comfortable with this change to the research protocol. An amendment was written requesting that I interview the CFH nurses and increase the number of CFH nurses and women participants from 12 to 15 if required. This was submitted to the Research Development Office, Royal Prince Alfred Hospital Camperdown, NSW. Approval for the amendment was given on 14th July 2017. The Research and Ethics office at UTS was contacted to apprise them of the amendment (see Appendix 7). This long series of difficulties slowed my data collection considerably.

The four CFH nurses had two years between the first and second interviews. When I read and compared their two interviews, there was very little difference between them, except in the second interview, they answered the question about loss through death. Some answers to their questions were remarkably similar. They provided different elements of their story but generally told their stories similarly.

Potential risks for this research are viewed from the CFH nurse's and women's perspectives. As a parenting centre staff member, my peers are the CFH nurses who agreed to participate in this study. However, I am employed as a nurse educator, so I have no management responsibility for the CFH nurses and have a different manager than the clinical nurses.

My nurse educator position is not a clinical-based role, so I do not work in any clinical teaching capacity in the residential units. My responsibility is to develop and deliver workshops, training programs and other organisational parenting education material. Therefore, my responsibilities limit my direct contact with the residential unit CFH nurses except when they attend educational programs. These learning experiences are generally relaxed and held in a mutually respectful, safe environment where the participants are encouraged to develop their ideas and skills (Wales et al. 2013). Thus, I aim to ensure I have the attributes of a valued and respected educator and provide the dynamics of influence for our relationship in the knowledge enhancement (Ilic et al. 2016; Singh 2020).

In administering the questionnaires, questions were asked briskly, which may have been challenging and unusual for the participants. Further, questions may not have been easy to answer. Consequently, the interview protocol placed the woman under mild stress (Hesse 1999). The interview could “surprise the unconscious” (George, Kaplan & Main 1996). I only asked the prescribed questions and probes and refrained from engaging in interactions that altered the participants’ natural responses to the questions. An essential requirement of the interview is that the woman’s safety is closely attended to. Therefore, a distress protocol was developed if a woman or CFH nurse required psychological or emotional support. Neither CFH nurses nor women were pressed to answer questions or continue the interview if unwilling to do so. Having gained considerable experience and qualifications in perinatal and infant mental health nursing, I am well qualified to recognise a participant in mental distress.

By 2017 during the period the transcribed AAIs were coded, it was evident that the classifications were more representative of a clinical sample. There were higher frequencies of AAI insecure attachment classifications and eight rare AAI classifications. The original plan had been to inform the CFH nurses and women of their attachment classification. However, under the circumstances, the supervisory panel and I decided to contact the Ethics Research and Development Office for further advice. After discussion with the Executive Officer, Ethics Review Committee, I was advised not to disclose the attachment classifications to the CFH nurses or women if it caused emotional distress. I agreed and suggested to the CFH nurses and women that I could not tell them their attachment classification because I had new advice from the Ethics Research Office. Some were disappointed, but the majority did not seem to mind.

METHODS

SAMPLING OF SITE AND PARTICIPANTS

STUDY SETTING

The research was conducted at three Tresillian RPS residential units. The three RPSs are situated in a large metropolitan city and serve a diverse cultural and socioeconomic population. The RPSs admit women, men, and their children, aged from birth to three years, for five-day residential stays to assist with parenting difficulties, postnatal depression, and other mental illnesses impacting parenting capacity and competence (for more information about Tresillian, see https://www.tresillian.org.au/).

SAMPLING APPROACH

A theoretical purposive sampling strategy was used for this research. This involved an interplay between collecting and examining the participants' narratives, reflecting on differences and similarities between the underpinning theory to guide further sampling (Coyne 1997; Emmel 2013b; Morse 1991b). An iterative and reflexive process was used to revise the findings, change direction, or delve deeper into the existing results to illuminate an unusual case (Palinkas et al. 2015). Ongoing purposeful theoretical sampling continued by comparing the emergent findings against existing theory and whether it merges or deviates from the theory. When considering the connections between constructionism and theoretical purposive sampling, Emmel (2013a, p. 18) asserts that "...theoretical concepts have to earn their way into the narrative of the research..." meaning the researcher is aiming

to gain theoretical accounts of social phenomena through coding or observations and noting the emergent data.

This purposive theoretical sample aimed to capture theoretical differences and similarities of the four central AAI attachment states of mind. Sampling was therefore undertaken in two stages. The first data collection stage included the voluntary recruitment of 12 CFH nurses and 13 women, after which both CFH nurses and women's data were collected, and the AAIs were coded and classified.

The second stage of data collection began when the coded and classified AAI transcripts were reviewed, and the selection of the four case studies was discussed with the supervisory panel. Four CFH nurses and five women were selected for the case studies. The AAI attachment classification of each CFH nurse and woman represented one of the organised classifications. Two nurses had secure-autonomous classifications; one had insecure dismissing, and another was classified U/CC. The women's AAI attachment classifications were as follows, one woman had unresolved/secure-autonomous classifications, one woman had insecure dismissing, one woman had insecure preoccupied, one woman U/CC, and one woman CC.

The first three small case studies in Chapter 6 represent the three main AAI organised attachment classifications secure-autonomous, insecure dismissing, insecure preoccupied and U classification. The fourth case study in Chapter 7 describes the AAI low-coherence classifications CC and U. The CC classification was chosen to illuminate an unusual or atypical AAI adult attachment category (Morse 1991b; Palinkas et al. 2015). All four case studies were purposely sampled to capture theoretical differences and similarities of the adult attachment states of mind of the CFH nurses and women in each case study.

PARTICIPANT CHARACTERISTICS

The total cohort recruited for this research were 12 CFH nurses and 13 women (n=25). After consent was obtained all of the 12 CFH nurse and 13 women were interviewed with the AAI and Nurse-client caregiving relationship interview (NCCRI). The purposive sample of four CFH nurses and five women was then selected from the full cohort (n=25), for the four case studies, Three nurses and three women represented the three prototypical organised adult attachment categories as well as U states

of mind. One nurse and two women described the atypical case study and were classified with U/CC adult states of mind.

SAMPLING PROCEDURES

Child and family health nurses: The Parenting Centre's Senior Nurse Managers provided an initial information session explaining the research. The session included a brief overview of the AAI explained in plain English. The adult attachment interview was presented in an easy-to-understand format that encouraged questions and discussions. The session covered research regarding the effects of therapist attachment on caregiving relationships. I explained that I wanted to know how to enhance the nurse-caregiving relationship by studying the attachment state of mind of the nurses and the women admitted to the residential units. This session was enthusiastically received. Once the Senior Nurse Managers understood the nature of the research, they were prepared to support their nursing team's participation.

After gaining the support of the Nurse Managers, the CFH nurses from the residential units were invited to a similar information session. A written information sheet outlining the research was given to the nurses, along with a consent form. The information sheet informed participants about the study and provided details of how privacy and confidentiality would be ensured (see Appendix 2 and 3 Nurses Information and Consent forms). Permission was sought to record digitally, code and store the AAI, the NCCRI and ACE-Q results. After the session, the researcher met with the CFH nurses to answer any questions about the research or their participation.

Seven nurses, who comprised the first sample, were recruited through the information sessions and signed their consent immediately. Six nurses, the second sample, volunteered through word of mouth and these nurses either contacted me by phone or spoke to me when I was in the residential units.

Recruitment of the women: the initial intention was to recruit the women at admission to the RPS. This was seen to be too complicated by the CFH nurses as they stated the admission process was already too busy. Therefore, the process was changed to minimise the women's likelihood of becoming distressed or overwhelmed. As a nurse usually admitted two women a day, it was agreed that, on the second day of those women's residential stay, I would come to the residential unit to see if one of the women was interested in participating. On Day Two, I returned, and the CFH nurse introduced me to

the women admitted the previous day. I did not read the women's admission notes before meeting them. The CFH nurse and I first spoke to whichever woman had a free moment from her baby. I introduced myself and carefully explained the research. If the woman was interested, I then provided the information sheet and gave her the consent form to sign (see Appendices 4 and 5, Women's Information and Consent forms). The woman was also informed that she could consider participating in the research and sign and return the form later. Fourteen women were approached to participate in the study, and all initially consented to participate. One woman withdrew from the research after discharging herself early from her residential stay, leaving thirteen women with complete data sets. Thirteen CFH nurses and 14 women initially volunteered to be a part of the research. One nurse withdrew from the study for personal reasons, and the study was completed with 12 nurses.

The final sample consisted of 12 CFH nurses and 13 women, making the sample size 25. There were eleven nurse-woman unique dyads, thus accounting for 22 participants. The twelfth CFH nurse worked with two women, accounting for the final three participants, making the final sample 25. None of the CFH nurses and women who participated together in their caregiving and care-receiving pairs, or triad were either matched or assigned according to their AAI classification.

DATA COLLECTION INSTRUMENTS AND MEASURES

THE ADULT ATTACHMENT INTERVIEW (AAI)

Bakermans-Kranenburg and van IJzendoorn (2009) investigation of 200 adult representation studies of more than 10,000 AAI's done over 25 years showed the distributions of AAI classifications in both non-clinical and clinical samples in various cultural populations and age groups. Bakermans-Kranenburg and van IJzendoorn used the three-way and four-way classification methods to interpret their results. The interview transcript uses three-way classification to classify the speaker into the three main organised categories: secure, dismissing or preoccupied. Four-way classification includes the unresolved classification with the three-way when the speaker discusses experiences of loss or abuse, and their interview shows evidence for unresolved/disorganised responses through their speech, i.e., unresolved/dismissing.

The Bakermans-Kranenburg and van IJzendoorn (2009) published data were reported as four-way distributions. The five AAI categories have been collapsed into four U categories and CC

classifications noted together as U/CC. The four-way classification has been used in the study and reported in this thesis. Studies demonstrate that unresolved states of mind are associated with greater adult psychopathology (Bakermans-Kranenburg & van IJzendoorn 2009; Bucheim & Horst 2003; Moran et al. 2008; Murphy et al. 2014; Thomson & Jaque 2017a; van IJzendoorn & Bakermans-Kranenburg 2008).

The AAI distinguishes between two broad population groups, clinical and non-clinical, with different AAI profiles. Samples drawn from the clinical population are at high risk of attachment difficulties. Bakermans-Kranenburg and van IJzendoorn (2009) review of the first 10,000 AAIs estimated that in four-way classification, the distribution of non-clinical women in their sample, 58% were secure, 23% insecure dismissing, 19% insecure preoccupied and 18% unresolved for loss or other trauma. In this sample, women's attachment distributions in clinical samples showed an overrepresentation of insecure attachment representations related to clinical disorders. In the four-way classification for the distribution of clinical women in their sample, 21% were secure, 23% were insecure dismissing, 13% were insecure preoccupied and 43% U/CC for loss or other trauma. The sample's preoccupied attachment state of mind showed more internalising disorders such as borderline personality disorder and higher rates of unresolved attachment states of mind (Bakermans-Kranenburg & van IJzendoorn 2009). Insecure attachment is overrepresented in these clinical populations, as is the U/CC category (Hesse 2016). In the Bakermans-Kranenburg & van IJzendoorn (2009) analysis, women with dismissing attachment state of mind presented with more externalising disorders such as anorexia or addiction. Overall, the women in the clinical sample were over-represented in the unresolved U attachment states of mind for loss, abuse, or other trauma. When the U and CC attachment classifications were combined, the frequency was 43% (Bakermans-Kranenburg & van IJzendoorn 2009; Hesse 2016)

The AAI was administered to all participants. To administer and code the AAI, I was required to undergo certification. A researcher must be an AAI-certified and reliable coder to use the instrument. I gained four-way reliability in the system in 2015 after attending my first AAI institute in Minneapolis with Dr Sonia Gojman de Milan and Dr June Sroufe. I attended my second AAI Institute at the University of California, Berkeley, in 2018 with Dr Mary Main and Dr Erik Hesse (see Appendix 9). As a trained and reliable AAI coder, I scored and classified all 12 CFH nurses and the 13 women's

transcripts. Eight of the 25 interviews in this research were second-coded by certified AAI instructor Dr Loyola McLean.

THE AAI PROTOCOL

The AAI is an hour-long interview in normative samples, but it may last much longer in clinical or non-normative populations. In this research sample, the length of the CFH nurse and women's interviews was as short as 35 minutes and as long as 90 minutes. The interview consists of 20 pre-planned structured questions in a set order, with follow-up probes that ask the participant about their childhood experiences with primary caregivers. It includes questions about their early relationship experiences with their primary attachment figures, including experiences of rejection, loss, separations and trauma. How the speaker tells their story determines their ability to give a coherent and plausible account of their past and current relationship experiences. This ultimately leads to the speaker's state of mind with regard to attachment (Main, Goldwyn & Hesse 2002). After a discussion with my principal supervisor, it was decided to remove Question 14, reducing the interview to 19 questions:

> *Q.14: other than any other difficult experience you've already described, have you had any other experiences which you regard as potentially traumatic?*

This question has been recently added to the interview and does not appear in the original 1996 protocol. This question was removed from the interviews in this research because we thought that such disclosure of overwhelming and significant trauma could interrupt the purpose of the woman's residential stay and the nurse if she were on duty.

The AAI asks the participant to present their attachment-related history and experiences with their parents or primary caregivers during childhood. The interview is a conversation between the interviewer and the participant. The AAI question takes the woman on an unexpected emotional journey that eventually enables the coder to look for structural differences in how the woman organises and tells her childhood story. The woman's evaluations and influences of experiences on her current relationships (Main, Goldwyn & Hesse 2003; Main, Hesse & Goldwyn 2008).

The first AAI question briefly asks the woman to overview her family of origin. The second question – *Can you describe your relationship with your parents as a young child?* – may immediately challenge the woman as this may be something she has not previously considered. The question that many

women find the most demanding is the identification of five adjectives to describe their parents. This is accompanied by a follow-up question that requires the woman to give an episodic memory to support the adjective. The questions move on to which parent were they closest to, and how the parents responded to them when they were emotionally upset, ill or physically hurt. Other topics women find challenging included what she and her parent did if they were separated and if she ever felt rejected as a child.

The interview has questions that have the potential to overwhelm and activate the woman's attachment system. The interviewer questions the woman whether she ever felt threatened due to parental discipline, had any experience of physical, sexual abuse or other trauma, or experienced the loss of a parent through death. The woman is asked to consider if there are ongoing effects on her personality from their childhood experiences. They are also asked whether they think their experiences have been a significant "setback" in their development (George, Kaplan & Main 1996, p. 51) and why they believe their parents behaved as they did during their childhood.

A significant aspect of the interview is questioning the woman about the loss of a parent or significant person in childhood and adulthood. These questions about loss are systematically probed to understand the woman's reaction, feelings, effects on personality, and changes over time and into adulthood. These questions are asked because losing an attachment figure is naturally disorienting or disorganising. The AAI assesses whether the significant loss from death remains disorganising into adulthood. Unresolved states of mind are associated with higher incidence of adult psychopathology (Bakermans-Kranenburg & van IJzendoorn 2009; Bucheim & Horst 2003; Moran et al. 2008; Murphy et al. 2014; Thomson & Jaque 2017a; van IJzendoorn & Bakermans-Kranenburg 2008).

Based on her language during the interview, the woman is classified as having an unresolved state of mind regarding the lost attachment figure. Linguistic indicators include lapses in several speech acts. Lapses in the monitoring of discourse are unusual absorptions where the woman maintains an idea that the dead individual is still living and seems to lapse into a momentary dissociative state (Hesse 2016; Hesse & van IJzendoorn 1999a; Main, Goldwyn & Hesse 2003). Other discourse lapses include unusual attention to detail or prolonged silences, which may also be dissociative in nature (Hesse & Main 2006; Hesse & Van Ijzendoorn 1999b). A related lapse is in the monitoring of reason which occurs when the woman expresses the disbelief that their loved one is dead.

GRICE'S MAXIMS – PRINCIPLES FOR COOPERATIVE DISCOURSE

The AAI is a cooperative endeavour between two people, the interviewer and the woman. Grice (1975, 1989/1991) proposed that conversational cooperation between speakers is constantly required for communication to be successful. According to Grice, speakers generally adhere to certain conversational maxims; violations of the maxims provide information about the speaker's state of mind. The woman's utterances during the AAI discourse are coded and scored for the overall coherence of the transcript and state of mind using Paul Grice's maxims of conversation: quantity, quality, relation, and manner (Grice 1989/1991; Hesse, Main & Goldwyn 2008; Main, Goldwyn & Hesse 2003). According to Hesse (1999) there are two criteria for a speaker to demonstrate the coherence of transcript and mind. Firstly, the speaker needs to be internally consistent and provide a congruent, truthful, and plausible account of their life story. Additionally, the speaker is required to cooperate or collaborate in the conversation with the interviewer. Speakers who are truthful, cooperative, and collaborative with no notable violations of Grice's maxims are generally classified as "secure autonomous".

A coherent state of mind indicates a secure attachment. The case studies presented in this research focus on Grice's maxims, as these are used to describe the coherence of the CFH nurses and the women's discourse (see Table 4.1).

Table 4. 1: Grice's maxims of conversation

Quality	***Quantity***
"Be truthful and have evidence for what you say" This maxim is violated when**,** for example**,** a speaker offers highly positive adjectives to describe their relationship with their mother but gives no specific episodes to support these. These types of violations are most often found in dismissing transcripts	"Be succinct and yet complete" This maxim is violated when the speaker's answers are either too short or too long. An answer needs to be as complete and "as informative as required". Violations occur with excess information that's tangled, confusing or completely irrelevant to the question. These types of violations are most often found in preoccupying transcripts. Alternatively, the speaker may not give any information or refuse to answer the questions. These types of violations are most often found in dismissing transcripts.
Relation or relevance	***Manner***
"Be relevant and have ready insight, awareness and understanding"	"A lack of clarity and order; obscurity of expression"

This maxim is violated when the speaker wanders from one topic to another or loses track of the question entirely, when they repeatedly talk about the wrong person or the wrong period of time. These types of violations are most often found in preoccupying transcripts.	This maxim can be violated in many ways by a speaker. The speaker may use nonsense words such as “dadadadadada”, quotes from their parents in the past, using jargon/psychobabble, change of viewpoint, phrases repeatedly inserted such as “kind of thing”, “sort of thing”, slips of the tongue, difficult to understand long sentences. These types of violations are most often found in preoccupying transcripts.

(adapted from Hesse, Main and Goldwyn,(2008; 2003)

Grice’s maxims of conversation are employed to understand how the speaker uses language to tell their story. Their language study assesses the transcript's internal consistency and collaboration with the interview process. Through the AAI coding system, a score is ultimately provided for the coherence of the transcript.

SCORING AND CLASSIFYING THE AAI TRANSCRIPT

The interviews are scored using dimensional nine-point scales. There are five scales for probable childhood experiences with both parents and other attachment figures. These are rejecting, involving/role reversing, pressure to achieve, neglecting and loving. The AAI also includes nine states of mind scales: idealising, involving anger, derogation, insistence on lack of recall, metacognitive processes, passivity of thought processes, fear of loss, unresolved abuse or trauma and unresolved loss through death. Finally, two global nine-point scales assess the speaker’s coherence of mind and coherence of transcript. The final rating of the interview is based on the overall coherence of the speaker’s transcript and, more importantly, the speaker’s coherence of mind, or the ability to produce a coherent and organised narrative of self-experiences that assesses the current state of mind with respect to attachment (Hesse 1999, 2016; Hesse, Main & Goldwyn 2008; Main, Goldwyn & Hesse 2003; Thomson & Jaque 2017a). The primacy of the Coherence of Mind Scale over the Coherence of Transcript cannot be overstated, as this is the underlying representation of the speaker’s state of mind. A speaker can be credited with moderate coherence of mind even when linguistic fluency is simple. When new coders are being trained, they are given access to transcripts in which the speaker may be dysfluent, use colloquialisms or have an unfamiliar accent or language usage. When this is the case, the issue is discussed and illustrated. Once the linguistic analysis of the transcript is completed and the speaker’s coherence of mind has been determined, they are assigned to one of

four main classifications (see Table 4.2). Less often, a fifth category, CC, is used. Once the interview transcript has been scored and classified, the final ratings and classifications are transferred to a score sheet (see Table 4.3).

Table 4.2: Adults states of mind with respect to attachment
Organised Categories
Secure (F) The speaker can give a reasonably clear, coherent, and collaborative account of his or her life story. This speaker demonstrates a valuing of attachment relationships, regards them as important and appears able to discuss experiences and events objectively and freely even if they had a troubled childhood. These speakers can provide evidence for their selected adjectives, are reflective and thoughtful. If their memories of their parents are negative, they appear implicitly forgiving, neither do they blame their parent or their self. These speakers often show humour, place their parents in context when criticising them, are compassionate, demonstrate a need to depend on others and miss their loved ones. They are collaborative, cooperative and internally consistent speakers thus meeting the two criteria for coherence of transcript. These speakers score moderate to high on the nine-point dimensional scale for coherence of mind and are judged coherent and have a secure attachment state of mind.
Dismissing (Ds) These speakers appear to limit their attention to the influence of attachment relationships on their life, they also restrict attention to feelings which are downplayed, minimised, or denied. May claim a lack of memory for childhood experiences with parents, or portray parents in a highly positive light, but offer no supportive evidence for positive parenting offer contradictory evidence. They may implicitly endorse negative aspects of parent's behaviour, claim their experiences were normal, made them stronger or more independent. On rare occasions attachment figures may be derogated. Dismissing speakers most often violate Grice's maxims of quantity and quality, meaning they are internally inconsistent thus failing to meet one of the two criteria for coherent discourse. These speakers score in the lower range on the nine-point dimensional scale for coherence of mind; they have an insecure attachment state of mind.
Preoccupied (E) These speakers appear to be excessively lengthy, confused, tangled, unobjective and preoccupied with early attachment relationships or experiences. So much so that the speaker is unable to collaborate in the interview and often wanders off topic, has lengthy irrelevant discussions, may seem vague, full of nonsense words, psychobabble, highly analytical or angry and conflicted. The speaker's personal identity seems to remain closely associated with their relationship to the parents. In a rare sub-category, the speaker appears to be preoccupied by frightening experiences that are inferred, referenced, or described during the interview that are unrelated and irrelevant to the question under discussion. Preoccupied speakers most often violate Grice's maxim of quantity, manner and relevance meaning they are non-collaborative speakers, thus failing to meet one of the two criteria for coherent discourse. These speakers score in the lower range on the nine-point dimensional scale for coherence of mind; they have an insecure attachment state of mind.
Disorganised and 'Cannot Classify'/Low-coherence AAI Categories
Unresolved/disorganised (U) During discussions of loss or abuse, the speaker shows marked lapses in the monitoring of reason or discourse, such as believing that a loved one is both alive and dead in a physical sense, being causal in their death where there is no evidence this occurred, unusual attention to detail or using

eulogistic/funereal speech. The speaker will also typically fit into one of the other three categories – F, Ds and E as well. These speakers score low on the nine-point dimensional scale for coherence of mind and are judged as having low coherence[36].
Cannot classify/Low-coherence (CC) A fifth and rarer category, CC is sometimes assigned to speakers who have experienced extreme abuse or complex developmental trauma. CC is a global breakdown is discourse strategy when "no single state of mind with respect to attachment is predominant". Unlike the three central organised categories, they have contradictory insecure discourse strategies when attempting to answer the interview questions. These strategies may manifest in several ways. The speaker may change discourse strategy at some point in the interview, for example, shifting from an insecure preoccupied to insecure dismissing state of mind. Alternatively, the speaker may present differing states of mind when describing different attachment figures, for example, presenting indices of insecure preoccupation with mother and insecure dismissing with father. Finally, the speaker lacks any sort of discourse strategy and has low coherence of mind scores with an absence of elevated scores for an insecure state of mind. These speakers score low on the nine-point dimensional scale for coherence of mind and are judged have low coherence states of mind.

[36] The speaker with a secure-autonomous attachment state of mind (F) generally scores moderate to high on coherence of mind. If they have also been rated as unresolved, they are then deemed to have low coherence of mind due to lapses in monitoring of reason or discourse. The unresolved category is always given as a first placement, in this case, the F category is given as a second placement i.e., U/F. This also occurs for U/Ds and U/E.

Table 4.3: AAI Ratings and Classifications Sheet Template (Gribneau 2003)

FINAL RATINGS AND CLASSIFICATIONS for CASE _____ (Interviewer: / /

Judge: _____ Date: __/__/__ Sex/ Approx. Age of Speaker: _____

SUMMARY: EXPERIENCES

Scales Scored for Experience	**Mother**	**Father**	**Other Person**
Rejecting	____	____	____
Involving/ Reversing	____	____	____
Pressured to Achieve	____	____	____
Neglecting	____	____	____
Loving	____	____	____

Experiences Present/ absent (by manual)

Abuse sexual (yes or no)	____	____	____
Abuse physical (yes or no)	____	____	____

Other abuse/ extreme events (give type if you believe qualifying) _____

Does speaker have children (yes/ no ____ Is speaker asked about (imagined) child(ren)? ____

SUMMARY: STATE OF MIND

Scales for States of Mind Respecting the Parents (or other persons)

	Mother	**Father**	**Other Person**
Idealizing	____	____	____
Involving Anger	____	____	____
Derogation	____	____	____

Scales for Overall States of Mind

Overall Derogation of Attachment	____	Highest Score for Unresolved Loss (do not forget to use asterisk if occurred in last year)	____
Insistence on Lack of Recall	____	Highest Score for Unresolved Trauma	____
Metacognitive Processes	____	OVERALL "U" score (highest of two above)	____
Passivity of Thought Processes	____	Highest Estimated Score for "Other" Trauma (name trauma, place in parens)	____
Coherence of Transcript	____		
Coherence of Mind	____	Fear of Loss	____

CLASSIFICATION _____

This form was created by N. Gribneau following the July 2003 version of the AAI manual (Main, Goldwyn & Hesse). Rev. 7/16

SCREENING OF AAI TRANSCRIPTS USING ACE-Q

The Adverse Childhood Experiences (ACE) study (Felitti et al. 1998) was conducted in a primary care setting to retrospectively and prospectively assess and understand the long-term effects and outcomes of child abuse, neglect and exposure to household dysfunction on an adult's quality of life, health and well-being. The study showed a significant relationship between the number of childhood exposures to ACEs and the number of risk factors contributing to disease conditions and health problems that cause morbidity and mortality in western countries (Dube et al. 2001; Dube 2003; Felitti et al. 1998). Felitti et al. (1998) found that adults with four or more ACE category exposures had four or more health risk factors, such as smoking, obesity, drug abuse, depression, or attempted suicide. In contrast, adults with no ACE exposures had no health risk factors.

The ACE questionnaire (ACE-Q) refers to all adverse childhood experiences during the first 18 years. The ACE-Q has ten main questions, and some of these include two or three parts. The types of childhood ACEs exposure are organised by categories starting with three categories of abuse. The first category of emotional abuse consists of two questions that inquire how often a parent insulted, humiliated, or swore to make them afraid. The second category is physical abuse and consists of two questions regarding how frequently their parent pushed, grabbed, hit, slapped, threw something and/or left marks on the child. Finally, the sexual abuse also has two questions regarding a parent, any adult stranger or family member attempting to touch, fondle, either try to or have oral//anal/sexual intercourse. There are two categories of neglect, and both have two questions each; emotional neglect enquires if the person answering the ACE-Q felt no one loved them, felt they were special or important, and whether they had a close, supportive family. Such things define physical neglect as insufficient to eat, dirty clothes, or a parent who abused alcohol or other drugs and did not attend to medical needs (Anda et al. 2004; Felitti et al. 1998). The final five categories were termed household dysfunction. They included one question on parental separation or divorce and three about domestic violence, such as whether the mother was hit, slapped, kicked, beaten or threatened with a knife or gun. Finally, there is one question for household substance abuse, mental illness or attempted suicide in the household, and an incarcerated family member (Anda et al. 2004; Dube et al. 2001; Felitti et al. 1998).

In this study, the ACE questionnaire was not given to the CFH nurses or the women to score independently; instead, the questionnaire was used to estimate ACEs in the AAI transcripts. The AAI questions concerning neglect, family violence, loss through death and divorce, parental emotional and psychological availability and evidence of household dysfunction resonate with the ACE-Q. Consequently, the CFH nurse and women's AAI transcripts provided an opportunity to use the ACE-Q to screen for their childhood exposure to abuse and household dysfunction that emerged in their narratives and compare with prevalence rates from primary care clinic samples of the original Kaiser Permanente ACE study cohorts (Dube et al. 2001; Dube 2003; Felitti et al. 1998). For this study, I included loss through the death of a parent or other intimate person in the household dysfunction category: question six, separation and divorce.

There is convincing evidence that a strong relationship exists between trauma, ACEs and unresolved attachment state of mind (Murphy et al. 2014; Thomson & Jaque 2017a). I speculated that if the CFH nurses and women reported four or more ACEs, it might be negatively associated with their psychological and physical health (Murphy et al. 2014). Although this research did not intend to replicate Murphy et al.'s (2014), I was interested to know if any similarities between the samples existed. Additionally, I aimed to identify if any subsequent ACE trauma corresponded with the AAI trauma and loss questions and was manifest in their adult attachment state of mind.

The Adverse Childhood Experience Questionnaire (ACE-Q) was not administered directly to the CFH nurses or the women. Instead, the ACE-Q was used to screen each CFH nurse and woman's AAI transcript to gather data for any evidence of adverse childhood experiences (ACEs). All ACEs were marked on the ACE Questionnaire and scored one for each question out of 10. A score of four or more ACEs out of the ten questions places a child at greater risk of long-term chronic physical and psychological ill-health in adulthood. The AAI transcripts' screening was to identify the number of ACEs the CFH nurses and women may have experienced in childhood. This method of using the ACE-Q for screening the AAI transcript was not used prior to this. A search of the academic literature could not locate any similar attempt. Therefore, this is a novel and untried method to identify ACEs.

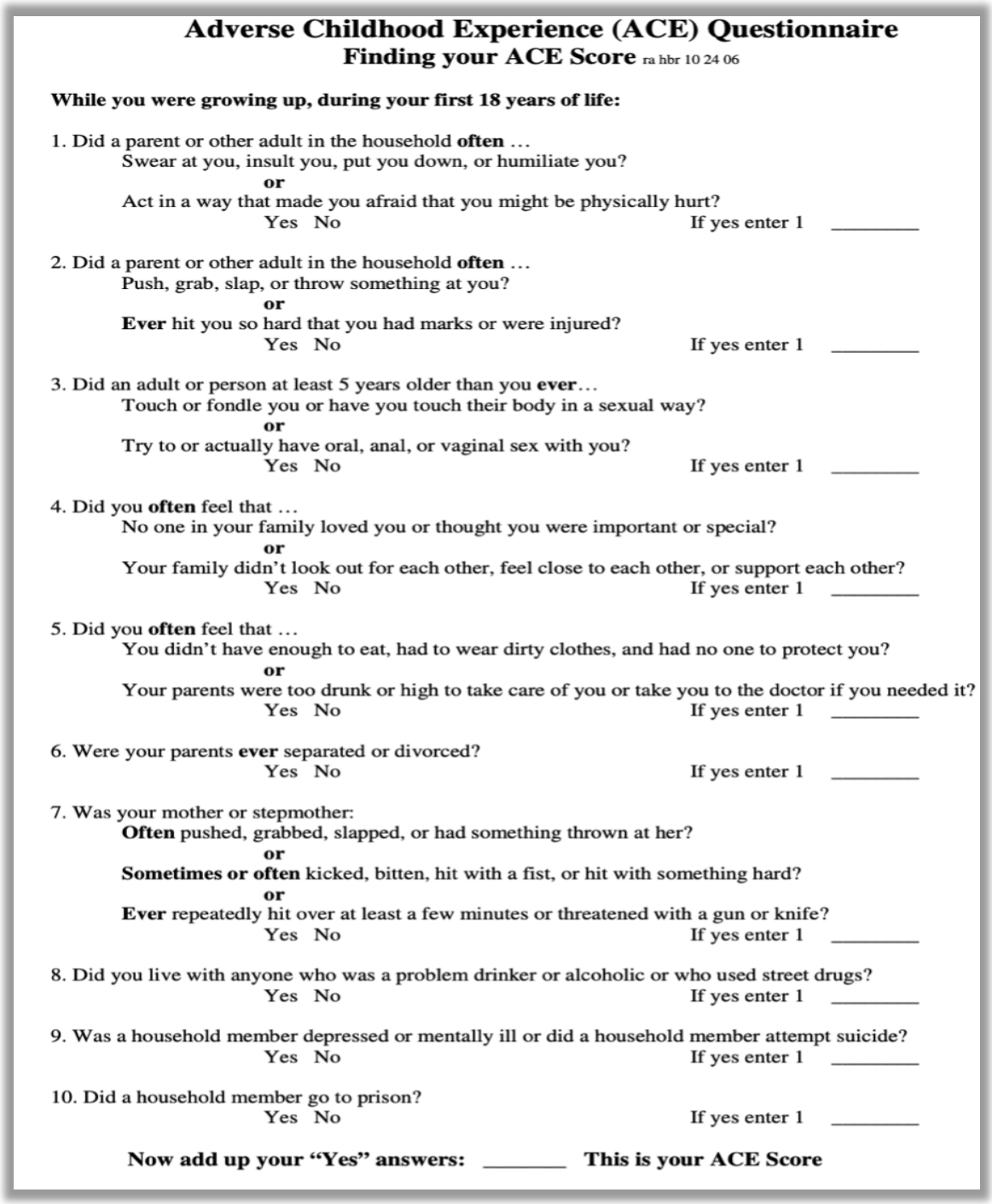
The first ACE study by Felitti et al. (1998) investigated whether people who had experienced household dysfunction or physical, sexual, emotional or psychological abuse in childhood were more likely to suffer from chronic illness or exhibit health risk behaviours. The researchers termed childhood

abuse “adverse childhood experiences”. The first ACE study established a relationship between ACEs before age 18 and long-term adverse physical and psychological health outcomes. Further, the relationship was “dose-response”; that is, the higher the number of ACEs, the greater the likelihood of long-term health problems such as heart disease, chronic lung disease, fractures, stroke, cancer, psychological illness, and chronic illness in adulthood (Dube et al. 2001; Felitti et al. 1998; Petruccelli, Davis & Berman 2019; Zarse et al. 2019). A systematic review and meta-analysis of ACEs and associated health outcomes highlighted that health professionals must consider screening the individuals in their care (Petruccelli, Davis & Berman 2019). Critically, health professionals need to be aware that even one ACE may impact children’s and adults’ long-term health and well-being (Petruccelli, Davis & Berman 2019).

About the ACE-Q

The ACE-Q is a brief 10-item self-report measure (see Table 4.4). The ACEs are categorised into three types: 1. childhood abuse accounting for psychological/emotional, physical, and sexual abuse; 2. Neglect, physical and emotional; and 3. household dysfunction, including parental mental illness, exposure to parental substance abuse or alcohol, criminal behaviour or imprisonment, parental separation or divorce and interpersonal violence towards mother or stepmother. ACE-Q questions are binary, scored yes/no, with one point for yes and zero for no. The presence of four or more “Yes” answers is the threshold that marks a high exposure to ACE experiences and is associated with a significantly increased risk of adverse, long-term health outcomes in adulthood.

Table 4.4: Adverse Childhood Experiences Questionnaire



Adverse Childhood Experience (ACE) Questionnaire
Finding your ACE Score ra hbr 10 24 06

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often** …
Swear at you, insult you, put you down, or humiliate you?
or
Act in a way that made you afraid that you might be physically hurt?
Yes No If yes enter 1 _____

2. Did a parent or other adult in the household **often** …
Push, grab, slap, or throw something at you?
or
Ever hit you so hard that you had marks or were injured?
Yes No If yes enter 1 _____

3. Did an adult or person at least 5 years older than you **ever**…
Touch or fondle you or have you touch their body in a sexual way?
or
Try to or actually have oral, anal, or vaginal sex with you?
Yes No If yes enter 1 _____

4. Did you **often** feel that …
No one in your family loved you or thought you were important or special?
or
Your family didn't look out for each other, feel close to each other, or support each other?
Yes No If yes enter 1 _____

5. Did you **often** feel that …
You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
or
Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
Yes No If yes enter 1 _____

6. Were your parents **ever** separated or divorced?
Yes No If yes enter 1 _____

7. Was your mother or stepmother:
Often pushed, grabbed, slapped, or had something thrown at her?
or
Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?
or
Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
Yes No If yes enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
Yes No If yes enter 1 _____

9. Was a household member depressed or mentally ill or did a household member attempt suicide?
Yes No If yes enter 1 _____

10. Did a household member go to prison?
Yes No If yes enter 1 _____

Now add up your "Yes" answers: _____ This is your ACE Score

THE AAI AND THE ACE-Q

Murphy et al. (2014), Thomson and Jaque (2017a) and Hiles Howard et al. (2017) have investigated the relationship between adult attachment state of mind and ACEs. All three studies investigated both

clinical and non-clinical populations. These studies suggest a moderate to strong relationship between an insecure attachment state of mind and a higher number of ACEs. They confirmed that four or more ACEs and lack of emotional support increased the risk of insecure attachment (Hiles Howard et al. 2017; Murphy et al. 2014; Thomson & Jaque 2017a). The AAI's three organised attachment classifications were the focus of a study by Hiles Howard et al. This study did not include the classifications U or CC. They found that welfare professionals had more ACEs than non-clinical participants. There was a high frequency of ACEs amongst welfare professionals, with 24.6% reporting four or more ACEs.

Additionally, 'preoccupied attached' welfare professionals had more ACEs than participants classified as 'dismissing' or 'secure'. Murphy et al. (2014) found that the likelihood of being classified as U/CC increased as exposure to ACEs increased. When the participant had been exposed to three ACEs, the chances of a U/CC classification was 38%; with four ACEs, the chances of U/CC attachment were 65%. Thomson and Jaque's (2017a) distributions of attachment classifications did not resemble the published norms of Bakermans-Kranenburg and van IJzendoorn (2009). Nevertheless, they found an association between increased ACEs and insecure attachment, especially for the participants who experienced loss during childhood. Study participants with a history of childhood trauma and loss were more likely to experience subsequent traumatic adult life events and have an AAI attachment classification of unresolved.

The three ACE studies presented here are significant for my research study, demonstrating a relationship between the number of ACEs and insecure attachment. Two studies, (Murphy et al. 2014; Thomson & Jaque 2017a), show a strong relationship between either U or U/CC classifications and four or more ACEs. In addition, Hiles Howard et al.'s (2017) sample of child welfare workers corresponds to my sample of CFH nurses, as does Murphy et al.'s (2014) cohort of women with infants. These two studies offer a glimpse of the attachment state of mind of professionals working with women with infants and children, their attachment state of mind (as classified by the AAI) and evidence of ACEs during their first 18 years.

NURSE-CLIENT CAREGIVING RELATIONSHIP INTERVIEW – NURSE AND CLIENT (NCCRI – NCCRI-N & NCCRI-C)

This research required an instrument to measure the caregiving relationship between the CFH nurse and the woman. I intended that the instrument would have four essential prerequisites, and these were to: understand the CFH nurses' experiences and ways of caring for the woman; the women's responses to the CFH nurse during mutual interactions and the woman's response when the CFH nurse was absent. The Nurse-Client Caregiving Relationship Interview – Nurse (NCCRI-N) aims to provide a parallel narrative to the AAI that may provide insight into how the CFH nurse's attachment state of mind affects how she perceives and subsequently provides caregiving to the woman. Correspondingly, the Nurse-Client Caregiving Relationship Interview – Client (NCCRI-C) also aims to provide a parallel narrative to the AAI, offering awareness of the woman's state of mind and how she perceives and receives the care her CFH nurse provides.

The interview schedule was required to apply to CFH nurses' and women's caregiving-care receiving relationship, have a nurse and client version, have elements of the working alliance and FPM goals, tasks, and helper qualities, and include some aspects of attachment. A search for nurse-client caregiving measures yielded several quantitative measures that examined nurse caregiving behaviours. Piredda et al. (2017) developed a 15-item Italian-language Nurse-Caring Behaviour Scale, demonstrating good construct validity and reliability. However, this scale was developed for use in the acute care setting and focused solely on the nurses' behaviours and not on the caregiving relationship. Jean Watson's (1979/2008) transpersonal theory of caring, Caritas, where the need to has been used to develop several scales. The following three measures are instruments based on Watson's (1979/2008) 10 carative factors as described in Chapter 2.

The 70-item Caring Nurse-Patient Interaction Scale (Cossette et al. 2005) assessed nurses' responses to statements regarding Watson's ten Carative factors. A one (least) to five (most) Likert scale was used to assess the degree the nurses' considered each of the ten caring attitudes important; the degree they felt competent in adopting each attitude; and the degree to which they felt realistic about the application of each attitude in clinical practice. Cossette et al (2006) reduced the original version of the 70-item scale to the Caring Nurse-Patient Interaction Scale – Short Scale. The new scale had 23 items in the same format. This scale focuses on the nurse's attitudes, behaviours

and cognitions of what it means to be a caring nurse. Neither scale has a reciprocal client version nor is relationship focused, so unsuitable for this research.

Duffy, Hoskins & Seifert (2007) developed another quantitative instrument based on Caritas, the Caring Assessment Tool (CAT). This is a 36-item, eight-factor scale. This scale measured the client's experience of the nurse's caregiving during their hospital stay. However, this scale focuses only on the nurse's behaviours, not the nurse-client relationship. Similarly, to the other nurse caregiving instruments reviewed here, this scale measures nurse caregiving behaviours and qualities from the client's perspective, not the caregiving relationship.

Another measure based on Watson's Transpersonal Theory was the 75-item Caring Behaviours Inventory, followed by the 43-item Revised Caring Behaviours Inventory (Wolf et al. 1994). The Revised Caring Behaviours Inventory is scored on a four-point scale and has five dimensions or subscales of caring, including respectful deference to others (courteous regard to others); assurance of human presence (investment in the other's need for security); positive connectedness (optimistic and constant readiness on the part of the nurse to help the other); professional knowledge and skill (proficient, informed and skilled nurse) and attentiveness to other's experience (appreciation of and engrossment in the other's perspective and experience). The Inventory underwent two more iterations, Caring Behaviours Inventory-24 Revised and the Caring Behaviours Inventory-16 revised (Wolf et al. 2017; Wolf et al. 1994). This scale closely reflects concepts found in attachment theory, such as focusing on the need for security, connectedness and attending to and taking the client's perspective. Nevertheless, these concepts are difficult to measure on a four-point quantitative scale. Additionally, the client's perceptions of the nurse's caring could affect how they answer the questions leaving the scale open to response bias. Finally, the scale does not address the nurse-client caregiving relationship from both perspectives.

Töyry & Vehviläinen-Julkunen (2001) developed a client response measure, the Humane Caring Scale, consisting of 60 items in five domains of care: respect for patient's social relations and privacy; support for patient's personal growth and development; appreciation of patient's emotional life; maintenance and promotion of patient's physical health; and provision of the necessary condition of humane caring. The scale was later modified to the Revised Humane Caring Scale, now 46 items, rated on a five-point Likert scale. The five subscales were renamed: maintenance of social relations

and privacy; communication and participation; respecting patients' feelings; maintaining and promoting physical health; and ensuring the necessary condition of humane caring (Goh et al. 2016). Similarly, to the other nurse caregiving instruments reviewed here, this scale measures nurse caregiving behaviours and qualities from the client's perspective, not the caregiving relationship.

The quantitative instruments examined in this short review represent the current measures to investigate the nurse-client caregiving relationship. A quantitative instrument that measures observable nurse qualities, attributes or behaviours from the client's or nurse's perspective did not meet the study requirements. Therefore, I developed a set of interview questions to meet the objectives of the research.

The qualitative interview for this research had two objectives. The first objective was to capture data concerning the initial meeting between the CFH nurse and the woman. This sets the scene for the woman and CFH nurse's caregiving relationship or working alliance (WA). Horvath (2000, 2001; 1991) explained that establishing a positive WA early in therapy is vital to successful outcomes, especially the client's perception of their relationship and the therapist as an individual. Bordin (1979; 1994) also proposed that the client's ability to develop therapy goals was impacted by their history of previous relationships. Therefore, the aim was to incorporate aspects of the WA as well as the FPM that would enable me to delve into the CFH nurse and woman's experience of their initial meeting, setting goals to work on together during their time together, and the intersubjective experiences of their caregiving and care-receiving relationship (Cortina & Liotti 2010a, 2010b; Trevarthen 2001).

The second objective of the interview related to Bowlby's assertion (1988e, p. 82) that attachment behaviour is a distinctive feature of people and continues from "the cradle to the grave". Therefore, the interview was designed to capture whether the women exhibited secure base behaviour, that is actively seeking out the nurse for help when distressed (Bowlby 1988b; Liotti & Prunetti 2010; Waters & Waters 2006). The woman's responses to the questions "how did it feel to be cared for by the nurse" and "did you feel dependent" with the subsequent prompts were asked to identify if the women actively searched out the CFH nurse as a "stronger and wiser" individual when distressed, thereby demonstrating secure-base behaviour (George & West 1999; Solomon & George 2011). As no other self-report or qualitative interview schedule met these specific requirements, I developed a semi-

structured interview called the Nurse-Client Caregiving Relationship Interview: Nurse version and Client version (see Table 4.5).

Table 4.5: The Nurse-Client Caregiving Relationship Interview: Nurse and client Versions

Nurse-Client Caregiving Relationship Interview

Nurse Version

1. Why did you work with (name) the way you did?

2. Can you describe the type of approach you used to work with [name)?

   Probe:
   a) explore this approach to identify the triggers/motivation for using this

3. How did you feel when you worked with (name)?

4. What were your expectations of your working relationship with [name)?

   Probe:
   a) What was your initial encounter like?
   b) How did it affect the way you developed goals and tasks?
   c) Tell me more about that

5. Was it a satisfying relationship?

   Probe:
   a) Can you tell me a little bit more about that?

Client Version:

1. How did it feel to be cared for by (name) during your admission?

   Probe:
   a) Can you tell me a little bit more about that?

2. What were your expectations of your working relationship with (name)?

   Probe:
   a. What was your initial encounter with (name) like?
   b. Did it affect the way you were able to develop your goals and tasks?
   c. Were you able to set some goals?

3. Did you feel dependent on [name]?

   Probe:
   a) Can you tell me a little bit more about that?

4. Did you find the relationship satisfying?

   Probe:
   b) Can you tell me a little bit more about that?

NCCRI/Nurse & Client Version/F.Chavasse/2022

The Nurse version consists of five questions and five probes, and further prompts were made when required. The first question asks the nurse to describe how she worked with the woman, allowing her to reflect on her experiences with the woman and begin to tell her story. This question was loosely based on question one of the AAI. Question two asked the nurse to describe the type of approach she used to work with the woman, and the prompts were to identify motivations or triggers. This question relates to the FPM in which the nurse received training and the nurse's own IWM. Question three moves to a deeper level and asks the nurse how she felt working with the woman, again tapping into her IWM. Question 4 moves to the working alliance and the nurse's expectations of the relationship; the probes are directly related to the Working Alliance Inventory (Horvath & Greenberg 1989). Finally, question 5 and its probe asks the nurse to consider whether her relationship with the woman was satisfying. Again, this question is related to the working alliance but also asks the nurse to consider whether her relationship satisfied her, a term more in keeping with attachment. Each question had specific prompts or a general, "Can you tell me a little more about that?"

The client or woman's version has four questions and six probes. The first question directly relates to the woman's attachment system "how did it feel to be cared for [your nurse] during your admission?" With a probe, tell me more. Question two asks the woman what her expectations were of the working relationship. This is similar to the nurse's question about the working alliance. Question three is specifically about attachment and enquires if the woman felt dependent on her nurse during her stay; it has a follow-up probe. Can you tell me more about that? Question three relates to the secure base concept as explored in Chapter one. The final question four is the same as the CFH nurses "did you find the relationship satisfying?" with the probe.

My supervisory panel checked the interview schedule, and we discussed how it would be used. The NCCRI was explicitly designed for the research to enable me to use it in concert with the AAI and ACE-Q. The narratives of the AAI and NCCRI allowed me to ascertain if the characteristics of the nurse's caregiving could be attributed to her attachment state of mind. Likewise, as classified by the AAI, the woman's attachment state of mind was crucial to gaining insight into how the woman received care from the CFH nurse. The narratives were analysed separately and then together. The ACE-Q was used to screen both interviews and medical records to look for adverse childhood

experiences that may have caused trauma and consequently affected the CFH nurse's caregiving and the woman's care receipt.

THE BENEFIT OF USING MULTIPLE SCALES

Combining the three methods used in the case study, the AAI, ACE-Q, and NCCRI generated a multifaceted picture of the participants' unconscious processes. The AAI examines the CFH nurses' and women's narrative discourse to uncover early experiences, including trauma, loss, rejection, unloving parental behaviour, and neglect. These events are adverse childhood experiences, and the early experiences and traumatic events identified shape CFH nurses' and women's IWMs. Both CFH nurses' and women's attachment state of mind as classified by the AAI determines whether they restrict (dismissing) or maximise (preoccupied) attention towards attachment-related topics, which lowers their coherence of mind (Hesse 1996; Minde & Hesse 1996). When both insecure dismissing and preoccupied strategies are substantially present, this represents global attachment disorganisation, meaning either the CFH nurse or woman lacks a single consistent attachment state of mind (Hesse 2016; Main 2000). In other words, there is no single way to organise and manage their attachment-related feelings, memories, relationships, beliefs, and desires.

The four case studies presented in this research use the findings of three methods to explain how the nurses cared, and the women received the care during their five-day residential stay. The first three case studies only included the organised attachment categories, whether secure or insecure for either the CFH nurse or the woman. The Dyads were not assigned by classification but occurred naturally in the day-to-day operation of the residential unit. The fourth, the main case, represents a CFH nurse with a low coherence U/CC state of mind and the two women she cared for who also presented with a low coherence state of mind U/CC and CC. Before turning to the case studies, the study's procedures will be described.

PROCEDURES

DATA COLLECTION METHODS

The data for this study relied on four sources of data collected over the four years, from 2016-2020. The data collection methods used were the AAI, NCCRI (Nurse and Client versions), the ACE-Q, and demographic data. Three instruments, the AAI, NCCRI (Nurse and-Client versions), and the ACE-Q of

data were chosen to provide a range of data to help answer the research questions and provide a greater understanding of how the state of mind of both the nurse and the woman she cared for, affected their caregiving relationship (Baxter & Jack 2008; Tellis 1997; Yin 2014). The demographic data provided information to understand the sample characteristics of the women and CFH nurses. The data collection for each case study was collected in three phases. The spoken language or narrative of the CFH nurses and women. This was done by semi-structured interview and audio-recording of the AAI; similarly, the CFH nurses and women's experiences of caregiving care-receiving were completed by semi-structured interview and audio-recording of the NCCRI, and the participant's childhood trauma was collected using the ACE-Q to screen the AAI transcripts for adverse childhood experiences.

DATA COLLECTION FROM THE CFH NURSES

There was no set time frame for the CFH nurse's AAI interviews, and each CFH nurse was interviewed when she was available. The AAI interviews occurred between 8th November 2016 and 30th July 2020. The CFH nurses were permitted by the Clinical Director of the Parenting Centres to be interviewed either during their usual work hours or after work in a private office in the Parenting Centre. All CFH nurses took advantage of this offer.

The four CFH nurses that required a second interview decided to do these either at their workplace in a private office or in the comfort of their home. I accommodated each CFH nurse's request. If the nurse became emotionally distressed because of the AAI, a Distress Protocol was put in place (see Appendix 8 Distress Protocol). None of the CFH nurses or women became highly distressed or inconsolable during their interviews. If the CFH nurse or woman was distressed, they were followed up the next day as required. The woman was asked if she would like a referral to Tresillian psychological services.

The CFH nurse's NCCRI-N interview was as close as possible to the discharge of the woman she was working with. This was usually done face-to-face, although, if the nurse worked part-time and was off-duty, the NCCRI-N was audio-recorded by a phone call as soon as possible after the woman's discharge. The CFH nurse's demographic data was collected when convenient for the nurse. They filled in a brief questionnaire providing their age, years of experience and qualifications. This data was gathered to appreciate their knowledge and expertise.

DATA COLLECTION FROM THE WOMEN RESIDENT AT THE RPS

The AAI was administered on day two and the NCCRI-C on day four just before discharge. The woman chose when to do the AAI, so if the woman was too busy or distressed on day two, another day was selected. The AAI and NCCRI-N were sometimes done on day four of her stay. None of the women objected to doing the two interviews at once. The length of time and the nature of the questions were provided before the interviews.

Most women decided to do the interviews once their baby or toddler was asleep. Two women chose to interview while their toddlers were present. The CFH nurses were aware when the women were being interviewed and were willing to provide uninterrupted time by attending to the baby or toddler when necessary. An interesting feature of interviewing the women admitted to a residential parenting unit was that it was not always possible to interview her without the baby or toddler in the room. If the baby were awake and needed to feed, the woman would feed the baby and often hold the baby throughout some part of the interview. This did not seem to affect the interview process as the woman appeared to focus on the questions, whether or not the baby was asleep. Some women did attend to their babies during the interview if the baby fussed for her attention; others did not. Most importantly, the baby in the room does not appear to have distracted the woman from the interview.

The toddlers were generally quiet in the two interviews, where the toddlers were awake and playing around the room. In these interviews, the toddlers did not seem to need much attention, and when they did require attention, the interview was paused, and the toddlers were given snacks and toys. Finally, the women's demographic data was collected from the admission notes in their medical record. This information was used to gain a picture of the background characteristics of women attending the RPS and the types of difficulties they were experiencing before and during their admission. The 25 AAI and 25 NCCRI interviews were digitally audio-recorded.

DATA ANALYSIS METHODS

The analysis of the data for each case study proceeded in two stages. Firstly, the women and CFH nurses' AAI was linguistically coded following the AAI protocol (Main, Goldwyn & Hesse 2003). For the NCCRI, the CFH nurse's and women's narrative or recounting of their caregiving and care-receiving experiences were analysed using Mary Ainsworth's four nine-point Maternal Sensitivity Scales (Ainsworth 1969) as well as comparing their NCCRI narratives to their coded and classified

AAI narratives for correspondences in state of mind. Finally, the ACE-Q was used to screen the coded and classified AAIs to search for adverse childhood experiences (see Table 4.6).

The final stage of analysis consisted of two analysis methods; these were: 1. cross-case analysis to look for themes, patterns, similarities and differences across the four case studies and 2. case-study comparison to synthesise the themes, patterns, similarities and differences between case studies to produce new knowledge and contribute emergent theory (see .Table 4.6.)

.Table 4.6: Analysis methods for each data collection method

	Data collection method			Analysis of data			
Instruments	**Spoken Language narrative**	**Nurse Caregiving women care-receiving**	**Childhood Trauma**	**Linguistic analysis**	**Screening AAI**	**Cross-case study analyses**	**Case study comparisons**
AAI	✓	✓	✓	✓		✓	✓
NCCRI	✓	✓		✓		✓	✓
ACE-Q			✓		✓	✓	✓

PREPARATION OF DATA FOR ANALYSIS

Audio recordings were transcribed by a professional transcriber, following the AAI protocol transcribing guidelines outlined by Main, Goldwyn and Hesse (2002). All the women's pauses were timed, dysfluencies and restarts included. Every participant was de-identified on both the audiotape and transcript using a digital code to ensure confidentiality. I reviewed the audiotapes while reading the transcripts to detect transcribing errors, and any errors were corrected before coding.

ANALYSIS METHODS FOR AAI DATA

AAI data were coded according to the scoring and classification system (Main, Goldwyn & Hesse 2003). Dr Loyola McLean co-coded eight of the 25 AAI transcripts, 32% of the participants' transcripts. Dr Loyola McLean is on my supervisory panel and is an AAI subject matter specialist and AAI certified instructor. The NCCRIs were analysed with checks by my supervisory panel. All recordings and transcriptions could be reviewed during the analysis of the transcripts and checked with the

supervisory panel when encountering difficulties with coding, language, meanings, or my interpretation of participant data. The ACE-Q scale was scored, and the implications of the findings were discussed in supervisory sessions and how best they could be used.

ANALYSIS METHODS FOR THE NCCRI NURSE AND CLIENT VERSIONS

Each of the 50 semi-structured interview transcripts was read several times to understand the speaker's language and her experiences before coding. A narrative analysis was then used to interpret the CFH nurse's and women's accounts of their experiences of caregiving and care-receiving. Similarly to the AAI the use of language was analysed for both women and CFH nurses, and the nurse's caregiving was analysed using *Ainsworth's Maternal Sensitivity Scales* (Ainsworth 1969; Ainsworth et al. 1978/2009). Mary Ainsworth (1969) identified four fundamental caregiving behaviours of the primary attachment figures that enable the child to use them as a secure base and safe haven, thus helping to establish a secure attachment to the caregiver. Ainsworth determined there were four key qualities of maternal caregiving behaviours: "Sensitivity versus insensitivity"; "Cooperation versus Interference"; " Availability versus ignoring and neglecting", and "Acceptance versus rejection of baby's needs". Using these critical maternal qualities, she developed nine-point scales, and with nine being the highest quality and one the lowest, she meticulously described maternal behaviour. These are the "Maternal Sensitivity Scales" (Ainsworth et al. 1978/2009). Although these scales were developed to assess maternal caregiving behaviours, more recently, her scales have been used to examine adult caregiving behaviours in romantic couple relationships (Collins & Feeney 2000; Crowell, Treboux, Yuan, et al. 2002). Ainsworth's work is the first principle or the foundational proposition of maternal caregiving behaviours. As attachment theory underpins this research, Ainsworth's four key caregiving qualities are the most applicable to analysing the caregiving behaviours of CFH nurses.

INTEGRATED ANALYSIS

The study's four CFH nurses and five women were selected through purposive theoretical sampling. Three CFH nurse caregivers and three women care-receiver pairs represented the three organised AAI classifications, secure, insecure dismissing and insecure preoccupied. In the main case study, one CFH nurse provided caregiving to two women during the same residential stay. The CFH nurse and the two women had the AAI CC classification. In addition to CC, one woman and the CFH nurse

had a U attachment classification. The attachment classifications of the CFH nurses and women who participated together were neither matched nor assigned. The AAI transcripts of CFH nurses and women were coded and classified after the women were discharged from the residential unit.

These nurse-woman caregiving pairs selected for the case studies were then studied in greater depth using the AAI scoring and classification systems as a framework to analyse their AAI transcript, consider similarities between the language they utilised in their AAI and determine if these reflected their attachment state of mind. Elements of the CFH nurses' descriptions of caregiving were also analysed using Ainsworth's (1969) sensitivity scales. The ways the CFH nurses integrated aspects of the FPM into their caregiving relationship were examined by the depth of descriptions of goal setting, strategy planning and personal qualities and attributes, such as empathy for the CFH nurse. The women's analysis focused mainly on similarities between AAI and NCCRI language and state of mind.

Once the CFH nurses' and women's interviews were analysed separately, they were compared within the case study to establish how each perceived the relationship.

RESEARCH QUALITY AND CREDIBILITY

Qualitative research involves observing human behaviour and, principally in my research, studying the spoken language to understand unconscious processes. The findings are presented in the representational language of attachment and offer dense, illustrative descriptions in four case studies. Janesick (2000, p. 394) believes that the value of the case study is its uniqueness: consequently, reliability in the traditional sense of replicability is pointless here. Therefore, what counts most in my research is whether the explanation fits the description of the cases and whether the explanation is credible (Janesick 2000). On the other hand, constructionist epistemology acknowledges multiple truths, so credibility and plausibility may not be unanimous (Gergen 2015d; Smith & Deemer 2000). Nonetheless, to ensure credibility and trustworthiness, several actions have been taken in this research (Noble & Smith 2015; Roberts & Priest 2006)

TRUSTWORTHINESS AND TRANSFERABILITY

Trustworthiness allows the qualitative researcher to demonstrate that their research findings can be trusted. Lincoln & Guba (1985) outlined an essential set of criteria to provide the trustworthiness of the research. These criteria include credibility, transferability, dependability, confirmability and

reflexivity. Korstjens & Moser (2018) maintain that credibility is concerned with the truth of the study and comparable to internal validity. The credibility of this study was established by participating in the long AAI and NCCRI with each CFH nurse and woman and then the subsequent prolonged engagement in coding each CFH nurse's AAI and NCCRI, then screening the AAI with the ACE-Q. Credibility was further established during the long analysis of the co-constructed caregiving and care-receiving interactions of the CFH nurses and women. This enabled the identification of key elements of the caregiving and care-receiving relationships.

Triangulation was established in three ways. Firstly, select examples of the three organised classifications and the two low coherence classifications. This fully represented the five AAI classifications for CFH nurses and the women they worked with. A sample of CFH nurses and women, 12 nurses and 13 women were recruited in three parenting centres to ensure trustworthiness. These case studies presented in this thesis provide detailed descriptions of the results through rich descriptions of the nurse's and women's histories, interpretations of their state of mind, their caregiving and care-receiving interactions and interpretations of each other and opportunities to listen to both CFH nurse and the women's voices. Secondly, four data sources were collected: the AAI, the NCCRI (nurse and client version), the ACE-Q and demographic data. Finally, the AAI was doubled-coded by Dr Loyola McLean and me to ensure agreement between us on the complex AAI transcripts.

Transferability for this research provides a rich, detailed, descriptive story about 12 CFH nurses and 13 women's caregiving and care-receiving relationship during a five-day stay at an RPS. Rich, thick descriptions of the data are thought to explain best and illustrate social interactions of significance and enable the reader to determine if the findings apply to their setting (Amin et al. 2020; Connelly 2016; Korstjens & Moser 2018).

Confirmability for this research was achieved by maintaining a complete inventory of the coded interviews, detailed notes of the analysis of the transcripts and monthly meetings with the supervisory panel to discuss findings. Member checking with the CFH nurses and women was not done due to the complexity of the interviews. Morse (2015) advises that sometimes checking the analysis with the participant is not always realistic if the result leads to the participant disagreeing that the result is wrong. A certified and reliable coder can only code the AAI, so member checking, in this case, is unrealistic.

Korstjens and Moser (2018) describe reflexivity as self-awareness of one's values, preconceptions and assumptions about why they are engaged and their role in their research. These essential questions can affect decisions made in the research. During the interviews, the CFH nurses and women were asked to retell potentially emotionally charged childhood histories or experiences of caregiving or care-receiving. In my research, I am not only close to the data while listening to and analysing, but I am also, as Frank (1997, p. 93) reminds me, "...embedded in the social life, not separate from it.." of the nurse-client caregiving relationships. Tufford and Newman (2012) suggest 'bracketing' is a method that may alleviate the difficulties that potentially have adverse effects in such situations, especially when the topic under research is critical. Gearing (2004) recommends three ways of bracketing: setting aside or suspending presuppositions surrounding a phenomenon internal to oneself. Another way is to focus on the phenomenon's essence to understand underlying presuppositions external to oneself. Finally, one may use a combination. My research employed reflexive bracketing, which required me to identify phenomena internal to myself and try to bracket these out with mindful self-awareness. Of course, bracketing out all personal values, assumptions, beliefs, and perspectives is not possible, so strategies were employed to enhance the process of my reflexivity.

After the AAIs were coded, I deeply reflected on the most emotionally challenging interviews. For example, I felt a great deal of empathy and sadness for the confusion and suffering of some CFH nurses who had experienced traumatic early parent-child relationships, which seemed to unconsciously affect their nurse-client caregiving relationships. Instead of feeling overwhelmed when I realised the unexpected difficulties, the knowledge gave me a greater impetus to understand how we could construct new ways to think about the nurse-client caregiving relationship. When I felt I could not continue "...thinking about thinking..." (Frank 1997, p. 87), I approached supervisory panel members to explore how the analysed narratives challenged my emotions, truths, constructs and beliefs. Surprising findings were brought to the supervisory panel for discussion and further reflection.

To ensure my coding was correct, members of the supervisory panel co-coded, and discussion occurred. My mistakes in research, writing and data collection were, and always are, an opportunity to reflect and construct new ways of gaining insight into the research process. Additionally, I kept a

reflective journal to think about the research journey and particular events that affected me. Excerpts of the diary are provided in Chapter 9, Reflective Commentary.

CONCLUSION

This chapter has described the epistemological and theoretical foundations, design, methodology and methods of this research and explained the research's theoretical framework, social constructionism, and its importance to the research and its relation to the chosen qualitative methodology. 'Theory-building case study design was selected for the case studies, and its significance for the research in developing emergent theory. Finally, the remainder of the chapter focused on the data collection and analysis of the AAI, NCCRI and ACE-Q.

Chapter 5: Demographic Data And Frequencies of Adult Attachment Classifications and Adverse Childhood Experiences

Introduction

This chapter begins with a description of the participants' characteristics, after which the results of the AAI classification of each participant into one of the five AAI adult attachment classifications will be provided. These results will then be compared with published norms (Bakermans-Kranenburg & van IJzendoorn 2009). Following this, the ACE-Q results will be compared to published norms (Dube et al. 2001; Felitti et al. 1998).

A description of the participants

The Nurses

All the CFH nurses recruited into the study were female; their identities on their AAI transcripts and audio recordings used a unique number corresponding to the woman or women she worked with; for example, Nurse N0001 worked with the woman M0001. If a nurse worked with two women, the numbering was N0001 and M0001.1 and M0001.2. Subsequently, the CFH nurses were given fictitious names in the dissertation for easy discussion. The following are the characteristics of the sample of CFH nurses from the three RPS in the research study. All the CFH nurses were female; All 12 CFH nurses were registered nurses with postgraduate qualifications in CFH nursing. The CFH nurse's age range was from 29 to 59 years. Ten nurses worked part-time, and two worked full-time. The years of experience as a registered nurse ranged from two to 40 years. Their years of experience as CFH nurse was from one year to 35 years. Seven CFH nurses had postgraduate nursing qualifications in mental health, neonatal intensive care, infant and perinatal mental health, midwifery, paediatrics, clinical teaching, counselling, lactation consultancy and community and human services (see Table 5.1).

Table 5.1: CFH Nurse Demographics

ID No	Age in years	Gender	Employ status	Basic quals	Post grad Specialty	Postgrad nursing quals/other	Years of experience as RN	Years of experience CFHN	Years at Tresillian
Dana	58	F	Part time	RN	CFHN	Graduate Certificate (Grad Cert) Community & Human Services; Grad Cert Adult Mental Health	15	8	8
Carol	57	F	Part time	RN	CFHN	Masters (Ma) Nursing Research; Graduate Diploma (Grad Dip) Perinatal/Infant Mental Health	30+	30	3
Abbey	59	F	Part time	RN	CFHN	Ba Arts	11	5	5
Tonya	45	F	Part time	RN	CFHN	Grad Dip Midwifery; Grad Cert Neonatal Intensive Care; Ma Nursing (Clinical Teaching)	24	7	3
Leoni	47	F	Part time	RN	CFHN	NIL	15	4	4
Betsy	59	F	Part time	RN	CFHN	Midwifery	40	25	25
Rachel	58	F	Part time	RN	CFHN	Lactation Consultant	40	28	5
Andrea	53	F	Part time	RN	CFHN	Bachelor (Ba) Midwifery; Lactation Consultant; Grad Cert Mental Health	35	10	10
Claudia	53	F	Part time	RN	CFHN	Midwifery	25 (as RN)	20	8
Molly	48	F	Full time	RN	CFHN	Grad Cert Paediatrics; Counselling Cert.	23	13	13
Renee	29	F	Full time	RN	CFHN	NIL	2	1	1
Alisha	42	F	Part time	RN	CFHN	NIL	15	9	1.5

THE WOMEN IN THE RESEARCH

Demographic data were collected for each woman and her child. Similarly, to the CFH nurses, the women's identities on their AAI transcripts and audio recordings were concealed using a unique number corresponding to the CFH nurse she worked with, for example, the woman's identifier-M0001 and the CFH nurse-N0001. The women were given a fictitious names for ease of discussion. The women's age range was 25 to 36 years—twelve women identified as Caucasian, and one woman identified as Aboriginal. The women who volunteered for the study were predominantly middle class. Recent studies of the characteristics of women attending RPS are more likely to be socially advantaged and well-educated (Dahlen et al. 2019; Priddis et al. 2018).

Based on the audit of their medical records, the women were presenting to the RPS asking for assistance with parenting their infant or toddler. When their admission notes were examined, there were five main concerns for their infant and or toddler. The main concern for admission was sleep and settling difficulties, with all the women being admitted for help. Problems with feeding either by breast, bottle or solid feeding were the next most important reason (92.3% n=12), as was help for adjustment to parenting (92.3% n=12). The final two worries the women were admitted for were support for their crying baby (69.3% *n*=9) and needing a toddler routine or help with toddler behaviour (61.5% *n*=8).

Table 5.2: Women's Demographics

Woman's ID	Age	Baby's Age & birth order	Reason on admission interview	Pregnancy-birth	Ethnicity
Alice	33	Male 6/12 – 1st	Lack of support; adjustment to parenting; fatigue and exhaustion; baby medical problems; sleep and settling; anxious	Uneventful NVD	Caucasian
Melissa	36	Male 20/12 – 2nd	Fatigue and exhaustion; depression; sleep and settling; weaning; EPDS 1 Ques 10; lack of support; alcohol addiction	Unplanned; binge alcohol use. NVD	Caucasian
Nicole	33	Female 10/12 – 1st	Fatigue and exhaustion; lack of support; anxious; sleep settling/feeding; poor relationships – mother/husband; low birthweight	Preeclampsia; ventouse; traumatic birth	Caucasian
Crystal	31	Female 20/12 - 1st	Fatigue and exhaustion; depression; sleep and settling/feeding; mother of baby just diagnosed with epilepsy	Unplanned; forceps; prolapse; traumatic birth	Caucasian
Marilyn	35	Male 7/12 2nd	Depression/anxiety; history of child sexual abuse; fatigue and exhaustion; unsupportive partner; sleep and settling/feeding;	Nausea & vomiting antenatal bleed; induced	Caucasian
Georgiana	32	Female 3/12 - 2nd	anxiety; fatigue & exhaustion; Adjustment to parenting; sleep and settling/feeding	Unplanned shock; NVD	Caucasian
April	25	Female 2 yr 1st & 2nd 8/12	adjustment to parenting; fatigue and exhaustion; EPDS 1 Ques 10; sleep and settling/feeding; unsupportive partner;	Both unplanned and regrets; caesarean x 2	Caucasian
Amy	35	Female 17/12 - 4th	Sleep and settling, night waking, fussy with solids; depression; now 14 weeks pregnant	Normal pregnancy NVD.	Aboriginal
Ally	31	3/12 1st child	Sleep and settling/feeding; Fatigue and exhaustion; infant crying and normal behaviours	Normal pregnancy NVD. 3rd degree tear	Caucasian
Holly	28	Female 15/12 - 1st	Sleep and settling/feeding; EPDS Ques 10 scored 2; complex family history; Fatigue and exhaustion; recent death in family	Eclampsia, hyperemesis Trauma birth	Caucasian
Jill	32	Females 2 yr 7/12 - 1st & 2nd 11/12 -	Fatigue and exhaustion; feeling overwhelmed; depression/anxiety; Sleep and settling/feeding;	POP, prolapse Traumatic birth	Caucasian
Sabrina	36	Female 6/12 -2nd	Sleep and settling/feeding; unsettled crying; lack of support; Fatigue and exhaustion; parent skills	Induced - NVD	Caucasian
Tabitha	33	Female 2yr 8/12 - 3rd	Little support – Single parent; depression/anxiety; own mother passed away 2009; support with parenting skills	Unplanned NVD	Caucasian

Table 5.3: Reasons for Admission: Parenting and Psychosocial Concerns

	Alice	Melissa	Nicole	Crystal	Marilyn	Georgiana	April	Amy	Ally	Holly	Jill	Sabrina	Tabitha	Total
Sleep & settling difficulties	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	13
Breast, formula and/or solid feeding problems	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	12
Adjustment to and Parenting	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	12
Crying baby/unsettled	✓		✓		✓	✓	✓	✓	✓		✓	✓		9
Infant/toddler routines	✓		✓	✓			✓		✓		✓		✓	8
Anxiety and/or depression	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	12
Fatigue/exhaustion/ Sleep deprivation	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		12
Difficult relationship mother: low support		✓	✓	✓	✓	✓	✓			✓	✓	✓		9
Calls herself a worrier	✓	✓	✓	✓	✓		✓		✓	✓			✓	9
Difficult pregnancy Birth Trauma		✓	✓	✓	✓		✓			✓	✓	✓		8
Not confident/can't cope	✓	✓	✓				✓		✓		✓		✓	8
Partner conflict: low support	✓	✓	✓	✓	✓		✓					✓	✓	8
Other Mental illness-Trauma		✓		✓	✓					✓	✓			5
Unplanned pregnancy		✓		✓		✓	✓						✓	5
EPDS yes Q.10		✓					✓			✓				3

On the other hand, when the women's admission entries to their medical records were examined, ten apparent reasons emerged that contributed to her admission to Tresillian. When the women were placed in each ten group, 92.3% (n=12) of the women who attended the parenting centre experienced anxiety and/or depression. The same percentage reported feeling fatigue, exhaustion or sleep deprivation (92.3% *n*=12). The following two most common concerns the women spoke about were relationship difficulties with their mother (69.2% *n*=9) or they considered themselves a worrier (69.2% *n*=9); a slightly lower percentage felt they could not cope or had low self-confidence (61.5% *n*=8). Eight women (61.5%) presented with a history of a complicated pregnancy or birth trauma, a further eight (61.5%) related they had a poor relationship and low support from their partner and five women (38.4%) had experienced trauma or mental illness other than depression or anxiety. Finally, 38.4% (n=5) women related that their baby was an unplanned pregnancy, and 23.08% (*n*=3) women answered positively to question 10 on their Edinburgh Postnatal Depression Scales (EPDS).

The EPDS is a 10-item self-report measure created to screen women for symptoms of postnatal depression initially during pregnancy and during the postnatal period (Cox, Holden & Sagovsky 1987; Murray 1990). The woman is asked to think about how she has felt over the last seven days and answer each question that scored zero to three. A score of $\geq$13 indicates a sign of possible symptoms of depression and a need for further assessment (Buist et al. 2006; Cox, Holden & Sagovsky 1987). EPDS Question 10 asks, "the thought of harming myself has occurred to me". A positive response to this question requires immediate discussion with the woman to determine if she is currently suicidal and needs further assessment, referral or even emergency help from mental health services. All women and sometimes their partners are offered the EPDS to fill in on admission to RPS. This enables the CFH nurses to provide the best psychological support if further assessment and referral are required by the woman in her care (Priddis et al. 2018; Sims & Fowler 2018).

None of the women had attended Tresillian for help with these difficulties and in some cases, seemed unaware they had troubles with their mental health and wellbeing. Most importantly, they were unaware of the impact on their relationship with their baby. These ten psychosocial concerns have a temporal relationship with some of the known adverse childhood experiences which are known to play a role in the later development of depression, anxiety, relationship difficulties, substance use, and suicide attempts (Anda et al. 2004; Dube et al. 2001; Felitti et al. 1998).

ATTACHMENT CATEGORIES BASED ON THE AAI

The RPS in which this research was undertaken is a community-based service catering to normative low-risk populations. CFH nurses who work in the centre and the women who attended the parenting centre would be considered a normative low-risk sample. Before presenting the findings, it is acknowledged that this small purposive sample for case study research reduces transferablility to a broader population of CFH nurses and the women they work with. Nevertheless, as a matter of great interest and importance to nursing research, this section will present the findings of the CFH nurse's and women's AAI attachment classifications and compare them to Bakermans-Kranenburg & van IJzendoorn (2009) published norms for both normative low-risk and clinical AAI distributions. There is no expectation that these AAI classification percentages provide evidence of statistical significance. In the case of the ACE-Q, the findings are offered as an indication of the historical trauma the CFH nurses and women have experienced.

In Table 5.4, the CFH nurse's and women's main organised attachment classifications are shown by colour to provide an initial representation of attachment classifications).

Table 5.4: Nurse-woman caring relationship: Attachment classifications

Dyad	Nurse's (n=12)	AAI classification	Women (n=13)	AAI classification
1.	Nurse Dana[1]	F4a	Alice	Ds3a Early discharge (ED)
2.	Nurse Carol Case study	U CC/E1/Ds2 (IRR)	Melissa Nicole	U CC/E1/Ds2(IRR) (ED) CC/Ds2/E1 (IRR)
3.	Nurse Abbey	F4a	Crystal	F4a
4.	Nurse Tonya	Ds3b	Marilyn	U F5 (ED)
5.	Nurse Leoni	F3	Georgiana	E2
6.	Nurse Betsy	F3	April	Ds1
7.	Nurse Rachel	F4a	Amy	Ds1
8.	Nurse Andrea	CC/Ds3/E2 (IRR)	Ally	Ds1
9.	Withdrew from research			
10.	Nurse Claudia	CC/E1/Ds3a (IRR)	Holly	U F5 (IRR)
11.	Nurse Molly	U CC/Ds2/E general (IRR)	Jill	E general
12.	Nurse Renee	Ds3a	Sabrina	F4a
13.	Nurse Alisha	U E3/E1 (IRR)	Tabitha	Ds1/Ds2

Attachment subclassifications

Secure F3 (*n*=2); F4a (*n*=5) F5 (*n*=2)

Dismissing Ds1 (*n*=4); Ds2 (*n*=5); Ds3a (*n*=3); Ds3b (*n*=1)

Preoccupied E1 (*n*=5); E2 (*n*=2); E3 (*n*=1); E general (*n*=2);

Unresolved U (*n*=6)

[1] All names and identifying details of nurses and women have been deidentified to protect privacy

Table 5.5 and Table 5.6 shows the main sub-category descriptors (norm, clinical and trauma/abuse). Table 5.5 presents the percentages of primary organised attachment classifications, without the CC alternate organised categories, and Table 5.6 includes the CC alternated categories. This was done to ensure that the CC primary organised (F, Ds, and E) categories are considered in the percentage rates of the interviews, and these are placed into their representative categories. These two tables identify the unresolved and CC categories as single discreet categories, as well as combined as U/CC.

The sub-category descriptors provide a glimpse of classifications not often seen in normative or low-risk samples. One CFH nurse was classified as “fearfully preoccupied by traumatic events” (E3), and two women and four CFH nurses were classified as CC.

Table 5.5: Nurse-women AAI classifications: frequencies of norms and clinical groups without cannot classify alternate sub-classifications

AAI Classification	Sample nurses (*n*=12)		Norm	Clinical	Trauma Abuse	AAI Classification	Sample women (*n*=13)		Norm	Clinical	Trauma Abuse
Secure	5 (41.6%)		56%	21%	14%	Secure	4 (30.7%)		56%	21%	14%
Dismissing	2 (16.6%)		16%	23%	11%	Dismissing	5 (38.4%)		16%	23%	11%
Preoccupied	1 (8.3%)		9%	13%	7%	Preoccupied	2 (15.3%)		9%	13%	7%
Unresolved	3*[1] (25%)	U/CC 5	Unresolved/cannot classify			Unresolved	3* 23.8%	U/CC 4	Unresolved/cannot classify		
Cannot Classify	4	41.6 %	UCC 18%	U/CC 43%	U/CC 68%	Cannot Classify	2	30.7%	U/CC 18%	U/CC 43%	U/CC 68%

Nurse-Women AAI classifications and frequencies norm and clinical groups without Cannot Classify[2]

[1] Not counted as a separate classifications in totals (*n*=12)

[2] Four-way distributions "American mothers community, low-risk sample" (Bakermans-Kranenburg & van IJzendoorn 2009, p. 241)

Table 5.6: Nurse-women AAI classifications: frequencies of norms and clinical groups with cannot classify alternate sub-classifications

AAI Classification	Sample nurses (*n*=12)		Norm	Clinical	Trauma Abuse	AAI Classification	Sample women (*n*=13)		Norm	Clinical	Trauma Abuse
Secure	5 (41.6%)		56%	21%	14%	Secure	4 (30.7%)		56%	21%	14%
Dismissing	2 (16.6%)		16%	23%	11%	Dismissing	5 (38.4%)		16%	23%	11%
Preoccupied	1 (8.3%)		9%	13%	7%	Preoccupied	2 (15.3%)		9%	13%	7%
Unresolved	3*[1] (25%)	U/CC 5	Unresolved/cannot classify			Unresolved	3* 23.8%	U/CC 4	Unresolved/cannot classify		
Cannot Classify	4 33.3%	41.6 %	UCC 18%	U/CC 43%	U/CC 68%	Cannot Classify	2 15.3%	30.7%	U/CC 18%	U/CC 43%	U/CC 68%

Nurse-Women AAI classifications and frequencies norm and clinical groups without Cannot Classify[2]

[1] Not counted as a separate classifications in totals (*n*=12)

[2] Four-way distributions "American mothers community, low-risk sample" (Bakermans-Kranenburg & van IJzendoorn 2009, p. 241)

Table 5.7 shows the AAI classifications for the participants combined. Here again, the data are presented as non-CC and CC-samples. Thirty-six percent (*n*=9) of both non-C and CC-samples were secure compared to a norm of 56%. The dismissing sample non-C was 28% (*n*=7) and the CC-sample was 52% (*n*=13) both significantly higher than a normative sample of 16%. The combined preoccupied non-cc sample was 12% (*n*=3) and the CC-sample was 40% (*n*=10) also higher than the norm of 9%. The AAI classification percentages of the combined sample in this study, show a closer resemblance to clinical samples

Table 5.7: Nurse-women AAI classifications: combined frequencies of norms and clinical groups with and without cannot classify alternate sub-classifications

Combined sample of nurse's and women attachment classifications without cannot classify alternatives

Total	Secure	Dismissing	Preoccupied	U	CC (*n*=6)	U/CC
Sample *n*=25	36% (*n*=9)	28% (*n*=7)	12% (*n*=3)	24%	24%	(36%)
Normative	56%	16%	9%	U/CC	18%	
Clinical	21%	23%	13%	U/CC	43%	
Abuse/PTSD	14%	11%	7%	U/CC	68%	

Combined sample of nurse's and women attachment classifications with cannot classify alternatives

Total	Secure	Dismissing	Preoccupied	U	CC (*n*=6)	U/CC
Sample *n*=25	36% (*n*=9)	52% (*n*=7)	40% (*n*=3)	24% (3CC)	24%	9 (36%)
Normative	56%	16%	9%	U/CC	18%	
Clinical	21%	23%	13%	U/CC	43%	
Abuse/PTSD	14%	11% (6CC)	7% (6CC)	U/CC	68%	

FREQUENCIES OF U/CC

The next consideration is the frequency of U and CC AAI classifications studied in the sample (Table 5.5 and Table 5.6). In the CFH nurses non-CC sample unresolved attachment is 25% (*n*=3) and CC is 33.3% (*n*=4). When unresolved and CC are combined, the CFH nurse's CC sample is 41.6% (*n*=6). The women's non-CC sample of unresolved attachment was 23.8% (*n*=3) and CC 15.3% (*n*=2). Combining the two classifications to U/CC, the women had a CC sample of 30.7% (*n*=4). Moving onto the combined sample of CFH nurses and women, unresolved and CC classifications were measured independently against the published normative sample of 18% for U/CC. In the study, the non-CC sample was 24% (n=5), and the CC was 24% (*n*=9). When the unresolved and CC were combined, the U/CC sample was 36% (*n*=9). Neither the CFH nurses nor women organised, or low-coherence states of mind resemble a normative or community sample. The implications of these findings have significance to nursing practice and will be explored in the rest of this study. The focal point of the main case study presented in chapter seven will be the AAI classification of low coherence states of mind U/CC.

ADVERSE CHILDHOOD EXPERIENCES IN THE CONTEXT OF ADULT ATTACHMENT

This small case study found higher frequencies of three or more ACE categories than the primary care sample in the original ACE study (Dube et al. 2001; Dube 2003; Felitti et al. 1998). Table 5.8 presents the frequency of adverse childhood events assessed from the AAI interviews using the ACE-Q. CFH nurses and women were exposed to three or more ACEs in each AAI classification. In each of the AAI organised categories, secure-autonomous, insecure dismissing and insecure preoccupied both the CFH nurses and women presented with three or more ACEs exposures.

Table 5.8: CFH nurse and women's frequency of adverse childhood experience exposure by AAI classification

Attachment classification	CFH nurses (*n*=12) N°Ace exposures			Women (*n*=13) N°Ace exposures			CFH nurses & women (*n*=25) N° Ace exposures				ACE Prevalence (%) per scores	
Secure	41.6% (n=5)			30.7% (n=4)			36% (*n*=9)				ACE exposure	ACE % (Dube 2003)
Ace exposure and %	0 25% (*n*=3)	2 8.3% (*n=1*)	3 8.3% (*n*=1)	1 7.7% (*n*=1)	2 15.4% (*n*=2)	4 7.7% (*n*=1)	0 12% (*n*=3)	1 4% (*n*=1)	2 12% (*n*=3)	3 ACEs (*n*=1) 4 ACEs (*n*=1) ≥3 8% (*n*=2)	0	31.3%
											1	24.2%
Dismissing	16.6% (n=2)			38.4% (*n*=5)			28% (*n*=7)				2	14.8%
Ace exposure and %	2 8.3% (*n*=1)		5 8.3% (*n*=1)	0 15.4% (*n*=2)	NI 7.7% (*n*=1)	1 7.7% (*n*=1)	5 7.7% (*n*=1)	0 8% (*n*=2)	NI 4% (*n*=1)	1 4% (*n*=1)	2 4% (*n*=1)	5 8% (*n*=2)	3	10.4%
													4	6.8%
													5	12.5%
Preoccupied	8.3% (n=1)			15.4% (n=2)			12% (n=3)					
Ace exposure and %	3 8.3% (*n*=1)			1 15.4% (*n*=2)			1 8% (*n*=2)			3 4% (*n*=1)		
U/CC	33% (n=4)			23% (n=3)			28% (*n*=7)					
Ace exposure and %	2 16.6% (*n*=2)	3 8.3% (*n*=1)	4 8.3% (*n*=1)	3 15.4% (*n*=2)	4 7.7% (*n*=1)		2 8% (*n*=2)	CFH nurses 3 ACEs (*n*=3) Women 4 ACEs (*n*=2)		≥3 20% (*n*=5)		

Highest ACE exposure per cohort AAI classification highlighted in red

A noteworthy finding emerged in the combined dismissing cohort of CFH nurses and women (*n*=7) where a CFH nurse and a woman each had five ACE exposures. The prevalence rate for five ACEs is 12.5%, and in this group 28% (*n*=2) had five ACE exposures. Finally, the combined cohort of CFH nurses and women in the U/CC group (*n*=8) with three or more ACE exposures was 20% (*n*=5). It is acknowledged that the small cohort (n=25) in this study does potentially affect the result of the frequencies presented.

CFH NURSE'S AND WOMEN'S FREQUENCY OF ACES BY CATEGORY

Table 5.9 presents frequency percentages by category compared to the Kaiser Permanente norms (Dube 2003). The CFH nurses and the women's ACEs were examined to determine their Both CFH nurses and women experienced high levels of emotional abuse, 41.6% of CFH nurses (*n*=5) 46.15% of women (*n*=6), with 44% (n=11) of full cohort experiencing emotional abuse, well above the norm of 12.2%. However, when it can to physical abuse the CFH nurses reported well below the published norm of 25.1%. Just two CFH nurses report physical abuse (16.6%), the women reported 23.1% (*n*=3) and the full cohort 20% (*n*=5). Regarding sexual abuse, one women disclosed (7.7%) being sexually abused. The nurses did not disclose any sexual abuse and of the total cohort only one women disclosed sexual abuse (4% *n*=1) well below the norm of 24%. This result is possibly incorrect and both the CFH nurses chose not to disclose sexual abuse. During the AAI some women did decline to describe some abuse experiences. Additionally, the CFH nurses may have chosen not to disclose this information to me as an "insider" researcher.

When it came to the category neglect published norm for emotional neglect is 16.7%. Here the CFH nurses scores 25% (*n*=3), the women 15.4% (*n*=2) and the full cohort 20% (*n*=5) just above the norm. The next neglect category is physical neglect. As this is a middle-class sample, the expectation is that the percentage for this will be low. The norm for physical neglect is 9.2%. In this sample, no CFH nurses experienced physical neglect; however, 15.3% of the women (*n*=2) did so above the norm. Overall, 8% (*n*=2) of the cohort experienced physical neglect.

Table 5.9: CFH Nurse and Women Frequencies (%) of Adverse Childhood

Adverse Childhood Experiences	Prevalence (%) of each category women (Dube 2003)	CFH nurses & women (*n*=25)	CFH nurses (*n*=12)	Women (*n*=13)
Abuse by category	*Percentages*	*Percentages*	*Percentages*	*Percentages*
#1 Emotional	12.2%	44% (*n*=11)	41.6% (*n*=5)	46.15% (*n*=6)
#2 Physical	25.1%	20% (*n*=5)	16.6% (*n*=2)	23.1% (*n*=3)
#3 Sexual	24.3%	4% (*n*=1)	0	7.7% (*n*=1)
Neglect by category				
#4 Emotional	16.7%	20% (*n*=5)	25% (*n*=3)	15.4% (*n*=2)
#5 Physical	9.2%	8% (*n*=2)	0	15.3% (*n*=2)
Household dysfunction by category				
#6 Parental separation, divorce (loss)	25.4%	24% (*n*=6)	25% (n=3)	23.1% (*n*=3)
#7 Mother treated violently	13.9%	20% (*n*=5)	25% (*n*=3)	15.3% (*n*=2)
#8 Household substance abuse	30.5%	4% (*n*=1)	8.3% (*n*=1)	
#9 Mental illness in household	25.3%	56% (*n*=14)	66.6% (*n*=8)	46.1% (*n*=6)
#10 Incarcerated household member	6.9%	0		
ACE score				
0	31.3%	20% (*n*=5)	25% (*n*=3)	15.3% (*n*=2)
1	24.2%	16% (*n*=4)	0% (*n*=0)	30.7% (*n*=4)
2	14.8	24% (*n*=6)	33.3% (n=4)	15.3% (*n*=2)
3	10.4	16% (*n*=4)	25% (*n*=3)	7.7% (*n*=1)
4	6.8	12% (*n*=3)	8.3% (n=1)	15.3% (*n*=2)
≥5	12.5	8% (*n*=2)	8.3% (*n*=1)	7.7% (*n*=1)
No information in transcript	-	-	-	7.7% (*n*=1)

In the household dysfunction category 25% (*n*=3) of CFH nurses, 23.1% (*n*=3) and the full cohort 24% (*n*=6) had parents who separated or divorced, which is the norm for this category of ACE. Conversely, the published norm for witnessing mothers treated violently is 13.9%. In this category 25% (*n*=3) of CFH nurses, 15.3% (*n*=2) of women and 20% (*n*=5) of the full cohort violence in the family. The highest frequency of ACE category for CFH nurses and women had a parent with a mental illness. CFH nurses had the highest frequency of 66.6% (*n*=8), 46.1% (*n*=6) of women, and 56% (*n*=15) of the full cohort experienced a parent with a mental illness. Neither the CFH nurses nor women disclosed that they experienced an incarcerated household member. Finally, 28% (n=7) of this sample (n=25) had three or more ACEs. Of the CFH nurses in the U/CC category, 25% (n=5) had three or more ACEs.

CONCLUSION

The links between the AAI classifications and rates of ACE exposure amongst the CFH nurses and women in this study are essential in establishing connections between their past and current nurse-client relationships. The number and burden of childhood ACE exposures place them at increased risk of developing health problems. Some difficulties associated with increasing ACEs are depression, suicide attempts, drug and alcohol use, and poor emotional and behavioural self-regulation (Dube 2003). Some women frequently present these problem types and are admitted to the parenting centre. It is worth noting that some of the CFH nurses may also experience similar undisclosed difficulties.

Another issue identified in the current study is that 25% (n=5) of CFH nurses and women were classified U/CC, which is often associated with mental illness (Fonagy & Bateman 2008; Lamott, Fremmer-Bombik & Pfafflin 2003; Speranza et al. 2017; Turton et al. 2001). Based on this finding and other evidence, the leading case study (Chapter 7) will examine how the CFH nurses and women's AAI attachment state of mind, ACE exposures, and any evidence of long-term adverse health outcomes, affects their capacity to engage in a meaningful nurse-client caregiving relationship affects their capacity to engage in a meaningful nurse-patient caregiving relationship.

Chapter 6: RESULTS – CASE STUDIES (SECURE AND INSECURE ATTACHMENT)

The case studies of four nurse-client dyads will be presented in the following two chapters. Each dyad included a nurse and the woman (or women) she cared for. Each dyad was selected to illustrate one of the three main organised attachment states of mind: secure-autonomous (F), insecure dismissing (Ds), insecure preoccupied (E), unresolved (U) and cannot classify (CC) (Table **6**.**1**). This chapter presents three of the four case studies covering the three main organised attachment states of mind: secure-autonomous, insecure dismissing and insecure preoccupied, and the disorganised classification unresolved (U). The next chapter, chapter seven, focuses on one case study to explore the cannot classify AAI category in greater depth.

The three case studies in this chapter provide insight into the CFH nurses' and women's attachment state of mind and caregiving relationship through the use of their voices via excerpts from the AAI transcripts and NCCRI. Their voices offer glimpses into their co-constructed caregiving relationship as seen from the perspective of their NCCRI and their unconscious perspectives embodied in their internal representation of attachment, garnered from the AAI.

TABLE **6**.**1**: THE FOUR CASE STUDIES

CASE STUDY	CFH nurse	Woman	AAI category
		CHAPTER 6	
1.	Nurse Leoni		Prototypically secure-autonomous (F3)
		Georgiana	Insecure-preoccupied - involving anger (E2)
2.	Nurse Dana		Secure - strongly valuing of relationships (F4)
		Alice	Insecure-dismissing - dismissing of attachment (Ds3a)
3.	Nurse Tonya		Insecure-dismissing - dismissing of attachment (Ds3b)
		Marilyn	Unresolved for abuse Secure - resentful/conflicted (U/F5)

		CHAPTER 7	
4.	Nurse Carol		Unresolved for loss (U/CC/E1/Ds2) Cannot classify/ passivity/devaluing attachment
		Melissa	Unresolved for loss (U/CC/E1/Ds2) Cannot classify/ passivity/devaluing attachment
		Nicole	Cannot classify/involving anger/ dismissing of attachment (CC/E2/Ds1)

CASE STUDY 1: NURSE LEONI (F3) AND GEORGIANA (E2)

The first case study provides data provided by Nurse Leoni and Georgiana (the woman). Leoni's subclassification was F3, prototypically secure-autonomous, the ideal for secure narratives. Leonie had three ACE exposures, including losing a parent in childhood. Even so, Leoni told her life story clearly and coherently; she was able to evaluate her experiences with compassion, humour, and balance. Leoni cared for Georgiana, who was classified with an E2 insecure, angrily preoccupied attachment state of mind. While Georgiana had only one ACE exposure, she remained angrily preoccupied with her parents, particularly her mother. This preoccupation made evaluating her experiences in a balanced, coherent way challenging for her.

Nurse Leoni was an experienced CFH nurse who had worked at the residential unit for over five years. From the beginning of the AAI, Leoni's discourse was fresh and lively, and her answers thoughtful. She demonstrated an ability to monitor her thoughts and feelings as she described her childhood experiences to me. In this illustration, Leoni was thinking in the moment while she was trying to come up with adjectives to describe her mother:

> ***Leoni:*** *So, 'busy' Umm (4 sec)[37] Oh gosh, it's so hard. I find this really hard for her. Yeah, umm, 'busy' is the one that comes to mind. I'm just trying to think what else between those ages. I'd say 'Preoccupied', umm (8 sec) Oh gosh, this is really, really, really hard. What if I*

[37] Parenthetical times in seconds are pauses

can't think of a word that isn't terrible there? I actually am wracking my ... (6 secs) between those ages. Umm, she was 'Constant', I suppose, she was always there. Yep. Umm.

***Fran Chavasse [FC]**: Would you want to put 'Constant, always there'?*

***Leoni:** Maybe just 'Constant, umm (4 sec) And she was rea- ah (5 sec) Gosh, it's so hard. (5 sec) I want to say 'reliable', and she was reliable, but I wouldn't use that to describe her, umm (5 sec) Umm, I'd say 'Distant' yeah, umm, and probably - I wouldn't say 'sad', but, umm, like, flat. Yeah.*

***FC**: Ok, so that's five. Yeah. So you've got: 'Busy; Preoccupied; Constant; Distant and Flat.*

***Leoni**: Yesss, that sounds terrible, doesn't it?*

***FC**: No, that's just how you remember your relationship. That's not terrible, that's just how you found it.*

***Leoni**: With her yep, true. I feel so bad about that. She was a hard worker, I was going to say 'worker' was another one, but I think they're probably - that probably captures it.*

In this instance, Leoni struggled to find adjectives to describe her mother in a thoughtful and balanced way. She acknowledged how difficult the task was for her; she even asked herself, "What if I can't think of a word that isn't terrible?" As Leoni carefully considered her adjectives, she remained open and contained in her assessment of her mother, neither angrily blaming nor dismissing her mother. Leoni almost seemed to be taking a fresh view of her experiences with her mother as she selected her adjectives. Leoni's whole interview was typified by the ease with her imperfections, a valuing of her attachment relationships, a thoughtful approach, balance, and acceptance of her childhood experiences with her mother. Using Grice's Maxims to consider coherence (Grice 1989/1991; Main, Goldwyn & Hesse 2003)[38], Leoni's AAI discourse is, on the whole, truthful because she provided evidence for her life narrative, in other words, a quality narrative. She was also collaborative and told her story clearly as it gradually unfolded during the interview. In terms of coherent discourse and the

[38] For more information refer to chapter 4

manner in which Leoni told her story, she expressed her thoughts and feelings freely, remembered what she had said throughout the interview without making contradictions and provided evidence for what she said, thereby making her interview internally consistent (Main, Goldwyn & Hesse 2003).

Leoni worked with Georgiana, whose AAI was classified 'Preoccupied' with respect to attachment with a sub-classification of angry/conflicted (E2). In contrast to Leoni's thoughtful and balanced responses to my request for adjectives to describe her mother, Georgiana's approach to the AAI was very different. Georgiana presented with her three-month-old second daughter, Millie, who was unplanned, and Georgiana described her pregnancy as a "shock". She reported being anxious and exhausted; her EPDS score was 15 out of a possible 30, just two points above the cut-off score of 13. She also answered "no" to suicidal thoughts or self-harm, scoring zero (0) on question 10 of the EPDS. Georgiana had postnatal depression with her first child but did not believe she had it with her second child, even though she was anxious. Millie frequently woke at night, and Georgiana wanted assistance to learn sleep and settling techniques and gain psychosocial support. Georgiana's narrative was termed "excessively long" in the AAI coding manual, and she frequently did not answer the interview questions, features representative of preoccupied transcripts (Main, Goldwyn & Hesse 2003). Instead, she gave very lengthy answers, blamed her mother for what others might perceive, and AAI coders recognise as "minor offences", and provided examples where she quoted herself and her mother in past conversations.

An example of Georgiana's preoccupied narrative is provided in the following angrily preoccupied, 24-line excerpt. Georgiana is offering a memory for her adjective to describe her mother as "judgmental":

> [39] ***Georgiana:*** *so, they were thinking about doing this two-week trip, and one morning she's left a basket of washing on the, on the table, and said, "Before you go to uni, can you hang out the, the clean laundry?" "Yep, yep," and then, I don't know, I lay around, whatever I was doing, and then just before I left, I thought, "Ah, shit, the laundry. All right, crap," but I had to catch a bus to*

[39] All quotes are verbatim. This includes ummm, odd words or phrases, sudden reference to the wrong person, words left out of sentences, slang

go to uni. So, I just took it out and basically flung it all on the line. Like, it was all hung out, but I just, like, I didn't use pegs. So, she picked me up in the afternoon from somewhere, and I remember we in the car, drove up the driveway, and we stopped, and said, "Georgiana, there's something I want to talk to you about." I was like, "Yeah? What have I done now?" and she's like, she says, what, "Did you hang out the laundry that I," I said, "Yes I did," so, "yes, it's hung out, it's dry." She says, like, in this serious voice, like this is grave concern, this matter, "Did you use pegs?" "Well, no, no I didn't use pegs. No." "Well, it could have all ended up on the grass." "But did it?" "No. That isn't the point." "What is the point? Is the laundry dry?"

"Georgiana, one of the things your father and I talked about, going on this trip, was whether or not you were old enough and responsible enough" – excuse me – "to, um, look after the kids, and I said to your father, you know, [Father], we just have to trust her, but then I come home," almost in tears at this point, "and I find you haven't even used pegs on the laundry." "Mum, is the laundry dry? Like, can it be brought in and put in people's drawers?" "Yes. That isn't the point." I'm like, "Mum, okay, well, if you don't want to go to Europe because I don't use pegs on the laundry, um, honestly, it's a matter for yourself." But, just, "You're not responsible enough," kind of, "you are," you know, "a bit too selfish to really worry about other people's concerns." I'm like, okay, ideally the laundry would have pegs on it, but let's not kind of read too much into the peg situation on the laundry. So, ultimately, they went on their holiday. It turns out the pegs was not quite of such national significance,

In this exemplar excerpt, Georgiana has used approximately 19 quotes between herself and her mother in a sentence that does not seem to conclude. Significantly she appeared to forget that she had been requested to describe a childhood memory and instead discussed her early adulthood. She had lost control of her narrative and violated Grice's maxims of collaboration: quantity, relevance, and manner. A preoccupied angry/conflicted attachment state of mind is characterised by intensifying personal distress and demonstrating a strong need for support, closeness and dependency on other people.

LEONI AND GEORGIANA'S CAREGIVING RELATIONSHIP

The NCCRI (Nurse and Client versions) shed light on the caregiving relationship between these two women. Leoni started her NCCRI-N by thoughtfully clarifying the first question regarding her way of

working with Georgiana, “Why did we make the decisions we made together?” and then continued as she described the type of approach she used to provide care:

> *Ah, at first, I just tried to listen to what – where they were at. Like, and what were her concerns, and discuss with her, really, we just tried to problem solve what had been going on and wondering why that had happened together; and then, like, offering some suggestions. But planning with her what did she want to get out of the stay, that was a big part of it, and working out what her expectations are, as well, because she – often that really impacts people’s stay here.*

The follow-up question was, “What was the trigger or motivation was for using this approach?” and she answered:

> *I think I try to look at the whole picture. So, I – it’s never just one thing. So, I always go in with a, ah, a view that I really need to get a whole picture of what’s going on for them and all different parts of their lives, not just what the baby’s doing. And I try to – I try to put myself in their place and say, “Well, how would I feel if I come in with my baby and” – and so I never want to make them feel guilty. I always try to say, “This is what we can offer you; this is one way we might be able to help you if you would like to do that. We – you know – we can help you.” I don’t ever – not prescriptive, really. I think I just try to listen and support them and then we kind of plan together. Yeah, so I don’t think – I always try to put myself in their shoes, really, and I think then I try to make clear to them, maybe make things a bit clearer from what they’re saying’s going on in a way to kind of pull everything into, “Maybe these are the issues that we can help you with,” and more clarifying of the big problems that might walk through the door.*

In these two excerpts, Leoni’s narrative indicated she was psychologically available and responsive to Georgiana. She recognised and acknowledged Georgiana’s need to have her difficulties heard and validated before being offered any solutions to her problems. Leoni also appeared to be very accepting of Georgiana’s emotional state and behaviour when she stated, “Well, how would I feel if I come in with my baby - so I never want to make them feel guilty”. Even if Leoni disagreed with Georgiana, her secure state of mind enabled her to take a balanced view and work with her

collaboratively, respectfully, and sensitively to help Georgiana and her family find a way to address their difficulties.

Georgiana was keen to see me and do her final interview (the NCCRI-C). After greeting her, I asked Georgiana how she felt being cared for by Leoni, and she responded:

> *Really great, actually. Yeah. She was very, um, comforting and calm and warm and not judgmental and just – I gave – had a good conversation around expectations which I think is a really important thing in the beginning of a stay like this, so that everybody – like, clarifying exactly what we*[40] *wanted to get out of it, but also whether or not that was realistic. So, I feel like she gave us a good sense of what was realistic and achievable for our stay here. And, um, I – that's really helped – it's, um, helped us really get a lot out of our stay, actually*

In the following extract, Georgiana explains why she felt dependent on Leoni:

> ***FC**: So, did you feel dependent on Leoni?*
>
> ***Georgiana**: Oh, for the first – I did for the first settle, because I couldn't have done it on my own. Like, I couldn't – I mean, that's why we're here, because I – you know, Millie and I – my husband and I talk about the fact that, um, we would have given up well before she did in that first settle. But ultimately Leoni showed us that it could be done, so, um, but, I didn't – the fact that she sort of included us and talked us through what we were doing and what she was doing and why, has meant that, actually, while I've been here, I've actually primarily tried to do the settling myself first, and then, it's made me think, that I can do that, and then if I'm stuck, to call for help. But, um, she didn't make me think that she was the one with the skills and knowledge that needed, um, to be present. It was that we had it as well, but she was there to help if we needed it. So, um, I think that's an important distinction, actually. It's not – I guess you can, in the health system, have people who are – I'm the one with the skills and knowledge, and I'll*

[40] Georgiana refers to her partner who also stayed frequently.

impart them to you – but she was, you know, she was showing us that we could do it. She was just helping us get there. Yeah.

***FC**: Is there anything else you'd like to add?*

***Georgiana**: I always like seeing her name on the little board that she's on shift. I enjoy having her as part of my stay here she's a really – I feel like she's someone you can just explain anything to, that there's not going to be a problem, she'll work with you no matter what the issue is, so, um, yeah. I always like it when she's on shift.*

Georgiana's narrative provided an opportunity to understand her experience receiving care from Leoni. Her first description of Leoni as "comforting and calm and warm and not judgmental" suggested that Georgiana responded positively to Leoni's sensitive and accurate interpretation of her initial communications. Georgiana's final comment, "I feel like she's someone you can just explain anything to", implied that Leoni's sensitive, responsive and available approach had provided Georgiana with the experience of a secure base throughout her residential stay. This enabled Georgiana to make the best use of her time in the residential unit.

CASE STUDY 2: NURSE DANA (F4A) AND ALICE (DS3A)

Dana was also classified secure with a subclassification of F4a, *sentimental regarding attachment*. Individuals with this subclassification tend to express great love and affection for their parents; generally, their parents are loving in return. Alice had an insecure dismissing attachment Ds3, which indicates that she attempts to restrict her attention to attachment-related experiences, thoughts and feelings. There was no indication of any ACEs in either Dana or Alice's AAI transcript.

Nurse Dana was a very experienced CFH nurse with postgraduate qualifications. She had been working at the residential unit for over ten years. She was calm, ready for her interview, and keen to be part of the research. Dana's AAI secure sub-category F4a reflected her strongly valuing of relationships. Her AAI classification indicated that she was mildly, and positively preoccupied with the past, and descriptions of her childhood experiences with her parents were frequently sentimental and affectionate. She seemed eager to please her parents and somewhat overly forgiving of some negative aspects of their parenting. Nevertheless, she could tell her story coherently, valued her

relationships and provided adequate evidence for her experiences. Dana's transcript showed no evidence of exposure to ACEs and was thus scored 0 on the ACE questionnaire.

In this excerpt, Dana gave an account of her relationship with her parents as a young child:

> *So, um, the relationship with my parents, um, I guess if I look back, I think, yes, I was the centre of their world in the sense that I was their only child. So, there was a sense of me being precious and protected. Um, and it, if I looked back at any part of my childhood, Mum, Dad, and I had some real in-jokes that only we understood and, ah, we had a lot of humour. There was a lot of humour in our relationship. Not very much physical affection but a lot of humour and a lot of conversation. Um, so we were quite talkative. But, ah, the other thing I remember, too, is that Mum and Dad always had each other and sometimes I was on the outer. Um, but I was quite an introvert as a child and so able to easily occupy myself for long periods of time. So, although I look at the three of us, sometimes they had each other and I was just alone doing things, um, that suited my temperament. yep*

Dana's language provides evidence for her treasured feelings of being "precious and protected". Yet, she balances this memory with the observation that she was sometimes "on the outer". This does not appear to be a dismissing statement, firstly because she has already acknowledged that her parents were not very affectionate and demonstrates she knows that affection defines loving relationships. Secondly, she accepts that her parents "had each other," which suggests she implicitly forgives her parents for sometimes excluding her; neither blaming her parents nor herself for leaving her to her own devices. Dana was expressing her feelings and thoughts about her early relationship with her parents. Her memory for her adjective to describe her mother as "warm" does not contradict her initial description,

> *I really struggled with maths because I'm more creative than mathematical and she had this wonderful idea that if I was on a swing, I could learn times tables and so she and I would sit, when it was around year 2 when I was learning my times tables and I was really struggling, she would sit with me every afternoon after school and we'd swing and she'd, um, work with me on those tables. But it was more than just learning the tables, it was all that warmth of happiness*

of me swinging and her being so attentive and helping me learn as an individual I, like, she really got who I was.

This excerpt illustrated Dana's valued and cherished feelings for her mother and her childhood experiences. Dana was a sentimental speaker regarding attachment, which characterised her as an F4a speaker.

Dana worked with Alice, whose AAI was classified as Dismissing with respect to attachment, with a sub-classification of Ds3a Restricted in Feeling. Alice's superficial approach to discussing attachment experiences in her AAI differed from Dana's sentimental and strongly valuing approach to attachment relationships.

Alice was admitted to the residential unit with her six-month-old first son Ben who had been born with a congenital birth defect that had required frequent hospitalisations. She reported that she was fatigued and exhausted; her EPDS score was six and zero (0) to question 10. There is no evidence of exposure to ACEs in her transcript, and I scored her 0 on the ACE questionnaire. She presented as highly tense and anxious but did not believe she had mental health issues or required psychosocial support. Ben was frequently waking day and night, and Alice needed assistance to learn sleep and settling techniques. She wanted Ben to start solids and reduce breastfeeding.

Alice was asked for five adjectives to describe her relationship with her mother. She offered words that portrayed her mother in moderately positive terms but had trouble supporting these with positive childhood experiences. When Alice was asked to provide an episodic memory of a time her mother was loving toward her, she responded:

Um (3 secs) Um, loving. Ah, what, what brings, so (3sec.) Um (14 sec.) I've got so many memories of, like, that I keep thinking of other memories of, like, my dad or my grandparents, but, ah, it's difficult to, um, pinpoint a memory with Mum. Um, what would it be? I don't know. Loving. Okay. (3sec) Maybe ... (5sec) I'm drawing a complete blank. I'm so sorry. Um. Yeah. Um (10 sec.) Um, yeah, I don't have a specific one for Mum.

Alice responded similarly, "Nothing specific" to her adjective to describe her mother as "caring". Quite frequently, Alice would offer out-of-context praise for her mother, phrases not meaningful to her

discourse, such as, “She always cared about making sure that everything was, yeah, just right”, rather than providing a specific incident or memory. Alice’s discussion of her experiences with both parents was relatively superficial. Her narrative gave the impression that examining feelings and emotions was foreign to her, and negative experiences were minimised. Finally, she used the receipt of material objects and being taken to activities as evidence of loving parents.

DANA AND ALICE’S CAREGIVING RELATIONSHIP (NCCRI NURSE AND PATIENT VERSIONS)

Dana and Alice were both interviewed using the NCCRI. Dana was glad to see me again and discuss her relationship with Alice, especially as Alice had not completed her residential stay and discharged herself a day early. The following short excerpts from Dana’s transcript indicated her strong desire to help Alice and baby Ben’s relationship. The first question I asked was, “What was the type of approach you used?”

> *So, I used an approach which was a listening, primarily, approach. So, I asked some key questions in the admission, I did a lot of listening and acknowledging and validating how difficult the journey so far had been and understand - and I showed an understanding around why she was doing things the way she was doing, um, and then, over the course of our time together, I gently challenged her around, um, her reason for being in the residential unit.*

Dana responded to the question, “W*hat was motivating you?”*

> *The motivation was helping the mum get the most out of this relationship she could possibly get out. I felt that she was quiet and reserved and probably wasn’t joyful in this relationship, and I guess for both mother and baby – I really wanted her to see him, um, explaining to her and, and reaching out to her and telling her what he needed and how that would give her joy, um, in, so the relationship was everything.*

Dana gave the impression that she may have realised she had not met all of Alice’s needs when she responded to the question, *“How did you feel when you worked with Alice?”*

> *She was very lovely and accepting of what I had to offer, and – but I was aware that we were only able to get to a certain point together.....Helping her move away from that [professional]*

part of her life and having a relationship with her son is a very separate, um, idea around how I relate and how I look at life ... So, although, um, through our interactions, perhaps I put some ideas in her mind about her relationship with her baby, um. But longer-term work would have been more effective.

Dana's primary focus appeared to be on Alice's and Ben's relationship, very much in keeping with her sentimental state of mind regarding the parent-child relationship. Dana's final answer to "Was this a satisfying working relationship?" was:

Um, I think, from my viewpoint, as I said, there are, there are a few major things that I felt, um, I couldn't, um, help this mum make a big difference, um, and – But I feel like I gave her, um, both the ideas, I gave her new ideas, and I gave her some, um, knowledge, um, that she could work with. Yeah.

Dana appeared to be fully aware that her caregiving relationship with Alice was not as effective as she would have liked it to be, and she came across as somewhat perplexed by the outcome. Dana stated that, from her viewpoint, there were significant areas where she could help Alice, blaming neither herself nor Alice. It did appear, in her intense desire to heal Alice and Ben's relationship, that she had not been able to develop her caregiving relationship with Alice fully. Perhaps this contributed to Alice's need to discharge herself early.

I met with Alice briefly before her discharge on day four. Her NCCRI-C interview was brief, reserved, and very complimentary of Dana. When asked how she felt she had been cared for during her stay and what had been her expectations, she answered:

It felt, it felt good, yeah. Um, Dana was very, she's very caring and very understanding, and also, I think, um, quite a calm person, so, yeah, very reassuring (6 secs). Um, I didn't really have any expectations coming in. Um, I think I just wanted support and it was clear that Dana would definitely be able to provide support.

In further discussing her expectations, Alice revealed that she wanted help for practical mothercraft skills. Alice was familiar with practical and functional caregiving, similar to the caregiving she has

already described receiving from her parents in her AAI. No doubt this is comfortable and familiar for Alice; she continues:

> *So I gave him a breastfeed and she was just so calm and very, you know, she sort of said, "I'll just sit here quietly," and, afterwards, she gave me a lot of reassurance around the breastfeed, which was really nice, because I've struggled with breastfeeding, um, and have been mixed feeding all the way through. But yeah, yeah, she was great, and so I – even from that, I thought, oh, okay, great, she knows what she's talking about and, um, you know, she was quite supportive. Yep.*

When Alice was asked about her goals, she again described the benefits of receiving practical support:

> *The goals, yeah, the goals that I set were around getting him to, um, eat more of his solids and then the night waking. I think that obviously the night waking, the solids ... she was, she was good. Yeah. Yep, she reassured me when he was feeding.*

When Alice was asked if she felt dependent on Dana, she answered,

> *No. Um, no. I don't think I would have had a dependency on anyone, really. I think it was probably not, not necessarily to do with the relationship with Dana, but more to do with my expectations of myself.*

I asked if she found their relationship satisfying:

> *Yeah, I did. Yeah, I did. Yeah. I think, um, yeah, yeah, definitely, definitely supportive.*

Finally, I asked if she wanted to say anything further, and she responded:

> *No, she was – every time I asked for help, she was there.*

What was apparent from Alice's interview was that her focus for her admission was on managing her baby's daily care, and it remained so at discharge. She seemed unprepared and challenged by the type of caregiving relationship that Dana offered. She made no mention of the parent-infant relationship work that Dana was most focused on, making it manifestly clear that this aspect of her

residential stay appeared to have either made a little impact or precipitated a defensive or protective need in her to restrict her emotional attention and withdraw from these interactions with Dana. Alice's denial of the need for dependency suggests a claim to strength, a defining indices of Alice's dismissing AAI classification. Alice gave the overall impression that her caregiving relationship with Dana had gone well and that her residential stay was a positive experience. Despite this, Alice did not complete her residential stay and discharged herself early on Day Four.

Thus, Alice's semantic description of her satisfying and supportive relationship with Dana during her residential stay was not supported by her observable behaviour of discharging herself early. Her dismissing state of mind precipitated an upbeat interpretation of her relationship and a withdrawal from her care-receiving relationship with Dana. Conversely, even though Dana was disappointed over the outcome of the admission, her secure state of mind left her open to reflect on why their caregiving and care-receiving relationship was not as successful, and it could have been.

CASE STUDY 3: NURSE TONYA (DS3B) AND MARILYN (U/F5)

Nurse Tonya had several postgraduate qualifications and brought a wealth of experience to her nursing work in the residential unit. When we met to complete the AAI, she greeted me cheerfully but seemed somewhat nervous as we sat down. I reassured her and asked if she wanted to proceed and had any questions for me. Tonya maintained her cheerfulness, answered that she was "fine", and we proceeded with the interview.

Tonya's AAI state of mind was insecure dismissing, sub-classification Ds3b – "restricted in feeling". Tonya's discussion of her childhood and her relationships remained at a superficial level throughout her interview. Even when she described a negative experience, she seemed remote from it or minimised it. Tonya's AAI transcript revealed she experienced two ACE exposures. Her mother had a mental illness, and she experienced physical abuse from her father. Despite this, Tonya offered positive adjectives for both parents, but she could not provide any substantive incidents to support her choosing them.

In the following two excerpts, Tonya focused on material needs and activities. She provides no substantial evidence of receiving affection from either parent or any evidence of their attention to her psychological or emotional needs. Here, Tonya selects “loving” to describe her mother:

> *I suppose I find it hard to say (3 sec) like what exactly what that loving means. Umm (10 secs) Umm (4 sec) So when I was younger I was -- really sporty and did a lot of athletics I think just being there, umm being very interested, ver. being umm very proud. – Umm -- I suppose letting me have those opportunities, I presume that -- would be loving, mhmm*

Tonya cannot provide an episodic memory or even describe what ‘loving’ means and ends her example with “I presume that would be loving”, as if the concept has set her a puzzle.

Tonya also described her father as “loving”:

> *Ummm, I suppose that still goes with the other things that I remember him saying that he was, umm, proud of me. Umm (5.8 sec) I felt like he, in the younger years he was there for just me, umm (5 sec) Loving. I suppose just providing making sure we had a house, and you know he went to work and earnt the money, umm so we could have the things that we needed. Umm ..they I suppose by providing.*

In contrast, Tonya immediately follows up her adjective “loving” for her father, with her final adjective for him “, strict”:

> *Mhhm, umm, I can remember that he got umm (4 sec) He used to I suppose (4 sec) like things done his way. Umm, heee .. I can remember him hitting me when I was younger. Umm (4 sec) I can remember him getting angry and cranky. He used to drink. And I do umm have memories of him getting cranky and umm, angry, and then fighting with mum. Mhmm.*

This recounting of a negative experience for her adjective “strict” appears to counter to her previous memories of loving as well as her other adjectives affectionate, and supportive. Her descriptions of her father’s anger continue throughout the transcript. Yet, Tonya dismisses and downplays these experiences and believes that her experiences have been favourable.

Continuing the theme of contradicting her positive adjectives, Tonya was asked what happened when she was emotionally upset and physically unwell. In this first excerpt, Tonya was prompted twice for a specific incident to describe a time when she was emotionally upset:

> *I'd probably go to my mum first. Um (4 sec) it's hard to remember when I was really young. Um (11 secs) I suppose I probably would have wanted affection from either my mum or my dad. Um, I probably would have made sure that I got it and I feel that I would have got affection, so maybe that's what I would have wanted. Um (5 sec) So, just, if you can repeat that question again.*

Tonya was asked to be a bit more specific,

> *I would probably cry –*

Tonya was prompted again.....

> *I suppose I remember fighting with my brother, quite a lot, and, um, I probably would cry, and I would go to my mum, and I would, um, tell her how I was upset or how I was feeling, um, and I feel that she would have listened to me, um, she probably would have got angry.... Um (5 sec) but she would have been there for me.*

This excerpt expressly focuses on the activation of Tonya's attachment system when she was emotionally distressed. When Tonya's attachment system was activated, she needed her parents to promptly provide her with a secure base-safe haven for soothing, reassurance and comfort. Tonya initially had trouble remembering a time when she had been emotionally upset. When she responded, her answer seemed speculative and remote, almost as if she was trying to establish the correct answer to this question. Her comment "....*so maybe that's what I would have wanted..."* seemed to suggest she was considering her response, and I wondered if she was reflecting on her emotional needs as a child. Nevertheless, when she finally stated she would probably cry, her description of her mother's response to her distress was incongruous with her adjectives for her mother were "loving, caring and kind".

Loving, caring, and kind mothers don't get angry with their children when they are emotionally upset, and their attachment system is activated. Tonya needed her mother as her secure base-safe haven to cuddle, soothe and reassure. Interestingly, Tonya discusses emotional needs and feelings, but rather than stating or showing her feelings, she frequently uses distancing phrases to prefix them, i.e. "I would probably cry" and "...I probably loved spending time with her...". Finally, to maintain a positive image of her mother, Tonya offers a cheerful wrap-up to finish this incident, "....*Um (5 sec) but she would have been there for me...".*

Tonya's narrative violates the maxim of 'quality' as it is not truthful, and she did not provide evidence for what she said during the interview (Main, Goldwyn & Hesse 2003). On the AAI, this is evidence for incoherence and internal inconsistency. Tonya's AAI identified that she was restricted in feeling and focussed on material objects and activities as evidence of loving relationships. The restriction of her attention to feelings of hurt and distress was evident when discussing her mother's response to her emotional distress. Tonya did not consider her negative experiences to have any considerable effect on her life, and she was never quite able to speak at a psychological or emotional level.

Marilyn was admitted to the residential unit with her second child, seven-month-old Becky. She had been referred because she was diagnosed with postnatal depression. Her EPDS score was 21 and positive (1) to question 10 (for suicidal ideation). A suicide risk assessment was done, and she was referred to the residential unit psychologist for further evaluation and intervention. Marilyn and Becky were admitted for help with sleep and settling during the night, beginning solid foods, parenting skills and psychosocial support.

When I met Marilyn, she seemed tense and anxious, so I explained the AAI carefully to ensure she could refuse and withdraw from the research if she felt too unwell, but Marilyn was keen to proceed with the interview. Marilyn's AAI state of mind main classification was U with regard to abuse, with sub-classification F5: secure-autonomous – somewhat resentful/conflicted while accepting of continual involvement. Unresolved responses to abuse are characterised by lapses in the monitoring of reason, discourse, and behavioural reactions.

Marilyn had been sexually abused by a maternal uncle over several years, starting when she was seven and continuing until she was 11. Marilyn had discovered some years earlier that the same man

had abused her mother. She was angry with her mother for knowing the risk and not protecting her. Marilyn's ACE questionnaire was scored with four ACEs, emotional neglect, sexual abuse, her mother's mental illness (depression and anxiety) and also described her mother as being psychologically and emotionally unavailable to her (emotional neglect).

Marilyn's first intrusion of her abuse occurred when I asked her a relatively benign question, "What usually happened when you were physically hurt, grazed knee, etc.?" her answer revealed some disoriented speech an unresolved indices:

> *Um (3sec.) Physically hurt, I wasn't really physically hurt by other children or by my parents. Sexually abused by my uncle, and that is, you just shut up. So, that was my reaction to that. Yeo.*

This slip may have been because her attachment system was already activated throughout the interview, and her traumatic memories of the abuse awakened. The seemingly safe question of being physically hurt had shifted Marilyn's attention from this ostensibly straightforward question to her unresolved trauma and a less integrated response with the odd ending of *"Yeo".*

Following the AAI protocol, I asked Marilyn if she had memories of abuse and had it occurred in her family? When she answered "Yes", I asked her what happened, and she replied:

> *Um, I don't want to – I spent a lot of time boxing that away, so I'm not really, at the moment, going to go into detail, but my uncle sexually abused –*[41]*. My mum's uncle. So, it wasn't – it was isolated in a way. And they lived on a farm, so even then, it was isolated within then when there was the opportunity, which didn't happen all the time. Um, but <u>it</u> was the kind of – it was a constant kind of messaging which created a lot of fear, um, like, the constant – like, a bit of a comment from him, a look, a comment, a, yeah, that, that's probably even more threatening than any acts, that threat of –.*

She told me she had spent a lot of time "boxing that away". This is a lapse of reason and a psychologically confused statement, as it is impossible to box memories away in one's mind; a

[41] Marilyn has not said "me" in this sentence because she attempts to deny her experience.

memory will always be there (Main, Goldwyn & Hesse 2002). Furthermore, Marilyn was unable to name her abuse but consistently referred to “it”, “that”, and “acts”. By not finishing this sentence, “but my uncle sexually abused –” Marilyn avoided identifying herself as the victim of her uncle’s sexual abuse; she unconsciously denied the abuse that happened to her. Alternatively, she may have been confused by the knowledge that he had abused her and her mother. Finally, her discourse was disoriented – “within then when there”, and she ended with an unfinished and ominous sentence.

When I asked Marilyn how her experience affected her currently as an adult, she answered:

> *Um, well it’s had various consequences throughout my life, but I can give you a recent example is. We were at the pub with my husband and my son and my daughter, and my son was running around with other kids around the pub. I would have just been 15 metres away, and my heart started racing, thinking, “He’s going to – a paedophile is going to get him and take him to the bathroom!”. So I, I was like – my husband – I said, “No, you’ve got to stop this, he’s got to come back here”. And my husband was like, “He’s fine, he’s just ...,” and I yelled at him, I said, “Fucking get him! I can’t handle it! Bring him back!” So, that real anxiety about it, and, yeah, oh, constant, constant fear. I don’t like him being in the front garden. I just had all the fences redone.*

In this excerpt, Marilyn described a continuing behavioural response to the abuse she suffered as a child. Her extreme response indicated continuing disorganisation and Marilyn’s need for ongoing psychological support.

Marilyn has other instances where she had lapses of reason:

> *So, you know, it’s on your mind because, you know, it does happen. You know. So, it does, it does, now that I’ve had children, it comes into my mind, but I just go, “Well, no, that’s not going to happen”, and just try and block out.*
>
> *Right now, I feel very depressed, but I’m not going to let that come back in, in how I connect with my family and my children.*

Since Marilyn had her children, she found the memories of her abuse very troublesome. In her effort to connect with her family and children and live an average family life, she attempted to manipulate

her mind into the belief that she could push the memory of the sexual abuse out of her mind saying, "I'm not going to let that come back in". This is another example of a psychologically confused statement. Marilyn was incapable of manipulating her mind to remove thoughts and memories of her abuse because unfortunately those memories will always be there.

Marilyn's secure sub-classification, F5, would ideally allow her to meaningfully engage and collaborate with Tonya in their nurse-client caregiving relationship. A secure state of mind generally allows a flexible approach to relationships. Despite this, Marilyn's main classification of an Unresolved attachment state of mind with regard to abuse had the potential to impact their care-receiving relationship adversely. This is due to the fearful and disorienting influence of reactivated memories of childhood sexual abuse and trauma during caregiving and care-receiving interactions.

NURSE TONYA AND MARILYN'S CAREGIVING RELATIONSHIP

When I went to interview Tonya for the NCCRI, Tonya greeted me cheerfully and was ready for her interview after her shift in the residential unit. Tonya was very upbeat when describing her caregiving relationship with Marilyn and thought it went well. Her overall portrayal of their caregiving relationship was very positive, and she used many highly positive adjectives to describe herself, Marilyn, and their relationship. I began by asking Tonya what type of approach she used,

> *Um (3 sec.) I tried to be friendly, tried to be supportive, um, I made sure I listened and had a good understanding of her issues. Um, as I said, I was doing the admission, so it is part of my role to sort of listen, support; maybe come up with the sort of goals and strategies, do a big assessment, um (5 sec.) Again, I felt quite comfortable with her. Um, yeah.*

I asked what the triggers were for this approach:

> *Um, again, I suppose to be caring, tried to be enthusiastic, try to be supportive (5 sec.) I try to be empathetic. Um, I suppose I try and be nice and helpful. Um, I suppose that's got a bit to do with my personality and things, but as I said, I feel like it is my role, um, yeah – and part of the assessment.*

Tonya went on to describe how she felt about her caregiving relationship with Marilyn:

Um, I was quite happy, I was quite comfortable, I felt quite confident. As I said, I thought we worked quite well together. (3 sec.) Um, I felt she was very honest with me. Um, I was happy, I thought the admission went quite well. Um, yeah, I felt she really opened up to me, so obviously she felt quite comfortable and safe to tell me about her previous history. Um, I thought we worked quite well together. Um, so I was happy. Um, I think she felt quite comfortable and happy with the admission.

Tonya seemed to be quite self-focused, and entirely concentrated on her requirements for her caregiving relationship with Marilyn and her caregiving attributes. Tonya's upbeat answers gave the impression that she was not being mindful of the dyadic nature of the caregiving relationship. When Tonya stated, "It's part of my role to sort of listen", she seemed to imply that listening was part of her list of caregiving tasks and Marilyn a 'concept' or a component of the program. Evidence for this came in the following excerpt when I asked Tonya what her expectations of the working or caregiving relationship with Marilyn were:

Um, so I expected that, um, she would sit down with me and be honest with me and. (3 sec.) Um um, what were my expectations of the work, working relationship? Um, I expected her to be honest and open. (3 sec.) Um, I expected her to give me information, which is part of the admission process. Um, I expected her to tell me the truth. Um, I expected her to feel confident; um, to talk to me. Um, I expected her to listen to me, um, to consider my point of view. Um, to be confident with what I had to say. Um, um, I expected her to probably, um, think about making some changes to the care that she's providing to her baby based on my recommendations. (5 sec.) Um um, I hoped that we could work well together. I think that's about all.

Tonya's responses continued to be upbeat but emotionally restricted, which was reminiscent of her AAI. In this excerpt, Tonya's narrative showed she had eleven specific expectations of Marilyn. This was a high set of expectations for Marilyn, who was struggling with postnatal depression, and a baby with sleeping and feeding difficulties. With regard to the AAI, this high set of expectations could be deemed "pressure to achieve" – an undesirable caregiving behaviour. Tonya's probable childhood experiences indicated some pressure to achieve, which may explain this instance here. Tonya's list of

expectations suggested she had not given any thought that Marilyn may disagree with her, experience ambivalence or have negative feelings towards her.

Rejection of feelings is all too often the experience of a person with a dismissing attachment state of mind and suggests that Tonya may avoid or even discourage Marilyn's negative feelings; in attachment terms, Tonya may reject Marilyn's distress and need for comfort (Talia et al. 2014). Throughout the interview, Tonya was keen to convey the image of happy and successful caregiving and care-receiving relationship with Marilyn. She told me six times she was pleased with their relationship, and seven times Marilyn was delighted with their caregiving relationship. This was possibly more evidence of her dismissing state of mind, where being upbeat and positive about her relationships is habitual in an attempt to restrict attention to any negative feelings (Main, Goldwyn & Hesse 2003).

Marilyn's primary reason for admission was depression and anxiety, and Tonya briefly mentioned this when I asked her about developing goals with Marilyn:

> *Um, most probably, because, um, I felt that she felt quite happy with our working relationship, I felt that she did trust me, I felt she felt comfortable to talk to me about her experience. Um, and because she wasn't –, she didn't come across as extremely anxious or depressed, although she later did sort of, um, say a little bit more, or admit a little bit more about being depressed, I felt she was happy with my recommendations, and it was quite easy to come up with goals and strategies for the baby's care*

Tonya started in an upbeat, positive manner and assumed Marilyn trusted her, then briefly mentioned she did not seem that depressed or anxious. Tonya admitted Marilyn confided more about her depression later in her stay, but she quickly downplayed this importance and returned to her upbeat, positive stance. Although Tonya briefly referred to Marilyn's postnatal depression twice, it did not appear to feature in her caregiving plan.

At the end of the interview, Tonya again briefly refers to Marilyn's depression and anxiety by indicating that Marilyn's admission may not have been as positive as described:

.

Um, (4 sec.) so, I think things I've said – she seemed happy, she seemed, um, like she felt comfortable and safe. Um, I, I thought she was very open with me. Um, I did think that she did like me. Um, I did think we worked well together. Um, I think that from being so open, she was sort of pushed to be a little bit more open than – She initially felt as comfortable with me, um, um, but I suppose that all come about from the counselling appointment. Later, she came and spoke to me about a few things that she wasn't happy with; something someone else had said, um, or something else that was done, or the way things were done. So, I felt she felt she could be open, and she trusted me. So, I thought we worked quite well together.

Here again, we can see Tonya beginning in an upbeat, positive manner and then moving to recognise that Marilyn did have some unhelpful experiences during her residential stay. Nevertheless, Tonya provides limited information, downplays Marilyn's experience, and quickly returns to her upbeat stance with a positive wrap-up, "So, I thought we worked quite well together".

I did not manage to see Marilyn before discharge as she went home early on Day 4 at lunchtime. I rang Marilyn at home and asked if I could do a home visit or interview her by phone. She declined a home visit but consented to do a telephone interview at a later date, and we arranged a time. When I rang her back for our interview, I sensed that Marilyn was somewhat reluctant. She seemed hesitant, so I asked if she was still okay with completing the interview. I reassured her that it was completely confidential and that she could withdraw any time she wished, so Marilyn agreed to do the interview, and we started.

Marilyn's interview was very short 19-lines to the NPCRI-P questions and prompts. She was very complimentary of Tonya and seemed to appreciate her structured and solution-focussed approach. In response to the first question, "How did it feel to be cared for by Tonya?", she answered:

Very good. She's caring, um, non-judgmental, um, very calm, yeah, it was good.

In response to what her expectations were of working with Tonya, she said:

Um, yeah, I think that she'd support me, very supportive. So that I would be, my situation would be that she, um – through all aspects of my health, and that, that she was inquisitive and a problem solver, help me solve these problems with Becky.

Marilyn pointed out that Tonya helped solve her problems, which she appreciated.

In the following two excerpts I asked about the way Tonya helped Marilyn develop her goals and tasks, and she explained how helpful Tonya's structured solution-focussed approach was for her:

Yes. Yes, because she was very open, um, and caring, it meant that I could open up a little bit more and, um, you know, we had good communication together, we were able to, um, you know, really set the right goals, and then, yeah, find solutions and work on that together. Um, analysing why Becky was waking up, um, looking at her feeding routine, and then creating a routine together .. And then, um, she would – was educating me on different settling techniques and how to understand, um, Becky's responses and how to respond to that and help her to settle by herself.

When I asked Marilyn if she felt dependent on Tonya, she answered:

Yeah, not just Tonya. There was, you know, the other CFH nurses, but yes, while I was there, I was dependent on her.

In this excerpt, Marilyn expressed a need to depend on all the nurses as well as Tonya, so I surmised she is happy to seek help and assistance from others when needed, an expectation of a secure-autonomous state of mind. Perhaps it can be inferred that Tonya is not her preferred nurse when she is distressed, even when Tonya is present on the unit. With this in mind, I asked Marilyn to tell me more about how she felt dependent on Tonya:

Um, yeah, that I, I, I went in there for the purpose of finding out more information about these, about Becky's sleep issues and Tonya was an – able to educate me, was a source of information, um, someone that empathised with me, um, so I depended on her to help me understand what was going on and come up with solutions. She's very warm, happy, positive, I feel like she made time for me. A very good experience.

Marilyn's final comments suggested that Tonya provided her with a similar operational kind of caregiving and support she had received during her childhood. Tonya was a happy, positive CFH nurse who provided a structured, problem-solving approach that helped resolve some of her parenting difficulties during the residential stay. Marilyn received a benefit from Tonya's practical approach to care and support. Nevertheless, Marilyn required the emotional and psychological support Tonya seemed unable to provide. Based on what Marilyn told me about her childhood experiences, she often felt unsupported and confused and spent time trying to "figure out" what was happening with her mother. She viewed neither parent as affectionate or more than instrumentally loving; Tonya's caregiving was possibly familiar, frustrating, and unsatisfying on some occasions.

CONCLUSION

In this chapter, three case studies were provided that represent the four main attachment classifications of the CFH nurses and the women to illustrate secure and insecure dismissing, preoccupied and unresolved adult attachment states of mind. The results of the NCCRI (nurse and client versions) were presented to examine the differences in caregiving the CFH nurses provided and how the women responded to the CFH nurses, each according to their attachment state-of mind. The discussion of the findings will be provided in Chapter 8.

Chapter 7: RESULTS – AAI 'CANNOT CLASSIFY' CATEGORY

This is the fourth of four case studies illustrating how the adult attachment states of mind affect relationship interactions, particularly in the nurse-client relationship. This case study presents the analysis of Nurse Carol and the two women she worked with, Melissa and Nicole, during their five-day residential stay at the RPS. As these three transcripts are very long and complex, Nurse Carol's AAI will be presented as the exemplar of the three low-coherence CC transcripts[42]. The presentation of the case study will start with the analysis of nurse Carol's AAI, and her voice will be used to highlight and explain the theoretical features of the U/CC classification. Following the AAI, Carol's NCCRI-N will be presented to construct an understanding of how Carol's state of mind affected her caregiving of both women. Correspondingly, the voices of Melissa and Nicole will represent their individual experience of Carol's nursing care. Finally, the three women's ACEs and their long-term psychological health outcomes will be presented. Table 7.1 presents the attachment classifications of Nurse Carol, Melissa and Nicole:

Table 7.2: Classification of participants, Carol, Melissa, Nicole

Participant	AAI attachment classification
Carol	U - Unresolved/disorganised
	CC-Cannot classify
	E1 - Passivity or vagueness of discourse
	Ds2 -Devaluing of attachment (U/CC/E1/Ds2)
Melissa	U-Unresolved/disorganised
	CC-Cannot classify
	E1 - Passivity or vagueness of discourse
	Ds2 – Devaluing of attachment
	E2-involving anger (U/CC/E1/Ds2)
Nicole	CC - Cannot Classify
	E2 - Involving anger
	Ds1 – Dismissing of attachment

[42] Melissa and Nicole's low-coherence/cannot classify transcripts are available on request

Table 7.3: Carol, Melissa and Nicole ACEs and reported negative health outcomes

Adverse childhood experience		Long-term Psychosocial Health Outcome
Carol – ACE by category		
#1	Emotional abuse	Depression-anxiety Relationship difficulties in workplace Low self-confidence
#6	Separation and Divorce	
#7	Domestic violence	
Melissa – ACE by category		
#1	Emotional abuse	Alcohol use disorder
#5	Physical neglect	Suicide attempts
#7	Domestic violence	Depression & anxiety
#9	Parent with a mental illness	Relationship difficulties with mother and husband
Nicole – ACE by category		
#1	Emotional abuse	Traumatic birth
#7	Domestic violence	Anxiety
#9	Parent with a mental illness	Relationship difficulties with mother and husband

The AAI results will be presented in the following order:

- Family history
- Probable experiences with mother and father
- State of mind scores with parents
- Loss
- Low-coherence - CC indices
- Overall state of mind coherence scores
- Final attachment classification

NURSE CAROL

FAMILY HISTORY

Carol was a weary-looking 52-year-old woman who had been a registered nurse for 25 years, a CFH nurse for 12 years, and a post-graduate nursing degree. Carol was the middle child and the only girl of five children. Her mother was her primary caregiver in a traditional household. The family lived in an upper-middle-class suburb of a large city. Both parents raised her until she was 13, when her father abruptly left the family. Carol's account of her early childhood experiences revealed at least four

exposures to ACEs. Carol had witnessed violence against her mother by her father, Carol feared her emotionally abusive, and emotionally neglectful father, and her parents separated when she was 13 years old, after which she did not see her father until adulthood.

INFERRED EXPERIENCES WITH MOTHER

Carol was asked for five adjectives to describe her relationship with her mother between the ages of four to 12 years. Carol's choice of adjectives attempted to convey a very positive relationship with her mother: warm, dependable, good mother, incredible mum and great mum. Carol was required to provide good quality episodic memories to support the positive image of her mother. Carol struggled to provide instances that would support her adjectives. Instead, she offered functional and concrete memories such as providing meals, sewing clothes for her or going on outings together. She gave an overall impression of a "really lovely childhood". In the following excerpt, Carol has difficulty providing a specific memory for her adjective "great mum"

> *I think it's just having fun together, going to shows and going to places, going with friends, um, I just felt like growing up, she was a great mum to have...and even my friends thought I had a great Mum.*

Carol offered an overall positive impression of her fun mother, who took her places and provided activities but could not give an episodic memory for "great mum". As further evidence of "a great mum", Carol recalled her friends saying, "lovely person" and a "great mum". In this instance, Carol replaced a second adjective, "lovely person", for her first, "great mum", which did not provide any more profound understanding of her relationship with her mother. She could only offer a sketchy, partial portrayal because she could not elaborate or define her interpersonal relationship. Finally, after struggling, Carol ended with:

> *Nothing specific, because I think it's just lots of, lots of little things. Yeah, yeah...*

Another illustration of Carol's desire to project a very positive image of her mother was when she tried to support her assessment of a "good mother", as in this excerpt when she offered behavioural routines:

The fact that she took me places and I had a really lovely childhood, I thought, in lots of ways. Um, so we'd enjoy a lot of things together. Telly programs together, knitting together, just, yeah, yeah. That's the main thing.

Carol tried to convey the impression of a good mother. However, again she could only offer behavioural routines such as organising the household and taking her to school or fun activities such as watching television. These are standard everyday activities the average mother usually provides for their children. Unfortunately, Carol could not substantiate her positive adjectives with a single instance of a loving memory such as physical affection or tender concern, the qualities of a sensitive, psychologically available mother.

In the following excerpt, Carol was asked directly if she remembered being held by either of her parents:

(7secs) I don't know. Isn't that funny? (6secs) I don't remember. I assume I must have been, by mum, but I don't have any memories of being held

Carol concluded, without any evidence, that her mother must have held her. Carol's lack of memory of being held or cuddled contradicted her positive representation of her mother. Another way Carol tried to project a very positive image without a supportive memory was by offering unnecessary and out-of-context praise for her mother, such as the following,

Always sewed everything, sew until midnight, um, just incredible mother...yep

Carol recalled being hospitalised for a week with a broken leg when she was eight years old. This memory also contradicted her positive representation of her mother:

When I was hospital with my broken leg [6secs] I remember being very angry at my mother because she didn't come, she only came once a day ... Mum could only come once a day...I remember being really angry with her, um, because I couldn't understand why she couldn't be there...I remember, um, being put in a cot in the middle of the whole ward and being dressed down for wetting the bed

When a prolonged separation confronts a child in a strange place with strange people, it is a distressing and fear-inducing situation for a child. Consequently, Carol's attachment system activated, and she urgently needed her safe haven for comfort and soothing. Carol's mother was her safe haven, but Carol did not mention her mother offering any comfort during her hospital visits. The lack of comfort, reassurance and safety in that strange situation probably accounted for her anger, confusion and bed-wetting. Rather than a soothing presence, her mother seemed to have been physically, emotionally and psychologically unavailable when Carol needed her the most. This is evidence that Carol's mother rejects her attachment needs when she is highly vulnerable, completely discrediting Carol's positive general impression of their relationship. Another defining feature in this excerpt appeared when Carol recalled her anger and confusion towards her mother. During this part of the narrative, Carol stopped and shifted her attention away from her mother to a non-attachment-related topic and explained that this incident is why she became a nurse. Carol may have been attempting to restrict her attention and downplay her attachment-related thoughts, feelings and needs:

> *And the nursing staff were really horrible to me, so that's why I wanted to be a nurse*

Finally, and unexpectedly, at the end of this excerpt, Carol seemed to shift her state of mind and take a balanced view of her experience and described the situation from her mother's perspective:

> *I do remember being angry at my mother at that time, and I don't, feel she understood, but thinking about it now, that was the normal thing. You, you went – you put your child in hospital, and you just went and visited them once a day....So, I think it was the era, but I think because we'd been so close, it was such a huge disruption. I don't know if that's the way I thought about it.*

INFERRED EXPERIENCES WITH FATHER

In contrast to Carol's very positive representation of her mother, Carol's first description of her father was "I was scared of my father", and he "made everyone tense". When asked to provide five adjectives to describe her relationship with him, she gave an overall negative constellation of words. These were: angry man, two-faced, polar opposites, pressure on you, never good enough. Carol gave generally plausible accounts to support her adjectives. These descriptions revealed her father as a

consistently rejecting, angry, and unloving parent. The first of Carol's adjectives was 'angry man'. In this excerpt, Carol describes her father's anger:

> *I still remember...when we [friend Jane] were about 7, I think, or 8, and we were at the table and we just couldn't stop giggling, as girls do, we just couldn't stop, and he was so angry and said, "don't be so ridiculous". I can't remember what he said, ... but I was used to it... in the end, I think we had to leave the table, because we just couldn't stop laughing. Um, I still remember that incident*

Although Carol's memory of her father's anger is still fresh, she claimed she had no memory of "what he said" and then downplayed her fear with, "I'm used to it." Finally, Carol's fear response was to laugh uncontrollably at the table until she was told to leave, an example of eight-year-old Carol's inability to self-regulate during a very stressful situation.

A childhood experience scored in the AAI, is 'pressure to achieve' an unfavourable parental behaviour. Carol's father pressured her and her siblings to succeed at mundane household tasks, schoolwork, and family social activities. During the interview, Carol recalled several examples of her adjective "put pressure on". In the following example, Carol was required to learn to answer the phone correctly. She describes undue pressure to achieve:

> *we all had to answer the phone...but I would be so frightened to answer the phone because you would never do it properly, so, the more anxious you got, the more you'd stumble, um, and he would always be saying, "you don't answer the phone properly" you never do it well enough, so we would all avoid answering the phone*

This excerpt and the following revealed the impact of how the fear of her father affected Carol. She described feeling "anxious" and "stressed" which had an adverse effect on her emotional wellbeing. This ongoing stressful, fearful emotional experience is the ACE category, emotional abuse. When Carol was asked for an incident when she felt threatened, she recalled when her father left the family home during a domestic violence incident. In this incident, her 16-year-old older brother stepped in to stop her father from hitting her mother:

I feel my dad was threatening, but just in verbal [sic]. He could speak and it would, I don't know what he would say, but it would really cut you to ribbons. You'd be feeling really stressed but I don't remember what he would say, but he didn't need to do, he never hit us or anything. He only needed to raise his voice and we were scared enough not to do anything... one of my brothers was home that day sick, when my dad went to put a hand to my mother, and he kicked him out...So, we didn't see him after that. I was 13, I think

Carol explained, after this incident, she did not hear from her father again until adulthood. Witnessing violence against her mother is another ACE category and an example of household dysfunction. When Carol was asked to recall memories of being comforted when separated from her father, emotionally distressed, sick, or hurt physically, she recalled the memory of breaking her leg and going to hospital for a week:

Hurt physically? I broke my leg at one stage. I was in pain, really distressed. Um, but I don't know that my father was there. I can't remember my father being there

And later, when asked how her parents responded to being separated from her while she was in the hospital, she answered:

When I was [in the] hospital with my broken leg - well, I don't know if my father even came to see me. I can't remember him coming to see me. I was [in the] hospital for a week

These two examples demonstrated how unresponsive Carol's father was to her attachment needs. It was unclear if he rejected Carol's need for comfort and safety or was disinterested and emotionally neglectful, another ACE category. Regardless, he was unavailable and emotionally uninvolved when Carol needed her father the most. In this excerpt, Carol also indicated momentary disorientation where she twice left the words "in the" out of her sentence.

STATE OF MIND WITH PARENTS

Carol provided a very positive representation of her mother, even though she could not provide adequate evidence for her positive adjectives, and some of her episodic memories actively contradicted them. This is a feature of dismissing speakers and violates the maxim of quality in the interview "be truthful and have evidence for what you say" (Main, Goldwyn & Hesse 2003) (see

chapter 5). Although Carol's mother was mildly supportive, she did not appear to provide any personal care or show any special interest in Carol as an individual. Carol's positive adjectives required her to give examples of affection, sensitivity and psychological availability. A discrepancy existed between Carol's portrayal of an "incredible and great mother" and her failure to provide episodes that would support these adjectives. Carol portrayed an idealised image of her woman, separate from the actual image she described during the interview. However, her idealisation was incomplete because Carol once stated during the interview that she thought she had put her mother on a pedestal. This statement reduced Carol's final AAI state of mind score for idealisation, and she received a score of 5 out of 9 for the moderate idealisation of her mother.

Carol displayed no idealisation of her father and provided credible support to describe her relationship with him. On the other hand, Carol engaged in derogating and contemptuous dismissal of her father during the interview, violating the maxim, 'quantity'. In this excerpt, her father contacted Carol after a long absence when he heard she had cancer:

> *His pride wouldn't let him do more than that..., but I'm really pleased my children didn't get to know him, because he's not someone I want my children to know*

Carol seemed to consider him unworthy of her time and dismissed her relationship with him. Furthermore, she dismissed his relationship with her children. After this brief contemptuous comment, Carol moved on to discuss other topics.

Carol's interview comprised violations of manner and relevance, a feature of preoccupied speakers. Carol was a passive speaker, frequently wandered off-topic and lost track of the question. She inserted vague phrases into her sentences such as "sort of thing" and "something like that" or nonsense words such as "*dadadadada"*. Carol had trouble conveying ideas but felt she needed to continue speaking, for example,

> *You wouldn't get fun things or stuff like that, but he would always think about that. Um, so, yeah, um, I think that, yeah, that's it.*

In the following example, Carol was asked about her adult relationship with her mother. This shortened excerpt from a 62-line answer shows Carol losing track of the question and wandering from topic-to-topic:

> *I know my father has had a huge impact, and it's only recently I've thought about the fact that we talk about DV. ... I'm done father's research, which is just ridiculous. ... When I saw how good my husband is, I realised what an important thing that is for people. ... You only need a mother because she was so good. ... So, really, it's had a big impact on my life, I think, but I've got there [laughs]*

This is a violation of quantity because she gave far more information than was necessary and in one instance used a run-on sentence of 10-lines. Carol's answers were often difficult to follow due to violations of relevance. These violations included lapses into jargon or clinical "psychobabble" and she discussed her father and husband when she should have been discussing her relationship with her mother. Carol became so absorbed in her memories that she lost track of the question, wandered off on unrelated topics, and spoke well beyond her conversational turn.

At the end of another very long conversational turn, Carol was so entirely absorbed by her thoughts did not remember the question and completed her answer with a very vague ending as if she had run out of things to say.

> *[43]They remind me of my son, and they all remind me, not so much, but my father, I think, ... just never learned to deal with his own emotions ... So anyway, where were we...*

Carol had violations of quantity, relevance and manner. Her representations of her childhood attachment experiences with her parents were wholly contradictory, with changes in discourse representing passivity of thought processes, derogation of her father and moderate idealisation of her mother. Carol's discourse was often challenging to follow, resulting in a low transcript coherence score, scoring 2 out of 9.

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[43] Carol's twin brothers

UNRESOLVED/DISORGANISED RESPONSES TO LOSS THROUGH DEATH

During the AAI, Carol was asked questions about loss resulting from the death of a parent during childhood. The same question was asked about loss through the death of a close loved one during adulthood. Carol was classified as unresolved with both her mother and father. Carol's lapses were all monitoring of reasoning and in her case, "slips of the tongue" to the present tense, and appearing to forget her parents were dead which indicated disbelief that the person is dead (Main, Goldwyn & Hesse 2003). She consistently exhibited a belief that her parents were simultaneously dead and alive. This was illustrated by discussing her mother's involvement in her life and her father's current behaviour and input into her life. The following excerpts provide illustrations of the subtle lapses of monitoring that Carol exhibited.

At the beginning of the interview ,Carol tearfully told me that her mother had passed away seven years ago:

> *I'm sorry [crying]... my brother just told me she died seven years ago today... I just, he just let me know that and I'd forgotten that it was today.*

Significantly, Carol had forgotten the anniversary of her mother's death at the beginning of the interview and had to be reminded of the anniversary by her brother. This lapse occurred again when she failed to mention her mother's death when I asked if she had any significant losses in adulthood. Finally, it happened a third time when Carol was prompted to discuss the loss of her mother, and she cut the question off and did not attempt to answer. Instead, she avoided the questions and discussed other aspects of her relationship with her mother.

In effect, Carol seemed to have forgotten that her mother had died seven years earlier. Furthermore, having failed to remember her mother's death, she seemingly refused to discuss her death when reminded. Forgetting a loss constituted a denial that her mother had died and a lapse in monitoring of reason, indicating disbelief that her mother was dead. In the following excerpt, Carol spoke of her mother in the present tense, as if her mother was continuing to have an active presence in her life, even though she had died seven years earlier.

> *There's a lot of foibles in my mother. I'm quite happy, but she, she did the best she could in the circumstances she was in.*

During the interview, in a discussion unrelated to loss, Carol indicated her father had died ten years previously. She did not mention her father's death when asked about important losses in adulthood. Instead, Carol related her experience as a 13-year-old, and described losing her father after her parents separated. This loss event seemed to have had a more significant impact on Carol than her father's death during her adult years. In the following excerpt, Carol brought her father into the present and spoke about him as if he was still involved with activities and other people in the natural and present world.

> *You know, he was a bookie. At times, you know, he's involved with the whole greyhound racing type people.*

Carol's father still seemed to have an ongoing presence in her life. When Carol was asked how her overall experiences with her parents had affected her, she answered:

> *Um, and I also think, study – I use study as an escape from my dad.*

In summary, Carol had lapses in monitoring of reason during discussions unrelated to loss through the death of her parents; and forgot to recall that her mother was dead when asked about her significant losses in adulthood. This was not a deliberate failure, particularly in her mother's case. Although Carol did speak about the loss of her father through death, when asked about the loss she recalled the loss of her father during her parents' separation and divorce. Although this is not scored in the AAI, it appeared to be an important loss and possibly accounted for some of her disorganised responses. Carol scored an unresolved-disorganised response to the loss of both her parents. Carol's state of mind with respect to loss was unresolved/disorganised (score 8/9).

LOW-COHERENCE - CANNOT CLASSIFY

When describing inferred experiences with her parents[44], Carol could only offer concrete, partial or perceptive-sensorial descriptions of her early relationships. Carol's adjectives for her mother were

[44] Except for questions specifically requesting information for mother and/or father the AAI asks about parents generally. The interviewer will probe for further information on either parent as necessary.

very positive, but she could only describe her mother's behavioural routines. In the following excerpt, Carol provided a concrete memory of "good mother";

> *... I'm thinking always having dinner and always doing, always doing three meat and veg, three veg and meat and always thinking about your food.*

Carol struggled to find episodic memories and gave vague answers that seemed like partial aspects of their relationships, such as the memory for "warm":

> *"she used to take me to tennis with her and I would go with all her friends to tennis"*

Carol seemed unable to elaborate or offer clear memories of quality, loving interpersonal experiences with her mother. This demonstrated that she had a vague global representation of her mother, undifferentiated from herself.

Other indices of low-coherence were provided when Carol entirely lost track of the interview question. Carol was asked for a memory of when her father "put pressure on", and she seemed to experience a moment of disorientation and absorption,

> *I think was um, um, like just never learned to deal with his own emotions and really, um yeah, um. So anyway, where were we?*

Carol seemed to have a fearful mental state concerning her father. Fearful intrusions frequently manifested when she was trying to describe her relationship experiences with her mother. There were several examples throughout the transcript, such as the following:

> *Um, and I just know I was probably scared of my father ... [His] presence would make everyone tense.*

> *Um, yeah, um, but in a way, I think that she was there to protect us.*

> *I think it was to get me away from Dad and let me have a break away from Dad.*

> *Um, so she made our place safe when in some ways it wasn't.*

> *She was pretty good at protecting us from, um, the reality*

Although Carol appeared preoccupied with these fearful intrusions during her inferred experiences with her mother, she did not seem frightened. Carol gave the impression that she was preoccupied with un-named events associated with her father, but it was difficult to ascertain if she had experienced a traumatic event.

Speakers with a low-coherence state of mind often laugh during their interviews. Carol frequently laughed throughout her interview. In this excerpt, she appeared to be distancing herself from fearful memories of her father:

> *I would be so frightened to answer the phone because you would never do it properly, no matter what you did. So, you [laughs], the more anxious you got the more you'd stumble!*

Carol was classified with Ds2 – Devaluing of attachment figures. Other low-coherence transcripts have demonstrated individuals showing a strong tendency to self-derogate. Carol provided an example of this when referring to her mother's death:

> *It's no big deal, I'm a cry-baby, anyway...[laughs]*

In this instance, Carol also laughed at herself.

An additional marker of low-coherence/CC transcripts is the use of second and third-person pronouns. Carol provided a memory for her adjective "never good enough" to describe herself in her relationship with her father. In this instance, she used both second and third-person pronouns when referring to herself:

> *[friend of father] was reading my report, and Dad was trying to say how well she'd done, but it just put the pressure on because if you didn't have a good report then you weren't, you weren't, you weren't seen as good enough.*

In the following excerpt, Carol indicated discourse collapse when she explained that her first experience of unconditional love came from her stepfather rather than her father:

> *Um it didn't matter what you did or what you got in your exams or anything, because he was a tradie and he just loved me.*

Carol's reason for why her stepfather loves her is psychologically confused. There is no reason a tradesman is more able or likely to provide her with unconditional love than any other tradesperson, professional person or person in general.

OVERALL ATTACHMENT STATE OF MIND

Carol presented contradictory discourse strategies throughout her transcript. Carol presents two incompatible organised states of mind, an unresolved state of mind concerning the loss of both her parents, demonstrating emerging indices of low-coherence.

THE ORGANISED STATES OF MIND

Carol showed contradictory discourse strategies throughout her AAI transcript and coded with two incompatible AAI insecure organised states of mind, dismissing and preoccupied, and an unresolved state of mind with regard to the loss of both her parents. Carol's three AAI classifications indicated indices of a low-coherence AAI attachment state of mind.

PREOCCUPIED CATEGORY: Speakers placed in this category appear to be preoccupied with their early attachments and related experiences. Their preoccupation with their early attachment relationships interferes with their ability to maintain collaborative conversation with the interviewer. There are two sub-classifications: E1- Passivity or vagueness of discourse and E2-Involving/preoccupying anger. Carol is classified: as E1 - Passivity or vagueness of discourse. Carol's speech in many parts of the interview conveyed a vagueness of thought processes described in the analysis. Carol frequently maximised her attention to attachment relationships, feelings, thoughts, and needs (score 6/9).

DISMISSING CATEGORY: Speakers in this category convey an attempt to restrict their attention to their attachment relationships and experiences. Attachment-related thoughts and feelings may also appear to be limited. There are four sub-classifications: Ds1-Dismissing of attachment; Ds2-Devaluing of attachment; Ds3-Restricted in feeling and Ds4-Cut-off from the source of fear of death of the child

Carol was classified as Ds2 – Devaluing of attachment. Carol was also assigned to the dismissing category. Carol is placed in this category because she frequently and explicitly devalues her relationship with her father. Carol often communicated active contempt when discussing her father

(Score 6/9. Carol was also classified as Unresolved/disorganised: (discussed in the section above) (score 8/9) and Cannot Classify: discussed in the section above.

Coherence of mind

Carol's score coherence of mind is based on her state of mind with regard to loss, unresolved/disorganised (score 8/9), coherence of transcript: incoherent (score 2/9; and contradictory states of mind throughout transcript: striking absence of coherence of mind (score 1/9)

FINAL ATTACHMENT CLASSIFICATION

This transcript was co-coded with Dr Loyola McLean and judged to be in the Cannot Classify classification, meaning Carol had no single state of mind with respect to attachment. Carol presented a global collapse of discourse strategies as she shifted from a dismissing (minimising) stance to a preoccupied (maximising) stance throughout the interview. Her contradictory insecure discourse strategies occurred when she described each of her parents. With respect to her father, she indicated a Ds2 – Devaluing of attachment as well as an unresolved state of mind. With respect to her mother, she showed E1 - Passivity or vagueness of discourse when describing her relationship with her mother, moderate idealisation when she conveys attempts to recall positive representations of her mother and an unresolved state of mind. This placed her in category two of the current criteria for Cannot Classify" placement: "The speaker presents differing states of mind in describing different people, e.g., E2 with respect to the father and Ds1 with respect to the mother or the speaker presents differing states of mind with the same person" (Main, Goldwyn & Hesse 2003)

The following factors contribute to Carol's CC classification:

1. Carol stated on the transcript's first page that she was afraid of her father and continued this preoccupation (maximising attachment) with expressing a fear of his anger throughout the initial part of the interview. In the latter half of the interview, Carol shifted her state to a dismissing (minimising attachment) stance and derogated her father, effectively downplaying her own affective experiences.
2. Carol tried to convey the impression that her mother protected her from her father. Despite this, she could not provide a convincingly supportive occasion that provided evidence of a

protective mother and, therefore, a safe haven. These incompatible beliefs may signify the intrusion of fragmented memories resulting in an unintegrated representation of her mother.

3. Carol's narrative suggested she witnessed domestic violence against her mother (an ACE) and indicated her mother needed to hide for safety reasons. Carol may have been fearful for her mother's safety, activating her attachment system and a preoccupation with her mother's safety, an indication of her mother as a helpless caregiver.
4. Carol presents two strategies restricting (minimising) her attention and idealising her mother. At the same time, she is preoccupied (maximising) her attention with her fear of her father's anger, and fear for her own and mother's safety.

Carols final classification is: Ud-Unresolved/disorganised/ CC-Cannot classify/ E1 - Passivity or vagueness of discourse/ Ds2 – Devaluing of attachment (U/CC/E1/Ds2)

THE NURSE-CLIENT CAREGIVING AND CARE-RECEIVING RELATIONSHIP

CAROL AND CARING FOR MELISSA

When women stay in the residential unit, they usually meet their admission nurse for the first time, and this was the case when Carol met Melissa. Admission to the unit is a lengthy procedure, generally taking two or more hours. Frequently, women become anxious, agitated, and upset during their admission and remain so for the first few days afterwards. It is not unreasonable for the CFH nurse to expect to spend time calming and soothing the woman and her baby. I began the interview by asking Carol about her first encounter with Melissa.

The first question was, "Can you describe the type of approach you used to work with Melissa?" Similarly, to her AAI, Carol gave a lengthy and somewhat confused response, and I had to remind her of the question twice:

> *Mainly listening. Um, because she talked a lot, um, and she seemed to need to get out a lot. Um, so that was my approach until I – because she was a little bit chaotic and all over the place, um, I needed to get clear what her message was.*

[prompted again]

I suppose the suicidality is one of the things. Um, the drug and alcohol abuse, which came out very early, and, um, I think she was a bit embarrassed by having to disclose that. Um, and I think she thought she might be able to come in without having to disclose that, so I think that made her, um, go off the rails.

[prompted again]

Um, so I think that unravelled her a little bit in the beginning, and I had to sort of contain, like, hear the story, but then bring it back and contain it all the time. But I didn't try and do, you know, paperwork, like "Is your blue book up – ". I didn't even try and do that with her.

Carol had lost track of the interview question and had become absorbed. Her responses were akin to a stream of consciousness as she described her reaction to Melissa's distressing experiences. Carol ended her lengthy response by explaining that she did not fill in Zac's personal health record. Turning her attention to routine nursing care may have felt like an unconsciously safe decision in an attempt to divert attention from the distressing material. I gave Carol another prompt,

To make sure I had clarity because I found it hard to gain clarity on what she really wanted in here. Um, and I'm still not sure that we actually met her goals. So, um, I was trying to work out what, what would be helpful to her. Yeah. So, I was trying to gain clarity for me.

Although Carol initially stated her approach was to "mainly listen" to Melissa, her response indicated that "listening" to her may not have been a straightforward undertaking. Carol appealed for clarity for herself three times so she could understand what was helpful for Melissa. However, it seemed Carol's motivation was self-focused on her need for clarity rather than offering understanding and support for Melissa's immediate distress.

Carol had described Melissa as "chaotic", and her disclosures made her "go off the rails", so Melissa was likely to be highly distressed. Carol did not seem to recognise that she was Melissa's nurse-caregiver and Melissa her client, who required an immediate soothing response. Carol needed to self-regulate in that type of clinical situation so she could provide a safe haven for Melissa, but her motivation to provide care was centred around her own needs. Unfortunately, her primary motivation seems to be centred around her need to find safety.

The following excerpt was Carol's response to the question: "How did you feel when working with Melissa?"

> ***Carol:*** *So, um, I was trying to work out what, what would be helpful to her. Yeah. So, I was trying to gain clarity for me.*
>
> ***FC****: How did you feel?*
>
> ***Carol:*** *Um, overwhelmed and a bit chaotic. Um, I had to really contain myself when I was with her, and I had – when she needed to do something, I was glad of a break. So, I had a break from her and then went back. Um, in fact I think, um, I almost avoided going back to her, um, because it felt – she felt overwhelming, and, um, I had to talk to someone about it, just one of my colleagues.*

Carol described how she approached the unit psychologist for help with her own highly distressed state, evidence that she was able to seek help for herself. Additionally, Carol observed that she was unsure if she felt overwhelmed because of "something with herself or Melissa". This comment was too brief to be considered reflective because she promptly shifted her attention and stated that "everyone else" shared her experience of feeling overwhelmed and did not want to be with Melissa.

Corresponding to her low-coherence CC state of mind, Carol seemed to be preoccupied with her distress, maximising her attachment needs as she sought help and support from the unit psychologist as well as her nursing colleagues; at the same time, she minimised Melissa's distress and distanced herself from her. This is further demonstrated in the following example,

> *She wanted to go home, frequently, during the week. Um, and I, I, I suppose I wasn't a part of trying to contain her, but I know that I, I talked to the psychologist to give me another handle on her, because we got her seen Tuesday morning by Person 3, so, Person 3 the psychologist, so that I felt like I had more of a grasp on what was happening, especially since she'd been suicidal before, and she had so much complexity. Um, and the psychologist was the one that said to me, "I, I think she's usually impulsive, and I really want her to commit to something and stay, just to feel what that feels like." And I think it was helpful that we got her to do that, even though we – she went home Thursday*

Here Carol seemed to have another change of stance. Her earlier assertion that she tried to contain Melissa when she was “chaotic and all over the place” altered as she supposed she “wasn’t a part of containing her”. It appeared Carol may have avoided providing care for Melissa.

Finally, I asked Carol, “Did you feel satisfied with your working relationship, and do you have any further comments?”

> *Not completely, no. No. Um, I felt there was so much more we could have worked on um, or she could have worked on with Zac or a different nurse, but I, I do, I don’t think she was able to, at that time. But I think it gave her some reflection time that she never had and never gave herself, um, time to do. So, yeah, I think, I think it actually – the stay really helped her to, to just have some down time and think and spend more time with her baby one-on-one*
>
> *No. I think that’s what mainly came out of it: seeing her with, Zac. She started to just - enjoying, and she talked about how much - she talked about, ah, about how much she enjoyed just spending time with him, and that didn’t happen. But she did miss her other daughter, but she even was able to keep that on hold and keep with the program and keep with Person 4. So, I think we probably did do more than I actually even, now I’m thinking about it, um, but it was quite subtle.*

Carol initially answered the question quite thoughtfully, then stopped and abruptly dismissed her involvement in the relationship and suggested that Melissa could have worked more with the psychologist or a different nurse. Carol concluded that neither she nor Melissa could not work on the admission goals and continued to downplay Melissa’s distress, difficulties, and needs. Then, she shifted from criticising Melissa and offered some praise to Melissa, such as spending her time in the residential unit, and playing with her baby. This was suggestive of the praise she gave her mother. This shift in state of mind enabled Carol to conclude that Melissa benefited from the stay at the RPS, even though she discharged herself early, a recognised negative outcome for a residential stay. In the meantime, Carol’s shift to a more upbeat and positive stance may have offered her the opportunity to downplay and manage the nurse caregiving experience with Melissa and provide her with self-reassurance. Nonetheless, it seemed evident that Carol's caregiving was dissatisfying and distressing for both her and Melissa.

MELISSA'S EXPERIENCE OF CAROL'S CAREGIVING

When I approached Melissa for her final interview, she appeared excited to see me and keen to speak with me again. Her description of her caregiving relationship with Carol was not a positive one which, in the long run, left her with an unenthusiastic opinion of the RPS.

Melissa's response to my first question, *"How did you feel being cared for by Carol during admission"* was a very long 104 lines. The most critical excerpts will be used to illustrate Melissa's experience of her admission. In this first excerpt, Melissa explained her immediate confusion at entering the busy residential unit:

> *From the minute I arrived, I went into a waiting room and then was taken through to the unit, ... I didn't really know who, sort of, everybody was and what the, what the sort of structure of the stay was going to be, exactly .... It was a little, it was a little bit all over the place. It's almost like when you, kind of, go in, um, that you kind of need to have, like, an orientation.*

Her response included several pauses of four or five seconds, indicating she may have been absorbed in memories of her admission. She may have been describing her current state of mind when she described her admission experience as "a little bit all over the place". Melissa offers further evidence of some disorientation:

> *It was basically like there was all these different people, and then somebody would just sort of pop up. Like, Carol did, my interview with me and then, um, I think Zac was crying ... and the way she was looking at me to start with, it was like, "Oh, we've really got a problem, there's something wrong with the kid". And then I felt really, ... you're having this personal conversation but it, it's not private....You're sitting in the main area, which I thought was weird. So, like, people can hear what you're saying.*

Melissa provided a visual-perceptual-sensory image of people and a "somebody" who kept "popping up" around her, reminiscent of the visual-perceptual-sensory imagery she used in her AAI. For some reason, Carol had chosen to do Melissa's admission interview in a communal meeting space. Melissa had every reason to be worried and distressed. Melissa continued:

That's not Carol's fault, like, I had a bit of paranoia around the fact that, you know, I shouldn't have come, and I shouldn't have wasted a space. ... Um, Carol put my mind at rest a little bit. ... She did say that but perhaps not as, I need quite a lot of reassurance, sometimes and she did reassure me, but I still, it made me feel – I wasn't feeling that easy about it. I felt a bit, like, embarrassed, ... I felt like I needed a baby that was waking every hour to justify sort of being there.

Consistent with her AAI and inability to coherently describe her relationship with her parents, Melissa struggled to portray the care-receiving relationship she had experienced with Carol. Instead, she blamed herself, self-derogated and put herself down when she stated, *"I shouldn't have wasted a space"*. Melissa did make minor negative complaints about Carol's caregiving, but these were soon taken back. The last passage was reminiscent of Melissa's portrayal of her relationship with her mother in her AAI. The passage showed that her thoughts seemed to be fragmented and confused.

Next, Melissa was asked, "What were your expectations of working relationship with Carol?" In comparison to her previous portrayal of Carol and her admission, Melissa gave a surprisingly brief response.

Melissa: *I don't think I even knew that Carol was my – I didn't know who Carol – I don't actually know who Carol is, was, if you know what I mean.*

FC: *Carol was the nurse who admitted you,*

Melissa: *Yeah, but I don't think, I'm not sure – I can't remember. Maybe I saw her twice, twice, and I saw her around and she'd sort of say, "Hey, how you going?" I didn't – but, I didn't, like, have, every day, a sit down with her. Yeah, I can't remember..., they weren't, in depth enough, were they, for me to realise that's what actually we were doing. Yeah. That's my answer.*

Melissa seemed to claim a lack of memory and denied any knowledge of meeting Carol, ostensibly downplaying and minimising any feelings of rejection and distress she may have had. Her apparent inability to recall an ongoing relationship with Carol blocked any further discussion of the question.

The next question I asked Melissa was, *What was your initial encounter like?*

It was okay. It was, to, you, – no, it was, it was okay. I mean, I think, obviously, it needed – well, clearly I needed to know more about what, who she was and what that, her relationship to me was, um, so then I would have even known if I hadn't seen her each day, I would have known that my expectation was..... I didn't realise that meant we had more of a relationship.

Melissa's description of her relationship with Carol reinforces the impression I received from Carol's interview; that is, Carol avoided caring for Melissa. Melissa's childhood experiences of rejection and neglect appear to be replicated in her care-receiving relationship with Carol. The following excerpt offers further details of their possibly troubled relationship:

There were moments when we went into my room and ...She said, quite curtly, a couple of times, "Well, well, what are you here for?" ..., "When does he wake up?" and I said, "He sleeps through", and I think that she was getting a bit frustrated with me, ... "Well, why are you here? Like, if he's sleeping through the night" and I think "I don't know", ... and then she sort of would backtrack a bit, going, "Look, I'm just I'm just trying to understand, like, how, how I can help you". So, she was sort of explaining, I guess, why she was sort of curt, and I totally get it, because she's right, ... my stay there was a little bit like "Why are you here?" And I was thinking to myself, "Why am I here? I don't really need help."

In the same way her childhood interactions occurred with her father, Melissa blames herself for not meeting Carol's expectations. Consistent with her low-coherence classification, there is "a fearful sense of failing to please" Carol, because she and Zac are not meeting Carol's requirements of her visit to the RPS. Melissa's father was frequently angry with her, so Carol's curtness could have triggered Melissa's anxiety and disorientation. In this excerpt, Melissa again made self-derogating comments to the question, "Did initial encounter affect the way you were able to develop your goals and tasks?"

Given that I was a bit scatty and all over the place she did quite a good job of being able to, sort of, put something down on paper.

So, she sort of managed to, out of a sort of messy person – ... she kind of did actually manage to get a few goals down.

Rather than perceiving her personal needs and feelings were disregarded or dismissed, Melissa devalued and blamed herself for Carol's failure to provide adequate caregiving. I then asked Melissa if she felt any dependence on Carol. She revealed that her representation of caregiving relationships did not include the experience of dependency, so it is just "not possible" to feel dependent.

> *No, No Basically, um – did I feel dependent? No, because I didn't really know, kind of, who she was. ... Yeah, I know – because, ultimately, like, with sleep issues, you know, ... it's not possible, where you're just with that one person, and they totally can see what you're talking about because they're there all the time and they're, like, you know, but how that – that's not possible.*

The following answer is reminiscent of Melissa's involving/role-reversing relationship with her mother and the sense of helplessness she must have felt:

> *it's just the way the set-up, the nurses almost have to rely on the mothers, a bit, to find out what's being – what you've been doing and what's going on, but the point is that the mothers are there because they're just, "I don't know what to do. You tell me" They want somebody to hold their hand. I think most people in there want to be told what to do...everything [research] has sort of led to this fear of crying and this fear of, mother's instinct knows best, and I'm sure there's things do go wrong where, you know, the nurses think they know something and it's...There's a danger there, you know..*

Melissa's absorption in defining dependency leads to a fear intrusion, "this fear of crying and this fear of you know" and "there's danger there, you know". This may indicate intrusive thoughts of an earlier traumatic event. Further evidence can be found in her final statement, where she alludes to her fear of night-time and the many strange and unknown nurses. These types of fears may be traced back to her early childhood experiences:

> *So, it would be possible to say, "Look, based on your plan and based on the nurses' shift, these are the people that are going to be caring for you, and here's a photo". Because, in the night, you know, we were sleeping, and then suddenly, like, the ... in the night, ... but early in the morning, you sort of meet the nurse for the first time, and it's like, oh, "Your baby's awake. ...*

and, it's like, you don't even know who this person is. It's like, it's a bit weird. Whereas if you've been given – ....Sure, their names on the whiteboard but that doesn't mean anything.

Melissa's interview ended the same way it began. When she was admitted she was anxious, fearful and overwhelmed. Her narrative in the NCCRI-C indicated she continued in this state of mind until she discharged herself on day four. Carol did not appear to be psychologically or emotionally available to provide Melissa a secure base and safe haven. This deficit in caregiving resulted in adverse outcomes for her admission to the RPS, and Melissa discharged herself at lunchtime on the fourth day of her residential stay.

CAROL AND CARING FOR NICOLE

Carol began her NCCRI-N by explaining that she could not remember how she worked with Nicole and then proceeded to free associate about Nicole and her husband. Similarly, in our previous interview, I had to remind her twice of the question, and her answers were very long:

Um, why did I work with Nicole the way I did? I don't remember, specifically, how I worked with Nicole, I'm afraid. Um, she was easy to work with, so I think that's why I haven't got specific recollection. Um, I took particular note of her and her husband's relationship, what they said to each other and how they worked with one another, and, in particular, note that she felt that he didn't understand what was going on for her and she was right... Then listening to her and what, what her concerns were, but she was quite clear, very, a lot of clarity, very easy to work with, very easy to do the goals of what she wanted... except that note that her, her mental health, her mental state, her affect ... Um, but because I was contained, I was able to take that all in and do the interview and it seem quite easy.

[Prompted]

I was able to be more structured with Nicole because she's quite able to be structured, so I was able to go through in a systematic way with her [referring to paperwork], um, but also listen, it was much more systematic than the way I did Melissa's interview, um, because it was easy to do it that way

Although Carol's first response was that she "can't remember," she involuntarily contradicted herself and described Nicole and her husband quite clearly. Similar to Melissa's interview, she discussed her own need to be contained and used the exact words and phrases, "listening to her" and "contained"; except in this instance, she did not describe herself as overwhelmed; instead stated it seemed "quite easy". When prompted, Carol again chose a safe behavioural nursing care routine that offered some insight into her preferred way of caregiving, "I was able to be more structured with Nicole" and "I was able to go through systematically". Behavioural routines are reminiscent of Carol's representation of her mother's caregiving. Carol explained why a structured approach was her choice of caregiving,

> *Now I'm thinking back, I think she's a teacher, or something like that, but I don't know. It just felt like she liked it that way, she knew what was coming, I'd explain what we were going to do and what we were going to do next, which, probably, I didn't even do with Melissa, because she just took me on the back foot so I worked out that this would be, I would just do, systematically, through the paperwork, which I do, sometimes, but, um, not all the time. But, with her, it felt like I could still listen to her, and do it that way and it felt okay...*

Finally, I tried to help Carol understand the question:

> ***FC:*** *Okay. So, the motivation <u>inside of you</u> for using a structured approach, why do you think that was?*
>
> ***Carol:*** *I suppose I thought it fit for her, um, and it seemed to work. Um, probably I'm flexible. I can go either way. Um, I don't have to do things in a certain manner, that makes it harder for me, because I do probably choose how the moment looks which way I'll go, so I don't have a set rigid routine. Um, um, not for – sorry, I've just forgotten...*

[another reminder and reframe]

> *I like the structured approach if I can get it. I think anyone would. It's just much easier and clearer.*

Carol struggled to elaborate on and define how she provided Nicole care. Initially, she assigned Nicole her belief that a structured approach was the best way to provide care and Nicole enjoyed knowing "what comes next". Following this explanation, Melissa intruded into her thoughts and our

conversation for the second time. Carol explained that her experience caring for Melissa had motivated her to try a more "structured approach" with Nicole. Carol seemed self-focused and motivated to protect herself from experiencing any overwhelming feelings similar to that of Melissa. Carol was then asked how she felt working with Nicole, as well as her expectations of Nicole:

> *Very easy. It felt a very easy alliance, um, um, it felt equal, and easy. Yeah. And that she would come to me if she needed anything or if she was concerned about anything, I would make myself available to her to just have moments of talking about how things were going, um, and when I did that, she was quite open, so that seemed to work quite well for us.*

Carol seemed to imply that she was available to Nicole when she needed or was concerned about "anything". However, she did not provide substantive episodes that would illustrate what "anything" was or the time of this. She described their relationship as equal, most unlikely in a nurse-client caregiving and care-receiving relationship. An equal relationship does imply a reciprocal adult-adult caregiving relationship. If this was the way Carol structured their relationship, this is possibly the reason she experienced it as "easy". Nicole was undoubtedly feeling vulnerable and had been admitted to the RPS seeking emotional, psychological, and practical parenting support. Nicole almost certainly did not need an equal relationship. Instead, she needed a nurse whom she could rely on to support her during her stay and who could increase her ability to provide sensitive and psychologically available caregiving to her baby. Carol did not seem to be able to provide this kind of caregiving and guidance to Nicole.

Carol was then asked to describe her initial encounter with Nicole, and she gave a very long and drawn-out response:

> *It was probably a little bit off-putting because that was when her husband was there, in the beginning, and she did the Edinburgh Scale, that was the first thing that ... and I don't know why I scored that first. Maybe it was her demeanour – I can't remember if she was teary or –, a bit vulnerable or something made me do the Edinburgh first, but just something about her told me to have a look at the Edinburgh, ...and her husband said, "I didn't know that. What's this Edinburgh?" And then I explained Edinburgh to him, and she said, "How come you don't know this? I've been crying every night for two weeks, and you don't know that I would have been*

getting worse," and he said, "I saw you crying, but I didn't realise that meant you weren't okay," and I thought, "Mmm," and then I looked at her and she just rolled her eyes, ... She was trying to show me what she was dealing with, I think. Um, and then he left....and then we did the interview, um, and on her own, she was much more able to verbalise.

In this extended excerpt, Carol became lost in her narrative and absorbed in describing Nicole's relationship with her husband, including quotes from a conversation between herself, Nicole, and her husband during the interview. Carol believed that Nicole tried to elicit her agreement regarding her husband's shortcomings when she stated, "then I looked at her and she just rolled her eyes". As her preoccupying discourse showed, Carol's thinking about Nicole's husband may have triggered intrusive memories of her mother and father.

Carol was asked about developing goals and tasks with Nicole:

Oh, I think she was very clear with what she wanted to do, and she had reasonable goals. They weren't, um, um, going against the development of her baby. She was quite sensitive and responsive and so, um, the goals were easily done, because I didn't have to try and reframe them or rearrange them a little to be more in line with infant mental health. She was quite reasonable.

[Prompt]

Well, I think we already settled the baby together, so that made it easier to have a language together in how we settled the baby ... I don't remember specifically. It was quite easy to do

Finally, Carol and I had a short exchange in an effort to help Carol, who seemed to struggle with the questions:

FC: *It sounds to me like she really wanted to work with you.*

Carol: *Right. Yes. I hadn't thought about it. Yeah. Yeah.*

FC: *Yeah - she was cooperative.*

Carol: *Yes. Yes. That's right.*

FC: *So, it sounds like a relationship that was cooperative; was it satisfying?*

Carol: *Yeah. Yes, I think so. Yeah. I felt that way.*

Even with prompts, Carol could not define how she cared for Nicole and her baby, nor could she elaborate on how she experienced their relationship. Carol had difficulty describing how she thought Nicole cared for her baby and used clinical jargon. When I asked how Nicole worked with her, Carol indicated an inability to remember. Even when pressed to consider how she and Nicole developed goals, Carol seemed unable to cooperate further with the questions. Carol's difficulty describing her relationship with Nicole echoes her caregiving relationship with her mother. At the end of the interview, I asked Carol if she wanted to say anything else about her caregiving relationship with Nicole:

Carol: *I would come up and I would always ask her how she was going and what was happening, and she was always very honest and open. I think I did one of her pathways, um, and then at the end of the time, I can't remember, but I think she might have disagreed that she'd met her goals, which was fair enough..... she was telling me why she thought that...and it was a really reasonable thing, – I think we both agreed what she was going to do next, I can't remember what that was, now, but she said, "I think I'm going to do this, that's what I think is going to work best for me," and I said, "Fair enough, that sounds good." So, it was a nice ending in that she knew what we could offer and what she could do, but she was choosing another path.*

FC: *Okay, and that was fine?*

Carol: *I think that was the equal relationship, we could bounce off each other... That's reasonable. You know, that's what's going to work for you better, or whatever.*

Carol's final comments directly linked to her statement that her relationship with Nicole was "equal and easy". Carol's approach to providing care to Nicole gave the impression that it consisted of behavioural routines and instrumental care. When I asked a question about providing care to Nicole, she often stated, "I can't remember", which seemed to indicate a dismissing stance or disengagement. She appeared to be preoccupied with her own attachment-related thoughts and

needs; she did not seem to recognise that Nicole had not achieved the goals of her stay and left the residential unit with no clear outcome of her stay in the RPS. This was not the intent of Nicole's admission to RPS and was perceived as a negative outcome.

NICOLE'S EXPERIENCE OF CAROL'S CAREGIVING

Before her discharge from the residential unit, I met with Nicole for her NCCRI-C. At our first meeting, although Nicole greeted me with her bright smile and friendly manner, she seemed a bit nervous; this time, she seemed more friendly and relaxed. Nevertheless, Nicole appeared somewhat cautious about discussing the outcome of her stay but was keen to proceed with her final interview and go home. Nicole's first question was, "How did it feel to be cared for by Carol during your admission?" Nicole responded:

> *I found Carol extremely personable and very comfort – comfortable to kind of just talk to. Never felt kind of standoffish, which you can, sometimes, with, um, care – well, primary care providers, you know, GPs, things like – the people you don't really – people you don't really know. So, when we had our intake, she was very personable, very open and honest and, you know, um, and friendly to talk, to talk to. So, she was lovely.*

Nicole's experience of Carol's caregiving during her admission was in direct contrast to Melissa's experience. Nicole chose six very positive adjectives to describe Carol. These were "extremely personable", "very comfortable", "friendly", "lovely", and "very open and honest", and doing so gave Carol a high standard of caregiving to meet. Nicole's highly positive adjectival constellation was reminiscent of her AAI. She portrayed her childhood relationship with her mother in a similarly positive light. Nicole continued in the same manner, and when asked, "What were your expectations of your working relationship with Carol?" she replied:

> ***Nicole:*** *that she would be my primary point of contact, I guess, um, and that the relationship I built up with her was go .., would be the, not necessarily the most important one, but the most, the one that happened the most often. You know, that's what I would hope for...it's nice to have one person that you feel like you can go and talk to if you're feeling like either you don't know the other nurses or you're not as comfortable with them, you have one person who, you know,*

you can go to, ... she made me feel like, in the first session, ... that I could go and see her if I needed to..

***FC:** And did that happen?*

***Nicole**: Yes. Yep, and whenever she came into the unit, she always made a point of coming to talk to me and see how I was going.*

Nicole's narrative indicated that Carol conveyed a much more welcoming message at their first meeting than she did to Melissa. In addition, Nicole described her expectation of Carol as the "relationship that happens the most often". She confirmed that Carol made a point of going to the residential unit to speak with her daily. Even so, similarly to Carol, Nicole did not or was not able to elaborate on or define how Carol cared for her and baby Zoe when she visited the unit "to talk to me [Nicole] and see how I was going". This resembled Nicole's AAI narrative, in which Nicole has difficulty describing all but the most functional aspects of her primary caregiving relationships. The follow-up question was, "What was your initial encounter with Carol like?" Once again, her response was suggestive of her AAI. Nicole gave a very upbeat, positive answer but only described Carol as "really friendly". The rest of her response had a paucity of detail, as she described partial aspects of their relationship, such as "I didn't feel like a client, you know".

Really friendly. Very – it was just, you know – she was, seemed genuinely happy to meet me, which was, it was good. I, I didn't feel like a client, you know, you know, provider kind of relationship, which, you know, sometimes it can be a little bit clinical, "This is your intake, here you go, fill in the forms, you know, let's talk about what you want out of this,". Um, but it was very friendly..

When Nicole was asked, "Was Carol able to help you accomplish your goals?" her answer was brief and to the point,

I think it gave me – because I felt comfortable with her, it gave me someone to talk to about – if I didn't feel like I was accomplishing them, I could have a chat to her about it, or the things that went well, I felt like I wanted to tell her that they went well. So, in that respect, yes.

In the following response, Nicole gave the impression that discussing her goals may have been more challenging. Carol had already explained in her NCCRI-N that Nicole had not achieved her admission goals. Nicole's childhood experience with both parents may have impacted her ability to define or elaborate on her experience of accomplishing her goals. Her statement, *"I felt like I wanted to tell her that they went well",* may indicate a childlike fearful sense of failing to please, similarly to her childhood experience with her father, who pushed her to achieve. These unconscious motivations may have had a triggering effect on Nicole's state of mind leading to a defensive reaction to exclude any overwhelming memories and a need to remain vigilant. This would explain Nicole's evasiveness, several restarts and brevity. In the following extract, Nicole is asked, "Did you feel any kind of dependency on Carol during your stay?"

> ***Nicole:*** *No. Not at all. Not at all, and, plus, she wasn't – she was in the unit a bit, ... I wouldn't say it was a dependence. It was nice when she was around because I felt like, oh, Carol is here, if I have a pressing question that if I asked someone else and didn't, wasn't really clear on what the answer was, I felt like, oh, she's here, I might just go ask her and see if that's that makes sense.*
>
> ***FC:*** *You didn't need to seek her out in any way?*
>
> ***Nicole****: No. No, No. No. she was around enough that if – she just popped in regularly, and so I didn't feel like I was, like, oh, "Where is she, I need to talk to her, I need to talk to her, she hasn't been around for a while", you know, so, I didn't feel like that. So, that's why I didn't feel like I needed to seek her out...*

Nicole began her response by denying and downplaying feeling any dependency on Carol. At the same time, she indicated a preference to speak to Carol. Nevertheless, there is a paucity of detail that it is difficult to determine how Nicole experienced her interpersonal care-receiving experiences with Carol. This again reflected her childhood experiences with her primary caregivers. Nicole's final question was, *"Is there anything else you'd like to say about your relationship with Carol during your stay?"*

> *No. I think it was the best relationship that I cultivated here. Um, her, like, we got along very well. You know, I found her very personable, very, I don't know. It, it almost was, like, she was*

very caring for Zoe, and was really interested in how she was going and how I was going and, you know, and made it very personal as opposed to, you know, "I'm just the nurse on duty." You know? "And I've looked at your file", kind of experience. It felt like she was, had a vested interest in how me, personally and Zoe, personally, were doing, and so that made a big difference. Yep.

Here Nicole is simply repeating what she has said throughout the interview. She presented a very positive overall image of her relationship with Carol but without any substantive incidents to demonstrate how Carol cared for her. She simply repeated some positive adjectives to describe her relationship with Carol, "personable", very caring", and "really interested".

In comparison to Melissa's 313-line interview, Nicole's very short 76-line interview was a highly positive representation of Carol with very little substantial detail about her care-receiving relationship with Carol. She seemed unable to elaborate or define any interpersonal aspects of her caregiving and care-receiving relationship with Carol. This paucity of detail regarding her caregiving relationship with Carol was resonant with her AAI classification Ds1 (dismissing of attachment). There are few indications of her preoccupied state of mind in this interview, except her sense of failing to please Carol. Nevertheless, Maier et al. (2004) observed that preoccupied states of mind share the tendency with dismissing states of mind to remain vigilant to processing attachment cues enabling rapid hyperactivation when necessary.

ACEs and Reported negative health outcomes

When reviewing the AAI transcripts, it emerged that all three women had cumulative exposure to ACEs; Nicole had experienced three ACEs Carol and Melissa experienced four ACEs (see table 7.2). They were exposed to a number of different ACEs and some of the ACE categories the women shared in common. All three women experienced emotional abuse and domestic violence. Melissa experienced physical neglect, and Carol's parents separated when she was 13 years-old. Both Nicole and Melissa had a parent with a mental illness. ACEs are known to be associated with adverse long-term health outcomes. All the women experienced adverse long-term health outcomes revealed in Melissa and Nicole's medical records. As an insider researcher and part of the nursing team, I was already aware of some of Carol's relationship, and emotional difficulties as Carol readily shared her difficulties (see table 7.2). These peer relationship and emotional difficulties were adverse outcomes

of her ACE experiences. All three women's cumulative exposures to ACEs contributed to their U/CC classification. The findings from the ACEs with be discussed in Chapter 8.

SUMMARY

Carol's low-coherence CC attachment state of mind did not allow her to elaborate on or define her caregiving relationships. Therefore, she could not coherently communicate the effect of her caregiving experiences for herself or the two women, Melissa and Nicole. The two women, Melissa and Nicole, experienced Carol's caregiving very differently, but both had adverse outcomes resulting from their RPS stay. Chapter eight will provide a complete discussion of this case study.

Chapter 8: DISCUSSION

When I started this research, I thought some nurses seemed to have trouble with their relationships with their clients. I questioned whether it was because they had an insecure attachment. My research suggests this is correct for the small cohort of nurses in this study and under certain circumstances, but there appears to be much more to it. What surprised me was that most of this cohort of nurses had experienced some type of attachment trauma or loss through the death of an attachment figure. Some CFH nurses seemed to have resolved their trauma and/or loss and achieved or "earned" their secure state of mind (Main, Goldwyn & Hesse 2003). However, other nurses remained U regarding attachment trauma and/or loss, leading to their U or CC state of mind. The attachment trauma and/or loss through death may potentially reduce the CFH nurse's capacity to provide quality caregiving when their attachment systems are activated under stressful circumstances.

This research aimed to understand how the attachment state of mind affects the nurse-client caregiving relationship. The study comprised six questions regarding the CFH nurses' and women's attachment states of mind and how these may affect the way their caregiving and care-receiving relationships:

1. Is there an association between a secure attachment state of mind and the quality of the caregiving and care-receiving relationship between the CFH nurse and the woman?
2. Is there an association between the CFH nurse's attachment state of mind and how she perceives her caregiving relationship with the woman?
3. Is there an association between the CFH nurse's attachment state of mind and how she provides care to the woman?
4. Is there an association between the woman's attachment state of mind and the way she perceives her caregiving relationship with the CFH nurse?
5. Is there an association between an insecure attachment state of mind and the caregiving relationship between the CFH nurse and the woman?
6. Is there an association between U and/or CC attachment state of mind and the caregiving/care-receiving relationship between the CFH nurse and the woman?

These case studies aimed to compare the analysis findings to theoretical concepts of nursing, caregiving and attachment theories, with the intent of contributing to and extending those theories.

This chapter focuses on aspects of the major case study of CFH nurse Carol and the two women she cared for, Melissa and Nicole. Each presented with a U/CC or CC. This case study was chosen because it represents an infrequent AAI classification in a normative population. In addition, three illustrative case studies of the organised and unresolved category are also presented to highlight salient aspects of the CFH nurse and women's caregiving relationships. Following the findings, the implications of the current study for nursing research and clinical practice will be explored. Finally, the limitations of the study will be considered, and suggestions for future research.

ADVERSE CHILDHOOD EXPERIENCES, OUTCOMES AND TRAUMA-INFORMED CARE

When reviewing the main case study transcripts of Carol, Melissa and Nicole, it was evident they presented with troubled and disrupted childhoods that had affected them in adulthood. The AAI enabled each woman to recount her childhood experiences with both parents, providing an insight into the woman's interpretation of their life history. When they recounted their experiences during their AAI, it became apparent they had cumulative exposures to ACEs. Of the three women in the main case study, Carol and Melissa had exposure to at least four ACEs, and Nicole had exposure to at least three ACEs. All three women had the AAI attachment classification U/CC or CC. When a child experiences three ACEs they have a 38% chance of having the AAI classification U/CC; when they have four the chances of an AAI classification of U/CC is 65% (Murphy et al. 2014).

The women each had different ACE exposures. These exposures included witnessing violence against their mother, having a parent with mental illness, an emotionally or physically abusive parent, an emotionally or physically neglectful parent, divorced or separated parents, a parent using drugs or alcohol and fear of a parent. Carol and Nicole experienced parents who separated and divorced before their 18th birthday. Separation and divorce may cause a child to experience a significant rupture with the parent that leaves the family home and subsequent grief and unresolved loss (Adam, Sheldon Keller & West 1995).

Any long-term separation from one parent after the divorce may cause an unresolved loss for that parent (Adam, Sheldon Keller & West 1995; Allen, Hauser & Borman-Spurrell 1996; Turton et al. 2001). This particular issue will be further explored later in the discussion. Experiences such as these can leave the CFH nurses and women who experience the loss of a parent through separation and divorce with complex and often contradictory feelings and thoughts about their parent.

Fourty-four per cent (n = 11) of the study cohort experienced emotional abuse, including emotional neglect with either mother or father. This is much higher than the Kaiser Permanente normative sample of 11%. In the main case study, Carol portrays her father as angry, threatening, and emotionally unavailable to her. Nicole implied she experienced an involved/role-reversing mother and an emotionally unavailable father. Finally, Melissa portrayed her father as angry, often neglectful and emotionally unavailable to her. Murphy et al. (2014) study found that 72% of people who were classified as U/CC described 'emotionally unsupportive experiences' from their caregivers in childhood.

Indeed, emotional abuse and parental separation are associated with insecure attachment and U/CC classification on the AAI, as well as psychological and emotional illness (Dube et al. 2001; Felitti et al. 1998; Murphy et al. 2014; Steele, Murphy & Steele 2010; Thomson & Jaque 2017a). In the current study, six CFH nurses and women classified as U/CC had been exposed to these two categories of ACE. Twenty per cent (*n*=5) of the CFH nurses and women in this sample described witnessing violence against their mothers. This rate is higher than the published norm of 13%. Carol witnessed violence against her mother, and Melissa watched her parents in domestic violence incidents. Both women described being fearful of these incidents throughout their childhood. According to Murphy et al. (2014), the ACE 'witnessing violence against mother during childhood was linked to a 75% likelihood of having an AAI classification of U/CC. The CFH nurses use a domestic violence (DV) screening tool during the women's admission to the residential unit. They offer the screening tool to each woman to check if the woman wishes to disclose she has experienced DV. The CFH nurses only offer the DV screening tool if they are alone to ensure the women's privacy, safety and well-being. If a woman has disclosed she has experienced DV, the CFH nurses can provide the woman with further assessment and referral and ensure her safety. Consequently, the CFH nurses are well prepared and

resourced to reassure psychologically and practically manage an immediate situation, as well as past events if and when disclosed.

It has been well documented that ACEs are associated with long-term physical and psychological health problems, substance use, impaired work performance, impaired interpersonal skills, relationship difficulties and emotional distress, (Anda et al. 2004; Felitti et al. 1998; Maunder et al. 2010; Strait & Bolman 2017). Carol, Melissa and Nicole reported current psychological and relationship difficulties, depression and anxiety This is the fourth of four case studies illustrating how the adult attachment states of mind affect relationship interactions, particularly in the nurse-client relationship. This case study presents the analysis of Nurse Carol and the two women she worked with, Melissa and Nicole, during their five-day residential stay at the RPS. As these three transcripts are very long and complex, Nurse Carol's AAI will be presented as the exemplar of the three low-coherence CC transcripts. The presentation of the case study will start with the analysis of nurse Carol's AAI, and her voice will be used to highlight and explain the theoretical features of the U/CC classification. Following the AAI, Carol's NCCRI-N will be presented to construct an understanding of how Carol's state of mind affected her caregiving of both women. Correspondingly, the voices of Melissa and Nicole will represent their individual experience of Carol's nursing care. Finally, the three women's ACEs and their long-term psychological health outcomes will be presented. Table 7.1 presents the attachment classifications of Nurse Carol, Melissa and Nicole:

Table 7.2). It was apparent from the medical records of the women in this study that 92.3% (n = 12) had experienced anxiety and depression, and 69.3% (n = 9) reported relationship difficulties with their mothers. 61% (n=8) of women in the study experienced problematic pregnancies and traumatic birth. Studies have found that a history of ACEs, depression and low social support are risk factors for a traumatic birth (Seng et al. 2013; Söderquist et al. 2009). Other research studies have found that mental health conditions, childhood abuse and negative perinatal emotions during delivery are associated with peritraumatic dissociation and later PTSD (Nijenhuis et al. 2001; Olde et al. 2005; Seng et al. 2013). Nicole reported she had had a traumatic birth, and Zoe was delivered by Ventouse-assisted delivery. Having a traumatic birth does not usually generate a referral for counselling or a supportive intervention for the women in the residential unit. This is probably because the CFH nurses lack a complete understanding of the psychological impact of the women's birth experiences and the

re-experiencing of the birth trauma in the postnatal period (Elmir et al. 2010; Simpson & Catling 2016). For a woman like Nicole, who has experienced ACEs and problematic childhood attachment relationships, re-experiencing her traumatic birth may affect her capacity to work effectively with Carol.

Melissa had experienced four ACEs; her multiple exposures to ACEs had a cumulative impact on her long-term health outcomes. She reported depression and anxiety and had made several suicide attempts. Dube et al. (2001) report that the lifetime prevalence of suicide attempts increases as the number of ACE score increase. This is one of the reasons the EPDS is used in residential units. Screening women for symptoms of postnatal depression and being vigilant for positive answers to question 10 enables further assessment by the residential unit psychologist and ensures an effective mental health intervention is provided.

Other factors associated with suicide risk are illicit drugs, alcohol use, depression and other mental illnesses. Frankenberger, Clements-Nolle and Yang (2015) found evidence that women with higher ACE exposures were more likely to drink in pregnancy than women with fewer ACE exposures; 30.4% of women with two or three ACEs drank during pregnancy, while 22.9% of women with no ACEs drank during pregnancy. Felitti et al. (1998) and Dube et al. (2001) found a strong graded relationship between the number of ACEs and alcohol abuse, depressive disorders and suicide attempts across the lifespan.

Melissa had an alcohol use disorder and abused alcohol during her pregnancy which may have put her infant, Zac, at risk of Foetal Alcohol Spectrum Disorder (FASD). Zac could be at risk of behavioural difficulties, regulatory disorders, maths, reading, learning and attentional problems requiring long-term interventions (Ordenewitz et al. 2021). Unfortunately, the risks associated with FASD frequently go unrecognised by health workers, and the parents remain uninformed of the risk and need for intervention (Shelton et al. 2018). Melissa told me she was aware of the FASD risk and had discussions with her doctor. However, it was unclear how serious Melissa took this risk for her baby.

This study found a high prevalence of exposure to three ACEs, especially for the CFH nurses (41.6%, *n* = 5) and, to a lesser extent, for the women (23.1%, n = 3). These percentages are well above the

norm of 10.4% for three ACEs (Dube 2003). A high prevalence of ACEs has been found amongst human services workers. Hiles Howard et al. (2015) found that 25% of their sample had four or more ACEs, and Esaki and Larkin (2013) found that 6% of their sample had experienced four or more ACEs. The current study revealed that the most frequently reported ACE was “growing up with a family member with a mental illness”. Eight of the nurses (66.6%) and six of the women (41.1%) had grown up with a family member with a mental illness; this is not dissimilar to Esaki and Larkin’s (2013) finding of 34% of their participants.

CFH nurses and women frequently face stressful situations where they must calm and self-regulate to cope with pressure. The high prevalence of ACEs and the six CC and three unresolved classifications in this study highlight an unseen dilemma for these women and CFH nurses when faced with stressful triggering events. When they cannot self-regulate, their observable behaviour may appear incongruous or unfeeling to an onlooker (for further analysis, see “wounded healer” in this chapter).

In the leading case study, Carol’s, Melissa’s, and Nicole’s narratives revealed ACEs that may have contributed to their final attachment classification of U/CC. All three women’s discourse in their AAI were judged U/CC or CC due to global lapses in monitoring reason, discourse, and behaviour. The U/CC classification often indicates emotional or psychological problems that negatively impact the caregiving (Hesse & Main 2006; Lyons-Ruth et al. 2005; Murphy et al. 2014; van IJzendoorn 1995). Evidence from the women’s medical records suggests that most women admitted to the RPS had caregiving difficulties. There were five main reasons the women came to the RPS for help. Four reasons indicated infant physiological dysregulation, 1) infant sleep and settling, 2) feeding difficulties, 3) settling and soothing a crying baby, and 4) establishing routines and understanding their infant’s behaviours. The fifth concerns adjustment to parenting.

In this study, ACEs are common in women attending tertiary care settings and the CFH nurses caring for them. As previously discussed, these adults face innumerable difficulties and an increased burden of ill-health (Anda et al. 2004; Dube 2003; Felitti et al. 1998; Strait & Bolman 2017; Zarse et al. 2019). The association of three or more ACE categories is associated with long-term poor bio-psychosocial health outcomes is well substantiated (Anda et al. 2004). ACEs have been associated with psychological abuse, trauma, loss of a parent, and other traumatic events such as witnessing domestic violence (Anda et al. 2004; Felitti et al. 1998; Murphy et al. 2014). The consequence of

cumulative ACE traumas places an adult at risk of an AAI classification of U/CC (Murphy et al. 2014). The high frequencies of some ACEs within the AAI transcripts highlight an unseen challenge for the women and the CFH nurses in their personal, social and professional lives.

CFH nurses and women with three or more ACEs and a possible history of trauma cannot be differentiated by simple observation from those who do not. Likewise, the AAI state of mind of the CFH nurses and women is unknown to them and unobservable to others. Consequently, the unpredictable environment of the RPS and the various relationships the CFH nurses have with the women, peers, and within the RPS have the potential to trigger memories of trauma and abuse. Triggered memories may cause the CFH nurse or woman to have an unexpected reaction, such as aggression, fear, distancing, withdrawal or dissociation or other inexplicable behaviour confusing to people. The response to the traumatised person's behaviour may unintentionally re-traumatise them (Isobel 2016; Purkey et al. 2018). Of course, this potentially disrupts the caregiving relationship between the CFH nurse and the woman. Incorporating an organisational trauma-informed care (TIC) approach recognises the high prevalence of trauma and its significant consequences on a person (Butler, Critelli & Rinfrette 2011; Isobel et al. 2021). A TIC approach ensures that all clients are asked sensitively about potential trauma, decreasing the risk of re-traumatisation (Elliott et al. 2005; Isobel 2016; Isobel & Edwards 2017; Isobel et al. 2021; Lathan, Selwyn & Langhinrichsen-Rohling 2021; Lewis et al. 2019; Palfrey et al. 2019). This study highlights the high number of ACEs in CFH nurses that can make them susceptible to unintentional re-traumatisation in the workplace (this will be discussed in the section "wounded healers").

UNRESOLVED LOSS FOR SEPARATION AND DIVORCE – PERCEIVED ABANDONMENT.

In the AAI protocol, loss is only scored for the death of a parent or other close person during childhood and adulthood. When I asked a CFN nurse, Carol, and client, Holly, about loss, I was given the same answer: they explained they lost their father when their parents separated and subsequently divorced. Both women were 13 years old when the separation occurred, and their memories of the event indicated the loss was traumatic. As a result, each had lapses in the monitoring of reason and discourse when the "loss" was directly discussed and at other times indirectly when the women discussed their father's abandonment of the family. Thereby the loss or separation of their father

(attachment figure) through abandonment due to divorce rather than death, generates a disorganised response and may result in similar indices of unresolved loss as identified in the AAI (Adam, Sheldon Keller & West 1995; Goldwyn & Hugh-Jones 2011; Turton et al. 2001).

Adam, Sheldon Keller and West (1995) study of adolescents 13-19 years of age found the experience of separation from their parents through divorce or fostering was a risk factor for attachment trauma. Their research identified that 50% of their clinical sample had an AAI classification unresolved for separation attachment-related-traumas. These findings have implications for Carol's and Holly's unresolved state of mind regarding their fathers. Turton et al. (2001) suggest that people who have experienced a traumatic loss through abandonment may become absorbed or disoriented when discussing their parents' influences in their lives. Holly's narrative portrayed her as profoundly distressed and desperate to stop her father from leaving. Her description of the night her father abandoned the family included disorganising perceptive-sensorial details, similar to unresolved transcripts, suggestive of deep absorption.

The effects of divorce on the young child and the developing adolescent have been the subject of much research (Aikins, Howes & Hamilton 2009; Bacro & Macario de Medeiros 2021; George, Solomon & McIntosh 2011; Lewis, Feiring & Rosenthal 2000; Main, Hesse & Hesse 2011; Solomon & George 1999). One of the foundations of Bowlby's theory is that over the first 12 to 14 years of life, a child's internal working model is open to change, subject to both positive and negative life events that affect caregiver behaviours (Bowlby 1988a; De Wolff & van Ijzendoorn 1997; Main, Kaplan & Cassidy 1985; Raby et al. 2015). Waters et al. (2000) explain that adverse life events that may alter caregiver behaviour are life experiences such as parental divorce, loss of a parent, life-threatening parental illness and mental illness. In a study by Riggs and Jacobvitz (2002) examining associations with mental health and early attachment relationships, they found that unresolved and preoccupied adults were more likely to have experienced parental separation or divorce and reported a higher frequency of physical or sexual abuse by a relative. Carol had an unresolved and insecure preoccupied attachment.

Carol and Holly were in early adolescence when their fathers abruptly left the family home. A longitudinal study investigated the impact of divorce on whether adolescent attachment representations remained stable between one and 18 years. This research found that those 18-years

old's whose parents divorced during early adolescence and had a secure attachment at one year, were 90% more likely to have an insecure attachment, compared to 60% of 18-year old's classified insecure at one year who remained insecure (Lewis, Feiring & Rosenthal 2000). Of particular note, Holly's AAI Classification was unresolved and secure autonomous, and Carol's AAI classification included unresolved and insecure preoccupied.

Divorce, a negative life stressor, was identified as a contributing factor to the emergence of an unresolved state of mind in Aikins, Howes and Hamilton's (2009) longitudinal study. This was due to several factors including the stresses placed on parents that affect their caregiving capacity making them less sensitive, less emotionally and psychologically available and often rejecting the young adolescent attachment needs.

According to Lyons-Ruth et al. (2003), this may represent another pathway that contributes to an unresolved state of mind during adolescence if parents separate and divorce. Holly's narrative portrayed her mother as helpless, withdrawn and unavailable to her when her father left the family home. Holly took the responsibility of calling the neighbour to help her mother. The neighbour took Holly and her mother back to her house and while the neighbour consoled and cared for Holly's mother, Holly was left alone with only the periodic support of the neighbours husband. Holly recalled, "I just kept randomly crying" through the night. Holly's recollection of her mother's helplessness and inability to provide a secure base-safe haven to organise her feelings suggest a "traumatic re-experiencing of (the) loss" and fear she must have felt that night (Bowlby 1988b; Lyons-Ruth et al. 2003). Her mother's withdrawal from her when Holly needed help, the lack of soothing effective communication, her inability to protect her from these frightening occurrences and finally finding herself in a strange house with an unfamiliar person must have been scary and traumatic (Lyons-Ruth, Bronfman & Parsons 1999; Lyons-Ruth et al. 2005). Investigations show that life stresses, such as divorce, negatively affected parental caregiving and reduced sensitivity and responsiveness, contributing to an adolescent's emerging AAI unresolved state of mind (Weinfield, Whaley & Egeland 2004).

Currently, the AAI does not code separation and divorce for the unresolved state of mind as there is insufficient evidence for it to date (Goldwyn & Hugh-Jones 2011). However, Bowlby (1980/1998) explains that the child's attachment system is intensely aroused when separated from the parent,

even in middle childhood and adolescence. When a child's protests are consistently ignored over a long period, the attachment system is likely to be deactivated. This is even more likely if the parent actively rejects the child (Bowlby 1988f). Carol reported feeling rejected when her father left and never saw him again, which suggests a lack of termination for her attachment system. Her deactivated attachment system excludes thoughts and feelings about her father resulting in emotional detachment. Carol's U/CC classification includes a dismissing (Ds2) state of mind, which may explain her devaluing her father and dismissing the effects of her experiences with him.

Bowlby (1980/1998) drew attention to the responses of adults who had lost or were separated from, a parent during childhood or adolescence. He described the resultant pathological mourning as "unconscious reproach against the lost person combined with conscious and often unremitting self-reproach" and a "persistent disbelief the loss is permanent"; that the person is dead (pp. 15-6). Carol provides more evidence with lapses in reasoning with respect to disbelief that her father left her during childhood. This is evident when she brings him into the present and discusses his continuing influence on her life. Furthermore, Carol's active derogation may be seen as an "unconscious reproach" towards her father (Bowlby 1980/1998). Carol's narrative reveals two propositional attitudes regarding her father's abandonment. When she explained that the loss of her father was significant as well as rejecting of her, yet she wanted him to go at the same time, it appears she has multiple models of this attachment-related event (Main 1991).

Adam, Sheldon Keller and West (1995) suggest that separation and divorce may be experienced as another attachment trauma and, as such, needs to be considered within the AAI coding system. The findings in this study suggest that both Holly and Carol had an unresolved state of mind concerning separation/abandonment during a traumatic separation from their father. In keeping with this aspect of this case study methodology, a further contribution to the coding of AAI unresolved loss states of mind is offered. This contribution strengthens previous research findings of adolescents who have experienced trauma through loss other than loss through the death of a parent (Adam, Sheldon Keller & West 1995; Goldwyn & Hugh-Jones 2011; Turton et al. 2001). Furthermore, when the caregiver withdraws from the child and their caregiving becomes rejecting or neglecting, less sensitive, less emotionally and psychologically available, helpless or hostile, the child's experience of loss,

abandonment and trauma are amplified (Aikins, Howes & Hamilton 2009; Lyons-Ruth et al. 2003; Weinfield, Whaley & Egeland 2004).

THE LOW-COHERENCE - CANNOT CLASSIFY STATE OF MIND

The current study revealed a more significant than expected proportion of CFH nurses and women classified with U/CC states of mind. Bakermans-Kranenburg and van IJzendoorn (2009) suggest that populations believed to be normative or healthy may not be as normative or healthy as presumed. Some individuals in these populations could be silently experiencing psychological distress from unresolved loss, abuse or trauma. This study of a community sample of CFH nurses and women may signify a group who suffer from psychological distress in silence.

In the current sample 41.6% (n = 5) of CFH nurses, 30.7% (n = 4) of women and the full cohort of CFH nurses and women 36% (n=9) classified as U/CC. Although this is a small purposive sample, it was compared to Bakermans-Kranenburg and van IJzendoorn's (2009, p. 241) published data on American mothers, low-risk community, clinical and trauma/PTSD samples. The distributions of the current sample are more representative of the U/CC clinical population (43%) than the normative (18%). Bakermans-Kranenburg and van IJzendoorn noted that the percentage of people classified as CC is difficult to determine in non-clinical samples, as they rarely present for study.

The U/CC state of mind is generally found in adult clinical populations such as child holocaust survivors (Koren-Karie 2000), prison populations (Lamott, Fremmer-Bombik & Pfafflin 2004; Turton et al. 2001), adults who experienced four or more ACEs (Murphy et al. 2014) and survivors of childhood sexual abuse (van Hoof et al. 2015). The individuals in these studies experienced extreme childhood attachment traumas such as parental loss or abandonment, trauma and abuse which caused PTSD (Stovall-McClough & Cloitre 2006), adolescent reactive attachment disorders (Goldwyn & Hugh-Jones 2011), parent-infant disturbances requiring psychotherapy (Hughes & McGauley 1997; Minde & Hesse 1996), borderline personality disorders (Bucheim & Horst 2003; Fonagy & Bateman 2007, 2008; van IJzendoorn & Bakermans-Kranenburg 2008) and dissociative disorders (Farina et al. 2014; Liotti 2004). With this in mind, I did not expect to find any nurse or woman with the U/CC classification, as it is deemed rare for normative samples.

Hesse (1996) defined CC as a breakdown in the general ability to gather a single organised state of mind throughout the interview. Cannot classify is typified by extreme contradictions in a person's state of mind resulting in a global breakdown in discourse strategy throughout their AAI. While there are no official category descriptors for low-coherence CC transcripts, some researchers have recently suggested that common indices characterise CC transcripts (Goldwyn & Hugh-Jones 2011; Speranza et al. 2017; Turton et al. 2001).

In the context of this study, it is essential to highlight the contribution to the further identification of low-coherence indices throughout CC transcripts. The types of low-coherence indices evident in earlier research (Goldwyn & Hugh-Jones 2011; Speranza et al. 2017; Turton et al. 2001) were present in four CFH nurses, and two of the women's AAI CC transcripts. Identifying these indices, such as derogation of attachment figures, self-derogation and derogation of others, laughing at their own pain and the failure to describe primary attachment relationships, helped substantiate that the globally disorganised AAI attachment state of mind CC. This finding is an important addition not only to nursing knowledge but to the field of attachment theory.

In addition, the impact of the CFH nurse and women's early childhood experiences of attachment trauma, including ACEs, may have mediated the emergence of the CC/low coherence state of mind. Most importantly, the culmination of these factors for nursing practice affected the CFH nurses' capacity to offer sensitive and responsive caregiving. Similarly, the women's CC state of mind affected how they experienced care from their CFH nurse.

A short overview of the low-coherence indices found in the transcripts follows. Melissa and Nicole use *"odd/lacking descriptors of the primary relationship" (Speranza et al. 2017)* to describe their early relationships, such as using only two or three adjectives to describe their caregivers or describe them in a negative form (Speranza et al. 2017; Turton et al. 2001). Melissa and Nicole used perceptive-sensorial details to describe their early attachment relationships. These disorganised perceptive-sensorial descriptions were used in the absence of a specified single or series of fearful, traumatic or loss events.

Carol is unable to offer anything but concrete or partial descriptions of her early experiences with her parents. Carol's adjectives for her mother are highly positive, but she can only describe her mother's

behavioural routines. Nicole and Melissa had difficulty describing specific experiences with each parent without discussing the other parent as well, almost as if, in their mind, their parents were hard to disambiguate. In Melissa's and Nicole's case, their early experiences with their father appear to have a disorganising effect even when there was no discussion of loss or trauma. None of the three women appeared to be able to elaborate on their early relationships or provide an enduring global representation of their primary attachment relationships. All three had trouble defining their interpersonal experiences or their significance in their lives.

Carol and Melissa frequently experienced moments of disorientation, or as Speranza et al. (2017) suggest, lapses in monitoring of reason, another marker of low-coherence-CC transcripts. Carol frequently and completely lost track of the question, and Melissa also experienced disorientation which was noticeable by long pauses. Hesse and Van Ijzendoorn (1999b) indicated that reasoning lapses fit well with the concept of absorption and show vulnerabilities to alterations in consciousness. A violation of reasoning occurs when Carol and Nicole use third and second-person pronouns throughout their narratives. Borelli et al. (2013) found that disorganised individuals used more second-person pronouns when discussing loss, suggesting this indicates an attempt to distance themselves from the trauma or depersonalise.

Another feature of low coherence/CC interviews is behavioural reactions. Speranza (2017) and Lyons-Ruth (2005) identified laughing[45] when recounting painful, negative or traumatic events as an extreme behavioural reaction. Laughing at pain suggests an attempt to distance or minimise the effect of the pain on the self. All three women laughed during their AAIs when describing their painful memories. Consistent with the tendency to laugh and minimise pain and distress, another behavioural reaction observed in low-coherence/CC speakers is a lack of emotional regulation. Turton et al. (2001) suggests that this kind of dysregulation could be called the "anger/derogation boundary", meaning both are intrinsically confused in these speakers. Speranza et al. (2017) define these

[45] Ordinarily laughter and crying are not transcribed into the transcript and the coder does not take these into account. Subsequent research has identified subjects with low coherence demonstrate a behavioural reaction, "laughter at their pain" therefore laughter has been included in the analysis.

speakers as oscillating between extreme de- and hyper-activation of emotional regulation. Melissa, Carol and Nicole struggled throughout the interview, which was observed in preoccupied passages peppered with laughter and derogation.

Carol appeared to have a fearful mental state that manifested only when she was describing her relationship experiences with her mother. When Carol described her fear, it was in the absence of threatening circumstances. This fearful preoccupation cannot be classified as an E3 as it is not pervasive across the transcript. Furthermore, it was difficult to determine if Carol has had a loss of memory regarding any traumatic events. Carol's present mental state may have been the result of being exposed to her father's anger and the lack of a secure base provided by her mother's disorganised helpless behaviour (Lyons-Ruth et al. 2005; Solomon & George 2011). It is essential to acknowledge that Carol's maternal grandmother experienced the loss of all her children except Carol's mother. It cannot be forgotten that second-generation effects of unresolved attachment trauma and loss profoundly affect caregiving. Carol may have experienced second-generation effects from her mother (Hesse & Main 1999; Hesse et al. 2003).

There are other features in the transcripts worth noting that Speranza et al. (2017) highlighted. Nicole appeared to have few memories of her primary relationships before eight years of age when her sister was born. When Nicole does recall a memory, she is uncertain if it is her own or her parents and questions her reality. Nicole's CC classification type was CC type one, i.e., a switch in attachment category from Ds1 to E2 with her mother during the interview. This may explain why she suggested during the interview that her mother might have influenced her memories of her father. Bowlby (1988f) observed that parents are "...extremely influential in affecting their children's thoughts, feelings and behaviours..." (p. 101). A child is often willing to conform to the wishes and beliefs of a pressuring parent that are contrary to the child's own experience.

Consequently, the child excludes processing information and ceases to be consciously aware or doubting their actual experiences. Nicole's attachment representation of both parents is fragmented and incompatible. Speranza et al. (2017) concur with Bowlby and submit that description of early relationships may not result from early memories. Instead, ideas and beliefs are told by the attachment figure to the child, which eventually the child comes to believe to be their memories.

Another manifestation of low-coherence worth noting occurred in Melissa's interview. Melissa told me her mother had cancer when Melissa was about 12 years old. Melissa showed no empathy towards her mother when she told the story and instead derogated her mother. Melissa was old enough to understand that her mother was seriously ill. This experience represented an extreme threat to her attachment system. As a result, it may have created a precarious sense of personal identity and representational fragmentation.

A notable feature of the transcripts were the women's derogating comments. This was observed in three specific ways. The traditional AAI coding system for derogation of attachment was prominent in Carol and Melissa's transcripts. However, derogation of others who were not attachment figures and self-derogation were very evident in their narratives.

Turton et al.(2001) reveals that it is common in clinical populations for the speaker to be self-derogating to indicate to the interviewer that they are not worth their time. Lyons-Ruth et al. (2003) research noted that participants identified with their hostile-helpless caregivers and devalued themselves. Goldwyn and Hughes (2011) also encountered extreme derogation and self-derogation in their clinical sample of traumatised adolescents. Bretherton and Munholland (1999) observed that as a consequence of defensive exclusion, the speaker might redirect the anger they feel toward the caregiver back towards themselves. This research concurs with Turton et al. (2001) and Speranza et al. (2017) when they suggest that for populations with extreme experiences and subsequent low-coherence-CC, the current AAI coding be extended to include derogation of others and derogation of self.

Finally, Nicole provided two interesting examples of what could be inferred as second-generation effects of unresolved trauma. (Hesse & Main 1999, 2000; Main & Hesse 1990). During her AAI, Nicole's baby woke up, and when she heard her cry, she laughed at the baby and did not go to pick her up. She continued to speak to me until the CFH nurse brought her baby to her. Nicole's response may have represented her need to downplay or minimise her baby's distress pointing to her AAI insecure dismissing classification. The second example occurred when Nicole was asked about what she learned from her childhood experiences and answered, *"she needs not just to have me".* This reply echoed her AAI interview when asked for adjectives to describe her mother. Her response when she was describing her mother as loving "...*we all never felt threatened or anything like that..."* not

only violates quality (be truthful and evidence for what you say) but seems indicative of her attachment state of mind related to experiences with her mother (Main, Goldwyn & Hesse 2003; Speranza et al. 2017; Turton et al. 2001).

Carol, Melissa and Nicole's interviews share the common features of low-coherence interviews indicated in the available literature (Goldwyn & Hugh-Jones 2011; Speranza et al. 2017; Turton et al. 2001). These three women were not from extremely depriving environments, yet all experienced childhood exposure to three or more ACEs and lived in dysfunctional households. Parental mental illness, separation and divorce, family violence, emotional abuse, and emotional and physical neglect were all prevalent in their early childhood years. Carol and Melissa were also coded as unresolved for the loss of a parent, and Carol was separated and abandoned from her father at 12. Their contradictory discourse throughout the interview demonstrated a global breakdown in representational strategy.

Using Speranza et al.'s (2017) indices for low coherence, each woman demonstrated odd or lacking descriptions of their primary relationships, global collapses in reasoning, discourse, and behavioural reactions. Applying Turton et al.'s (2001) criteria, I found the anger/derogation boundary, the child-like preoccupation to please the interviewer and derogation, self-derogation and derogation of non-attachment figures. Finally, Goldwyn and Hugh-Jones (2011) also found high levels of derogation in the population of adolescents with Reactive Attachment Disorder. Identifying the low-coherence/CC indices of the above three studies in my case study adds to the limited understanding of low-coherence/CC classification. This case study continues the heuristic approach of other researchers by a minute examination of difficult-to-code transcripts to develop further a consistent categorical descriptor of low-coherence/CC.

Further findings in the low-coherence transcripts relate to how the three women spoke about their experiences of caregiving and care-receiving. In their AAI narratives, the women did not seem able to define or elaborate on their relationship with their parents coherently. Due to their difficulties defining or elaborating on their relationships with their parents, they could not provide a clear description of the caregiving they received. The women's early inferred caregiving experiences gave the impression that they had an unstable sense of self and experienced "representational fragmentation" (Goldwyn & Hugh-Jones 2011; Koren-Karie, Sagi-Schwartz & Joels 2003; Lamott, Fremmer-Bombik & Pfafflin

2003). The women's "representational fragmentation" translated into their caregiving and care-receiving relationships in the residential unit. The CFH nurse and the woman she worked with responded to each other in their inchoate representational dance. There are three findings of note from the low-coherence transcripts.

Firstly, Carol described providing contradictory caregiving behaviours that were an uncomfortable and confusing experience for the women. In her account, she reported avoiding and withdrawing, being insensitive and rejecting, other times caring and very attentive, and sometimes just indifferent. Solomon & George (2011) maintain that a woman transfers caregiving patterns from her own caregiving experiences. Thus, it can be inferred that Carol's representations of her past caregiving experiences are contradictory.

A recurring feature of Carol's NCCRI-I narrative was her rumination on her negative experience of caring for Melissa and the negative feelings this engendered. Marcusson-Clavertz et al. (2017) found that individuals who had AAI unresolved attachment experienced high negative affect and were less able to control their thinking; they also felt disconnected from those around them. This is conceivably one reason why Carol distanced herself, withdrew and avoided Melissa. Another motivation may have been to alleviate her attachment fear or anxiety and exclude them from her awareness (Bowlby 1988d; Lyons-Ruth et al. 2005; Speranza et al. 2017).

Consequently, Carol's internal representations of contradictory caregiving and past attachment traumas often prevented her from offering sensitive and responsive caregiving to Melissa and Nicole (Condino et al. 2020; Fraiberg, Adelson & Shapiro 1975; Iyengar). Unfortunately, Carol seemed unaware of the significance of the ACEs and subsequent attachment trauma she experienced and the effects it might have on her caregiving interactions.

One of the aims of admission to the RPS is to enhance parental sensitivity, responsivity, and psychological and emotional availability. Carol frequently found this a problem due to her own caregiving experiences. Thus, the second finding of note is that rather than providing help with enhancing their caregiving, Carol repeated aspects of her own unresolved/disorganised caregiving experiences from her parents, possibly by unconscious representational processes. The transmission of unresolved/disorganised caregiving from caregiver to caregiver within the family is known as the

intergenerational transmission of attachment and subsequent caregiving behaviours (Bretherton 1990; Fraiberg, Adelson & Shapiro 1975; Iyengar ; Solomon & George 2011). Furthermore, it is conceivable that Carol may have replicated aspects of caregiving behaviours the women received from their own parents (Ainsworth 1969; Ainsworth et al. 1978/2009; Lyons-Ruth et al. 2005; Van Ijzendoorn 1992). It can be inferred from her AAI narrative that Carol did not experience a secure base or opportunities for safe and confident exploration, so she could not provide a balanced, secure base experience for Melissa and Nicole (Bowlby 1969/1982, 1988i; Collins & Feeney 2000; Waters & Cummings 2000). Carol's AAI inferred experiences show she had parents who were not emotionally and psychologically available, sensitive to her needs, affectionate or delighted in her. Carol's apparent unexamined experience of her parenting prevented her from providing a sensitive, available and balanced, secure base relationship with others (Ainsworth 1969; Ainsworth et al. 1978/2009; van IJzendoorn 1995).

A third finding consistent with Carol's fragmented, incoherent attachment representation or "multiple models" of attachment (Bowlby 1973/1998, p. 238) is that she exhibited different caregiving behaviours with each woman. When Melissa maximised her distress, indicating her need for attention and help, Carol avoided and downplayed Melissa's distress and dependency. Carol seemed helpless and fearful of Melissa's distress, so she avoided her and made herself unavailable. This ultimately led Melissa to discharge herself early from the RPS. She may have possibly done this to protect herself from any further hurt and rejection. This may have been a trauma response, repeating her AAI childhood descriptions of herself hiding during parental conflict (Bowlby 1973/1998, p. 113; Bowlby 1988e, p. 89; Condino et al. 2020; Iyengar ; Kozlowska et al. 2015). Melissa discharged herself early at lunchtime on day four of her stay resulting in a negative outcome for her RPS stay.

In contrast, Carol infers she is inconsistently available to Nicole, seemingly indifferent towards aspects of her care and other times attentive. Carol describes her relationship with Nicole as "equal and easy". Nicole's description of her caregiving relationship with Carol lacks too little detail to understand their relationship, similar to her childhood experiences with her parents. Despite her high praise for Carol personally, Nicole did not achieve the goals of her admission, resulting in a negative outcome. Carol did not have a stable or coherent representation of her childhood attachment relationships. This translates to her fragmented caregiving style and evidence of the intergenerational transmission of

attachment experiences from her parents and subsequently her attachment state of mind (Hesse 1999; Hesse & Main 1999; Van Ijzendoorn 1992; van Ijzendoorn, Juffer & Duyvesteyn 1995).

With help, all three women could shift their incoherent attachment state of mind. A therapeutic relationship with someone sensitive, psychologically and emotionally available and who can ensure each woman experiences a secure base and safe haven could provide a corrective attachment experience. This will happen if health organisations become more aware of the silent and invisible suffering of the nurses and women in their care.

Carol, Melissa and Nicole's interviews share the common features of low-coherence interviews indicated in the available literature (Goldwyn & Hugh-Jones 2011; Speranza et al. 2017; Turton et al. 2001). These three women were not from extremely depriving environments, yet all experienced childhood exposure to three or more ACEs and lived in dysfunctional households. Their contradictory discourse throughout the interview demonstrated a global breakdown in representational strategy. Firstly, identifying CFH nurse Carol and the two women, Melissa and Nicole, as having low-coherence/CC indices in their discourse adds to the limited understanding of low-coherence/CC classifications. Secondly, the case study provides noteworthy findings on how an incoherent attachment state of mind disrupts the caregiving and care-receiving relationship with resultant adverse outcomes for the women's state of mind and their admission goals.

SECURE AND INSECURE ATTACHMENT CATEGORIES

The following discussion will focus on the findings from the analysis of three representative case studies from the cohort of the 12 nurses and 13 women who participated in AAI in the case study research. The CFH nurses and women in the three case studies each represented one (or more) of the four main attachment classifications: secure-autonomous (F), insecure-dismissing (Ds) and insecure-preoccupied and the disorganised category unresolved (U) (see Chapter 6). The NCCRI nurse and client versions were used to analyse the caregiving relationship.

Firstly, two nurses and one woman were classified with a secure attachment state of mind. Consistent with attachment theory, both nurses Leoni and Dana were able to focus on the needs of the women but in quite different ways according to attachment state of mind (Ainsworth 1969; Bowlby 1988h).

This provides evidence that secure caregivers provide differing degrees of sensitivity and responsiveness.

Leoni's attachment classification was prototypically secure-autonomous. She was psychologically and emotionally available, enabling her to offer sensitive and flexible care, which is fundamental to a successful caregiving relationship (Ainsworth 1985a; George & Solomon 1996; Solomon & George 1996). Leoni was able to provide Georgiana with a secure base, effectively balancing Georgiana's need to approach for "comfort and reassurance" and encourage her in the exploratory work of her residential stay, providing her with a new type of relationship, corrective attachment experience and a positive admission outcome (Bowlby 1988h; Maunder & Hunter 2016; Waters & Cummings 2000).

Dana was rated F4a secure-autonomous – sentimental regarding attachment. Although Dana was also secure and generally sensitive to her client Alice, Dana was less attuned to Alice's communications leading her to misinterpret some of Alice's needs (Ainsworth 1969; Oxford & Findlay 2015). Dana provided sensitive and responsive caregiving concerning some of Alice's needs. Still, there were ruptures in their relationship involving Dana's own needs, resulting in Alice discharging herself early and a negative outcome for her admission. Despite this, Dana's secure state of mind enabled her to reflect and consider what went wrong with their caregiving relationship so she could adjust to future caregiving.

The second finding regarding Georgiana was her E2 preoccupied – angry/conflicted state of mind and her response to Leoni's caregiving. Due to a propensity to maximise emotion, there was a possibility she may have been emotionally chaotic and overinvolved in her communications with Leoni (Maunder & Hunter 2016). Studies have found that preoccupied clients may present themselves as needier but are not always as amenable to treatment, resist support and make smaller gains in the therapy (Borelli & David 2003; d'Elia 2001; Dozier 1990; Fonagy et al. 1996; Talia et al. 2014). Again, Leonie offered a secure base and safe haven from which to explore and achieve the goals of her admission and return when she needed help or support (Ainsworth 1989). Unlike the inconsistent experiences with her parents, Leonie provided a consistent, balanced, corrective caregiving experience, resulting in successful outcomes and a complete residential stay.

Thirdly, this study classified a high percentage of women with a dismissing state of mind. In the four representative case studies selected by purposive sampling, three women were classified as dismissing (Ds1, Ds3a, Ds3b), and all downplayed or dismissed their need for emotional and psychological help. This is an important finding for the nurse-client caregiving relationship, given that frequency rates for insecure-dismissing attachment in this sample are higher than the published norms for a community sample (Bakermans-Kranenburg & van IJzendoorn 2009). Individuals with an insecure dismissing state of mind minimise their need for help if their caregiver rejects or ignores them (Dozier 1990; Dozier, Cue & Barnett 1994; Petrowski et al. 2013; Talia et al. 2014). Researchers have found that dismissing clients respond similarly to their therapist and their parents, affecting the therapeutic relationship and outcomes (Bender, Farber & Geller 1997; Bucheim & Horst 2003; Korfmacher et al. 1997; Mallinckrodt, Coble & Gantt 1995). These clients are less emotionally engaged, have less commitment, have lower expectations, and discourage proximity to their nurse or therapist (d'Elia 2001; Dozier et al. 2001; Korfmacher et al. 1997; Mallinckrodt 2010; Talia et al. 2014).

Finally, Marilyn's organised attachment state of mind was F5: secure-autonomous – somewhat resentful/conflicted while accepting of continual involvement. While her state of mind was secure, the childhood abuse that had contributed to her unresolved attachment state of mind had not been acknowledged. This lack of understanding of the long-term effects of childhood abuse and attachment trauma ultimately infused her caregiving relationship with Tonya and reduced the efficacy of their caregiving relationship (Korfmacher et al. 1997; Moran et al. 2008; Steele & Steele 2008b; Stovall-McClough & Cloitre 2006). It was vital for Tonya to provide a secure base and a safe haven to ensure Marilyn felt safe throughout her admission and achieve her goals (Bowlby 1988h; Collins & Feeney 2000; Waters & Cummings 2000). Tonya could only support exploration and provide caregiving at a functional and operational level. Regrettably, Marilyn's attachment system was triggered by memories of her abuse and trauma. Her fearful response caused her to withdraw from Tonya and other CFH nurse's (Bowlby 1973/1998, p. 113; Bowlby 1988e, p. 89; Kozlowska et al. 2015). Tonya's inability to soothe and provide empathic support for Marilyn may have unintentionally contributed to a re-traumatising episode in the RPS (Elliott et al. 2005; Isobel & Edwards 2017). Marilyn discharged herself early on Day Four, resulting in adverse outcomes for Marilyn personally and for her admission goals.

An unresolved state of mind due to attachment trauma or loss has ramifications for all women admitted to the RPS. TIC approaches need to be implemented to ameliorate this (Butler, Critelli & Rinfrette 2011; Isobel et al. 2021; Muzik et al. 2013). An unresolved attachment predicts a parent's infant being disorganised (Bakermans-Kranenburg, Schuengel & Van Ijzendoorn 1999; Bakermans-Kranenburg & van IJzendoorn 2009; Hesse 2016), and people with unresolved attachments frequently experience PTSD and avoidance symptoms (Fearon & Mansell 2001; Stovall-McClough & Cloitre 2006). From a simple first principles point of view, learning new approaches to anything is difficult, including parenting when one is afraid, confused, disorganised or dissociated – hallmark emotions of an unresolved state of mind (Kozlowska et al. 2015).

This case study research supports the central tenet of attachment theory. It provides evidence that a secure attachment state of mind enables the nurse caregiver to provide sensitive, psychologically and emotionally available caregiving to their client, enhancing their caregiving relationship to benefit their client (Ainsworth et al. 1978/2009; Bowlby 1969/1982; Diamond et al. 2003). Furthermore, nurses with an insecure attachment state of mind seem to struggle to provide a secure base and safe haven for their clients. They tend to be less flexible, more self-focused, less empathic, and provide inconsistent care to their client's (Ballen et al. 2010; Dozier, Cue & Barnett 1994; Hesse, Main & Goldwyn 2008; Hiles Howard et al. 2013; Rubino et al. 2000). In short, a less satisfying caregiving relationship results in adverse nurse-client caregiving and care-receiving outcomes. Finally, the women with unresolved states of mind had a less effective care-receiving relationship with their nurse and lower commitment to caregiving, resulting in adverse outcomes (Korfmacher et al. 1997).

CAROL'S CAREGIVING RELATIONSHIPS – THE NURSE-CLIENT CAREGIVING RELATIONSHIP INTERVIEW – NURSE VERSION

A mother brings her own attachment experiences (state of mind) to the caregiving relationship with her child (Bretherton 1990; Solomon & George 2011; Van Ijzendoorn 1992). An examination of the predictive validity of the AAI to find correspondence between parental attachment state of mind and infant security showed associations with infant attachment and parent attachment state of mind and their responsiveness to their infant (van IJzendoorn 1995). Fraiberg, Adelson and Shapiro's (1975) term "ghosts in the nursery" is another way to understand the attachment internal representations that disrupt or distort caregiving. Fraiberg, Adelson & Shapiro (1975, p. 419) advise that while a narrative

of events may be recalled, the “associated affective experience” drives the parent’s attachment state of mind and hence the kind of caregiving they provide to their child.

Carol’s attachment state of mind shifts between a dismissing (minimising) and preoccupied (maximising) strategy as she attempts to care for Melissa. These competing mental state strategies reflect her AAI CC classification. Additionally, Carol is unresolved concerning the loss of both parents. Carol’s childhood experiences of household dysfunction, disrupted caregiving experiences, and attachment trauma can affect her capacity to care for Melissa effectively. To understand the origins of Carol’s caregiving state of mind, it is worthwhile to consider the association between her inferred childhood experiences of caregiving and her current adult attachment state of mind. Carol’s first CC classification is AAI E1, corresponding to the infant classification insecure-anxious/resistant (C2); the second classification is AAI Ds2, corresponding to the infant classification insecure-avoidant (A2).

Ainsworth et al. (1978/2009, p. 237) noted that the caregiving behaviour of mothers with babies classified C2 (passive) was “highly inaccessible and ignoring” their babies. In addition, these mothers “tuned out” the baby’s crying. Cassidy and Berlin (1994) reported that mothers of infants classified as C initiated the fewest interactions with their infants in the first six months. About Carol’s second CC classification, Ds2, Ainsworth noted the caregiving behaviour of mothers with babies classified as A2 avoidant was “inaccessible for long periods, they were bored with the maternal role and found other interests to occupy them”. Carol portrayed her mother as inconsistently available, rejecting and helpless; her father was also rejecting, emotionally abusive, neglectful and angry. In infancy, the attachment system is unidirectional, but affectional ties– romantic, familial, or social – tend to be reciprocal in adulthood. Adults maintain a desire for closeness and proximity to loved ones, feel lonely when they are gone, offer caregiving and receive it turn (Ainsworth 1985a; Crowell, Treboux, Yuan, et al. 2002; Feeney 2004; Feeney & Collins 2001).

On the other hand, therapeutic caregiving relationships tend to be unidirectional, with the therapist or CFH nurse becoming the secure base for the client. This enables the client to feel safe enough to explore the goals and tasks of their admission (Bowlby 1988d). Carol is supposed to provide Melissa and Nicole with a secure base and safe haven during their stay. Her adult attachment state of mind and caregiving systems are linked to secure-base behaviour.

There does not appear to be direct evidence in her AAI to suggest that Carol has experienced a secure base relationship (Bowlby 1969/1982). Moreover, in her NCCRI-N, Carol did not show any evidence that she had a secure base attachment representation around which to organise her caregiving behaviours (Bowlby 1969/1982; Waters & Waters 2006; Waters, Brockmeyer & Crowell 2013). Carol seemed disconnected from supporting Melissa and Nicole's exploration and achievement of their admission goals. She seemed to recognise their distress correctly but did not read it as a request for her support. When confronted with Melissa's distress, Carol's self-motivation was to gain clarity for herself rather than empathise with Melissa's distress (Feeney & Collins 2003). She was not motivated to soothe Melissa's distress, instead was focused on her own worries and thoughts (Ainsworth 1969). Carol did not know how to respond to the women's distress. Carol is alternately preoccupied and focused on her attachment experiences, downplaying or minimising her own or the women's distress. Therefore, she cannot regulate and soothe Melissa or Nicole when their attachment system is activated by fearful situations (Ballen et al. 2010; Lyons-Ruth 2007).

The analysis of the NCCRI-N showed five underlying relationship themes that formed Carol's caregiving response to Melissa and Nicole. Firstly, although Carol could recognise when Melissa and Nicole were very distressed and their attachment system activated, Carol's response was generally confused, either helpless or dismissing. Carol started her interview by describing Melissa's mental health conditions and suicide attempts. She believed Melissa was embarrassed to disclose this information and made a derogating statement, "she went off the rails", to describe her distress. Similarly, in Nicole's admission, Carol explained screening her for PND, and when discovering Nicole's depression and suspected distressing marital problems, she did not express any concern. In neither women's situation did Carol show sensitivity or empathy for the women, the core component of secure caregiving. Carol seemed to recognise the women's distress but could not find an appropriate response to soothe and regulate the women, demonstrating characteristics of a rejecting, psychologically and emotionally unavailable caregiver (Ainsworth 1969; Ainsworth et al. 1978/2009; Beebe et al. 2010). Additionally, it appears Carol cannot manage her conflicting emotional needs, leading to the second theme.

The second theme that underlies Carol's caregiving relationships is her preoccupation and self-focus on her own distress and emotional needs. Carol is emotionally and psychologically unavailable to

both women, especially when they are distressed and require a relevant and soothing response (Cassidy & Berlin 1994; Pederson et al. 2014). Ainsworth (1969) described such caregivers as inaccessible, ignoring or neglecting because they tended to become lost in their worries or thoughts. Carol told me frequently during her NCCRI-N that she was overwhelmed by Melissa's significant difficulties and understandable distress. Instead of showing empathy for or reflecting on Melissa's plight, Carol was preoccupied with her own discomfort and upset. She recognised Melissa's problems and her distress, but rather than appropriately respond; she maximised her own attachment needs. Researchers have found that preoccupied caregivers' responses are more inconsistent and self-focussed and perceive their clients as more needy and dependent, which Carol seemed to imply she did when caring for Melissa (Collins & Feeney 2000; Diamond et al. 2003; Dozier, Cue & Barnett 1994; Talia et al. 2020).

The third theme that underlies Carol's caregiving relationships is her helplessness and tendency to become overwhelmed. In some cases, Carol gave the impression that she was like the ambivalent-resistant baby making continuous minor complaints, struggling passively and helplessly to get their attachment needs met. This prevented her from "exploring" her options and providing flexible caregiving. Examples include her constant, minor complaint about preferring to take a "structured approach" to the admission interview (Cassidy & Berlin 1994; Main, Goldwyn & Hesse 2003). Carol's preference for being "more structured with Nicole" and "I was able to go through in a systematic way" may represent an intrusive and controlling style of caregiving (Ainsworth 1969; Cassidy & Berlin 1994; Feeney 2004). Carol struggled to regulate her emotional state when there was an affective breakdown with Melissa and Nicole. In these situations, Carol would withdraw from the women's attachment behaviours and seek support for her own distress (Kelly, Slade & Grienenberger 2005; Lyons-Ruth et al. 2005). Lyons-Ruth et al. (2007) viewed this type of maternal or caregiving profile as "helpless-fearful", a two-person dyadic system where one person's needs predominate, and the other feels helpless to exercise any initiative in the relationship. Carol's own internalised representational model of caregiving may have been activated when confronted by Melissa's highly distressed state, and her own needs then predominated over Melissa's.

Carol's caregiving helplessness may also be attributable to her unresolved state of mind (Cassidy & Mohr 2001; Lyons-Ruth et al. 2005; Solomon & George 2011). Berthelot et al. (2015) found that

caregivers who were unresolved for trauma and confronted with their infant's distress experienced reactions of caregiving helplessness, distress and fear. When Carol admitted Nicole, I inferred from her NCCRI-N narrative that she appeared preoccupied with Nicole's husband and keen for him to leave the room. Hesse and Main (2000) maintain that intrusions unconsciously associated with alarming memories such as Carol's fear of her father's anger can cause sudden state shifts, which may indicate an unresolved state of mind. Carol may have been experiencing a wide array of fear behaviours, such as running away, inhibition of action and wary watching. Children who grow up with emotionally abusive parents show a "picture of frozen watchfulness" (Bowlby 1973/1998; Bowlby 1988e, p. 89). In evolutionary terms, this fear is a physiological activation of defence response, unconscious and overwhelming and often occurs in clinical disorders such as PTSD (Kozlowska et al. 2015).

The fourth theme that underlay Carol's caregiving relationships was her avoidance of Melissa. Avoiding indicates that Carol was not physically, emotionally or psychologically available to Melissa when she was distressed or in high emotional need situations, a dismissing caregiving quality (Dozier, Cue & Barnett 1994; Feeney 2007; Feeney & Thrush 2010). Research has demonstrated that dismissing caregivers show less empathy and are more likely to downplay and avoid others' distress (Feeney 2007). Carol did not seem to take the women's perspective, understand their experiences or make their behaviour meaningful and predictable, demonstrating a low level of reflective functioning (Ainsworth 1969; Fonagy et al. 1991; Fonagy et al. 1998). Carol described herself handing over the care of Melissa and withdrawing because she found her overwhelming. Bowlby (1973/1998) described avoidance as fear behaviour that occurs when the attachment system is activated. The caregiving situation with Melissa may have aroused an unknown component of fear or alarm in her.

Concerning nursing theory, Tudor's (1952) study found that mental health (MH) nurses avoided clients because they found them difficult or overwhelming, which led to a mutual withdrawal between their clients and themselves. Moreover, the nurses' avoidance was excluded from the nurses' awareness. Peplau (1952, p. 142) also points out that the unexplained discomfort and anxiety the MH nurses experience during interpersonal interactions may threaten their "worthwhileness". Considering these four themes, Carol's caregiving appears inconsistent, distorted and disrupted; her preoccupied, dismissing, and unresolved states of mind seem evident throughout her narrative in both NCCRI-N's.

She cannot maintain a coherent sense of self and her caregiving appears to be affected because of this (Ainsworth et al. 1978/2009; Fraiberg, Adelson & Shapiro 1975; Lyons-Ruth et al. 2005; Solomon & George 2011). These findings offer an insight into the unseen effects of attachment trauma on the caregiving system. Hiles Howard et al. (2013) study with welfare workers found insecure attachment negatively influenced their helping behaviour. Borelli and David (2003) suggested that therapists with an anxious attachment style were less empathic to their clients.

Clients seek help for difficulties and expect to be cared for when distressed, and their attachment system is activated (Adshead 2002; Maunder & Hunter 2016). The CFH nurse's caregiving system functions as a security system for her client in her care (Cortina 2013). These findings demonstrated that when a CFH nurse is unaware of her attachment traumas and subsequent U/CC state of mind, her caregiving has the potential to become disrupted and distorted. In Carol's case, she gave the impression that she was replicating both women's childhood parenting experiences. Carol's unremembered "parental ghosts" had emerged in a repetition of her past rejections and became Melissa and Nicole's unconscious aggressor (Fraiberg, Adelson & Shapiro 1975).

RESEARCH SUMMARY

This research posed six questions that the case study findings can now answer.

> Question 1: *Is there an association between a secure attachment state of mind and the quality of the caregiving and care-receiving relationship between the CFH nurse and the woman?*

The research found that the two nurses with a secure attachment state of mind in the case study demonstrated their ability to manage caregiving relationships in two ways. CFH nurse Leoni balanced encouraging Georgiana to achieve her admission goals and providing a secure base when she required help. Subsequently, this was a successful admission with positive outcomes with both CFH nurse and woman feeling satisfied. Leoni was sensitive, managed relationship ruptures, and reflected on her clinical practice.

Dana was also sensitive and empathic to Alice but missed some of Alice's verbal and non-verbal cues. Their relationship ruptured, and some goals of admission were not met. Dana provided

opportunities for exploration, which Alice took advantage of and enjoyed. Dana was keen to be Alice's secure base and scaffold her care with intense sensitivity. On the other hand, Alice did not want or require a secure base and withdrew from Dana's desire to provide this care. The critical outcome for Dana was that she recognised her caregiving was not quite right for Dana, and she flexibly reflected on how to do it differently next time.

In summary, secure attachment was associated with sensitive and responsive caregiving relationship, either with positive outcomes or if the outcome is not quite right, the CFH nurse can reflect and change practice.

> Question 2*: Is there an association between the CFH nurse's attachment state of mind and how she perceives her caregiving relationship with the woman?*

This research analysis indicates Carol's attachment state of mind prevented her from coherently elaborating on or defining what kind of caregiving relationship she provided to either Melissa or Nicole, thereby profoundly affecting her ability to reflect on clinical practice.

The analysis demonstrates that the two nurses with secure attachments were coherently and flexibly able to describe, elaborate and reflect on the outcomes of their caregiving relationships with the women they cared for. The nurse with insecure attachment provided less flexible caregiving, more self-focussed and instrumental. She showed no inclination to reflect on the less beneficial outcomes of the caregiving relationship.

In summary, it does appear from the findings that there is an association between the CFH nurse's attachment state of mind and how she perceives her caregiving relationship with the women she works with.

> Question 3: *Is there an association between the CFH nurse's attachment state of mind and how she provides care to the woman?*

The analysis suggests that there is an association between the nurses secure, insecure and U/CC attachment state of mind and the way she provides care.

Carol's low-coherence/CC attachment state of mind affected her ability to care for Melissa and Nicole. She provided contradictory and inconsistent care to both women, reminiscent of the inferred experiences childhood experiences with her parents she recalled in her AAI narrative. She could neither provide a secure base nor encourage exploration.

The analysis also indicates that Tonya's insecure dismissing attachment state of mind enabled exploration through very useful structured practical caregiving to Marilyn. Nevertheless, she could not provide a secure base when Marilyn was distressed due to her tendency to downplay distress.

On the other hand, nurses Leonie and Dana's secure state of mind enabled them to provide more balanced, sensitive care and respond promptly to the women's distress.

In summary, it seems from the findings that there is an association between the CFH nurse's attachment state of mind and how she provides care to the women in her care, especially when the woman is distressed and needs a secure base.

> Question 4: *Is there an association between the woman's attachment state of mind and how she perceives her caregiving relationship with the CFH nurse?*

The analysis confirms that the attachment state of mind of the women is associated with how they perceived their caregiving relationship with the nurse. All five women responded to the CFH nurses differently, according to their experiences of being parented. Importantly, their responses also seemed dependent on the nurses' attachment state of mind and ability to provide a secure base and encourage exploration, achieving their admission goals.

In summary, it may be inferred that the nurse-client relationship resembles both primary and romantic attachment caregiving relationships. In many cases, but not all, the CFH nurse is unconsciously perceived by the woman in her care as a secure base during her stay. Women exposed to ACEs and subsequent attachment trauma are particularly vulnerable and more likely to seek soothing and comfort from their nurse. The vulnerable and traumatised women in this study responded to the CFH nurse who cared for them in patterns reminiscent of their childhood experiences with their parents.

Question 5*: Is there an association between an insecure attachment state of mind and the caregiving relationship between the CFH nurse and the woman?*

The analysis reveals that there is an association with an insecure attachment state of mind and disruptions in the nurse-client caregiving relationship. The CFH nurse has difficulty balancing attachment needs such as encouraging safe exploration of the woman's goals during admission and a secure base for comfort when distressed and needing help. Additionally, CFH nurses with insecure attachment appear to have a limited capacity to reflect on the caregiving relationship if there is a rupture and the client discharges early.

In summary, CFH nurses with an insecure dismissing attachment state of mind seem to have difficulty responding to the women's distress and may even ignore and avoid distressed women. In the same way, women with an insecure dismissing state of mind may avoid emotional content and deny or downplay mental illness or anxiety symptoms. This is not a conscious response on the part of the CFH nurse or woman but a defensive response to protect themselves from their distress. Similarly, a CFH nurse with a preoccupied attachment may provide inconsistent care, sometimes attending to distress and other times ignoring it. Correspondingly, a woman with a preoccupied attachment may be highly distressed and consistently seek and need attention if worried or anxious.

Question 6: *Is there an association between U and CC attachment state of mind and the caregiving/care-receiving relationship between the CFH nurse and the woman?*

The analysis suggests there is an association between the three women Carol's, Melissa's and Nicole's low-coherence U/CC attachment state of mind and a disrupted the nurse-client caregiving care-receiving relationship. Carol found caring for the troubled women particularly difficult because they possibly triggered her attachment traumas. Both Melissa and Nicole's residential stay resulted in adverse outcomes.

In summary, the CC, and U states of mind appeared to markedly effect the nurse-client caregiving relationship. The ACEs and subsequent attachment trauma of the CFH nurse and the women contributed to the emergence of the U/CC states of mind, thus causing interference in their capacity to form meaningful caregiving and care-receiving relationships.

The six questions posed in this research were answered in the affirmative. However, this is a small purposive sample; the results should be viewed with care, and the study be replicated with a larger sample.

CFH Nurses as wounded healers

The CFH nurses in this research were not asked why they became nurses. Nevertheless, five nurses with insecure states of mind volunteered during their interviews, they wanted to be nurses because they believed their troubled childhoods enabled them to empathise with and understand their client's experiences much better. People who become nurses because of troubled and traumatic past experiences have been referred to as "wounded healers" (Barnett 2007; Newcomb et al. 2015; Zerubavel & Wright 2012). Research into the wounded healer concept has found that nurses who wish to "help" troubled people present themselves with qualities such as greater self-awareness, strength or empathy (Barnett 2007; Gilbert & Stickley 2012). Conversely, it has been found that those affected with troubled pasts experience high-stress levels, have less effective coping strategies and have difficulty managing boundaries (Conchar & Repper 2014; Cushway 1995; Graves 2008; Wheeler 2007; Zerubavel & Wright 2012). When a nurse has not identified their own "wounds", and their motivation is to care because of their experience of trauma and adversity, there is a risk to those receiving their care (Ballen et al. 2010; Jackson 2004). There are not only risks to clients, but nurse wounded healers face the risk of burnout, compassion fatigue and re-traumatisation (Conchar & Repper 2014; Mottaghi, Poursheikhali & Shameli 2020; Newcomb et al. 2015; Pines 2004; Wheeler 2007). Attachment theorists have indicated that nurses or therapists with insecure states of mind were less able to respond to distress signals because of their anxiety reactions or discomfort with closeness, and therapists with childhood role-reversed caregiving experiences are drawn to caregiving roles (Cushway 1995; Westmaas & Silver 2001).

The difficulty for many of those with a troubled background who are eager to help is their unconscious need to resolve or heal their childhood traumas. Because stigma is still associated with trauma and mental illness, nurses tend to keep their wounds hidden (Conchar & Repper 2014; Gilbert & Stickley 2012; Zerubavel & Wright 2012). In reality, it does not matter that the nurse or therapist has been wounded; most important is that the wound is recognised, and the effects understood so that recovery can be attained (Barnett 2007; Dunning 2006; Zerubavel & Wright 2012). An essential part of

recovery is the ability to disclose trauma and an associated mental illness without fear of stigma and reprisal (Gilbert & Stickley 2012; Newcomb et al. 2015; Zerubavel & Wright 2012). Although there is a general trend in health services to encourage self-care, it is generally assumed to be the nurse's responsibility. The nurse-wounded healer often lacks self-awareness, denies the need for self-care and subsequently avoids self-reflection opportunities (Conchar & Repper 2014; Graves 2008).

Therefore, wounded nurse healers need to begin with the freedom of appropriate self-disclosure to a person with experience in the childhood trauma (Barnett 2007; Newcomb et al. 2015; Zerubavel & Wright 2012). The opportunity for self-disclosure and healing can only occur if the nurse feels safe and free from anxiety and shame (Zerubavel & Wright 2012). Subsequently, nurses who identify themselves as wounded healers require support to heal and an employer to normalise personal therapy as part of reflective practice, a culture not prevalent in the nursing (Barnett 2007; MacCulloch & Shattell 2009; Wheeler 2007; Zerubavel & Wright 2012). Once nurses can heal and live with their wounds of childhood trauma experiences, they can provide valuable transformative healing opportunities for their clients (Amundson & Ross 2016; Dunning 2006; Jackson 2004; St. Arnaud 2017).

IMPLICATIONS FOR THE CFH NURSE-PATIENT CAREGIVING RELATIONSHIP

This case study has drawn attention to the powerful influence of the CFH nurse and woman's attachment state of mind and the potential to either enrich or disrupt the nurse-client caregiving relationship. When a memory of her childhood trauma unconsciously triggers the CFH nurse during caregiving interactions, the quality of her nursing care is disrupted (Barnett 2007; Courtois 2018; Isobel et al. 2021; Knight 2018; Zerubavel & Wright 2012). Nurses with unresolved childhood trauma are believed to have an unconscious motivation to help clients with troubled pasts and are frequently termed wounded healers (Barnett 2007; MacCulloch & Shattell 2009; Wheeler 2007). These nurses are often unaware of their vulnerabilities to stress, burnout and interpersonal difficulties with clients and peers (Barr 2020, 2022; Copeland et al. 2020). To address this problem for the CFH nurses and the women in their care, an organisational trauma-informed approach may raise awareness for nurses

of their ACEs and their susceptibility to re-traumatisation (Ballard et al. 2019; Isobel et al. 2021; Muzik et al. 2013; Wheeler 2007).

A trauma-informed model of care offers organisation-wide education for the whole workforce to raise awareness and foster coordination of trauma-informed services (Isobel et al. 2021; Strait & Bolman 2017). As part of introducing a trauma-informed model of care, education is necessary to increase the awareness of CFH nurses about the impact of their ACEs on the caregiving relationship and to provide opportunities to screen for ACEs (Strait & Bolman 2017). The strength of a trauma-informed model of care is that it offers the client a compassionate and sensitive approach in a safe environment that recognises the relationship between a person and the consequences of their trauma (Isobel et al. 2021; Stokes et al. 2017). Additionally, organisations must identify the requirements of the wounded healer nurse if they are to embrace TIC (Knight 2018). These are different to the rest of the workforce, especially when the nurse is unaware of the effects of their trauma or considers help unnecessary. Implementing a trauma-informed model of care includes educating the nursing workforce, encouraging change in attitudes towards clients' and nurses' attachment trauma, and ensuring more sensitive and empathic care (Isobel 2016; Isobel & Edwards 2017; Isobel et al. 2021). Nurses require access to skilled mental health practitioners when they wish to disclose their trauma and are offered the benefits of support through frequent and reliable workplace reflective supervision (Courtois 2018; Knight 2018).

Seventy years ago, a psychiatric nurse, Gwen Tudor (1952), recognised the importance of nurses seeking reflective supervision to help them work with clients who tested their ability to provide sensitive and responsive caregiving. Tudor (1952 recognised the value of reflective supervision when she understood her feelings towards a particularly challenging client and why she was avoiding the client. This reflection and understanding of her clinical practice led to nursing care to alleviate the situation (Schwartz & Tudor Will 1953; Tudor 1952).

The current case study research also identified a CFH nurse facing a similar dilemma of needing to avoid her client as. Carol would have benefited from reflective supervision that enabled her to reflect on her thoughts, feelings, beliefs and attitudes regarding the women she worked with (Heffron, Reynolds & Talbot 2016; Tomlin, Weatherston & Pavkov 2014; Weatherston & Osofsky 2009).

However, due to the impact of Carol's attachment trauma, her client's stories and behaviours during their residential stay triggered and dysregulated her during her interactions with the women she cared for, as detailed in her case study (Courtois 2018; Knight 2018; Portman-Thompson 2020). Carol was unaware of her difficulties, but neither were her colleagues nor the people in the management organisation's place supportive strategies to help CFH nurses and other health clinicians with unresolved attachment trauma.

A whole of organisation trauma-informed model of practice approach is a way to address the potential for re-traumatisation experienced by CFH nurses and other employers who have been exposed to ACEs and subsequent unresolved attachment trauma. This approach does not single out individuals and enables organisational learning and healing. A trauma-informed model of practice is built on five principles these are safety – because people who experienced trauma have been subjected to unsafe environments, trustworthiness, empowerment, offering choices for their care and collaboration in the care (Berger & Quiros 2014; Elliott et al. 2005; Fleishman, Kamsky & Sundborg 2019; Knight 2018; Portman-Thompson 2020). Ideally, Carol would have been offered reflective supervision in a physically and emotionally safe environment, where she had the opportunity to examine her clinical practice, debrief her experiences, share her perspectives and work with her supervisor to explore alternative perspectives – thereby enhancing her reflective functioning (Berger & Quiros 2014; Courtois 2018; Eaves et al. 2020; Fonagy et al. 2002; Knight 2018; Murphy et al. 2015). Another supportive approach is providing the CFH nursing team with a trauma-informed model of team supervision to enable the nurses to process and understand clients admitted to the RPS with attachment trauma (Moloney et al. 2018).

Kezelman and Stavropoulos (2012) advise that responding appropriately to health workers and their clients who have experienced attachment trauma requires an organisational paradigm shift in service delivery to support CFH nurses and the rest of the workforce. This shift requires a collaborative and integrated approach that involves implementing a trauma-informed model of care (Isobel 2016; Isobel et al. 2021). Organisational leadership is required to introduce strategies such as the development of policy and guidelines for the care of health workers and their clients, map service delivery of policy to practice, screen for trauma using ACE-Q or similar, and support nurse educators with specialised knowledge to deliver education and training to the whole workforce (Kezelman & Stavropoulos 2012),

The implications of the attachment state of mind for insecure CFH nurses and women are far-reaching. Individuals with a dismissing state of mind are believed to be less committed to therapeutic interventions, particularly when associated with attachment-related events such as distress, reminders of trauma, loss or rejection (Bick & Dozier 2008; Dozier et al. 2001; Korfmacher et al. 1997; Talia et al. 2014; Teti et al. 2008). Similarly, dismissing therapists may present themselves as more distant, unavailable, and less involved in interventions (Bartholomew & Horowitz 1991a; Dozier, Cue & Barnett 1994; Rubino et al. 2000). On the other hand, nurses with a preoccupied state of mind are likely to focus on their clients' distress, become over-involved in the nurse-client relationship, yet may respond less empathically. Their clients may present themselves as more needy and dependent (Borelli & David 2003; Dozier, Cue & Barnett 1994; Petrowski et al. 2013; Slade 2008; Tyrell et al. 1999). The four case studies highlighted the unconscious internal representations permeating the nurse-client caregiving relationship. Like Fraiberg, Adelson and Shapiro's (1975) "ghosts in the nursery", these internal attachment representations of CFH nurses and the women in their care may either enhance interventions or hinder them.

The first step toward resolution of the CFH nurses' distress in the workplace is the recognition of their trauma as their motivation to care (Ballen et al. 2010; Jackson 2004). Identifying these CFH nurses in the residential unit is of primary importance to breaking the second-generation effects of trauma and the cycle of abuse (Berthelot et al. 2015; Hesse & Main 1999). Additionally, the CFH nurses require skilled support and recognition of their trauma so they do not continue to suffer in silence. Adding knowledge to the low-coherence/CC category descriptors will address a deficit in knowledge and enable therapists to understand the indicators of low-coherence.

Finally, nurses require high-quality and consistent education and training in attachment theory and its application to clinical practice. This is generally provided in university-based postgraduate programs, conferences or seminars rather than easily accessible workplace education programs. Attachment, like nursing, is about caring for people in a relationship from "the cradle to the grave" (Bowlby 1988e, p. 82). Nurses require more than a superficial knowledge of attachment theory to use current evidence to guide their clinical practice (Skela-Savič et al. 2020; Yoo et al. 2019). Quality nursing attachment research that is interesting and applicable to nursing practice needs to be conducted. This current research has provided a step in that direction.

LIMITATIONS

Several limitations must be considered when interpreting the results of this case study. This small, purposive sample was chosen for deep analysis of the four case studies. The small sample size reduces the transferability of the findings, and in future studies, a larger sample size may be more instructive. Qualitative scholars argue that sample size may be arbitrary as it depends on the qualitative inquiry used, method, and unstructured or semi-structured interview (Morse 2000). Indeed, Morse (1991b) proposes that purposive sampling does not look for representative population characteristics but is selected for participants with atypical experiences. The research site was a specialist residential well-baby parenting service. These residential services are, to my understanding, only available in Australia.

Other limitations exist. Due to the first-stage sampling method of self-selection, the characteristics of CFH nurses and women's reasons and interests in this particular study were open to selection bias affecting the transferability (Peter & Roberts 2022; Wolbring & Treischl 2016). The semi-structured interview NCCRI nurse and client versions were developed, administered and analysed specifically for this research. Consequently, the NCCRI requires further refining and analysis.

Finally, other limitations were that all the women spoke English as their first language, all were Caucasian except one Aboriginal woman, and all were middle class and had a minimum of 12 years of education.

FUTURE RESEARCH

This research begins to address the gap in nursing research identified in the literature review concerning the effect of the nurse's and women's attachment state of mind on their caregiving relationship. Further research, using a larger sample of nurses, would enable a deeper understanding of how nurses' secure and insecure attachment state of mind affects the co-constructed nurse-client caregiving and care-receiving relationship. Additionally, further investigation is required to understand how ACEs and subsequent early attachment trauma impact some CFH nurses and women, resulting in U/CC states of mind—following this line of investigation, a deeper understanding of how the CFH nurse and the women with U/CC classify states of mind co-construct their caregiving and care-receiving relationships. This knowledge may help determine the clinical implications for nursing

practice. Critically, this research provides direction for implementing best practice CFH nursing strategies to address the difficulties inherent in the caregiving and care-receiving relationship of CFH nurses and women with U/CC classified states of mind.

CONCLUSION

As the literature review revealed, research has examined the effect of nurses' attachment on a range of areas such as their empathy, physical or psychological health, workplace difficulties, working alliance with clients, emotional regulation and burnout. This research has been undertaken by teams of psychologists, doctors and nurses using self-report attachment measures. This doctoral study addresses the gap in the investigation by using the AAI to study the effect of women's adult attachment states of mind on their caregiving relationship. This has not been examined before in nursing research. This study found low-coherence CC attachment classifications in a small, purposive community sample of CFH nurses and the women they cared for. This provides new and exciting support for previous substantiated research that traumatised wounded healers are not readily identifiable in the CFH nursing workforce. This points to the need to raise awareness, educate and support the CFH nursing workforce by implementing a whole of organisation trauma-informed model of care.

Chapter 9: REFLECTIVE COMMENTARY

In January 2013, I embarked on an unexpected journey that led me to make many surprising discoveries. During that time, I acquired a prodigious amount of experience, knowledge and enormous satisfaction when I made amazing research connections.

THE EARLY DAYS

These were confusing and busy. I knew what I wanted to do, but that was quite different from actually doing it. My initial focus was arranging to have the Adult Attachment Interviews (AAI) done as soon as possible. I wanted an independent person to do the AAIs, so the nurses felt free to disclose any trauma and abuse experiences. I had made a mutual arrangement with another PhD student to save money. I agreed to code her 50+ NCAST Parent-Child Interaction (PCI) feeding and teaching scale videos. In return, she agreed to do my 25 AAI interviews. I trusted this student to hold to our agreement.

I spent quite a lot of my spare time coding the NCAST-PCI videos, but I got them done for her, and she was grateful. But my trust in her reciprocity was misplaced. The first hitch occurred following ethics approval in July 2015. I contacted her to plan to interview the nurses, but she requested a delay of six months. I reluctantly agreed to this, but she decided not to go ahead at the end of this period, explaining she had hurt her back. I was furious – and disappointed. I felt used and let down over our mutual agreement. She lived some distance south of Sydney and suggested the nurses drive to her, knowing this was an unreasonable request. My reflections on this experience have been consistently confused and ambivalent. I can take her perspective and understand that she may have had an injury, and there was nothing she could do. Nevertheless, I could move past feeling that my particular expertise with the NCAST PCI scales had been exploited, and she had no intention of reciprocating. I have never resolved this experience, but I have learned not to make a similar agreement again.

I found a second AAI interviewer in mid-2016 the following year. I trained her in the AAI interview protocol, and she proceeded to interview seven nurses, and those interviews were transcribed. Unfortunately, when I began to check the transcribed interviews, the interviewer had not followed the AAI protocol on six of the seven interviews. She had been leaving out the question about loss. On

reflection, this was my fault that I did not check the transcribed interviews as soon as I received them; I just trusted she would do them correctly. I quickly learned that I needed to keep my eye on the ball during my research; this was a steep learning curve. My tendency to see big pictures and not bother with the minutia, including processes, was holding me back – another learning episode. These interviews had to be redone to keep the nurses in the research. When I approached the interviewer to discuss it, she informed me she could not do further interviews. Unfortunately, her father had died only a year prior, affecting her ability to do the interviews. This incident made me aware that it is essential to check with potential AAI interviewers that they have not experienced a recent loss or trauma – another learning chalked up.

This glitch held back my data collection for a year, which was disappointing, and sometimes I experienced anxiety about the lost time. As I was to discover when the ethics approval was updated, and I could do the AAIs myself, data collection went smoothly, and I felt more in control. I learned from this experience that if I have a small sample, it may be more expedient to do the interviews myself, particularly as the data quality did not seem to suffer. On reflection, I also see I needed to feel more in control of the process and not give up that control to other people. This became a theme for me throughout my PhD journey.

After this experience, I approached the six nurses and explained the mistake and asked if they would be willing to undergo the interview again with me. I was surprised when they all happily agreed. I spoke to my supervisory team, and it was decided to request an amendment to the ethics approval to conduct the nurse interviews myself. I then talked to the five nurses who had not yet been interviewed but had consented to the previous arrangements, and they seemed happy with the change. All the nurses I spoke to said they felt comfortable and pleased they were being interviewed by me, which made me feel honoured to be so trusted. I submitted and approved an amendment to the protocol and went forward. Not one nurse disclosed sexual abuse. I thought this was unusual, especially since ACE research suggests that 24% of women experience sexual abuse. I suspected this was not disclosed to me because they knew me. Being an insider researcher has its drawbacks.

When I was in the residential units for the interviews, the nurses and women spoke to me when they saw me. I think they were curious about the interviews and wanted to know more. I spoke to them, and the nurses and women usually wanted me to explain their attachment classification. I always

explained that I could not because I had spoken to the Local Health District Ethics Research Development Office, who had advised that I was unable to provide the information. I was glad I had that safety net because explaining their classifications to the nurses and women would have been difficult. I thought that in some cases, they may have needed therapeutic interventions. Carol, the main case study nurse who was classified as U/CC, often came to my office and wanted to speak to me about the interview and her classification. She believed she had an “anxious” attachment. I listened, reassured, soothed her and eased her mind over her attachment classification. She always left seemingly okay; I think she just wanted to talk. Carol often came to speak to me about her difficulties, even before I began the research,h so this was not very unusual.

Being an insider-researcher brought with it unexpected challenges such as this. Most of the research participants were fascinated with their attachment, and it took all my skill to divert their attention from wanting to know their classification. One of the psychologists who knew I was doing the research asked me to do the AAI on one of her clients. I indicated that I could not code it in time to make it meaningful for her practice. She seemed fine with this. Being an insider researcher with the residential teams was more challenging than expected due to the nurses’ fascination with their AAI and the prospect of knowing their attachment state of mind. I managed their need to see without them becoming angry or upset.

I developed the Nurse-Client Caregiving Relationship Interview (NCCRI) during this period. This was done out of a need to have an instrument that answered my particular questions about the nurse-client caregiving relationship. I had already given the nurses and the women the Working Alliance Inventory to fill in but discovered that almost every woman had idealised their relationship with the nurse. The results were meaningless, so I did not keep the WAI in the research or use any of the results. That is response bias for you! So, I thought that I could just make up my own semi-structured interview. But I wondered, “Isn’t that a bit daring for a nobody researcher like me?” I did it anyway and just used it. I did not even think it might have gone through some testing at the time. Like everything I do, it was a spontaneous “I’m using this”! On reflection, I’m not sorry I did it this way because it has done precisely what I wanted. I would tweak it a little and change a few words, but it has married nicely with the AAI and provided a narrative insight into caregiving that I’m very happy with.

Finally, the other significant experience in the initial phase of my PhD journey was the beginning of my shift in thinking about being a researcher and looking at my data and work through a research lens. This was difficult and required discipline. I had to read more deeply, critique more objectively and acknowledge that I bring my own biases to the research that affect how I view the world. The biases I bring are my unique worldview, views and beliefs about nursing, life experiences, and especially attachment experiences. This all colours and brings life to my research, but at the same time, if I'm not aware of my biases, it obscures and darkens the multiple truths I am attempting to understand and make sense of.

MIDDLE STAGES

Several things happened during this period. I took a leave of absence because I needed a stress-free break. The break helped me, and I could continue feeling much better. During this period, I struggled with my first attempt at a literature review which was just not working for me. I could not get it right, and finally, when it was submitted to a journal, it was refused pretty quickly, which I expected. I knew it wasn't any good and decided to give up. At this point, I think I have made some decisions. I was going to take complete control of myself and my thesis. I did not feel I had the right direction and needed to go back to the beginning and reflect on what I was doing. So that is what I did and came up with a plan.

I asked the third supervisor to help me with the AAI and attachment theoretical components (LM). This was great because I struggled independently and was thrilled to have LM and her expertise with the AAI. I decided I was done with trying to write publishing papers, and for the rest of my candidature, I was going to focus on my main game – the thesis. So, no more writing articles. Finally, I was going to figure out how to do the thesis my way. So, for a little while, I was pretty angry about stuff. I even wrote an angry literature review where I trashed everyone who wrote an article about attachment. This was gratifying but pointless. That review got put in a folder – it is not a bad piece of work; it is just a bit harsh. I look at it now and then to reflect on how necessary it was for me to do so that I could move forward. In the end, I calmed down, refocused, moved to the next stage and became very productive.

During this period, I focussed on coding the AAIs, and NCCRIs, screening the AAIs for ACEs and analysing the data. Coding the AAIs proved to be an emotionally draining experience. I expected the

nurses and women to have normal or community frequencies of secure and insecure attachment classifications. Instead, I was confronted with attachment classifications more like clinical samples; more worryingly, I coded four nurses and two women with the rare CC classification. I found it not only unexpected but shocking!

When I first coded these transcripts, I thought I must have been coding them badly, and I re-coded them three times before I approached LM to co-code. I was confused about the transcripts, doubted my coding abilities and thought I had lost the plot because there could not possibly be six CC transcripts in a sample of 25. But there was, and I was not wrong. I was relieved to find out I could code after all, and in fact, I must be a pretty good coder to pick up six CC transcripts. I have been reflecting on why I can see the incoherencies in the transcript when perhaps others cannot see them as well. Loyola and I spoke about how difficult low-coherence transcripts are to code and how much practice it takes. Helping her when she does the AAI institutes must help me a lot. I can only think that I have immersed myself in so many books and articles on low-coherence transcripts and read case study examples of speech patterns of other traumatised women and men, reading them over and over to understand their traumatised state of mind that somehow the transcripts stood out. I am proud of this achievement in my research because I had no idea I would succeed at such a difficult coding skill.

Unfortunately, I found the women's stories of extreme abuse and trauma very disturbing. I have had to seek counselling and support to reflect on my experiences of reading and coding so many sad and terrible abuse stories. I found it helpful to think and reflect on the aspects of me affected by these stories and the meaning they had for me. I have put this personal therapy to good use in analysing the data and coming up with ideas and solutions, which brings me to the final stages of the research.

FINAL STAGES

In the final stages of the thesis, I focused on analysis and writing up the discussion. I spent most of my time alone interpreting the data. Once I had done so much research, I could come back to the literature review with new eyes and understanding. In no time, a recent literature review emerged that addressed the questions I had asked. I had been looking at it the wrong way and forgotten my focus. I realised I had not been searching in the right direction or using the correct search terms. It had taken

me to the final stages of my research journey to understand that I had been searching for the nurses in all the wrong directions! Finally, my literature review found how to join nurses to the attachment.

At this stage, I felt that things were moving for me. All my thoughts were coming together, and I was writing more quickly. My findings were exciting. My one main difficulty was going off track and down rabbit holes," as my supervisor, CF, says. I found it hard not to do this because once I started reading and searching for the literature, I found more and more helpful information that I wanted to cram into my thesis. Sometimes I felt like I could not get enough information, and it was hard for me to stop. I had to discipline myself to stop reading and adding more and more analysis and exciting news. In the end, with lots of encouragement from my supervisors, I could stop, cut back, streamline all my beloved analysis and rambling, and come up with a clear discussion. To do that, I had to cut out all those precious bits of information and put them in another document so I could save them – they seemed too good to waste! Finally, I had a complete final draft thesis to submit for third stage assessment. It seemed unbelievable.

Then came my third stage presentation. I worked hard on the preparation for two weeks, going over and over the PowerPoint, and practising timing and pacing. Then I presented to the assessment panel and my work colleagues and, thankfully, passed. It was such a tense experience, but I did it. The whole process gave me new eyes and clarity on my thesis. I think this was because I had to be succinct in the presentation, and I could see that I had not explained things enough in some places. My supervisors also clarified areas in the PowerPoint as well. The questions I asked to defend my thesis made me aware of areas to improve. Overall, the third stage assessment helped me shape and define the final form of my view. The experience went from one I had to "get through" to another learning episode that helped me stand back and think that sometimes I'm too close to my work.

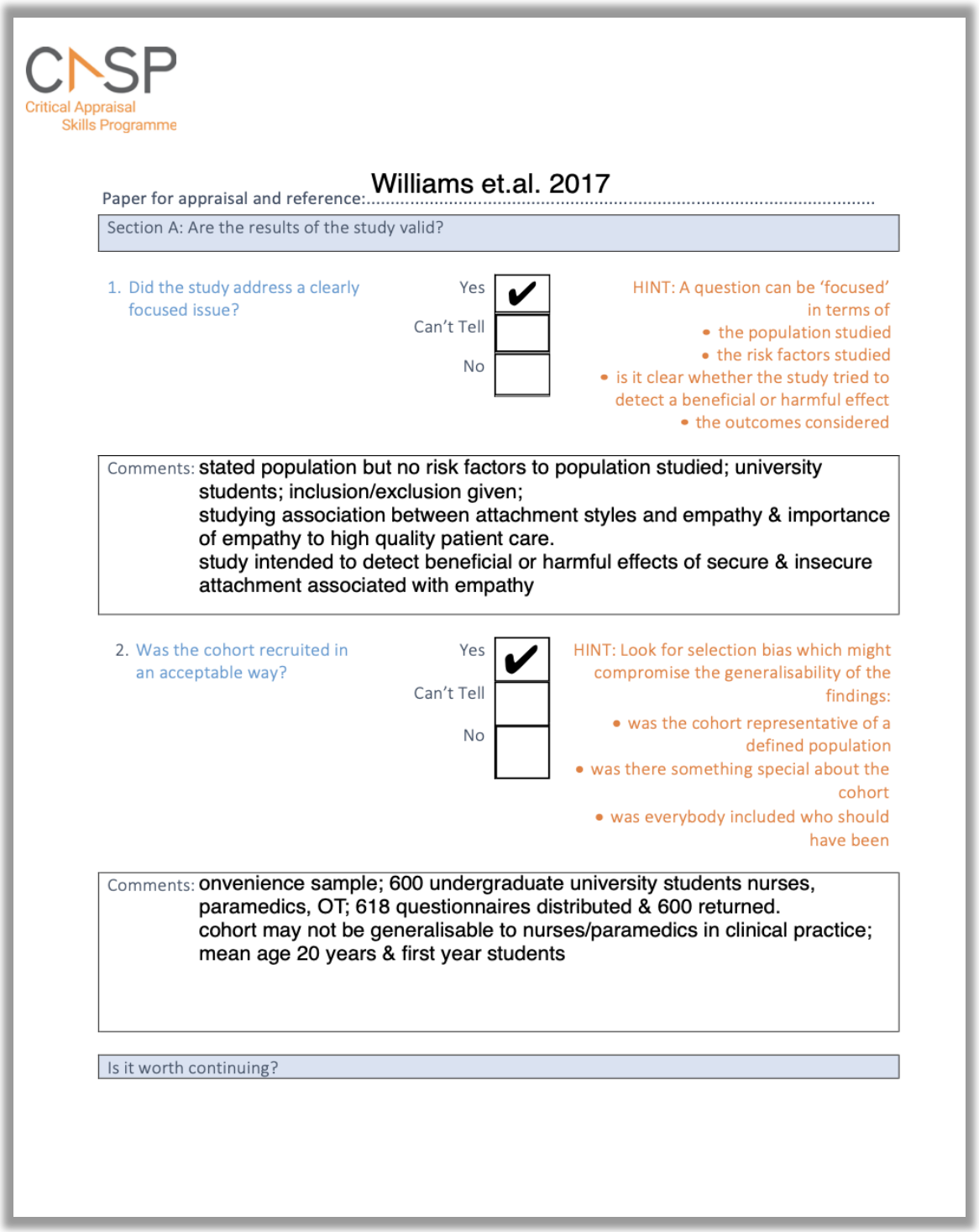
FINAL THOUGHTS

This research has been one of the most meaningful experiences of my life. I feel I have grown professionally, clinically and academically as a nurse. I also think I've grown personally – perhaps I am now more restrained, less dependent and more methodical. What I value the most is that I've learned how to gather, attain, critique, synthesise, assimilate and keep searching for knowledge.

Finally, now I know why some nurses struggle with their nurse-client caregiving relationships. They have experienced attachment trauma and suffer in silence. They often do not have good peer relationships and are blamed for their dysregulated or “difficult” behaviours. I have observed and worked with nurses like this for a long time, and now I know there may be a reason. What a discovery! That is what research has done for me, which enabled me to find a much more extensive answer to a small question. But the solution brought along more significant questions waiting to be answered.

APPENDICES

APPENDIX 1: CASP EXAMPLE



CASP
Critical Appraisal Skills Programme

Paper for appraisal and reference: Williams et.al. 2017

Section A: Are the results of the study valid?

1. Did the study address a clearly focused issue?

Yes ✔
Can't Tell
No

HINT: A question can be 'focused' in terms of
- the population studied
- the risk factors studied
- is it clear whether the study tried to detect a beneficial or harmful effect
- the outcomes considered

Comments: stated population but no risk factors to population studied; university students; inclusion/exclusion given;
studying association between attachment styles and empathy & importance of empathy to high quality patient care.
study intended to detect beneficial or harmful effects of secure & insecure attachment associated with empathy

2. Was the cohort recruited in an acceptable way?

Yes ✔
Can't Tell
No

HINT: Look for selection bias which might compromise the generalisability of the findings:
- was the cohort representative of a defined population
- was there something special about the cohort
- was everybody included who should have been

Comments: onvenience sample; 600 undergraduate university students nurses, paramedics, OT; 618 questionnaires distributed & 600 returned.
cohort may not be generalisable to nurses/paramedics in clinical practice; mean age 20 years & first year students

Is it worth continuing?

CASP
Critical Appraisal Skills Programme

3. Was the exposure accurately measured to minimise bias?

Yes ✔
Can't Tell
No

HINT: Look for measurement or classification bias:
- did they use subjective or objective measurements
- do the measurements truly reflect what you want them to (have they been validated)
- were all the subjects classified into exposure groups using the same procedure

Comments: all measures psychometric properties appear adequate. attachment measure RSQ self-report. attachment assessed into styles by RSQ and everybody had the same procedure with other self-report measures

4. Was the outcome accurately measured to minimise bias?

Yes
Can't Tell ✔
No

HINT: Look for measurement or classification bias:
- did they use subjective or objective measurements
- do the measurements truly reflect what you want them to (have they been validated)
- has a reliable system been established for detecting all the cases (for measuring disease occurrence)
- were the measurement methods similar in the different groups
- were the subjects and/or the outcome assessor blinded to exposure (does this matter)

Comments: mentions the following confounding factors - response bias due to self-report; convenience sampling may have led to non-respondent bias from more than first year students

CASP
Critical Appraisal Skills Programme

5. (a) Have the authors identified all important confounding factors?

Yes	
Can't Tell	
No	✔

HINT:
- list the ones you think might be important, and ones the author missed

Comments: reported none. all instruments were self-report which are open to response bias; self-selection bias may also have been a factor;

5. (b) Have they taken account of the confounding factors in the design and/or analysis?

Yes	
Can't Tell	
No	✔

HINT:
- look for restriction in design, and techniques e.g. modelling, stratified-, regression-, or sensitivity analysis to correct, control or adjust for confounding factors

Comments: no they haven't mentioned any of the listed factors

6. (a) Was the follow up of subjects complete enough?

Yes	
Can't Tell	
No	

HINT: Consider
- the good or bad effects should have had long enough to reveal themselves
- the persons that are lost to follow-up may have different outcomes than those available for assessment
- in an open or dynamic cohort, was there anything special about the outcome of the people leaving, or the exposure of the people entering the cohort

6. (b) Was the follow up of subjects long enough?

Yes	
Can't Tell	
No	

CASP
Critical Appraisal Skills Programme

5. (a) Have the authors identified all important confounding factors?

Yes ☐
Can't Tell ☐
No ☑

HINT:
- list the ones you think might be important, and ones the author missed

Comments: reported none. all instruments were self-report which are open to response bias; self-selection bias may also have been a factor;

5. (b) Have they taken account of the confounding factors in the design and/or analysis?

Yes ☐
Can't Tell ☐
No ☑

HINT:
- look for restriction in design, and techniques e.g. modelling, stratified-, regression-, or sensitivity analysis to correct, control or adjust for confounding factors

Comments: no they haven't mentioned any of the listed factors

6. (a) Was the follow up of subjects complete enough?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- the good or bad effects should have had long enough to reveal themselves
- the persons that are lost to follow-up may have different outcomes than those available for assessment
- in an open or dynamic cohort, was there anything special about the outcome of the people leaving, or the exposure of the people entering the cohort

6. (b) Was the follow up of subjects long enough?

Yes ☐
Can't Tell ☐
No ☐

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Critical Appraisal Skills Programme

Comments: N/A - no follow up

Section B: What are the results?

7. What are the results of this study?

HINT: Consider
- what are the bottom line results
- have they reported the rate or the proportion between the exposed/unexposed, the ratio/rate difference
- how strong is the association between exposure and outcome (RR)
- what is the absolute risk reduction (ARR)

Comments: yes % attachment distributions given and mean attachment scores. paramedics highest in attachment security; nurses highest in insecure fearful, dismissing & preoccupied attachment; nurses scored lowest mean on empathy; mean difference between nursing & other groups on dismissing scale was statistically significant - this group was less empathic

8. How precise are the results?

HINT:
- look for the range of the confidence intervals, if given

Comments: table provided demonstrating 95% confidence intervals for attachment styles & empathy

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9. Do you believe the results?

Yes	✔
Can't Tell	
No	

HINT: Consider
- big effect is hard to ignore
- can it be due to bias, chance or confounding
- are the design and methods of this study sufficiently flawed to make the results unreliable
- Bradford Hills criteria (e.g. time sequence, dose-response gradient, biological plausibility, consistency)

Comments: Sample adequate for testing. the design and methods appear reliable. tables clear

Section C: Will the results help locally?

10. Can the results be applied to the local population?

Yes	
Can't Tell	✔
No	

HINT: Consider whether
- a cohort study was the appropriate method to answer this question
- the subjects covered in this study could be sufficiently different from your population to cause concern
- your local setting is likely to differ much from that of the study
- you can quantify the local benefits and harms

Comments: used a self-report attachment measure for romantic attachments with a student population and generally people without much life experience so results should be viewed with caution. Not generalisable

11. Do the results of this study fit with other available evidence?

Yes	✔
Can't Tell	
No	

Comments: results generally fit with other studies regarding insecure attachment; it's a good cohort study would benefit using the AAI to get a deeper understanding of attachment state-of-mind

CASP
Critical Appraisal Skills Programme

12. What are the implications of this study for practice?

Yes	✔
Can't Tell	
No	

HINT: Consider
- one observational study rarely provides sufficiently robust evidence to recommend changes to clinical practice or within health policy decision making
- for certain questions, observational studies provide the only evidence
- recommendations from observational studies are always stronger when supported by other evidence

Comments: it has important implications for practice; but it's a preliminary study and needs to be repeated with a more diverse population of nurses.

APPENDIX 2: NURSES' INFORMATION SHEET

UNIVERSITY OF TECHNOLOGY SYDNEY
Faculty of Health
PO Box 123, Broadway NSW 2007

NURSE-MOTHER WORKING ALLIANCE STUDY
INFORMATION FOR PARTICIPANTS - NURSE

Introduction

You are invited to take part in a research study into the 1) the important elements that influence the working relationship between a mother with an infant under two years and the Tresillian nurse assigned to her care; and 2) how these elements influence the development of a positive and productive working relationship or alliance. Fran Chavasse as a PhD student at the University of Technology, Sydney, is conducting the study at Tresillian Family Care Centres. Professor Cathrine Fowler, and Dr Angela Dawson from the University of Technology are the research supervisors.

Study Procedures

If you agree to participate in this study, you will be asked to sign the Participant Consent Form. You will then participate in an hour-long audio-recorded interview prior to working with the mother in your care (this may be done at your convenience and at a place of your choosing). At the end of the your shift you will be asked to fill in a short questionnaire and take part in another short interview with the researcher. We are also seeking permission to view the progress notes and care plan within the medical record of your client in your care to understand what occurred during your time working with the mother.

Risks

The researcher is an experienced Tresillian nurse. The research has been carefully designed and there are few if any risks. It is possible; however you may feel unsettled or sad when talking about your childhood. In the event that you do become unsettled or sad the interview will be terminated. You will also be offered emotional support and a referral to a service such as the Employee Assistance Service

Benefits

There are no anticipated direct benefits to you through your involvement in this study.

Costs

Participation in this study will not cost you anything, nor will you be paid.

Voluntary Participation

Participation in this study is entirely voluntary. You do not have to take part in it. If you do take part, you can withdraw at any time without having to give a reason. There will be no impact on you personally in your work relationships or in your workplace

Confidentiality

All the information collected from you for the study will be treated confidentially, and only the researchers named above will have access to it. The study results will be used to assist Fran Chavasse complete the requirements for a PhD. The results may be presented at a conference or in a scientific publication, but individual participants will not be identifiable in such a presentation.

Further Information

When you have read this information, Fran Chavasse will further discuss it with you further and answer any questions you may have. If you would like to know more at any stage, please feel free to contact her.

This information sheet is for you to keep.

Ethics Approval and Complaints

This study Protocol Number X15-0089 has been approved by the Ethics Review Committee (RPAH Zone) of the Sydney Local Health District. Any person with concerns or complaints about the conduct of this study should contact the Executive Officer on 02 9515 6766 and quote protocol number.

APPENDIX 3: NURSE CONSENT

UNIVERSITY OF TECHNOLOGY SYDNEY
Faculty of Health
PO Box 123, Broadway NSW 2007

NURSE-MOTHER WORKING ALLIANCE STUDY

CONSENT FORM (Nurse)

1. I, ...

   Of .....
   have read and understood the Information for Participants on the above named research study and have been given the opportunity to discuss the study with Fan Chavasse.

2. I acknowledge that I have read the participant information form, which explains why I have been selected, the aims of the study, the procedures involved in the study and the nature and the possible risks of the investigation as far as they are currently known by the researchers. The research has been explained to me to my satisfaction.

3. I understand that the interviews will be audio recorded

4. Before signing this consent form, I have been given the opportunity of asking any questions relating to any possible physical and mental harm I might suffer as a result of my participation and I have received satisfactory answers.

5. I understand that I can withdraw from the study at any time without prejudice to my relationship with the Tresillian Family Care Centres

6. I agree that research data gathered from the results of the study may be published, on the understanding that I cannot be identified.

7. I understand that if I have any questions relating to my participation in this research, I may contact the principle researcher, Fran Chavasse, on mobile 0411265452, who will be happy to answer them.

8. I acknowledge receipt of a copy of this Consent Form and the Participant Information Statement.

_____	_____	_____
Signature of participant	**PRINT name**	**Date**
_____	_____	_____
Signature of witness	**PRINT name**	**Date**

APPENDIX 4: WOMEN'S INFORMATION SHEET

UNIVERSITY OF TECHNOLOGY SYDNEY
Faculty of Health
PO Box 123, Broadway NSW 2007

NURSE-MOTHER WORKING ALLIANCE STUDY
INFORMATION FOR PARTICIPANTS - MOTHER

Introduction

You are invited to take part in a research study into the 1) the important elements that influence the working relationship between a mother with an infant under two years and the Tresillian nurse assigned to her care; and 2) how these elements influence the development of a positive and productive working relationship or alliance. Fran Chavasse as a PhD student at the University of Technology, Sydney, is conducting the study at Tresillian Family Care Centres. Professor Cathrine Fowler, and Dr Angela Dawson from the University of Technology are the research supervisors.

Study Procedures

If you agree to participate in this study, you will be asked to sign the Participant Consent Form. You will then participate in an hour-long audio-recorded interview prior to working with the nurse who will work with you (this may be done prior to coming to Tresillian). At the end of the day you will be asked to fill in a short questionnaire and take part in another short interview with the researcher. We are also seeking permission to view the progress notes and care plan within your medical record to understand what occurred during your time working with the Tresillian nurse.

Risks

The researcher is an experienced Tresillian nurse. The research has been carefully designed and there are few if any risks. It is possible however, you may feel unsettled or sad when talking about your childhood.

Benefits

There are no anticipated direct benefits that you will experience as a result of your involvement in this study.

Costs

Participation in this study will not cost you anything, nor will you be paid.

Voluntary Participation

Appendix 5: Women's Consent

UNIVERSITY OF TECHNOLOGY SYDNEY
Faculty of Health
PO Box 123, Broadway NSW 2007

Participation in this study is entirely voluntary. You do not have to take part in it. If you do take part, you can withdraw at any time without having to give a reason. There will be no impact on your interaction with Tresillian staff or the care that is provided by Tresillian

Confidentiality

All the information collected from you for the study will be treated confidentially, and only the researchers named above will have access to it. The study results will be used to assist Fran Chavasse complete the requirements for a PhD. The results may be presented at a conference or in a scientific publication, but individual participants will not be identifiable in such a presentation.

Further Information

When you have read this information, Fran Chavasse will further discuss it with you and answer any questions you may have. If you would like to know more at any stage, please feel free to contact her.

This information sheet is for you to keep.

Ethics Approval and Complaints

This study Protocol Number X15-0089 has been approved by the Ethics Review Committee (RPAH Zone) of the Sydney Local Health District. Any person with concerns or complaints about the conduct of this study should contact the Executive Officer on 02 9515 6766 and quote protocol number.

APPENDIX 6: INITIAL ETHICS APPROVAL

You are asked to note the following:

- **This letter constitutes ethical approval only.**
- **You must NOT commence this research project at ANY site until you have submitted a Site Specific Assessment Form to the Research Governance Officer and received separate authorisation from the Chief Executive or delegate of that site.**

  On the basis of this ethics approval, authorisation may be sought to conduct this study within any NSW public health organisation and/or within any private organisation which has entered into an appropriate memorandum of understanding with the Sydney Local Health District, Sydney Local Health Network or the Sydney South West Area Health Service.

  The Committee noted that authorisation will be sought to conduct the study at the following sites:

  - Tresillian Family Care Centres
- This approval is valid for four years, and the Committee requires that you furnish it with annual reports on the study's progress beginning in **July 2016.** If recruitment is ongoing at the conclusion of the four year approval period, a full re-submission will be required. Ethics approval will continue during the re-approval process.
- This human research ethics committee (HREC) has been accredited by the NSW Department of Health as a lead HREC under the model for single ethical and scientific review and is constituted and operates in accordance with the National Health and Medical Research Council's *National Statement on Ethical Conduct in Human Research* and the *CPMP/ICH Note for Guidance on Good Clinical Practice*.
- You must immediately report anything which might warrant review of ethical approval of the project in the specified format, including unforeseen events that might affect continued ethical acceptability of the project.
- You must notify the HREC of proposed changes to the research protocol or conduct of the research in the specified format.
- You must notify the HREC and other participating sites, giving reasons, if the project is discontinued at a site before the expected date of completion.
- If you or any of your co-investigators are University of Sydney employees or have a conjoint appointment, you are responsible for informing the University's Risk Management Office of this approval, so that you can be appropriately indemnified.
- Where appropriate, the Committee recommends that you consult with your Medical Defence Union to ensure that you are adequately covered for the purposes of conducting this study.

APPENDIX 7: ETHICS AMENDMENT

ADDRESS FOR ALL CORRESPONDENCE
RESEARCH ETHICS AND GOVERNANCE OFFICE
ROYAL PRINCE ALFRED HOSPITAL
CAMPERDOWN NSW 2050

TELEPHONE: (02) 9515 6766
EMAIL: Ethics-RPA@sswahs.nsw.gov.au
REFERENCE: X15-0089 & HREC/15/RPAH/121 9.68/MAY17

Health
Sydney
Local Health District

9 August 2017

Ms F Chavasse
Centre for Midwifery, Child & Family Health
Faculty of Nursing
University of Technology Sydney
PO Box 123
BROADWAY NSW 2007

Dear Ms Chavasse,

Re: Protocol No X15-0089 & HREC/15/RPAH/121 - "How is the working alliance affected by the attachment state of mind of a mother and the child and family health nurse assigned to her care?"

The Executive of the Ethics Review Committee, at its meeting of 9 August 2017 considered your correspondence of 5 May 2017 and Professor C Fowler's correspondence, dated 16 June 2017 (received 3 August 2017) and gave its approval of the following:

- To recruit a second mother for each nurse to enable a comparison of how the nurses build their therapeutic alliance with different mothers
- To increase the number of nurses recruited up to fifteen

In addition, the Executive noted the following:

- The withdrawal from the study of two health workers who were assisting with data collection, and

- The protocol deviations that have occurred in three of the seven interviews conducted to date and the need to re-interview three of the nurses. The steps that have been taken to rectify these deficiencies were noted.

Yours sincerely,

Merela Ghazal
A/Executive Officer
Ethics Review Committee (RPAH Zone)

HERC\EXECOR\17-05

APPENDIX 8: DISTRESS PROTOCOL

How does attachment state of mind affect the nurse-caregiving relationship?

Distress Protocol

Prior to the interview, the researcher will ascertain the CFH nurse and woman's emotional state:

1. If the CFH nurse and woman feel comfortable with the researcher interviewing them the interview will proceed. All interviews completed by the researcher.
2. If either CFH nurse or woman becomes distressed or overwhelmed by the interview it will be:
    a. paused as necessary and the CFH nurse or woman asked if they wish to stop the interview,
    b. offered tissues and support until the participant is ready to resume the interview.
    c. If the CFH nurse or woman becomes too distressed the interview will be terminated if deemed appropriate by interviewer or at CFH nurse or woman's request
3. Tresillian Family Care Centres has well-developed procedures to manage such situations. To ensure no harm occurs to the women or CFH nurses, the following procedures will be followed.
    a. Women will be referred to a mental health professional working at Tresillian Family Centre if required.
    b. CFH Nurses will be referred to the Employee Assistance Service, if required.
4. The researcher has considerable mental health experience and is well-qualified to recognize emotional distress, give support and make appropriate referrals.

APPENDIX 9: AAI RELIABILITY CERTIFICATION

UNIVERSITY OF CALIFORNIA, BERKELEY

BERKELEY • DAVIS • IRVINE • LOS ANGELES • MERCED • RIVERSIDE • SAN DIEGO • SAN FRANCISCO

SANTA BARBARA • SANTA CRUZ

DEPARTMENT OF PSYCHOLOGY
3210 TOLMAN HALL # 1650

BERKELEY, CALIFORNIA 94720-1650
TEL: (510) 642-5292

January 18, 2015

Dear Fran Chavasse,

We are delighted to congratulate you on having completed and passed the full 30-case reliability testing for the analysis of the Adult Attachment Interview.

You have been found highly reliable across 30 cases in sequence whether we consider a three-category analysis (the Dismissing, Secure and Preoccupied adult attachment categories), or whether the fourth, Unresolved/disorganized category is considered as well.

This represents an outstanding accomplishment, and we look forward to learning about your forthcoming work with this instrument.

Mary Main

Erik Hesse

APPENDIX 10: AAI INTERVIEW PROTOCOL

Appendix 1

ADULT ATTACHMENT INTERVIEW PROTOCOL

Introduction: I'm going to be interviewing you about your childhood experiences and how those experiences may have affected your adult personality. So, I'd like to ask you about your early relationship with your family, and what you think about the way it might have affected you. We'll focus mainly on your childhood, but later we'll get onto your adolescence and then to what's going on right now. This interview often takes about an hour, but it could be anywhere between 45 minutes and an hour and a half

1. Could you start by helping me get oriented to your early family situation, and where you lived and so on? If you could tell me where you were born, whether you moved around much, what your family did at various times for a living?
2. I'd like you to try to describe your relationship with your parents as a young child…if you could start as far back as you can remember?
3. Now I'd like to ask you to choose five adjectives or words that reflect your relationship with your mother starting as far back as you can remember – as early as you can go, but say age 5 to 15 is fine. I know this may take a bit of time, so go ahead and think fo a minute….then I'd like to ask you why you chose them. I'll write each one down as you give them to me.
4. Now I'd like you to choose five adjectives or words that reflect your childhood relationship with your father, again starting from as far back as you can remember in early childhood – as early as you can go, but again say, age 5 – 12 is fine. I know this may take a bit of time, so go ahead and think again for a minute…then I'll ask you why you chose them. I'll write each one down as you give them to me.
5. Now I wonder if you could tell me, to which parent did you feel the closest to and why? Why isn't this feeling with the other parent?
6. When you were upset as a child, what would you do?
7. What is the first time you remember being separated from your parents?

8. Did you ever feel rejected as a young child? Of course, looking back on it now, you may realize it wasn't really rejection, but what I'm trying to ask about here is whether you remember ever having felt rejected in childhood?
9. Were your parents ever threatening with you in any way....maybe for discipline, or even jokingly?
10. In general, how do you think your overall experiences with your parents have affected your adult personality?
11. Why do you think your parents behaved as they did during your childhood?
12. Were there any other adults with whom you were close, like parents, as a child?
13. Did you experience the loss of a parent or other close loved one while you were a young child – for example, a sibling, or a close family member?
    a. Did you lose any other important persons during your childhood?
    b. Have you lost any other close persons in your adult years?
14. Other than any difficult experiences you've already described, have you had any other experiences, which you would regard as potentially traumatic?
15. Now I'd like to ask you a few more questions about your relationship with your parents. Were there many changes in your relationship with your parents after childhood? We'll get to the present in a moment, but right now I mean changes occurring roughly between your childhood and your adulthood?
16. Now I'd like to ask you, what is your relationship with your parents like for you now as an adult? Here I'm asking about your current relationship?
17. I'd like to move now to a different sort of question – it's not about your relationship with your parents; instead it's about an aspect of your current relationship with (child of participant). How do you respond now in terms of feeling, when you separate from your child/children?
18. If you had three wishes for your child twenty years from now, what would they be? I'm thinking partly of the kind of future you would like to see for your child. I'll give you a minute to think about this one.
    a. For individuals without children they will be asked to think in hypothetical terms about an imaginary child

19. Is there any particular thing, which you feel you have learned above all from your own childhood experiences? I'm thinking here of something you feel you might have gained from the kind of childhood you had.
20. We've been focusing a lot on the past in this interview, but I'd like to end up looking quite a ways into the future. We've just talked about what you think you may have learned from your own childhood experiences. I'd like to end by asking you what would you hope your child (or your imagined child) might have learned from his/her experiences of being parented by you?

This is the end of the interview. The interview now begins helping the participant to turn his or her attention to other topics or tasks. Participants are given a contact number for the interviewer/researcher, and encouraged to feel free to call if they have any questions

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