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Attachment style and clinical outcome within a DBT-informed Therapeutic Community

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Abstract

Purpose – There is evidence that attachment style and clinical outcomes are related within Therapeutic Communities (TCs). This study sought to examine any possible relationships between self-reported adult attachment style, therapy programme engagement and measures of psychological distress and dissociation on admission and discharge within a residential TC.

Design/methodology/approach – Ex-clients of the TC were contacted by post and invited to take part in this service evaluation. Additional data was sourced from a database of routinely collected outcome measures. Of 281 ex-clients, the final sample in this study was N=32.

Findings – When attachment style is conceptualised dimensionally, participants identified most strongly with a fearful attachment style, and least with a preoccupied or secure style. A range of attachment styles were reported. A significant association was apparent between self-reported secure attachment and reduced levels of psychological distress upon discharge from the TC. The potential for changes in client attachment patterns following TC membership is discussed.

Originality – To date, this is the first known study to report on the relationship between self-reported adult attachment style and psychological outcomes specifically for women with self-defeating behaviours within a TC.

Research limitations/implications – The small sample size and correlational nature of this study means that results should be interpreted cautiously. Nevertheless, results are of clinical relevance for inpatient or residential therapy programmes (including TCs). Such programmes should routinely assess client attachment style to ensure appropriate interventions and adaptions are implemented.

Introduction

Bowlby's (1969, 1982) seminal work on attachment proposed a developmental theory: that infants developed internal constructions ("internal working models") of their self in relation to others, primarily based on interactions with their primary caregiver. Reliability and consistency in caregiver interaction was proposed as crucial, given that the primary caregiver must act as a secure base from which the infant can explore their social world, and a safe haven to retreat to when needed (Bowlby, 1982). If reliability and consistency was established, the infant was likely to internalise safe, loving, proportionate and affectionate internal working models. Conversely, if caregiver behaviour proved unreliable and inconsistent, the internalisation of inadequate, unfulfilling, disrupted or disturbing models of interaction was likely.

Infant responses to the Strange Situation procedure (Ainsworth *et al.*, 1978) were found to fall into three main categories, or attachment patterns: securely attached, insecure-resistant (or "ambivalent") and insecure-avoidant (Ainsworth and Bell, 1970). A fourth attachment style termed "disorganised" was later identified, characterised by the infant's lack of behavioural and attentional organisation (Main and Soloman, 1990).

Fonagy and Allison (2014) suggested that an infant's chance of secure attachment is influenced by their carer's sensitivity to it's emerging intentionality. In turn, this develops the infant's sense of subjective self and enhances their resilience to adversity and their future cognitive, social-cognitive, and emotion-regulating capacity. Internal working models provide the infant with frameworks of expectation for future relationships (Danquah and Berry, 2013). In adult life, these styles of relating are often described as *secure*, *preoccupied*, *dismissing* and *fearful/unresolved*.

The Consortium for Therapeutic Communities (TCTC, 2020) defines therapeutic communities (TCs) as "structured, psychologically informed environments…places where the social relationships, structure of the day and different activities together are all deliberately designed to help people's health and well-being". Relationships with other clients and staff (including the re-experiencing and re-enacting of previously difficult interactions) is a central tenet of a TC (Kennard, 2004).

Attachment, clinical outcomes and Therapeutic Communities

The intense and sustained interpersonal focus of a TC may be considered one form of attachment-focussed intervention, with the potential to produce meaningful changes in relational patterns: "everything that happens between members (staff and patients) in the course of living and working together, in particular when a crisis occurs, is used as a learning opportunity" (Kennard, 2004, p. 296). Stalker *et al.* (2005) found that attachment-focussed interventions (such as TCs) may improve the clinical outcomes for those reporting histories of childhood abuse. As many as 75% of TC members may have previously reported a history of childhood sexual abuse (McFetridge *et al.*, 2015).

There is some evidence that an individual's attachment style may have an influence on their motivation and subsequent outcome within a TC (Ramos, 2017). One study found that those completing therapy within a residential TC also tended to report better clinical outcomes, including significant reductions in psychological distress (McFetridge and Coakes, 2010).

The relationship between attachment style, group processes and group therapy is supported by a number of papers (Chen and Mallinckrodt, 2002; Marmarosh *et al.*, 2009; Markin and Marmarosh, 2010; Marmarosh, 2014; Tasca, 2014). An outcome of participation in a TC may be a change in attachment style during the course of therapy (Taylor *et al.*, 2014). A democratic TC within a prison setting found that after one year of treatment there was an increase in secure and a decrease in insecure attachment styles (Miller and Klockner, 2019). It is therefore apparent that although attachment styles may influence motivation and clinical outcomes within TCs, such attachment representations may themselves be amenable to change.

The present study

This study sought to examine the possible relationship between self-reported adult attachment style, therapy programme engagement and measures of psychological distress and dissociation on admission and discharge within a TC. To the authors knowledge, this is the first study to explore the relationship between these factors within a residential TC.

Therapy took place within a former specialist residential TC[1] for adult women, located in the North of England. The TC was Dialectical Behaviour Therapy (DBT; Linehan, 1991) informed, and aimed to assist women who had a history of 'self-defeating behaviours' sufficiently severe to warrant a tertiary NHS referral and funding. These self-defeating behaviours were primarily self-injurious and suicidal acts, but were often accompanied by eating disordered or impulsive/risky behaviour. Almost all clients had a previous primary diagnosis of BPD, and 75% had previously reported a history of childhood sexual abuse. The therapy programme was offered to clients for a maximum of one year, followed by a monthly 'graduate group' for a further 12 months post-discharge.

Method

Participants

Participants were former clients (N=32) of the TC between 2000 – 2016 who returned postal questionnaires. Time since leaving the TC ranged from 2 – 835 weeks (M=389, SD=293).

Measures

[1]*The Acorn programme for self-defeating behaviours* was an inpatient unit located within The Retreat hospital, York. The programme was in existence from 2000–2018.

The Relationships Questionnaire (RQ; Bartholomew and Horowitz, 1991) was selected to examine adult attachment style. The RQ is a self-report measure of four adult attachment styles: Secure, Fearful (fearful-avoidant), Preoccupied (ambivalent) and Dismissing (dismissive-avoidant). The RQ provides a categorical and dimensional measure of attachment. Respondents select an attachment style they most identify with and also rate self-identification with all four attachment styles on a 1-7 likert scale (1 = 'Disagree strongly', 4 = 'Neutral/Mixed', 7 = 'Agree strongly'). For the current study, this dimensional measure of attachment was used as these are considered to better reflect individual differences (Fraley *et al.*, 2015). The RQ was selected for its brevity, ease of self-administration and good reliability and validity (Ravitz *et al.*, 2010).

The ***Clinical Outcomes in Routine Evaluation – Outcome Measure*** (CORE-OM; Evans *et al.*, 2000) is a 34-item self-report general measure of psychological distress. It has four subscales: well-being, problems/symptoms, functioning and risk. The CORE-OM gives an overall score, an overall mean score and four subscale scores. For this study the overall mean score was used. The CORE-OM has excellent internal and test-retest reliability (Evans *et al.*, 2002) and was a routinely administered outcome measure within the TC.

The ***Dissociative Experiences Scale - II*** (DES-II; Carlson and Putnam, 1993) is a 28-item self-report measure of dissociation and dissociative experiences. Respondents rate the applicability of each item on a scale of 0% to 100%. The measure has three subscales: absorption and imagination, amnesic experiences and depersonalisation and derealisation. For this study the overall mean DES-II score was used. The DES-II has excellent internal consistency (Zingrone and Alvarado, 2001; Patihis and Lynn, 2017) and was a routinely administered outcome measure within the TC.

If previous admission and discharge data on the CORE-OM and DES-II were available for a participant, this was retrieved from the service evaluation database.

Programme engagement was assessed using the proxy measure of the total number of days the participant spent as a resident within the TC.

Design

This study was a service evaluation project and consequently NHS ethics approval was not sought. This project was, however, reviewed by the host organisation's research governance committee. Additionally, current clients within the TC were consulted for their views on the acceptability and value of the project. There was consensus that the project was meaningful, acceptable and low risk. A postal sample was then derived from former clients.

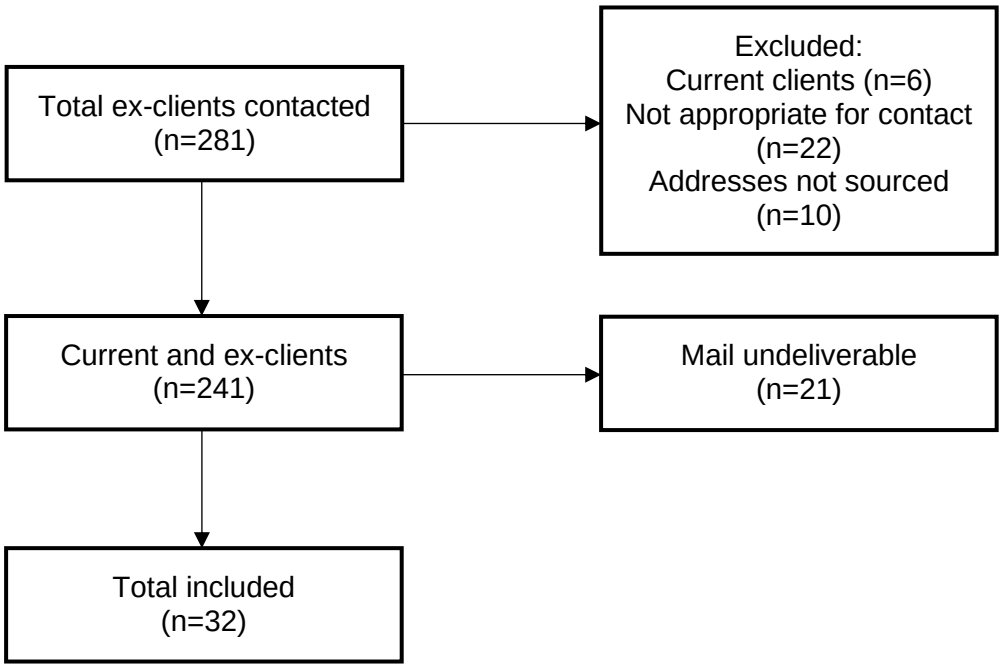
Procedure

The routine service evaluation database, comprising all current and former clients (N=281), was independently screened by four staff members. Current clients were excluded as they were still in therapy, and had contributed to the design of the study. Individuals who were either deceased, declined further contact, or inappropriate to

contact (due to safeguarding/legal reasons) were excluded. Former clients for whom a current address could not be sourced were also excluded (figure 1).

Remaining potential participants were contacted by post, with a letter of invitation, consent form, the RQ and a prepaid return envelope. Twenty-one questionnaires were returned as 'undelivered'. All participants provided written consent to take part in this project, in addition to prior written consent for their data to be used for the purposes of research, audit or service evaluation[2].

[FIGURE 1 HERE]



Analysis

Descriptive statistics were reported for each variable. To examine for associations between variables, bivariate correlational analysis was conducted. Independent samples t-tests were used to assess for differences between those participants who formed the current sample and those former clients who did not.

Results

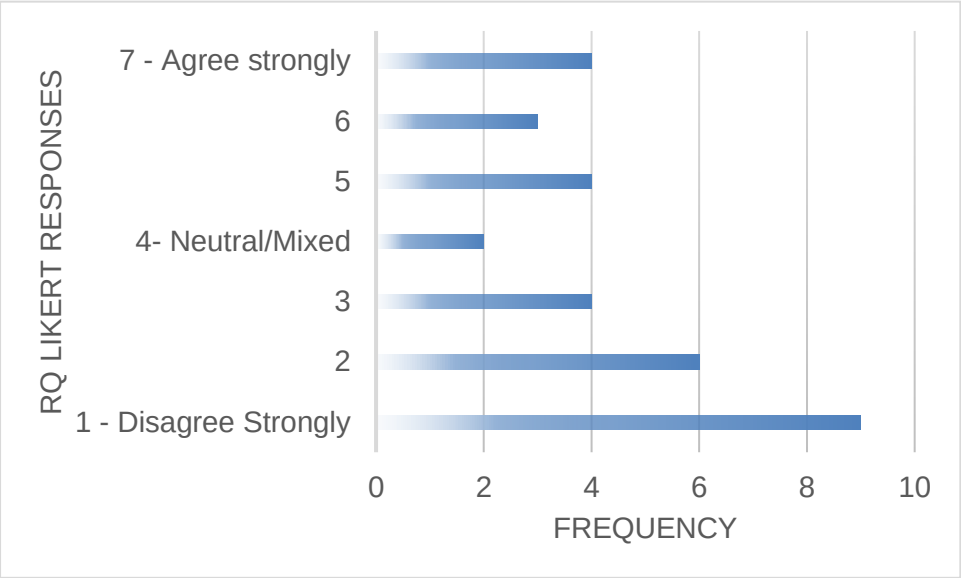
Of 220 potential participants, 32 (14%) responded. The duration of participation within the residential TC for this sample ranged from 72 – 378 days. Overall mean CORE-OM and DES-II scores for this sample were comparable at admission and discharge.

[TABLE I HERE]

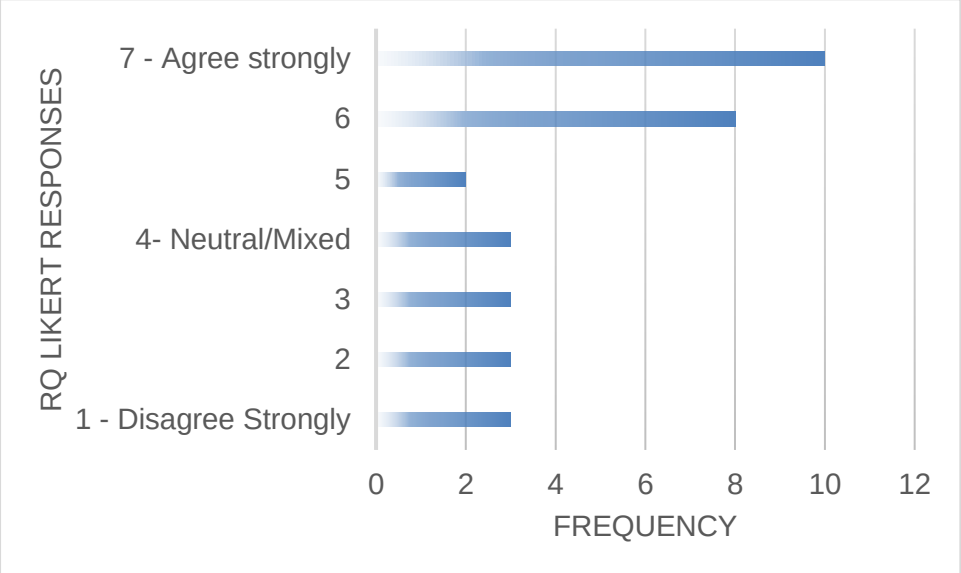
[2]This study preceded the implementation of the General Data Protection Regulation (GDPR).

Days inpatient *N=32*	CORE-OM admission *N=29*	CORE-OM discharge *N=29*	DES-II admission *N=30*	DES-II discharge *N=25*
289 (109)	2.2 (0.7)	1.9 (1)	37.6 (23.4)	37.3 (23)

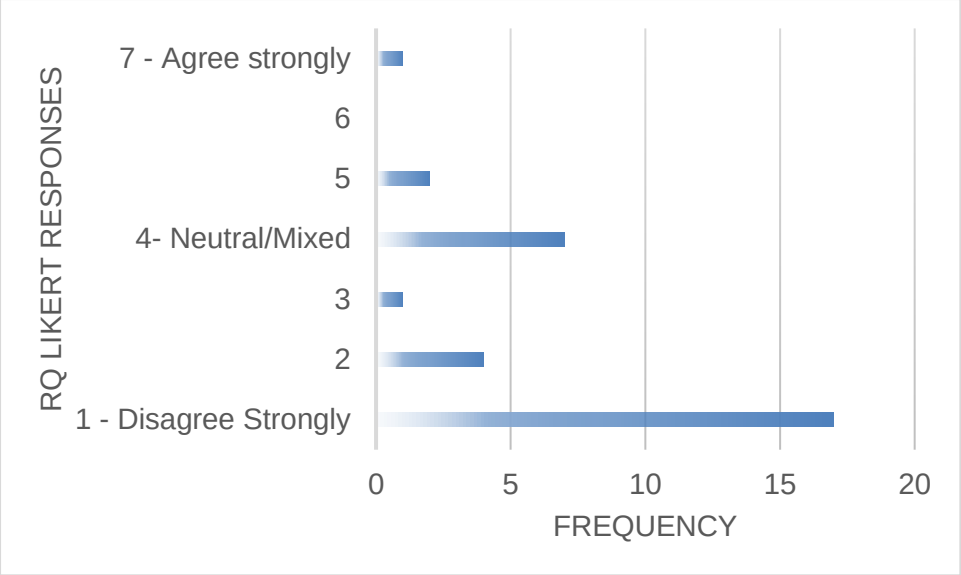
[FIGURE 2 HERE]



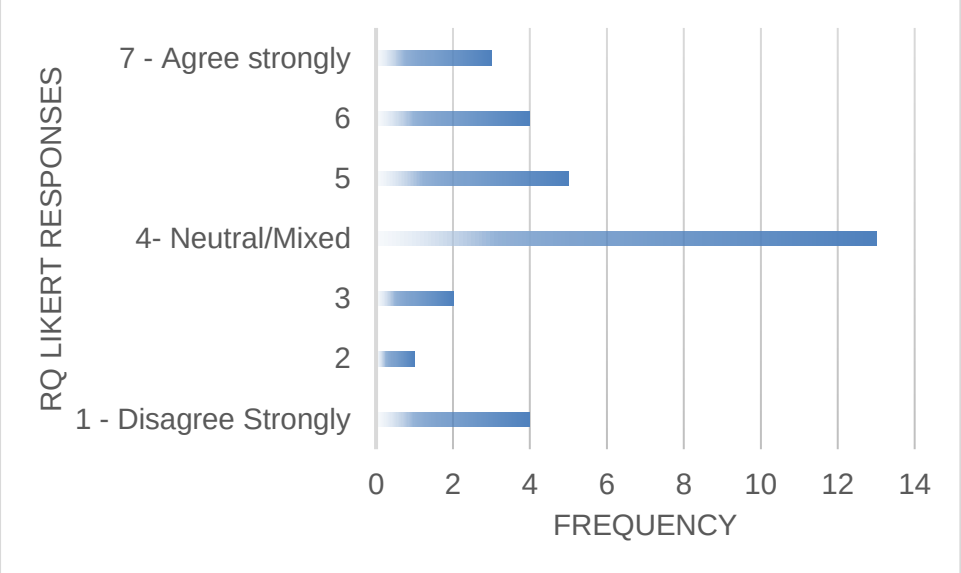
[FIGURE 3 HERE]



[FIGURE 4 HERE]



[FIGURE 5 HERE]



Figures 2 - 5 detail each participant's response for all attachment styles. A response of 1/2/3 on the RQ likert scales indicates varying levels of disagreement with the proposed attachment style, 4 indicates neutral or mixed feelings, and 5/6/7 indicates varying levels of agreement.

When attachment style is self-reported as a dimensional construct, it is evident that the majority '*disagreed strongly*' that they were secure or preoccupied in their attachment. Most participants endorsed '*agreed strongly*' for fearful attachment, and the majority were '*neutral/mixed*' for dismissing attachment.

Tests of normality indicated that assumptions for parametric testing were not met, therefore a non-parametric procedure was used. Independent samples Mann-Whitney U tests examined differences between CORE-OM and DES-II on admission and discharge, and days as an inpatient, for participants who responded (study sample) compared to those that did not.

[TABLE II HERE]

Days inpatient	.000**
CORE-OM admission	.030*
CORE-OM discharge	.332
DES-II admission	.520
DES-II discharge	.059

Analysis revealed a significant difference between groups in mean CORE-OM admission scores (responders=2.14; non-responders=2.39) and in the mean number of days as a TC resident (responders=inpatient 289; non-responders=187). There was no significant difference in mean CORE-OM discharge scores or DES-II admission/discharge scores between groups.

Bivariate correlations revealed no significant relationships between attachment style and TC engagement. A significant relationship between CORE-OM scores at discharge and self-reported secure attachment was apparent. Self-identification with a fearful attachment style had positive, albeit non-significant, correlations with all variables.

[TABLE III HERE]

	Days in-patient	Admission mean CORE-OM score	Discharge mean CORE-OM score	Admission DES-II score	Discharge DES-II score
Secure	-.145	-.230	**-.445***	.104	-.130
Fearful	.180	.173	.347	.201	.263
Preoccupied	-.135	-.277	-.103	-.299	-.267
Dismissing	.133	-.103	.122	.108	.132

Discussion

Given the nature and range of difficulties experienced by people diagnosed with BPD who self-harm, a DBT-informed Therapeutic Community might be imagined to be of benefit. Earlier clinical outcome studies appear to support this (McFetridge *et al.*, 2015), however evidence for changes in clients' relational patterns remains elusive. This study therefore aimed to explore the relationship between self-reported attachment styles and outcome measures for former clients of a residential DBT-informed TC.

Results indicate that those who stayed within the TC longer, and those who had comparatively lower levels of psychological distress on admission, were more likely to agree to participate in this study. When self-reported attachment style is conceptualised dimensionally, participants generally identified most strongly with a

fearful style, and least with a preoccupied or secure attachment style. Participants mostly reported mixed/neutral identification with a dismissing attachment style. One significant association was apparent; those who identified as securely attached were more likely to leave the programme with comparatively lower levels of psychological distress. Though not significant, associations between participants identifying more strongly with a fearful attachment, and higher DES-II scores on both admission and discharge, were evident. In contrast to other attachment styles, participants reporting fearful attachment also appeared to join and leave the TC with relatively greater levels of psychological distress.

It has been suggested that that fearful attachment is one of the most characteristic attachment styles of those with BPD (Agrawal *et al.*, 2004), so it is perhaps unsurprising that this was the style most participants in the study identified with. Had attachment styles remained unchanged during therapy, agreement with a secure attachment style is less likely to have been reported. However a substantial proportion of this sample (31%) reported this style, and this was also significantly associated with lower levels of distress upon discharge. Participants disagreed most with a preoccupied attachment style, suggesting they may experience less dependence within their relationships. A dismissing attachment seemed to be the style that participants felt overwhelmingly neutral/mixed about.

One possibility is that the attachment styles and inner working models of self/others may have changed following the intensive interpersonally-focussed therapy inherent within a residential TC. Similar therapeutic change has been reported in other studies (Taylor *et al.*, 2014; Miller and Klockner, 2019).

However, this can be no more than a tentative interpretation of the results due to the limitations of this study, the most pertinent being the small sample size. Ascertaining attachment styles from a single, brief measure of attachment does not necessarily provide a valid, reliable or comprehensive assessment. The attachment style of clients was not assessed pre-therapy, so there are no baseline data to compare with. Furthermore, the sample opting in (14%) was disappointingly modest and varied widely in time since having left the TC. Other differences were also evident between those who opted into this study compared to those former clients who did not.

Given the correlational nature of this study, caution should be exercised in ascribing causation, e.g. it is possible that subsequent therapy or life experiences may have contributed to a shift in attachment style, rather than this being associated with experiences within the TC.

As either party involved in the return to the parental home may witness, it is possible for former patterns of relating to be rekindled by this contact and context. The experience of receiving communication from the TC may therefore have activated client attachment systems. Internal representation of their TC experience may have influenced motivation to take part, or even the endorsed attachment styles.

There were, however, a number or strengths of this study. Current clients of the TC were consulted during the design phase of this study. This ensured that the design, methodology and approach were accessible and acceptable to this client group, and that the results would be of clinical relevence. This study also included the evaluation

of routinely collected outcome data. This naturalistic clinical data minimises researcher bias and improves the reliability and validity of results. To the best of the authors knowledge, this is the first study that has attempted to explore the relationship between self-reported adult attachment style and psychological outcomes for a residential TC.

Future research directions

Future studies might explore the active ingredients of a DBT-informed TC. Comparison of outcomes of a DBT programme with a Therapeutic Community may provide some insight into the function attachment style plays in psychological distress. Analysis of the experiences of clients taking part in such therapy programmes, through attachment-focussed qualitative interviews, would provide potentially rich descriptions of the most useful elements of the interpersonal aspects of the TC, and the impact these have on relationships.

It is equally important to consider the impact of staff attachment styles within TCs or intensive therapy programmes. The attachment style of therapists has an effect on the quality of the therapeutic alliance (Black *et al.*, 2005). Examining staff attachment style could prove useful to examine what effect, if any, this had as a moderating or mediating variable on therapeutic outcomes within such programmes.

Clinical implications

The results of this study suggest that when attachment styles are conceptualised as dimensional, change in relational patterns may be achieved for adults following participation in a TC. This may also be associated with reduced psychological distress. For services supporting clients receiving a diagnosis of BPD (or distress around interpersonal relations as a primary concern), incorporating elements of a DBT-informed Therapeutic Community may be helpful.

The general consensus of self-identification of fearful attachment styles in the current sample has clinical implications for services delivering mental health care. Services should be tuned in to the specific attachment needs of the population they are working with, as this will inform the appropriateness and effectiveness of intervention. The results of this study, and of previous research (Taylor *et al.*, 2014), suggest it is possible for attachment patterns to change following therapy.

In keeping with recommendations for the use of attachment theory in the design and delivery of long-stay mental health services (Bucci *et al.*, 2014), programmes should routinely assess self-reported attachment style on admission and discharge, in order to assess change over time. Routinely assessing attachment style has the additional benefit of potentially informing discharge planning and the client's likely response to this ending (Bucci *et al.*, 2014).

Conclusion

When conceptualised dimensionally, adult participants of a DBT-informed Therapeutic Community reported identification with a range of attachment styles. A positive association between self-reported secure attachment and lower

psychological distress upon discharge suggests that the therapy programme may have nurtured a more secure interpersonal style of relating, or weakened the representations of insecure attachments. The absence of pre-therapy attachment data however necessitates caution in discerning any firm conclusions. Potentially fruitful future research may include the routine collection of self-reported attachment data at regular intervals during therapy, and the examination of staff attachment styles. Qualitative insights from clients may permit a focus on the relational aspects of the therapeutic milieu that are most effective.

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