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Abstracts

Systematic Review of the Literature

Objective: The current mixed-methods systematic review evaluated available literature to find out which attachment-based interventions have been implemented for people with intellectual disability (PWID) and whether they are efficacious and acceptable.

Methods: Five databases were searched (in July 2023 and April 2024), using terms related to intellectual disability and attachment-based interventions. The search yielded 793 papers; 15 papers (13 studies) met inclusion criteria. Relevant data was extracted from each study. The quality of each paper was appraised using the Mixed Methods Appraisal Tool. Findings were synthesised in an integrative review.

Results: Of the included studies, 7 had PWID as participants and 6 had caregivers of PWID. Interventions included education, psychotherapy, technology assisted therapy, video interaction guidance/feedback and circle of security. Research methods varied.

Conclusions: Evidence for efficacy and acceptability of interventions was mixed but promising. Most studies had limited generalisability. Therefore, further research is required. Pre-registration with PROSPERO [351287].

Service Improvement Project

Background: Children and young people (CYP) residing in residential homes are vulnerable and may experience difficulties developing trusting relationships with professionals/services, particularly CYP with experience of exploitation.

Setting: Residential homes for CYP on the ‘edge of care’ overseen by a local authority in England.

Objective: To understand experiences of receiving and providing support within such homes. To find out how things could be improved to support all CYP within the current setting, and whether adaptations are needed for those with exploitation experiences.

Participants: Five CYP (all boys, aged 12-17 years) and seven staff members.

Method: Participants took part in semi-structured interviews. Transcripts were analysed using thematic analysis.

Results: Two main themes were identified from CYP: (1) 'the push and pull of relationships' and (2) 'what the CYP value'. Two main themes were identified from staff: (1) 'supporting all CYP open to the residential edge of care service' and (2) 'supporting CYP with experience of exploitation'.

Conclusions: Recommendations were generated from findings. Conclusions and limitations are discussed.

Theory Driven Research Project

People with both substance use difficulties (SUDs) and depression (known as dual diagnosis [DD]) have worse treatment outcomes and higher relapse rates compared to those with depression or SUDs alone. One possible explanation for this is a difference in attachment styles amongst the two populations. This study compared attachment styles of people with DD (n=36), depression only (n=36) and a control group (n=39). Secondary analyses compared prevalence of anxious and avoidant attachment in the DD group and the association between attachment style and both current substance use, and depression severity (N=183). No significant differences in attachment styles were found between people with DD and depression only, although both groups had higher levels of insecure attachment than the control group. People with DD had higher levels of anxious than avoidant attachment. Additionally, anxious attachment was found to be associated with current depression severity but not substance use (across all participants).

Systematic Review of the Literature (SLR)

A Systematic Review of Attachment Interventions for People with Intellectual Disability and their Caregivers

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Proposed Journal & Rationale: Journal of Intellectual Disabilities – an international journal which aims to provide peer-reviewed exchange of best practice, knowledge and research to bring about advancement of services for people with intellectual disability and their carers.

Abstract

Objective: The current mixed-methods systematic review evaluated available literature to find out which attachment-based interventions have been implemented for people with intellectual disability (PWID) and whether they are efficacious and acceptable.

Methods: Five databases were searched (in July 2023 and April 2024), using terms related to intellectual disability and attachment-based interventions. The search yielded 793 papers; 15 papers (13 studies) met inclusion criteria. Relevant data was extracted from each study. The quality of each paper was appraised using the Mixed Methods Appraisal Tool. Findings were synthesised in an integrative review.

Results: Of the included studies, 7 had PWID as participants and 6 had caregivers of PWID. Interventions included education, psychotherapy, technology assisted therapy, video interaction guidance/feedback and circle of security. Research methods varied.

Conclusions: Evidence for efficacy and acceptability of interventions was mixed but promising. Most studies had limited generalisability. Therefore, further research is required. Pre-registration with PROSPERO [351287].

Keywords: learning disability; intellectual disability; attachment theory; attachment interventions; relationships

Introduction

Intellectual Disability and Attachment Theory

Intellectual disability (ID) is characterised by significant difficulties with intellectual functioning (intelligence quotient (IQ) <70) and adaptive functioning (i.e. ability to complete developmentally appropriate daily activities) with childhood onset (American Psychiatric Association, 2013; BPS, 2015). IDs are categorised based on level of functioning – as mild, moderate or severe and profound (BPS, 2015). People with intellectual disability (PWID) also have increased prevalence of diagnoses of Autism Spectrum Disorder (ASD), physical disabilities and sensory disabilities, compared to people without ID (Department of Health, 2001; NHS England and NHS, 2019). Furthermore, they are thought to have increased difficulties with forming and maintaining attachment relationships (Hamadi and Fletcher, 2021).

According to attachment theory, a parent/caregiver's sensitivity (ability to perceive and accurately interpret communication signals) and responsiveness to their infant's needs influences the infant's attachment strategies (how they form and maintain relationships with others), view of themselves and others, as well as their regulation of emotions and behaviour throughout the life span (Bowlby, 1969; Ainsworth et al., 1978; Bowlby, 1977; Groh et al., 2017). Infants who experience care as consistent and responsive are thought to develop 'secure' attachment strategies (they are able to seek support from others and self-regulate their emotions), whereas infants who experience care as inconsistent or inadequate develop insecure attachment strategies (sometimes categorised as 'anxious/ambivalent' or 'avoidant'). Those who experience care as fearful or frightening develop disorganised attachment strategies (Main and Solomon, 1990; Ainsworth et al., 1978). All attachment strategies are considered adaptive for the infant's environment.

PWID have been found to have increased prevalence of insecure and disorganised attachment strategies compared to secure, in both clinical and non-clinical populations

(Hamadi and Fletcher, 2021; Bateman et al., 2023). See Cassidy (2016) and Solomon and George (2016) for further understanding of early attachment theory and categorisation. The current paper considers a broad conceptualisation of attachment theory, attachment-related behaviour (any behaviour guided towards attaining and maintaining the availability of an attachment figure) and the implications for care-receiving and care-giving attachment relationships for PWID, for reasons discussed below (Verhage et al., 2023; Schuengel et al., 2013) .

There are a number of reasons why PWID may experience increased difficulties with attachment relationships (Fletcher et al., 2016). For example, parents may be less likely to consistently recognise and meet needs of children with ID, due to their difficulty communicating/expressing them – requiring additional sensitivity and attunement (Giltaij et al., 2015; Schuengel and Janssen, 2006). Additionally, parents of children with ID report increased distress and mental health (MH) difficulties, which can impact interactions and attachment (Singer, 2006). The role of parental grief for an imagined 'healthy child' is suggested to impact attunement to a child's needs (Fletcher, 2016; Atkinson et al., 1999). Furthermore, PWID are at increased risk of physical and psychological abuse, which is associated with insecure and fearful attachment strategies (Wright, 2013). PWID also often require additional support, i.e. from family, professional carers (PCs) or residential care, meaning they may experience a high number of, and changes to, caregiving and attachment figures across the lifespan (Fletcher et al., 2016). This poses additional challenges to the development and maintenance of secure attachment relationships when individuals are reliant on multiple carers.

PWID may sometimes express attachment needs through distressed behaviour, sometimes referred to as "challenging behaviour" (CB) (Skelly, 2016). This can be distressing for caregivers, both familial and professional. Other attachment-related behaviour which can

be experienced as ‘challenging’ for PCs includes PWID becoming ‘overly fond’ of them (expressed by them following PCs around or becoming upset when they leave) (Larson et al., 2011). It is important to consider how caregivers respond to distress, CB, and attachment-behaviours and how they develop and maintain relationships with PWID, as this may impact future distress, communication and relationships. Variations in attachment behaviour of PWID has been found to be partly explained by differences amongst professional caregivers (De Schipper and Schuengel, 2010), confirming the individual nature of the person’s attachment relationship to each caregiver.

Additional measurement sensitivity and considerations may be needed to study attachment and related concepts in PWID, particularly those with significant communication difficulties (Walker et al., 2016). Walker et al. (2016) argues further investigation and validation of attachment specific measures for PWID is warranted due to a lack of established measures. However, the effectiveness of attachment-based interventions may be indicated through varied different outcomes, such as reduced distress, reduced distressed behaviour, improved emotional wellbeing and/or increased parental sensitivity or attunement (Rinaldi et al., 2022; O'Hara et al., 2019; Kennedy et al., 2011; Birdsey et al., 2022; Hodes et al., 2017; Ainsworth et al., 1974; Skelly, 2016).

Attachment Interventions

Attachment difficulties and insecurity are associated with MH difficulties, increased distress and distressed behaviour (Conradi and de Jonge, 2009; Pielage et al., 2005), which are all prevalent within ID populations (Mullen, 2018). Due to increased risk, it is important appropriate support is implemented for PWID and their caregivers. Furthermore, as parents with mild ID are over-represented within child protection services, and their children disproportionately adopted rather than provided family support (Booth et al., 2005), interventions supporting parent-child relationships are important.

Attachment interventions aim to improve the relationship and sensitivity between caregivers and care-receivers, in the hope of supporting emotional wellbeing and functioning (BPS, 2017; Steele and Steele, 2017). Although most attachment-based interventions were not developed for PWID, they are considered transferable (Fletcher and Gallichan, 2016). Interventions finding promising results (in people without ID) include video-feedback, video-interaction guidance (VIG), the circle of security (COS), and child-parent psychotherapy (Kennedy et al., 2011; Yaholkoski et al., 2016; Cicchetti et al., 2006; Van Ijzendoorn et al., 2023). Alexander et al.'s (2023) review of attachment interventions for children with disabilities or developmental delay, found emerging literature indicated early attachment interventions may effectively increase attachment security in that population. Research evaluating attachment-based interventions for PWID and/or borderline intellectual disability is also beginning to emerge, with promising outcomes (Hodes et al., 2017; 2018; Hofstra et al., 2023). Furthermore, increasing awareness of attachment theory has been suggested helpful for increasing sensitivity of people supporting PWID (Schuengel et al., 2013).

Relevance of Study

Hamadi and Fletcher's (2021) systematic review concluded further evaluation of the efficacy of attachment-based interventions for PWID is required, to help understand their impact on reducing distress and MH difficulties. Further development and availability of effective attachment-interventions may help to increase independence, quality of life (QoL) and wellbeing for PWID. There is currently no systematic review exploring efficacy/effectiveness and acceptability (whether consumers or participants experience an intervention as satisfactory i.e. in terms of content, comfort, delivery or credibility (Proctor et al., 2011)) of attachment-based interventions for PWID specifically. The current mixed-methods review aims to critically evaluate available literature and answer the following questions:

- What type of attachment-based psychological interventions have been implemented for PWID across the lifespan?
- Are attachment-focussed psychological interventions efficacious and acceptable for PWID and their support networks/carers?

Method

A mixed-methods integrative review was conducted to appraise and synthesise quantitative, qualitative and mixed-methods research. An integrative approach was taken to help provide a general overview of the current attachment-based intervention literature (both quantitative and qualitative), given the topic is potentially broad, literature sparse and research methods varied (Noyes et al., 2019). Findings of qualitative and quantitative data were integrated. The Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) reporting guidelines were followed (Page et al., 2021; Shamseer et al., 2015; Moher et al., 2009). The findings between and within the studies were explored within the integrative synthesis. The review was pre-registered with PROSPERO [351287].

Search Strategy

A systematic review was conducted using five electronic databases: PsychINFO, Medline, CINAHL, Scopus and Cochrane library. Google Scholar was used for additional scoping to ensure search completeness and reference lists of included studies hand-reviewed. Searches were conducted in July 2023 and updated in April 2024.

Search Terms. The search terms aimed to capture ID and attachment-based intervention studies. Outdated terms for ID were included to ensure all relevant papers were found. Their use is not endorsed by the author.

1. “Intellectual disab*” OR “learning disab*” OR “learning difficult*” OR “intellectual difficult*” OR “intellectual impair*” OR “learning impair*” OR “developmental

disorder" OR "developmental disab*" OR "learning handicap" OR "mental* handicap*" OR "intellectual* handicap*" OR "mental retard*"

2. attachment*
3. Training OR intervention OR therapy OR "video interaction guidance" OR "video feedback"

Eligibility Criteria.

Inclusion criteria:

- Qualitative, quantitative and mixed-method research studies – evaluating completed attachment-based interventions for PWID (mild – severe and profound) and their caregivers
    - Attachment-based interventions: individual or group-based interventions aimed at improving attachment, parent-child/carer-PWID interactions or relationships, or factors that support secure attachment
- Participants of any age, who completed an attachment-based intervention for PWID - including PWID, parents/guardians or PCs of PWID
- Research undertaken in any setting
- Papers published any year

Exclusion criteria:

- Not a completed research study (i.e., theoretical papers, systematic reviews, meta-analyses, reflective case studies, books, or pre-registrations)
- Not written in English
- Studies where not all participants have mild – severe and profound ID (i.e. some have developmental delay or borderline ID), or are a caregiver of PWID (i.e. participants are intervention facilitators)

Study Selection

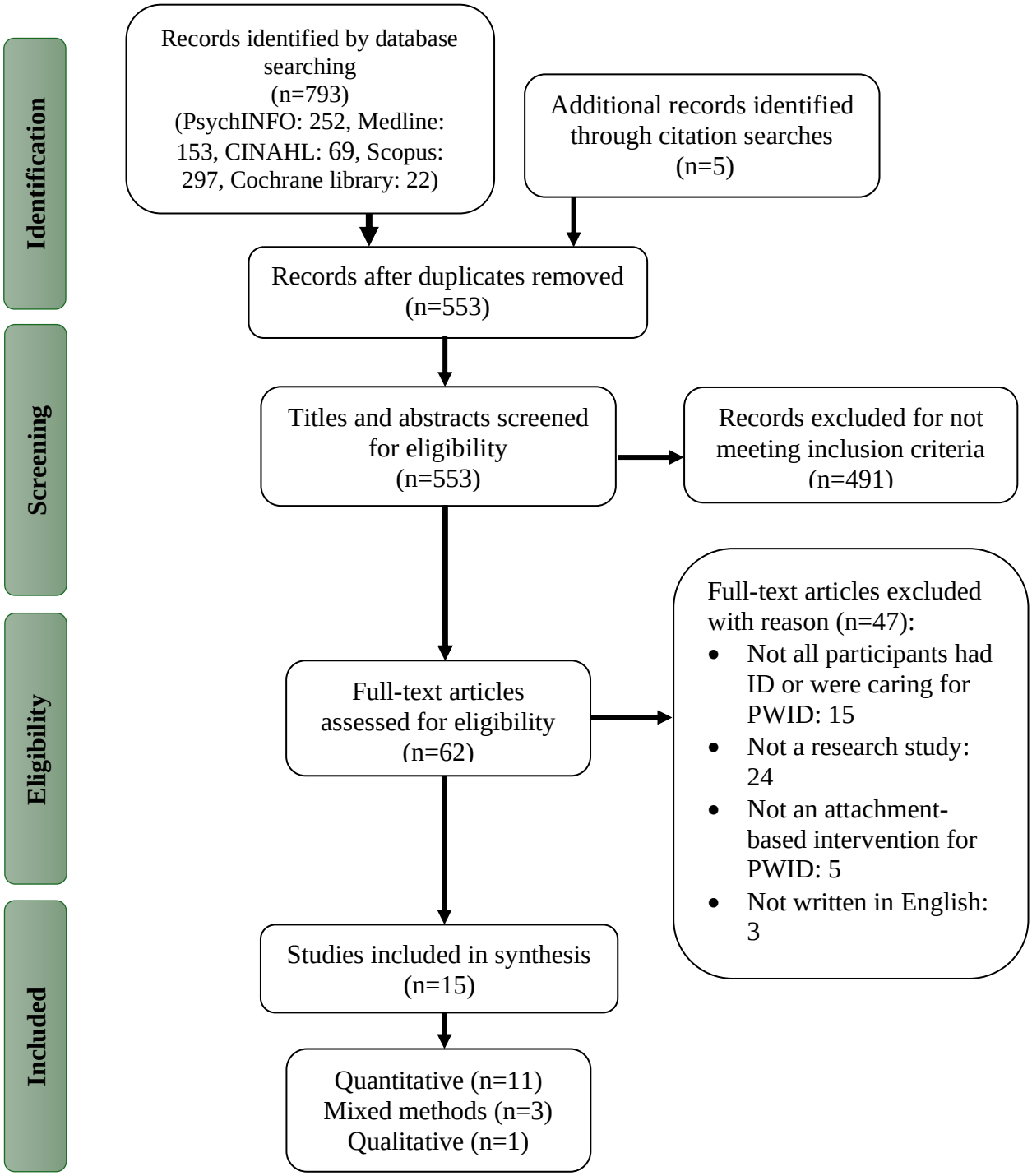
Identified papers were extracted into Endnote reference management software for screening. Duplicate papers were removed. All titles and abstracts were reviewed according to inclusion and exclusion criteria, and a random 20% sample of papers were double screened by an independent reviewer. Cohen's kappa statistic, a measure of inter-rater reliability, was used to determine scoring agreement amongst the two researchers (k=0.93). Discrepancies (n=2) were discussed and resolved. As inter-rater reliability was high, remaining abstracts and titles were screened by the lead author only.

The remaining papers underwent full-text screening by the lead author and 25% were additionally full-text screened by the independent reviewer (k=0.81). Discrepancies (n=1) were discussed and resolved. As inter-rater reliability was high, remaining texts were screened by the lead author only.

The selection process is summarised in the PRISMA flowchart (see figure 1.1). This figure illustrates the number of papers found (793) and included/excluded at each stage, including reasons for exclusion at full-text screening. In total, 15 papers were eligible for the current review. These figures include the updated search in April 2024, which yielded 27 additional documents (three of which were duplicates), none of which met inclusion criteria for the current review.

Figure 1.1

PRISMA Flow Chart – Study Identification and Selection



Data Extraction and Quality Assessment. A data extraction tool was created on Microsoft Excel to increase reliability. Data regarding study characteristics was extracted from each paper meeting inclusion criteria. An independent reviewer also extracted data from 50% of studies. Any discrepancies (n=1) were resolved via discussion. Extracted data was organised by type of participant group – PWID (see table 1.2) and caregivers of PWID (see table 1.3). See appendix B and C for further data. Quantitative, qualitative and mixed-methods studies are presented within the same tables, with findings synthesised in the synthesis/results section.

The Mixed Methods Appraisal Tool (MMAT) was used to assess quality of each study's methodology (Hong et al., 2018). This tool consists of two optional screening questions (included in the current review), to determine if the study is empirical research, and a total of 25 appraisal questions (Hong et al., 2018). It can appraise five different types of methodology: qualitative, RCTs, non-randomised, quantitative descriptive and mixed-methods. Each methodology has 5 appraisal questions (covering criteria most relevant) (Hong et al., 2018). Mixed-methods studies are appraised with 15 questions (five each for the qualitative, quantitative and mixed-method element). Questions can be answered "yes", "no" or "can't tell". Case-studies and case-series were appraised using the 'quantitative descriptive' criteria as results of these studies were predominantly described and presented for individual participants only. The tool does not provide cut offs or scores to define paper quality - the authors recommend sharing scoring for each relevant item, as this is more informative. However, descriptors can be used to illustrate percentage of quality criteria met, if accompanied by further detail (Hong, 2020). See appendix D for quality questions and criteria.

The lead author and independent reviewer independently rated 53% of included papers using the MMAT. Initial inter-rater reliability was high (K=0.82), with reviewers having 93%

agreement. Reviewers met to discuss scoring and associated discrepancies (n=4). They discussed each item until discrepancies were resolved and a standardised way of interpreting the item was agreed (see appendix E for initial discrepancies). As inter-rater agreement was high, only the lead author appraised the remaining papers.

The current review examined papers with different methodologies and participant groups. Findings were synthesised using an integrative synthesis and organised according to participant groups: PWID and caregivers of PWID. Quality appraisals of each study were included within the synthesis, to summarise research strengths/limitations.

Results/Synthesis

The current review included 15 papers. Multiple reports of the same research study were collated and appraised as a single study (Higgins et al., 2023). Therefore, the current review included 13 studies (total participants across studies: N=265). All scored "yes" on the screening questions and were deemed empirical research (Hong et al., 2018). Attachment interventions were available across all levels of ID and the lifespan. Included interventions were education, video-feedback/VIG, psychotherapy, COS and technology assisted therapy for social anxiety (SA). Research methodologies, data collection, and outcome measures varied. Quality of studies varied from meeting 20% of quality criteria to 100%. See table 1.1 for quality ratings.

Most studies (12/13) conceptualised attachment as the emotional/affectional bond between caregiver and care-receivers, which helps facilitate emotional coping and exploration of the world (Bowlby, 1969; Ainsworth et al., 1974; Bowlby, 1977; Bowlby, 1988). Caregiver attunement and sensitivity were recognised as facilitators of secure attachments (Ainsworth et al., 1974). See appendix B and C for further information. Seven studies included PWID as direct participants and six included caregivers as direct participants. Results are summarised within these two participant categories and relevant interventions for each.

Table 1.1

Quality Ratings Using MMAT

Author (year)	1.1	1.2	1.3	1.4	1.5	2.1	2.2	2.3	2.4	2.5	3.1	3.2	3.3	3.4	3.5	4.1	4.2	4.3	4.4	4.5	5.1	5.2	5.3	5.4	5.5	Quality criteria met
Birdsey et al. (2021)	Y	Y	Y	Y	Y											Y	Y	Y	Y	CT	Y	Y	Y	Y	CT	****
Damen et al. (2011) & Schuengel et al. (2012)																Y	Y	Y	N	Y						****
Hoffman et al. (2019)																Y	Y	N	CT	Y						***
Johnson et al. (2017)	Y	Y	Y	Y	Y											Y	CT	N	CT	Y	Y	Y	N	N	N	**
Jonker et al. (2015)																Y	Y	N	CT	Y						***
McInnis (2016)																Y	Y	N	N	N						**
Muddle et al. (2021)	Y	Y	Y	Y	Y																					*****
Pearson et al. (2019)											Y	Y	Y	Y	Y											*****
Pethica & Bigham (2017)																Y	Y	N	Y	N						***
Sterkenburg et al. (2008a) & Schuengel et al. (2009)																Y	Y	Y	N	Y						****

Sterkenburg et al. (2008b)																Y	Y	Y	Y	Y							*****
Vandesande et al. (2023)	Y	CT	N	N	N						Y	N	N	N	Y						N	Y	CT	N	N	*	
Wingerden et al. (2019)						CT	Y	N	CT	N																*	

NB: Key: yes (Y), no (N) and can't tell (CT).
***** means 100% quality criteria met, **** means 80% quality criteria met, *** means 60% quality criteria met, ** means 40% quality criteria met,* means 20% quality criteria met.

People with Intellectual Disability

Table 1.2

Extracted Data from PWID Studies

Author (year)	Study design	Attachment intervention	Sample size	Summary of participant traits	Data collection methods	Main outcome measures	Main findings
Hoffman et al. (2019)	Case-series	Technology assisted therapy for social anxiety (TTSA)	N=6	Aged 27-56. Mild to moderate ID. Additional needs: blind or visual impairment (VI) & social anxiety (SA).	Observations (by professional carers [PCs]), questionnaire (self-report)	Adult behaviour checklist (ABCL); brief symptom inventory (BSI); psychopathology inventory (PIMRA) anxiety subscales; intellectual disability quality of life (IDQOL); frequency of messages.	**Efficacy:** Anxiety scale scores sig. reduced (self and carer-report). Anxious and angry messages, anxious behaviour and CB sig. reduced. Psychological functioning and QoL increased sig.

Jonker et al. (2015)	Single case-study	TTSA	N=1	Age: 27. Moderate ID. Additional needs: VI & SA.	Observations (by PCs), questionnaires (self-report and carer report)	ABCL; BSI; PIMRA anxiety subscales; residential daily observation lists; frequency of messages; social validity questionnaire.	**Efficacy:** Anxious and angry messages sig. reduced. ABCL and BSI indicated significant anxiety reductions, whilst PIMRA did not. The ABCL aggression subscale showed CB did not sig. change. PCs reported reduction in frequency and intensity of anxious and CB. **Acceptability:** Practicality and effectiveness were rated lower post-intervention by PCs. Client rated intervention higher post-intervention, but differences were not significant.
McInnis (2016)	Single case-study	Disability psychotherapy	N=1	Age: 28. Mild ID.	Observations (by PCs), projective techniques, questionnaires (self & carer-report)	The Frankish Model (FM) of emotional development (observations); object relations technique (ORT) and house tree person (HTP) – projective techniques; target problem behaviour recording sheet; BSI; Manchester attachment scale (MAST).	**Efficacy:** The FM tool found improvements in wellbeing, development and functioning. Various ORT and HTP changes were reported. Problem behaviour reduced from session 22 (first data collection) and ceased session 88. BSI had minimal change. MAST scores were not reported, therapist stated baseline assessment reflected insecure attachment and post-intervention reflected secure.

Pearson et al. (2019)	Non-randomized control trial	Education	N=25	Aged: 16-22. Mild to moderate ID.	Questionnaire (self-report, via structured interview)	Parent-child questionnaire (created for study, assessing attachment knowledge).	**Efficacy:** Knowledge sig. increased. Gender, age and IQ were not sig. associated with knowledge increase.
Pethica & Bigham (2018)	Single case-study	Video interaction guidance	N=1	Parent. Mild ID.	Questionnaire (self-report), observations (by researchers)	Self-assessment of parenting (using visual scale); observations of sensitive interactions (during recordings); verbal feedback from professionals.	**Efficacy:** Participant reported feeling more confident she was able to be listened to by her children. Sensitive interactions increased. Professionals reported they appeared more confident in parenting interactions. The children were removed from the child protection register towards the end of the intervention.
Sterkenburg et al. (2008a) & Schuengel et al. (2009)	Case-series	Integrative attachment-psychotherapy and behaviour modification (BM)	N=6	Aged: 10-17. Severe ID. Additional needs: blind or VI.	Observations (by PCs and researchers)	Severe challenging behaviour consensus protocol (CEP); challenging behaviour scale for PWID (SGZ); residential observation lists of challenging behaviour (CB); frequency of target behaviour (in therapy videos).	**Efficacy:** CEP scores sig. reduced. SGZ changes were not significant. Frequency of CB reduced (for those with reliable data). Target adaptive behaviour sig. increased for attachment therapist. Reductions in target CB were not sig. different between therapists. Physical

						Physiological arousal indicators.	indicators had mixed results across participants.
Sterkenburg et al. (2008b)	Single case-study	Integrative attachment-psychotherapy and BM	N=1	Age: 17. Severe ID. Additional needs: blind.	Observations (by PCs and researchers)	Residential observation lists (of CB); frequency of target behaviour (during therapy videos); attachment behaviour observations; physiological arousal indicators.	**Efficacy:** CB sig. reduced. BM conducted by the attachment-therapist led to sig. more adaptive target behaviour than the control therapist. Physical indicators had mixed results. Proximity seeking and avoidant attachment behaviours were demonstrated sig. more with the attachment therapist (contact maintenance and resistance were not).

Various interventions and methods were conducted with PWID. All used quantitative data and most used case-study or case-series designs (6/7). Participants varied from 10-years-old to 56-years-old. Four studies included participants with comorbid visual impairment (VI), and one focused on a parent with ID (it was not reported that their children had ID). All seven studies explored efficacy/effectiveness, and one also explored acceptability (see table 1.2 for further detail of efficacy and acceptability findings).

Education. Education interventions aim to increase knowledge of attachment and relationship principals, in hope of subsequently increasing attachment-related behaviours. Only one study (Pearson et al., 2019) used education. Pearson et al. (2019) evaluated an attachment-education DVD intervention for young adults with ID (who were not current or expectant parents), to explore effectiveness in improving attachment knowledge (regarding parent-baby relationships). It found statistically significant increases in knowledge, providing evidence for efficacy.

Quality appraisal. Pearson et al.'s (2019) non-randomised study met 100% quality criteria, providing preliminary high-quality evidence that attachment-education interventions may be efficacious at increasing attachment-knowledge. Use of follow-up evaluation is a strength. Despite promising results, the study does not determine whether increased knowledge would increase attachment-related behaviours. As participants were not parents, conclusions cannot be drawn regarding parent-child relationships. However, the intervention could be a helpful proactive/early intervention for future parents. Further study is needed to confirm findings, particularly with randomised design, using parents who have ID and using behaviour change measures, as well as research exploring acceptability.

Psychotherapy. Three studies (Sterkenburg et al., 2008a; 2008b; McInnis, 2016; Schuengel et al., 2009), using case-study and case-series design evaluated attachment-based psychotherapy adapted for PWID.

Sterkenburg et al.'s (2008a) study (also reported in Schuengel et al. (2009)), and Sterkenburg et al.'s (2008b) evaluated integrative attachment-based behaviour modification (BM) via experimental case-study and case-series. Intervention incorporated attachment-focussed psychotherapy (the therapist built an attachment-relationship with participants through sensitive and positive responses) and BM to reduce distressed behaviour. Both studies found reductions in emotional and behavioural difficulties, suggesting the intervention is efficacious. They both found BM conducted by the attachment-therapist led to significantly more adaptive target behaviour than the control therapist, suggesting attachment-based BM is more advantageous than standard.

McInnis (2016) evaluated 'disability psychotherapy' which used psychodynamic and counselling approaches to promote psychological wellbeing and attachment security (Frankish, 2013). Findings suggested intervention was efficacious as it reduced emotional difficulties and distressed behaviour.

Quality appraisal. Sterkenburg et al. (2008a) and Schuengel et al. (2009) met 80% quality criteria and Sterkenburg et al. (2008b) met 100%. Overall quality was high for the chosen methodology, particularly use of valid and/or reliable measures. However, Sterkenburg et al. (2008a) omitted data regarding CB for 2/6 participants as reports were inconsistent/unreliable, which could have biased results. Sterkenburg et al. (2008b) was strengthened by including an attachment-based observation tool to assess impact on attachment behaviours, although not validated, it had acceptable inter-rater reliability. However, although they stated more attachment-behaviours were demonstrated with the attachment-therapist, as proximity-seeking and avoidant attachment behaviours significantly increased compared to the control therapist, it could be argued these findings are contradictory and suggestive of an insecure attachment relationship.

McInnis' (2016) explorative case-study met 40% quality criteria. Although they adapted measures for the participant's cognitive abilities (i.e. using drawings to illustrate Brief Symptom Inventory [BSI] answers), which is a clinical strength, it may have impacted validity and reliability. Further measurement issues included: no report of projective technique psychometric properties, introducing the behaviour observation sheet in session 22, and the attachment scale being completed retrospectively. These factors, with the limited sample size and lack of statistical analysis, suggest conclusions must be interpreted with caution.

These studies add to the limited attachment psychotherapy literature for PWID. Studies by Sterkenburg et al. (2008a; 2008b) provide preliminary evidence for efficacy of attachment-based BM reducing distressed behaviour. However, they are limited by their case-study and case-series design which lack generalisability and follow-up. McInnis' (2016) evidence, although positive, is limited by poor quality. Further evidence is needed to support efficacy findings, and research which also explores whether participants find the intervention acceptable.

Technology Assisted Therapy for Separation Anxiety (SA). Jonker et al. (2015) and Hoffman et al. (2019) evaluated effectiveness of technology assisted therapy for SA for PWID and visual impairment (VI). They aimed to reduce SA and teach person permanence via a digital application to contact caregivers whilst apart. It involved participants sending pre-set messages about their mood, i.e. "I am sad" and caregivers responding acknowledging this i.e. "you are sad". All exchanged messages were discussed when reunited, based on an attachment-based protocol (Marvin et al., 2002). Both studies included observations, questionnaires and frequency of messages. Results suggest the intervention may be efficacious at reducing anxiety and distressed behaviour. Jonker et al. (2015) also explored acceptability of the intervention by incorporating social validity questionnaires for

participants and caregivers. Acceptability outcomes indicated participants and caregivers were generally positive about the instrument at completion. However, caregivers rated practicality and effectiveness of device lower post-intervention, suggesting it was not as effective or practical as expected. In future research, it would be helpful to explore why that was (i.e. by using open ended questions/interview).

Quality appraisal. Jonker et al. (2015) and Hoffman et al. (2019) both met 60% quality criteria for their case-study and case-series design. The novel approach of using adapted technology is innovative. Both studies used valid and reliable measures, but neither used a SA measure despite this being the intervention focus and suggesting it significantly reduced it (Hoffman et al., 2019) – this is a significant limitation. There are limited outcome measures validated for PWID and authors claimed none existed for SA, however, aims and conclusions should have been adapted accordingly (e.g. stating the intervention aimed to reduce anxiety). Use of both carer and SU reports is a strength, and inclusion of an adapted SU validity scale (using images) is a clinical strength, particularly as it was the only study to explore acceptability for participants with an ID.

Despite appraised strengths, it was not possible to determine risk of non-response bias, as both studies failed to report how much data was imputed. Overall, the studies provide preliminary evidence for the intervention being efficacious, with some evidence regarding acceptability. However, further research is needed, particularly non-randomised and randomised group studies, to address limited generalisability and methodological issues/reporting.

Video-feedback/Interaction Guidance. National Institute for Clinical Excellence (NICE) (2016) recommended video-feedback (or 'video interaction guidance' [VIG]) to improve parent-child attachment. It aims to increase parental sensitivity (recognition and response to child needs) (Ainsworth et al., 1974; Kennedy et al., 2011). Parents/caregivers are

supported to reflect on videos of interactions with their baby/child, and feedback is used to reinforce sensitivity.

Pethica and Bigham's (2018) VIG case-study used observations and self-reported rating of parenting (via a visual scale). The study incorporated adaptations for PWID i.e. providing image scrapbooks from recordings as a visual reminder. Findings suggested video-feedback outcomes were positive, suggesting efficacy.

Quality appraisal. Pethica and Bigham's (2018) case study had several shortcomings (meeting 40% quality criteria): observation inter-rater reliability was not reported, the self-rating tool was not validated, and statistical analysis not explained. However, using informal assessment tools seemed clinically appropriate given participant vulnerability.

The adaptations made for PWID is a clinical strength, as it accounts for individual needs which could improve efficacy. Findings suggest video-feedback may be feasible for parents with ID, when adapted appropriately. However, Pethica and Bigham's (2018) claims video-feedback was efficacious are limited by methodological shortcomings and sample size. Further, high quality, research is needed to evaluate video-feedback for parents with. As well as qualitative studies exploring acceptability.

Caregivers of People with Intellectual Disability

Table 1.3

Extracted Data from Caregiver Studies

Author (year)	Study design	Attachment intervention	Total sample size	Summary of participant traits	Data collection methods	Main outcome measures	Qualitative methods and data	Main findings
Birdsey et al. (2022)	Case-series (mixed methods)	Circle of security (COS)	N=6 (n=4 completed, n=2 dropped out)	Parents of PWID (aged 5-13, mild-moderate ID).	Questionnaire (self-report), session transcripts	Parental stress scale; parental acceptance questionnaire; acceptance and action questionnaire; caregiver helplessness questionnaire.	Thematic analysis of session transcripts	**Efficacy:** Quantitative results were mixed: two parents showed no reliable change; one showed increase in stress, psychological inflexibility and acceptance; and one showed reduction in acceptance and mother-helplessness. **Acceptability:** Qualitative themes included "'*being with' your child*", "*being 'bigger, wiser, stronger, kind*'", "'*the COS: exploration and returning to safe hands*'", "'*shark music*'", "'*rupture and repair*'" and "'*delight in me*'".

Damen at al. (2011) & Schuengel et al. (2012)	Case-series	Video feedback	N=72 (n=51 in Schuengel et al. (2011)	PCs of PWID (study focussed on relationship with 12 SUs, aged 13-54, moderate-severe ID).	Observations (by researchers), questionnaire (self-report)	Quality of interaction observations (codes: frequency of confirmation used by caregivers, responsiveness and affective mutuality); social validity scale (SVS); adult attachment interview (AII).	N/A	**Efficacy:** Confirmation by caregivers and client initiatives responding to by PCs sig. improved, whilst caregiver initiatives responded to by clients did not. Intervention effects were not sig. moderated by caregiver attachment style. **Acceptability:** All completing the SVS indicated intervention was effective, 63% rated effectiveness as intermediate, none reported negative changes and 61% rated the intervention "workable".
Johnson et al. (2017)	Mixed-methods	Education	N=24 (n=6 dropped out due to changing job)	PCs of PWID (study focussed on relationship with 5 SUs, aged 24-52, severe-profound ID).	Observations (by researchers), field notes, interviews (with PCs)	Positive engagement and relationships observation tool (codes: SU engagement, staff contact interaction mode, relationship processes) created for study; field notes.	Social constructivist inductive analysis of interview transcripts and notes	**Efficacy:** Quantitative findings were variable (observations demonstrated strong effects for one SU, minimal for two SUs and none for two SUs). Findings across SUs varied. **Acceptability:** Qualitative themes included: *"sharing the moment", "recognising individuality", "sharing the message", "training" and "obstacles*

								to changing practice". Staff suggested they tried implementing learning but time constraints and capacity were barriers.
Muddle et al. (2021)	Qualitative	COS	N=6	Parents of PWID (aged 4-14, moderate-severe ID).	Interviews and focus groups (of parents)	N/A	Thematic analysis of interview and focus group transcripts	**Acceptability:** Themes included: "*COS concepts are relevant to all children",* "*parenting children with learning difficulties is different*", "*COS can create a focus on my child being different and this can be painful*", "*recommended changes to make COS suitable for parents with learning difficulties*".
Vandesande et al. (2023)	Mixed-methods	Education	N=16	Parents of PWID (aged: <10, severe-profound ID).	Questionnaire (self-report)	Viewing experience questionnaire and knowledge questionnaire (both created for study); perceived maternal parenting self-efficacy scale; daily diaries.	Descriptive illustration of quotes (no formal analysis)	**Efficacy:** No significant changes in self-efficacy or attachment knowledge. **Acceptability:** All parents reported videos were a good intervention medium and they would recommend to peers.

Wingerden et al. (2019)	RCT	Education	N=100 (11 dropped out) (experimental n=53, WLC n=47)	PCs of PWID (adults, mild-moderate ID).	Questionnaire (self-report)	SVS; knowledge questionnaire (created for study); self-efficacy in nurturing role scale; empathy quotient; interpersonal reactivity index.	N/A	**Efficacy:** Knowledge sig. increased. No effects for empathy and self-efficacy. **Acceptability:** Experimental participants reported small but significant reductions in beliefs around intervention effectiveness at changing behaviour and increases in ease of use.

Various interventions were conducted with caregivers. Of the 6 studies, 3 included parents of children with ID (up to 14-years-old) (Muddle et al., 2022; Birdsey et al., 2022; Vandesande et al., 2023) and 3 included PCs (of children and adults) (Johnson et al., 2017; Damen et al., 2011; Wingerden et al., 2019; Schuengel et al., 2012). The studies of Johnson et al (2017) and Damen et al (2011) also included PWID as participants, as their studies observed specific caregiver-receiver relationships. Five caregiver studies explored efficacy/effectiveness and all six explored acceptability (see table 1.3 for further detail of efficacy and acceptability findings).

Education. Three papers evaluated education for caregivers. Wingerden et al. (2019) conducted an RCT. Vandesande et al. (2023) and Johnson et al. (2017) used mixed-methods. Johnson et al.'s (2017) study explored whether a relationship model (Johnson et al., 2012) could be translated into an educational intervention to increase PCs' ability to understand and facilitate relationships for PWID.

Both Wingerden et al. (2019) and Vandesande et al. (2023) collected outcomes regarding knowledge, self-efficacy and acceptability. Vandesande et al. (2023) developed a questionnaire to explore acceptability and adapted the parenting self-efficacy scale (for pre-term infants). Whereas Wingerden et al. (2019) used valid and reliable measures of self-efficacy and empathy. Regarding efficacy, Wingerden et al. (2019) found their phone application significantly increased knowledge, however, there were no effects for empathy and self-efficacy. Regarding acceptability, experimental participants reported small but significant reductions in beliefs around intervention effectiveness and increases in beliefs about ease of use. Vandesande et al.'s (2023) findings also supported acceptability. However, there were no significant changes in self-efficacy or knowledge, suggesting limited efficacy.

Johnson et al. (2017) incorporated observations (of carer interactions with five service users [SUs]), field notes and interviews. Qualitative findings provided insight into

staff perceptions of acceptability regarding the training and its implications, including ways the intervention improved relationship practices with SUs. Staff suggested time and capacity were barriers to implementing learning. Overall findings were variable across SUs. No measure of knowledge was used.

Quality appraisal. Wingerden et al.'s (2019) study met 20% of randomised study quality criteria. Although increases in knowledge were positive, practical conclusions cannot be drawn as no behavioural observations were undertaken. It was not possible to determine several quality criteria, possibly due to reporting limitations rather than methodological (i.e. randomisation was not adequately described and it was not clear if all assessors were blinded to intervention during each data collection stage). Experimental condition data was not complete post-intervention, highlighting imperfect adherence. Reasons for incompletion included “lack of time” (n=5) and “I kept forgetting” (n=12) which has feasibility implications. Strengths included RCT methodology and reporting of participant ethnicity (as many included studies omitted this).

Vandesande et al.'s (2023) study maximum quality criteria was only 20% for a mixed methods study. Qualitative rationale and methods were unclear, interpretations were poorly substantiated by data, and confounding variables not considered. All parents completed the videos, supporting feasibility.

Unlike Vandesande et al. (2023), Johnson et al.'s (2017) mixed-method study met all qualitative quality criteria. However, although they reported using ‘inductive’ analysis, multiple themes were named after elements of the programme, suggesting analysis was not truly data-led. Despite qualitative quality, maximum mixed-method quality criteria was 20%. It was not clear how many invitees responded/declined to take part (or their characteristics) and results did not report reasons for missing data. Regarding measurement, despite good inter-rater reliability for non-occurrences of relationship behaviours, it was poor for

occurrences. Furthermore, staff suggested observations were poorly timed. This suggests the observation tool and timing may have been inappropriate. Although mixed-methods was rationalised and integrated to answer the question, interpretation was not drawn from synthesis. A significant strength of the study is assessing practical impact of learning through observations - the only educational study to do so. However, no knowledge measure was used - meaning inferences could not be made about the relationship between increased knowledge and behaviours.

Overall, findings regarding efficacy and acceptability were varied. Wingerden et al.'s (2019) RCT provided promising evidence for increases in knowledge, despite Vandesande et al.'s (2023) less rigorous study finding otherwise. Johnson et al.'s (2017) findings regarding efficacy were also mixed. All studies could only meet a maximum of 20% quality criteria, due to methodological and/or reporting limitations, meaning findings must be interpreted with caution – despite use of scientifically favoured methods, RCT (particularly) and mixed-methods. Therefore, further high-quality research is required particularly using RCTS and/or practical measures to assess efficacy and acceptability.

The Circle of Security. COS is a parents group aiming to increase secure attachment and sensitivity to their child/children (Mercer, 2015). It uses psychoeducation and therapeutic techniques, including videos and reflection, and also hopes to reduce distressed behaviour and increase parental self-esteem. Evaluations have previously focussed on parents of typically developing children (Muddle et al., 2022), as COS is not ID specific. Muddle et al. (2022) and Birdsey et al. (2022) evaluated COS for parents of children with ID. Muddle et al. (2022) collected qualitative data to explore opinions of parents who had completed COS, whilst Birdsey et al. (2022) conducted a mixed-methods case-study.

Themes found by Muddle et al. (2022) suggested parents thought COS was relevant for all children, but adaptations were needed to consider differing attachment and

communication needs of children with ID. This could help to make COS more acceptable and efficacious as some parents found content upsetting. Adaptation suggestions included: more pre-course information; video clips/images of children with ID, and descriptions of more diverse distressed behaviours. Findings suggest the content of the COS intervention was not acceptable for parents of a child with an ID.

Birdsey et al. (2022) evaluated efficacy by measuring parental stress, psychological flexibility, acceptance, and helplessness. Efficacy results were mixed. They suggested qualitative data offered explanation for mixed quantitative findings. Similar to Muddle et al. (2022), qualitative findings suggested the intervention was not acceptable, as parents thought COS did not capture differing needs of children with ID, compared to typically developing children, and how they may need parenting differently. Additionally, group attrition was high (33%).

Quality appraisal. Muddle et al. (2022) met 100% qualitative quality criteria. Furthermore, data collection was conducted by researchers who had not facilitated the intervention, which may have reduced bias. Birdsey et al. (2022) met 80% of mixed-method quality criteria. Strengths included collection and interpretation of qualitative data, varied valid and reliable questionnaires, clear rationale and integration of mixed-methods (qualitative findings supported quantitative). However, statistical analysis was not explained.

Both studies suggested COS is not currently acceptable for parents of children with ID, as current content does not consider their additional parenting, attachment and communication needs. Qualitative findings have practical implications for improving acceptability and efficacy for the population. Parents of children with ID could help to co-produce and evaluate an adapted COS to make it more appropriate. Evaluation would benefit from addition of observational measures, to assess practical implications. Despite small

sample sizes, both studies provide quality literature, sharing the parent voice, but are also limited by their exploratory nature.

Video-feedback. Damen et al.'s (2011) study (also reported in Schuengel et al. (2012)), used an AB case-series design to assess video-feedback for PCs, to improve quality of interactions with SUs. Regarding efficacy, quality of interactions was assessed using observations, and findings suggested video-feedback led to significant improvements in some aspects. Regarding acceptability, caregivers evaluated perceived intervention effects and ease of use, and were generally positive about the intervention.

Quality appraisal. Damen et al.'s (2011) study met 80% quality criteria for its methodology. A notable strength is the inter-rater reliability of observations was regularly checked for code drift and retraining provided if agreement was below 80%. Furthermore, many PCs partook – suggesting feasibility as a training approach. Quality criteria was not met for low risk of non-response bias as some observation records were incomplete (leading to 11 caregivers being dropped from analysis) and further values were missed to improper completion. Findings suggest video-feedback may be an efficacious and acceptable intervention for PCs. Despite Damen et al.'s (2011) study being of high methodological quality for a case-series, generalisability is limited by small SU sample. Further research is required.

Discussion

This integrative review aimed to synthesise and appraise quality of research evaluating attachment-based interventions for PWID and their caregivers. The review critically appraised 13 studies (15 papers), to explore what types of attachment-based psychological interventions have been implemented for PWID across the lifespan, as well as determine whether they are efficacious and acceptable. Evidence was synthesised based on

participant groups and interventions for each. Findings support literature highlighting a need for effective attachment-based interventions for PWID (Fletcher et al., 2016).

Interventions facilitated directly with PWID included education, psychotherapy, technology assisted therapy and video-feedback/VIG (for parents with ID). Positively preliminary evidence suggests attachment interventions for PWID may be efficacious regarding varied attachment-related outcomes. Further research (including experimental and RCT designs) is needed to strengthen evidence and address limited generalisability of current studies. Qualitative or mixed-method research is needed to clarify if participants with ID find interventions acceptable.

Interventions facilitated directly with caregivers included education, circle of security (COS) and video-feedback. Evidence for efficacy of attachment-based interventions for caregivers of PWID is more mixed than studies with PWID as direct participants. Caregiver education interventions require further study, including clearly reported RCTs to determine efficacy. COS requires adaptation considering parent feedback and further evaluation. Video-feedback requires further high-quality research to support preliminary efficacy and acceptability evidence.

The current findings add to the evidence base reporting effectiveness of attachment-based interventions for people both with and without ID (such as neurotypical individuals and those with Autism, developmental delay or borderline ID) and their caregivers (Kennedy et al., 2011; Yaholkoski et al., 2016; Cicchetti et al., 2006; Van Ijzendoorn et al., 2023; Alexander et al., 2023; Hodes et al., 2017; Hofstra et al., 2023). A number of participants with ID expressed CB and psychological distress, whilst caregivers identified additional challenges in responding to their attachment needs (Birdsey et al., 2022; Muddle et al., 2022; Sterkenburg et al., 2008a; Sterkenburg et al., 2008b; Hoffman et al., 2019; Jonker et al., 2015; McInnis, 2016). This supports literature suggesting PWID experience additional

attachment-related difficulties and reinforces that standard attachment-based interventions and measures require appropriate adaptation and sensitivity for the population (Giltaij et al., 2015; Schuengel and Janssen, 2006; Skelly, 2016; De Schipper and Schuengel, 2010; Walker et al., 2016).

Most of the approaches included within the current studies were reactive interventions (psychotherapy, technology assisted therapy, video-feedback/VIG and COS), used to reduce attachment difficulties, distress and/or distressed behaviour which was already present for the PWID and their caregiving relationships (Birdsey et al., 2021; Damen et al., 2011; Hoffman et al., 2019; Jonker et al., 2015; McInnis, 2016; Muddle et al., 2021; Pethica & Bigham, 2017; Sterenkburg et al., 2008a; 2008b). However, the education interventions were used as a proactive or early intervention strategy, to support PWID and/or their caregivers (i.e. by training professional carers) to increase their knowledge of attachment theory and strategies to help foster secure attachment relationships (Johnson et al., 2017; Pearson et al., 2019; Vandesande et al., 2023; Wingerden et al., 2019). Given the risk of increased distress and attachment difficulties for PWID, the use of proactive or early attachment intervention strategies (such as education) could be an effective way of reducing this risk and preventing such difficulties from developing. Further research is needed to explore the long-term benefits of proactive interventions.

Given PWID often require additional support throughout their lifespan, including from PCs/supported living and residential care (Fletcher et al., 2016), it is promising that interventions took place across the lifespan, within an array of settings and considered different types of attachment-relationships.

Strengths and Limitations of Literature

Researchers and participants undertaking the current studies, have contributed to an important but sparse field, which can be challenging to research (due to sample

heterogeneity, as well as additional vulnerabilities, communication and measurement considerations).

Several included studies had high quality methodology for their type of research as assessed by the MMAT (Pearson et al., 2019; Sterkenburg et al., 2008b; Sterkenburg et al., 2008a; Birdsey et al., 2022; Muddle et al., 2022; Damen et al., 2011; Hong et al., 2018), but were limited by other factors. Although case-studies, case-series, qualitative and non-randomised studies can provide important preliminary evidence regarding intervention efficacy and acceptability, they are not as informative as RCTs which are a gold standard method of research (Hariton and Locascio, 2018). Only one RCT was included in the current study, which was limited by methodological or reporting shortcomings (Wingerden et al., 2019).

Despite case-studies and case-series not lending well to robust and generalisable research, they lend well to clinical work and may reflect the reality of interventions PWID typically receive from services (Pethica and Bigham, 2018; McInnis, 2016). Studies reporting adaptations made to support individual needs of participants provide helpful ideas which could support individualised/person-centred care, based on a person's cognitive abilities, i.e. using visual scales for measures and scrapbooks/take-away material to reinforce learning (Pethica and Bigham, 2018). Only one study in the current review explored intervention acceptability for participants with an ID (Jonker et al., 2015), this is a significant limitation of the current literature and requires further attention to ensure PWID are satisfied and comfortable with the interventions they receive.

As highlighted in previous literature, measurement of interventions was inconsistent (Hamadi and Fletcher, 2021). Although many studies used valid and reliable measures, the use across papers was varied. This is not surprising given the broad scope of attachment-based interventions included within the study, but may in part be due to the lack of validated

attachment measures for PWID (Walker et al., 2016). Measures used to assess interventions included those for distressed behaviour, psychological distress/symptoms, self-efficacy, self-esteem, parental acceptance, QoL, anxiety, observations of interactions, parental stress and knowledge. Although these factors are all relevant to attachment, lack of consistent measurement across studies means it can be difficult to compare and synthesise findings.

Further research evaluating attachment-based interventions using a standardised combination of measures such as questionnaires and practical observations tools (exploring attachment relationships as well as other attachment-relevant behaviours and psychological outcomes), could help to strengthen the field by demonstrating both theoretical and practical implications whilst supporting comparisons across research. Further investigation is needed to develop and validate attachment-related measures for PWID, to encourage consistent and standardised use across research.

Additional Implications

It is evident from the current studies that researchers and clinicians agree attachment theory is particularly important to consider for PWID (BPS, 2017). Further high-quality research, with appropriate sample size, is needed to evaluate efficacy and acceptability of the discussed interventions. Such research will help to inform clinical provision within ID services.

Qualitative findings suggest, clinicians should be sensitive to differing needs of children with ID and their parents, and adapt interventions and/or information accordingly (i.e. including images/videos of PWID in materials/examples) (Birdsey et al., 2022; Muddle et al., 2022). Clinicians providing attachment-based interventions for PWID and caregivers, should robustly evaluate their work and publish findings, to help add to the limited evidence base. This should include reporting qualitative feedback regarding acceptability for PWID.

Strengths and Limitations of the Current Review

A strength of the current integrative synthesis is being the first to evaluate attachment-based interventions for PWID across the lifespan. Although also considered a strength of the current review in its ability to provide a broad overview of the literature, by exploring a broad conceptualisation of attachment-based intervention, as well as quantitative and qualitative methodologies, it was difficult to directly compare and synthesise studies. The MMAT is a useful appraisal tool for mixed study reviews, as it can evaluate studies with different methodologies (Hong et al., 2018). However, it has been suggested MMAT criteria can be more difficult to judge than other appraisal tools as they focus on quality of method not reporting quality (Hong and Pluye, 2019; Hong et al., 2018). The current lead author and independent reviewer met to discuss any tool criteria and guidance which needed further clarity. Furthermore, by nature of the MMAT tool grouping and appraising different methodologies with different criteria, it does not highlight or specify which type of methodologies are of strongest scientific value.

For appraisal items marked "can't tell" the current authors did not contact authors of assessed papers to determine whether criteria were met but not adequately reported. Therefore, quality of such studies may be higher than assessed in the current review.

Conclusion

This systematic integrative review synthesised findings from 13 studies (15 papers) each evaluating an attachment-based intervention for PWID and/or their caregivers. Findings were divided by intervention participants. Attachment-based interventions included education, psychotherapy, technology assisted therapy for SA, video-feedback/VIG, and COS. Overall, evidence regarding efficacy and acceptability of interventions was promising and requires further high-quality research (lending itself to generalisability) to build on preliminary findings.

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Service Improvement Project (SIP)

Exploring the Needs of Children and Young People on the Residential Edge of Care and the Potential Impact of Child Exploitation on Those Needs

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Proposed Journal & Rationale: Child Abuse and Neglect – an international and interdisciplinary journal which publishes reports and research on child welfare, public health and social service systems. It intends to be useful for scholars, policy makers and professional practitioners.

Abstract

Background: Children and young people (CYP) residing in residential homes are vulnerable and may experience difficulties developing trusting relationships with professionals/services, particularly CYP with experience of exploitation. **Setting:** Residential homes for CYP on the 'edge of care' overseen by a local authority in England. **Objective:** To understand experiences of receiving and providing support within such homes. To find out how things could be improved to support all CYP within the current setting, and whether adaptations are needed for those with exploitation experiences. **Participants:** Five CYP (all boys, aged 12-17 years) and seven staff members. **Method:** Participants took part in semi-structured interviews. Transcripts were analysed using thematic analysis. **Results:** Two main themes were identified from CYP: (1) 'the push and pull of relationships' and (2) 'what the CYP value'. Two main themes were identified from staff: (1) 'supporting all CYP open to the residential edge of care service' and (2) 'supporting CYP with experience of exploitation'. **Conclusions:** Recommendations were generated from findings. Conclusions and limitations are discussed.

Keywords: child social care, child exploitation, attachment theory, trauma, residential homes

Introduction

In the UK, over 400,000 (3%) children are in the social care system, with there being 10,818 possible places in residential homes (Office of National Statistics, 2022; 2023). Children's social care services (CSCS) support vulnerable children and young people (CYP), and their families. These services aim to keep CYP safe; ensure the best care is available if they cannot live at home/with family; and create conditions where they can thrive (Department for Education [DfE], 2016). Involvement varies, depending on need. CYP under CSCS commonly experience multiple stressors, particularly those placed into residential care. CSCS are typically involved in supporting CYP identified as experiencing child exploitation (CE), in collaboration with other agencies (Child Safeguarding Practice Review Panel [CSPRP], 2020).

Child Exploitation

CE is when somebody uses a child (under 18 years old) for their own financial gain, sexual gratification, and/or labour (Home Office, 2022). Exploitation can take different forms including sexual, criminal or modern slavery. Bribery, coercion and violence may be involved (Home Office, 2022). Any child or young person (YP) can become a victim, but some 'push factors' increase vulnerability, such as prior neglect, abuse, family conflict and/or insecure accommodation (Local Government Association [LGA], 2021; Scott & Skidmore, 2006). Victims may not recognise exploitation, as they think the acts are consensual or exchanged for something they want/need i.e. affection or money – 'pull factors' (Bristol Safeguarding Children Board, 2015). Others may act in fear (The Children's Society, 2019).

Previously, child sexual exploitation (CSE) victims were considered active/consenting participants by professionals, contributing to protection failings (Oxfordshire Safeguarding Board, 2015). Often exploited CYP are criminalised rather than treated as victims, most commonly those coerced into the drug trade (i.e. 'county lines': drug networks/gangs who coerce them into moving/selling drugs across the UK, via telephone orders) (LGA, 2021; The

Children's Society, 2019). However, attitudes and responses have begun to change. CYP at risk of or experiencing exploitation are extremely vulnerable and risk serious harm (CSPRP, 2020). There are various guidelines recommending how they and their families should be supported (CSPRP, 2020; DfE, 2017; LGA, 2021; *Metropolitan Police Service*, 2021). It is paramount exploited CYP are considered victims (not offenders) and treated as such, even though they may not recognise themselves as victims (*Metropolitan Police Service,* 2021).

A study exploring evidence regarding CSE victims residing in children's homes, found increased awareness and growing but limited research in the area (Britain et al., 2017). The authors suggested robust research and understanding is needed to know which interventions are most effective for CSE disruption and recovery. Findings suggested approaches for CYP with other complex needs are relevant and could be tailored for CSE, rather than a CSE care model being needed (Britain et al., 2017). For child criminal exploitation (CCE) research is particularly limited, and research is needed to evaluate effective interventions (CSPRP, 2020). Caluori et al. (2022) suggested 'exile', where criminally exploited looked-after children are moved away from their local area to break ties with exploiters, are ineffective and fail victims. Strengths-based and relationship driven approaches are considered most effective (CSPRP, 2020; Maxwell et al., 2019). The importance of CYP with CE experience sharing their views, and being involved in shaping policy and research, has been stressed (Britain et al., 2017; CSPRP, 2020). As well as preventative interventions tackling social and economic marginalisation (Olver & Cockbain, 2021; Robinson et al., 2019)

Voices of the Young People and Parents

The limited research exploring exploited CYP experiences is possibly due to high levels of vulnerability and difficulty in researchers gaining access. Lanctôt et al. (2020) found increased post-traumatic stress symptoms in girls living in residential settings with CSE

experience, compared to those without. Emerging research into experiences of parents of exploited CYP, found parents reported feeling isolated, stigmatised, and judged for seeking help rather than supported (Dando, et al., 2022; Maxwell, 2022). Dando et al. (2022) found parents were frustrated by dominant 'vulnerable' narratives suggesting CYP are only vulnerable to exploitation if they experience factors such as parental mental health. They argued this hindered awareness that any child can be a victim, and increased parental blame (Dando et al., 2022). However, parents who volunteered for these studies may not be representative of all parents of exploited children.

Research exploring experiences of CYP in CSCS homes and care leavers highlights the importance of feelings of safety, belonging, continuity, and trusting relationships with professionals/staff (Children's Comissioner, 2019; Rice, Mullineux, & Killick, 2022; Wilson et al., 2020). Wilson et al.'s (2020) systematic review highlighted the importance of emotional safety for CYP experiencing child protection services, suggesting sense of belonging and self-actualisation is as important for wellbeing as food and shelter.

Voices of Frontline Staff

Research regarding staff experiences of working in children's homes, and supporting exploited CYP, also requires further exploration (Britain et al., 2017). Parry et al.'s (2022) study exploring experiences of children's home workers identified themes of staff wellbeing, knowledge, peer-support, self-reflection and professional identity as important for optimising provided care. Home managers supporting CYP with CSE experience highlighted staff must be skilled at building trusting relationships with CYP – facilitated by them being nurturing, caring, honest and resilient, regardless of transgressions (Britain et al., 2017). Olver and Cockbain (2021) interviewed professionals responding to county lines exploitation (of adults and CYP). Participants reported county lines is misunderstood (particularly the relationship between being both a victim and committing offences). They suggested inconsistent

information sharing and resources hinder professional responses, and argued victim vulnerabilities should be addressed to prevent exploitation, as enforcement alone is insufficient (Olver & Cockbain, 2021).

Theoretical Frameworks

Bronfenbrenner's (1992) ecological systems theory (EST) can be applied to understand the impact of a child's social environment on development. EST suggests each person is influenced by a complex ecological system with five sub-systems (Bronfenbrenner, 1992). It has been applied to understand factors contributing to CE (Lopez & Minassians, 2018)

The sub-systems include the:

1. Microsystem: immediate environment (i.e. family, friends, school or professionals)
2. Mesosystem: connections within the microsystem
3. Exosystem: indirect environment and social systems (i.e. extended family, finances, media and government agencies/policies)
4. Macrosystem: social/cultural values
5. Chronosystem: changes over time

CSCS intervene within the mesosystem, and when indicated, become part of the microsystem to ensure safety. A child's experience of caregivers, within their immediate environment, will influence subsequent development. CYP who experience abuse and/or neglect from caregivers typically develop insecure attachment styles as an adaptive response (Ainsworth et al., 1978). Attachment styles influence how CYP develop relationships with new people and can influence engagement with professionals. Those who experience neglect or rejection may develop greater reliance on 'avoidant' attachment strategies characterised by self-reliance, and those with intermittently met needs may develop greater reliance on 'ambivalent' attachment strategies characterised by high emotion and dependency on others (Ainsworth et al., 1978). CYP who experience caregivers as fearful or frightening may

develop more ‘disorganised’ attachment strategies characterised by conflicting fear and longing for closeness (Crittenden & Ainsworth, 1989; Main & Solomon, 1990).

When intervening, CSCS services sit within a YP’s immediate environment and can influence other parts of their life (mesosystem). This provides opportunity for repairing attachment relationships and/or disrupting remaining exploitative relationships. However, it is not clear how CYP experience another ‘power figure’ coming into their microsystem. The power of CSCS is enshrined within the law (*Children Act*, 2004), or is given over by those with parental responsibility often without the CYP’s consent. Consequently, service support and CYP's perception of this can significantly impact their ‘ecological system’, continued development and risk or safeguarding from further harm.

Rationale for the Current Project

Research exploring experiences of CYP receiving CSCS support, particularly those residing in children’s homes and/or with exploitation experience is limited. CYP receiving such support are vulnerable and may experience difficulties developing trusting relationships with professionals/services due to past experiences. Additionally, those with exploitation experiences are likely to still experience push/pull factors towards exploitative relationships (Scott & Skidmore, 2006), which may be a further engagement barrier. Without asking CYP, we cannot understand their experiences, or factors promoting successful engagement/support.

Research exploring experiences of staff in children’s homes is also limited. It is important to understand staff views, as the relationships they provide for CYP are vital for engagement, recovery from harm, emotional regulation and development (Garfat, 2008; Parry et al., 2022).

Service Context

This study took place in homes for CYP on the ‘edge of care’ or in care overseen by a local authority. The homes supported CYP at risk of being brought into care permanently, or

currently in long-term care, for various reasons, some of whom have experienced exploitation. They provided intensive residential support to CYP (aged 12 – 18 years), families and carers, aiming to prevent placement breakdowns. This could include residential stay; assessment; family support; multi-disciplinary liaison and consultation. The homes have capacity for 18 CYP at a time.

Consultation with the service clinical psychologist, revealed that anecdotally it was thought by staff to be harder to support, engage and reduce risks for CYP with exploitation experiences than those without. However, no formal/structured exploration of this had taken place. Therefore, the current study was designed.

The research took place over four-months, commencing February 2023. The aims of the study were to hear from CYP residing in the homes, and staff, to:

1. Gain insight into perceptions of CYP accessing this support, of their needs, current support received, as well as associated facilitators/barriers.
2. Understand staff experiences of supporting CYP (including associated facilitators/barriers).
3. Find out how things could be improved to support CYP and their different needs.
4. Find out whether things needed to be done differently to better support CYP with exploitation experience.

Findings were used to generate service recommendations.

Method

Participants and Recruitment

Eligibility criteria were:

- Group 1 - CYP: currently residing in the homes, aged 12-18 years, able to provide informed consent (or assent, with consent given by legal guardian)

- Group 2 - staff: currently working in the homes

CYP were initially invited to partake via verbal discussions with the researchers and/or staff (before being provided further written information for consideration). An email invitation, with the study information sheet, was sent to all staff. At the time of the research, 12 CYP lived in the homes (10 boys and 2 girls) and 50 staff members worked there (roles included managers/assistant manager roles, senior/advanced practitioners, family support workers and residential children's workers - see appendix G for further details).

A total of N=13 participants took part. Five CYP (n=5) were interviewed – all boys, aged 12-17 years. The majority (n=4) were white British and one had white and black Caribbean heritage. Length of time at the homes varied from four weeks to 17 months. None had experienced exploitation (to the service's knowledge). Although CYP with experiences of exploitation were approached and invited to partake in the research, they declined - see 'limitations' section.

Seven staff (n=7) were interviewed - six females and one male, all white British, aged 27-59 years. Lengths of service ranged 10 months to eight years. Four staff were advanced residential family support workers, one an assistant team manager and two were registered managers.

The service was also asked to provide data on the number of CYP who had come through their service within the past year.

Procedure

Two semi-structured open-ended interview schedules were created, informed by the study aims - one each for CYP and staff. They were created in collaboration with the lead researcher, academic supervisor and service's clinical psychologist. The CYP interview schedule (see appendix H) was reviewed by two CYP, with lived experience of residential care, and refined according to their feedback.

Although questions varied slightly (to be appropriate for each group), both interview schedules covered similar themes (i.e. facilitators/barriers to engagement and developing relationships). The staff interview (see appendix I) also included questions directly asking about supporting exploited CYP. For ethical reasons, CYP were not asked directly about experiences or impact of exploitation (Rothman et al., 2018).

Participants providing informed consent (or assent with parental/guardian consent) to take-part, completed a demographics questionnaire and individual semi-structured interview with the lead researcher, for up to 60 minutes (audio recorded). After completion, participants were debriefed and signposted to support.

Data Analysis. Service data is described using numbers and percentages. Interview audio recordings were transcribed verbatim into written transcripts. Transcripts for the two groups were coded and analysed separately, by the lead researcher, using NVivo software. Transcripts were uploaded to NVivo and different 'nodes'/tabs created (to organise data or ideas) for each analysis stage (for each participant group), and reflexive notes.

Braun and Clarke's (2006; 2021) six-stage process for reflexive thematic analysis (TA) was used:

1) Transcripts were read and reread for familiarisation. Initial familiarisation notes were made.
2) Data was systematically coded by labelling keywords/phrases that appeared interesting or important (using NVivo's 'code' function) – words/phrases could be coded multiple times.
3) Initial themes and subthemes were identified by comparing, grouping and organising codes with similar/related meanings. Tables were also created on Microsoft Word to help organise themes and extracts. A brief description was written for each theme/subtheme.

4) Potential themes were developed and reviewed. A thematic map was created and modified. Coded extracts were reviewed for each theme, their cohesiveness considered, and re-organised as appropriate. Validity of themes was considered regarding the overall dataset and whether they accurately reflected its meaning.
5) Themes were further refined and defined– to ensure they appropriately reflected all data (for that group) and were well represented by extracts (which were organised to support the theme's narrative/meaning). The research supervisors reviewed themes and extracts at this stage.
6) The report was written.

Braun and Clarke's (2021) updated guidance was incorporated to ensure good practice regarding transparency and specific adherence to reflexive TA methodology – in particular, reflexivity and theoretical/epistemological underpinnings were described and considered throughout the analysis and write-up, and the six-stages were followed flexibly with each step re-visited as required.

An inductive approach to analysis was used. A critical realist/contextualist theoretical stance was taken for analysis and interpretation, underpinned by the premise people's experiences are lived realities existing in broader social contexts (Braun & Clarke, 2021; Edwards et al., 2014).

Reflexivity Statement (of Lead Researcher)

My interpretation of the data (including coding and construction of themes) was unavoidably influenced and informed by my prior knowledge about the service, relevant literature (i.e. on care experiences and child exploitation), theoretical underpinnings of the study (EST & attachment theory) and the epistemological stance. Furthermore, it was influenced by the aims of the study which required me to consider possible improvement recommendations for the service, informed by previous literature and guidance.

In addition to this, particularly whilst facilitating interviews with the CYP, the data collection process is likely to have been influenced by my identity and background (as an adult, female, mental health professional with a high level of education), which inherently contrasted to the CYP participants who were all children, males, currently completing secondary school education and under the care of a local authority. These differences may have created a power imbalance between us which influenced their confidence and comfortability in sharing their true responses to the given questions. Furthermore, as I have not experienced receiving nor providing residential care (such as the participants), it is possible I did not truly understand the nuanced meaning of the interview responses and may have misinterpreted some of the data.

Study Approval

Approval for this study was provided by a research panel at the University of Oxford and the local authority where the research took place.

Results

Forty-four CYP had lived in the homes over the past year. Seventeen (39%) had experienced exploitation - four (24%) had experienced CSE (all girls) and 13 (76%) CCE (all boys).

Children and Young People Interviews

Two main themes and eight subthemes were developed from CYP interviews, demonstrated by thematic map in figure 2.1. See appendix J for coverage of themes across data. Themes are described below, with further description and illustrative quotes presented in table 2.1 and 2.2. Quotes chosen to illustrate themes aim to broadly represent the views of all participants (see appendix K for more).

Theme 1: The Push and Pull of Relationship. This theme highlights the complex fluctuating nature of relationships the CYP had with people and systems within their life. Each subtheme

represents a different type of relationship, exploring facilitators and positive aspects (pull) as well as barriers and difficult (push) aspects of these.

Theme 2: What the CYP Value. This theme highlights different aspects of support and everyday life important to the CYP. Each subthemes explores a different element of this.

Figure 2.1
Thematic Map

Table 2.1

CYP Themes and Illustrative Quotes

Theme 1: The push and pull of relationships

Subtheme	Description and quotes
1a) "S*ometimes they care too much":* Relationships with residential staff	The CYP spoke highly of the staff and their relationships. Things which helped to build the relationships included engaging in fun activities together, discussing shared interests and staff being "*themselves*". The CYP expressed knowing that the staff were there for them and that they could rely on them to help with things they needed. CYP also spoke about the more difficult elements of relationships with staff such as conflicts/disagreements, feeling as though they've let the staff down and them "*caring too much*". *"I just guess I'd bond over some of them with what I like. Like not many of them, like anime or anything like that, but some of them have kids closer to my age. So it's easier to get along with them and some of them like stuff exactly like me. So I guess it's just common interest."* - YP 1 *"Yeah, and they don't try to be your parents. It's like. They don't try to step in as a replacement for like my dad. They're just themselves like. You know they care but they won't like… it's just respect innit."* - YP 3 *"When they p*** you off. And then they act like nothing's happened. So sometimes staff can really p*** you off. And then they'll just like forget about it… Which is what I also do with staff, because I also p*** them off."* - YP 3

1b) "*It's not my mum's, so I have mixed feelings":* Relationship to the home	Some CYP expressed having "*mixed feelings*" about being at the home. Two highlighted they would prefer to be at home with their family but they also recognised the positive changes which have happened since being at the home. Three CYP reported to have negative pre-conceptions and worries about the home before they moved there. However, they said it was not like they expected it to be. Positively, all of the CYP said they felt safe at the home. *"When I first came, I'm quite different from when I first was here, so I think I've like changed quite a lot. And even though for me it's not the most ideal situation to be in, I can't deny that it's like, helped me become better and like changed me in some ways."* - YP1 *"I don't really think there is anything bad about being here. Obviously, it's not like the perfect situation, 'cause everyone could be at home with their family. But, considering that we're not with them, to be honest it's better than you thought it'd be."* - YP5 *"Yeah, it's good staying here. I thought it was gonna be worse when I first came. Yeah, it is actually a lot better."* – YP4

1c) "Y*ou know what they've gone through, so you kinda know how they feel":* Peer relationships	Friendships with other CYP within the home were seen as important and as having a big impact on the experience of being there (both helpful and unhelpful). Two CYP also reported worrying about what the other CYP would be like before they moved in. *"I think it's just, it's a bit different obviously from an actual house, but, in the aspect where you live with kids that've gone through similar stuff. Or like the same things you have. It's just a bit, I don't know, it's just nice. [….] It's just like, you know what they've gone through, so you kinda know how they feel."* – YP 5 *"Sometimes it can be very annoying. Like the past week we had a new kid move in. That didn't go very well for me. Sometimes it's like one of the best feelings in the world. Some of the times, it's like you feel great, like, when, you get along with everyone and like one small argument can change that for like months. And it's like, wow, great…"* – YP 3
1d) "Y*ou've got to understand like, although you don't live with your parents, they're still your parents":* Birth family relationships	The young people's loyalty to their birth family was highlighted, although they recognised some of the difficulties within these relationships. *"I'm more calm and reserved than I used to be […] 'Cause I guess the fact that the stress of not having like brothers running around every five minutes and annoying me sometimes. Maybe that was it. But although they annoy me, I do still love them."* – YP1
1e) "M*e and my social worker don't get along":* Relationship to social worker	Two of the YP highlighted having a difficult relationship with their Social Worker. *"Me and my social worker don't get along. She gets blocked too many times. I just don't like her […] I just block her number. I've had enough. She does my head in, keeps ringing me."* – YP4
Theme 2: What the CYP people value	

Subtheme	Description and quotes
2a) *"It's good because you always know they're gonna help ya":* Being taken care of (physical and emotional needs)	The CYP spoke about feeling well supported by staff, for both their practical and emotional needs. *"After a while and when I knew that I was properly staying here. And like there was no waking up, this is real. I ended up crying. I went to for a walk with him* [staff member]. *And he helped me and said like don't worry, like you'll be able to come back home soon. So yeah. Although I was sad. He helped me like with it."* - YP1 *"They take care of me […] You know how you treat a child? That's how."* – YP2
2b) "*Things are always miscommunicated, everything in this household is":* Communication and consistency	The CYP spoke about communication and consistency as being important, and the lack of them as being difficult. *"When they actually listen to you. And say they are gonna do something and actually do it. Because, yeah. That's one thing about living in a care home. Staff might say they're gonna do something, but that doesn't always mean they will."* – YP3
2c) *"Internet for everything":* Material requests	The CYP were predominantly happy with the care and support they received at the home. They highlighted material things they would like to change, such as increasing pocket money, improving the Wi-Fi connection and increasing the length of time the Wi-Fi is on. *"I'd keep the Wi-Fi on all night. I would. That Wi-Fi, I hate it going off at 10:00 O'clock."* – YP4

Staff Interviews

Two main staff themes and eleven subthemes were developed. The themes and subthemes are demonstrated by thematic map in figure 2.1. Themes are described below.

Theme 1: Supporting All CYP Open to the Residential Edge of Care Service. This theme demonstrates important considerations when supporting all CYP at the homes. It was

suggested all CYP at the homes, whether they have experienced exploitation or not, have similar needs due to histories of relational difficulties and trauma. Each subthemes considers a different aspect of this.

Theme 2: Supporting CYP with Experience of Exploitation. This theme considers experiences and needs of CYP who have been exposed to exploitation. Each subtheme considers different aspects of CE and foundations of intervening.

Table 2.2

Staff Themes and Illustrative Quotes

Theme 1: Supporting all CYP open to the residential edge of care service	
Subtheme	Description and quotes
1a) *"Every child's journey is different":* The importance of understanding the YP's experience and getting to know them	Getting to know each YP and understanding their lived experience was highlighted as vital, particularly as each YP requires individualised support. Staff shared that although reading prior background information was helpful and informed their initial interactions with each YP, the most important thing is spending time and getting to know them themselves, as background information does not always match up to the YP in front of them. *"I try to meet them as the young person that walks up to the door and then I build a relationship with them, alongside starting to get an understanding of their journey and where they've come from."* – S2 One staff member suggested the value in staff receiving training by people with lived experience of exploitation or being in care: *"I think, probably training from people who've experienced first-hand exploitation and hearing kind of from young people or care leavers, people who've kind of been through it and come out the other side. I think their insight would be really helpful. You know, I've done the training with the youth justice and exploitation service and that was very informative. I learned loads of things, but yeah, I think if you could hear it directly from the young people what worked for them, that would be useful."* – S5

1b) "*The best thing we can do for our young people is offer safety, nurturing and understanding":* Building trusting relationships	Staff highlighted the importance of building trusting relationships with CYP, via spending quality time, as well as traits which staff need to effectively facilitate this. These included being authentic, consistent, fair, funny, nurturing, and self-aware. *"Empathy, humour, honesty, integrity and a little bit of crazy."* – S2 *"They need to be fun. They need lots of nurture, lots of love and empathy. Lots of energy. Happy to try out things like even if they might be a bit nervous. Like, you know, we've had staff that don't like ice skating or we've had a child that's been nervous about ice skating. But I think actually for them to do that together. It's OK for a member of staff to say "I'm a bit nervous about this, I haven't done it before" and kind of you can learn with the child to and take that risk together."* – S6

1c) "*They don't trust anyone*": Barriers to engagement and relationships	A number of barriers to CYP building positive relationships and engaging with staff were highlighted. These included past birth family experiences, relational trauma, previous social care experiences, mistrust, pre-conceptions about care homes and not wanting to be in the home. This theme also reinforces the need for staff to develop trusting relationships with CYP. *"Well, they don't trust anyone. That's the biggest barrier you've got. They don't trust anyone. In their world everyone's gonna leave them. So why, why should they then put any effort into a relationship when they already come into our home and they already know that they're leaving."* – S3 *"I think the biggest barrier we come across is poor experience of social care before."* – S2 Two staff suggested CYP who have experienced exploitation may find it more difficult to engage and create positive relationships with staff as they are more mistrustful than those who have not. *"I think they're much more mistrustful of you, and probably because we're much more mistrustful of them. I think you're second guessing what they're doing, they're second guessing what you're doing and it's kind of a vicious cycle. I guess probably on both sides that "oh, I don't want to connect because this is going on and it's likely they're not going to be able to stay here because it's not safe for them".* – S5

1d) "*They are young people who have been through significant trauma each and everyone of them":* Trauma and attachment informed care	By nature, all CYP coming into the homes will have experienced some sort of trauma – whether physical, emotional or relational. Staff highlighted the importance of understanding this. Principals which foster a greater security in attachment relationships were deemed to underpin the care provided by staff, including unconditional care and nurture. However, it was suggested that some CYP find this difficult to accept because of their past experiences and relational trauma. *"A lot of them are more scared of a soft approach and nurturing and a show of affection and love, than they are of being in that really abusive heightened situation because they genuinely just don't know what to do with it."* – S3 *"I think you need compassion and empathy. Understand that these are young people who have been through significant trauma each and every one of them. So they are gonna need more than 'good enough parenting'. They're gonna need somebody that takes the time to understand them, that doesn't judge, that can feel frustrated when they don't go into school, but also can take the time to see why that's not happening."* - S5

Theme 2: Supporting CYP with experience of exploitation	
Subtheme	Description and quotes
2a) "*It's all around identity and feeling accepted":* The push and pull of exploitation	A number of factors which 'push' and 'pull' CYP towards exploitation were discussed. Pull factors included the "buzz" or excitement, fear, sense of community/belonging and sense of identity. Push factors included rejection by birth families, short-term placements and the vulnerability of being in care. *"It's all around identity and feeling accepted and that's why they end up in kind of the gangs and things, isn't it? Because they just don't feel, generally the children we've spoken to, they haven't found a place within their family. They don't feel accepted, they don't feel heard. They don't know where they fit. Whereas within the gang or the people have been exploited by, they feel like they fit and have been accepted."* – S6 It was suggested by two staff that other CYP within the homes can become vulnerable to exploitation when there is a YP in the house who is being exploited. *"Because we have a duty to protect the other young people in the home and I think that's what makes it really difficult. You're trying to balance kind of that one young person who might be being exploited with the needs of five other children who you know can't be exposed to that world."* – S5

2b) "We're behind the curve": Prevention, early identification and early intervention	Prevention, early identification and early intervention were identified as important by all staff. This included additional support for parents. Difficulties in communication amongst staff teams as well as the police having high thresholds and requiring concrete evidence for getting involved were highlighted as barriers to this. *"I mean it's early intervention work, isn't it? That's where you need to go back to. Umm, I mean you need that of all children, but particularly with exploitation."* – S6 *"If there was any way that we could have ways of identifying it and working with parents and even... You know, this is where a lot of professionals need to stop bringing their own opinions on parents because the parents that tend to shout the loudest tend to be those that are affluent and, you know, come from good backgrounds, good upbringings. But most of the children that are actually at the highest risk are those from the families that are probably already on the radar but deemed to just be a troubled family anyway. So it's just 'another thing'. And I think we need to be very careful that, you know, these young people are being exploited by adults, by criminals, and if the parents are asking for help we need to be going in and trying to unpick it with a child, way before they're then being brought into care and being sent out of county because they're at harm."* -S3 *"Umm, I'd like to see the exploitation screening tools used as much to rule the issues out, as to rule them in."* – S6

2c) "*There should be much more definition and understanding*": What is exploitation and how do we evidence it?	Staff spoke about there needing to be more definition around what exploitation is and how it presents. They also highlighted the difficulty in evidencing exploitation and the need for tools which help to do so. *"What is exploitation as a baseline? How far up the ladders within this exploitation are people? Are they kind of on the peripherals and they're starting to deal a bit of weed and there might have been a knife involved or actually these people are running quite large amounts of drugs around the country? Everyone will go "ooh it's county lines" but where does it sit on spectrums of these?"* – S2
2d) "I always observe and take from other people": Staff learning from each other and experience	All staff suggested their confidence and skills in supporting exploited CYP, and talking about it with them, has developed over time through experience and learning from colleagues. "*I always observe and take from other people and see how they're doing things.*" – S3 *"I think that more shared experience training would be really useful for everybody. People who have done it quite a lot and people who haven't done it at all. You can always learn something new off of somebody who's thought it about outside the box and you say "I like that I'm having that one"."* – S2

2e) “Once you know, it’s too late”: Staff hopelessness and anxiety	Staff expressed hopelessness and anxiety around the prospect of successfully disrupting exploitation. Most were uncertain about what interventions are effective and what else could be done to support CYP who are being exploited and break those ties. *“We are quite powerless outside of these walls and once they go out in the into the community, we don't really have much erm, I guess knowledge of what they're up to, where they are. […] Once you're at the point where you know a child is being exploited, it feels almost as if it's the kind of lost battle that, that moment you become aware it's too late. You needed to support them earlier, like they’re kind of in too deep now.”* – S5

2f) "*There's no narrative around some of the information that's provided*": Information sharing and multi-agency working	Staff spoke about the challenges of communication within a big staff team and house structure. They suggested this can impede on coherently picking up on early signs of exploitation. *"Now, if you're not picking up on those small things, your story and your narrative is fragmented. You kind of, it's writing on a piece of paper and passing it to the next that adds to the next line to that story that adds the next line to that story, or recognizes that that makes sense."* – S1 Multi-agency working was valued by the majority of staff, however, many of them said this needed to improve amongst the relevant services (social care and the police) to effectively recognise and intervene within exploitation. Staff identified wanting particular information from the police or social care, regarding local intelligence and exploitation mapping. They suggested such information could help them to identify and intervene with possible exploitation earlier. Staff also identified limitations within social care, particularly around social worker resources, training and capacity. *"I think perhaps for those that have experienced exploitation, kind of better planning with the police before their admission would be helpful. You know, having from the police or youth justice [service], names that we should be aware of, that we should be looking out for and kind of be concerned if we hear them straight away."* – S5 *"No, just that if there was an outcome, you know that, resources really. Allowing social workers to have the skill set before they start getting involved with some of our children. […] But it always comes down to the same things, doesn't it time and resources."* – S7

2g) "*They need to be part of the plan*": Intervention, breaking the cycle	Staff spoke about the interventions used to try and disrupt exploitation. There were differing views about moving CYP away, to break ties with exploiters. Although generally it was thought to be ineffective or only a short-term solution. Some staff highlighted the potential for intensive community interventions. It was suggested that CYP experiencing or who have experienced exploitation should be placed in longer-term placements, rather than short-term. As well as smaller homes for placements, with less children in them. *"There are extreme incidences where a disruption is really important. However, some of the best stuff is done within the community and with the right people."* – S1 *"It's always about just letting them know there are other options and working with them over that long term period. But I think for young people who are exploited, I think they definitely need to be in a long-term placement. I think putting them in short-term placements will only ever push them back into that life because there's no security for them for four to six or eight weeks."* – S3

Discussion

This project explored views of CYP residing in children's homes for those on the 'edge of care', as well as staff working there. It aimed to understand facilitators and barriers for all CYP receiving such support, and whether this needed improving generally and/or adapting for CYP with exploitation experiences. CYP were predominantly positive about the care received and their relationships with staff. Relationships with peers, birth families and social workers were also highlighted as important. They valued the support they received, as well as communication and consistency. Staff suggested all CYP require individualised support with a focus on building trusting relationships, due to past trauma and relational experiences which can be a barrier to engagement. However, specific considerations

regarding CE were identified, including the need for prevention, early identification, effective interventions and improved communication. Staff expressed hopelessness in being able to effectively disrupt exploitation once started, but shared their confidence and knowledge around supporting exploited CYP increased via experience and learning from others. Findings support previous literature (Britain et al., 2017; CSPRP, 2020; Children's Comissioner, 2019; Garfat, 2008; Olver & Cockbain, 2021; Parry et al., 2022; Rice et al., 2022; Wilson et al., 2020).

All themes from CYP interviews are related to their microsystem (immediate environment) (Bronfenbrenner, 1992). This suggests CYP consider their immediate environment to be most influential upon their life or may be unaware of the impact of other parts of their ecological system. The themes from staff interviews, considered the CYP's microsystem, mesosystem, exosystem, macrosystem and chronosystem (Bronfenbrenner, 1992). This suggests staff have awareness of the influences and interactions within a YP's whole ecological system, which can impact their experiences, needs and risk or protection from exploitation - highlighting the need for services to consider all sub-systems.

The theme of 'the push and pull of relationships' highlights the significant influence of different relationships within the YP's immediate environment. Although CYP were not asked explicitly about birth family or peer relationships, most of them spoke about them, highlighting their importance and impact on experiences within the home. The CYP findings were consistent with previous literature highlighting the importance of positive staff relationships, as well as safety, trust, consistency, fun and quality time with staff (Children's Comissioner, 2019; Garfat, 2008; Rice et al., 2022; Wilson et al., 2020). This aligns with attachment theory and principals of fostering secure attachment relationships (Ainsworth et al., 1978). The most common suggestion was for the internet connection to be improved/increased, suggesting CYP's emotional and physical needs were well met by staff.

The staff themes support Britain et al.'s (2017) suggestions that care approaches for CYP with other complex needs are appropriate for those with exploitation experiences, and could be tailored individualistically. The theme ‘supporting all CYP open to the residential edge of care service’ illustrates the importance of individualised care which considers impact of past trauma and attachment needs (Ainsworth et al., 1978; Perry, 2014), suggesting attachment and trauma-informed principals were well embedded amongst staff. It highlights the importance of staff building trusting relationships through getting to know CYP, spending quality time, creating safety, nurture, authenticity and consistency – in line with previous literature and attachment theory (Britain et al., 2017; Children’s Comissioner, 2019; Rice et al., 2022). Reported barriers to CYP building positive relationships and engaging with staff aligns with past relational trauma and attachment literature (Golding, 2010). This theme predominantly considers the influence of CYP’s microsystem and mesosystem (Bronfenbrenner, 1992).

The theme ‘supporting CYP with experience of exploitation’ supports previous literature and guidance (Caluori et al., 2022; CSPRP, 2020; Robinson et al., 2019). It demonstrates the need for approaches to CE considering CYP’s whole ecological system (Bronfenbrenner, 1992). Staff highlighted that CYP within care homes are particularly vulnerable to exploitation ‘push and pull’ factors – given their current circumstances and experiences (LGA, 2021; Scott & Skidmore, 2006). The suggestion more definition and understanding is needed, as well as means to evidence early exploitation stages, supports research suggesting there is misunderstanding around CCE (Olver & Cockbain, 2021).

The sub-theme ‘“we’re behind the curve”: prevention, early identification and early intervention’ echoes literature stressing the need for such measures, rather than reactive interventions (Olver & Cockbain, 2021). This, along with expressions of staff hopelessness, illustrates the current lack of and need for effective interventions to disrupt exploitation once

begun (CSPRP, 2020). The current homes tend to see exploited CYP once exploitation is already embedded and are used to try and break the cycle, rather than for prevention. It is unclear how such hopelessness may impact interactions and support provided for exploited CYP. The most commonly referenced intervention was CYP being sent away for their safety. However, this is thought to have limited impact long-term, particularly as it removes CYP from their current support networks and positive community links (Caluori et al., 2022; CSPRP, 2020; Olver & Cockbain, 2021). Short-term placements, typically provided by the current homes, were thought to push CYP further towards exploitation as they lack long-term stability (CSPRP, 2020). Transient placements likely make it difficult for CYP to build trust and secure attachment strategies. Current findings suggest research is needed into effective interventions for disrupting exploitation (CSPRP, 2020).

Despite uncertainty around how to disrupt exploitation, staff expressed confidence in generally supporting CYP with exploitation experiences within the home and talking to them about their experiences. They shared this confidence came from experience overtime, learning from peers and self-reflection, supporting previous research (Parry et al., 2022). Furthermore, the current study echoed suggestions that improved communication within and between services is needed (CSPRP, 2020; Olver & Cockbain, 2021). The significant number of CYP being supported by the current service over the past year with exploitation experiences, demonstrates the importance of the current study and need for further understanding.

Limitations and Additional Considerations

It is a significant shortcoming that this project did not recruit any CYP with exploitation experience, despite efforts (i.e. regular home visits, rapport building, and working with staff). Therefore, their voices are not heard within the findings. Although one YP with exploitation experience spoke to the researcher informally, they did not want to be

voice recorded and were uncomfortable with the formal research process. It is possible formalised processes may deter exploited CYP from participating in research, given the potential for increased mistrust/fear (CSPRP, 2020). There were other CYP in the home at the time of the research, with exploitation experiences, who may not have been approached by researchers or staff to partake given their current engagement and circumstances. Staff may have been protective of these CYP being involved due to risk. This highlights additional barriers to including exploited CYP within research. Future research, which overcomes potential barriers is needed – including using alternative research methods such as annonymous online surveys, which could also help increase sample size.

The researcher/interviewer tried building rapport with CYP, by regularly visiting the homes to become familiar to the CYP, discussing their interests, as well as engaging in games prior to interviews. This was necessary to build trust and create comfortability with the researcher, whilst also being transparent about their remit and role (i.e. how often/long they would be present at the homes, the possible outcomes of the research, how findings would be shared). However, building prior rapport could have led to response bias. Furthermore, the CYP likely experienced significant power imbalances with professionals given their vulnerabilities, including the current researcher/interviewer (see 'reflexive statement' above), which may have influenced their engagement and deterred them from sharing critical views about the homes.

It is likely CYP who participated were engaged and trusting of the home/staff, and therefore their views may not mirror those with a less positive experience. Furthermore, only five CYP took part, all of whom boys and mostly white British. Although this was mostly representative of the current population of CYP at the homes, it means findings may not reflect views of CYP with other characteristics who may have a different experience in the service (i.e. girls, or of a different ethnicity). This is particularly important given service data

highlighted possible gender differences in exploitation experience of CYP at the homes (i.e. girls more likely to experience CSE and boys CCE). Voluntary staff recruitment may have led to bias sampling of staff particularly interested in exploitation. The staff participants had all worked in the service for a significant length of time and were all in senior roles (i.e. advanced family support workers or managers), meaning their responses were based on considerable experience and expertise. This means possible learning needs of less experienced staff may not be captured by the results. Furthermore, findings may not be generalisable to wider services, given the specific service context/locality the project was undertaken.

The current researchers attempted to conduct and model ethical research processes (for future researchers), by prioritising the emotional safety/needs of the participants and holding this in mind throughout the research process (i.e. when design the interview schedule, reviewing it with EBEs, building rapport with CYP prior to interviews, being transparent about the research processes, facilitating the interviews and sharing the results/recommendations). This included ensuring the results of the study (including individual quotes, themes and recommendations) were presented to the service managers (to be actioned), as well as available to participants if desired and published in a peer-reviewed journal.

Service Recommendations

Based on findings and consultation with the service clinical psychologist, service improvement recommendations were made – some relevant for wider services. Findings and recommendations were presented to the manager and consultant clinical psychologist for the homes, see appendix L for response. Given the CYP were predominantly happy with the support received at the homes (recommending mostly material changes), most improvement recommendations are informed by staff. Furthermore, recommendations related to

exploitation are considered relevant for all CYP accessing the homes, including those without current exploitation experience, given their increased vulnerability. The recommendations are relevant to CYP's microsystem, mesosystem and exosystem (Bronfenbrenner, 1992):

- For staff to be aware of the possible "push and pull" influence of all relationships in the CYP's lives (recommendation informed by CYP theme 1).
- For staff training on CE to include and/or be co-produced by people with lived experience of care homes and exploitation (informed by staff theme 1a). To provide opportunity for staff to hear the lived reality of this experience and gain understanding of what is helpful/unhelpful when supporting CYP. This could also increase staff hopefulness around CE recovery and opportunities for growth beyond these experiences. Co-production has benefits for both people with lived experience and professionals (Wood et al., 2022).
- For CYP with exploitation experience to be involved in future research and service development (informed by staff theme 1a and limitations of the current study) (Happell et al., 2018; Olver & Cockbain, 2021).
- To facilitate staff reflective practice sessions focussing on their work with exploitation (informed by staff themes 2d and 2e). For staff to share work/interactions that have gone well; less well; how they had difficult conversations and what they may do differently next time. This could develop self-reflection, skills and confidence in this area, providing opportunities to learn from and model peers. Sharing successful examples could also help to reduce staff hopelessness (Aurora et al., 2023).
- To review the service exploitation screening-tool and its use, and ensure it adequately captures all CE (informed by staff themes 2b and 2c). The tool should be used with all CYP (and updated as required), not just those with suspected exploitation, to support early identification.

- Where possible, for CYP with exploitation experience to be offered longer-term placements (informed by staff themes 1c, 2b and 2g) – to provide increased opportunities for building trust and effective intervention (CSPRP, 2020).
- For parents/carers to be provided CE information, how to recognise the signs and respond (informed by staff theme 2b) – to support early identification and intervention (Dando et al., 2022).
- If inconsistencies in practice and communication are reported (within and/or between services), to use current systems to review and ensure this is improved (informed by CYP theme 2b and staff theme 2f). Furthermore, it may be helpful to review current information sharing related to exploitation risk, to support identification of potential inconsistencies.

Conclusion

The current study adds to the limited research exploring the experiences, and sharing the voice, of CYP residing in children's homes. It provides further insight into the importance and impact of different relationships within their lives, as well as what such CYP value. It enhances previous research sharing the voice of staff working within children's homes, as well as the limited CE literature base. Findings from staff suggest all CYP in such homes require individualised, trauma and attachment-informed care. However, additional considerations are needed for CYP with exploitation risks. Improved prevention, identification and intervention strategies are required – as well as research evaluating their impact. Additionally, research and policy informed by the voices of those with CE experience is needed.

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Theory Driven Research Project (TDRP)

A Comparison of Attachment Styles in People with Comorbid Substance Misuse and Depression, Depression Alone and a Control Group

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Abstract

People with both substance use difficulties (SUDs) and depression (known as dual diagnosis [DD]) have worse treatment outcomes and higher relapse rates compared to those with depression or SUDs alone. One possible explanation for this is a difference in attachment styles amongst the populations. This study compared attachment styles of people with DD (n=36), depression only (n=36) and a control group (n=39). Secondary analyses compared prevalence of anxious and avoidant attachment in the DD group and the association between attachment style and both current substance use, and depression severity (N=183). No significant differences in attachment styles were found between people with DD and depression only, although both groups had higher levels of insecure attachment than the control group. People with DD had higher levels of anxious than avoidant attachment. Additionally, anxious attachment was found to be associated with current depression severity but not substance use (across all participants).

Keywords: dual diagnosis, substance use disorder, depression, attachment

Introduction

People with concurrent substance use difficulties and depression (known as a dual diagnosis [DD]) have higher incidence of other psychological and social challenges than those with either problem alone or the general population (Crawford & Crome, 2001; Crome, et al., 2009; Department of Health [DOH], 2009; Hayes et al., 2011; Tucci et al., 2010). A substance use disorder, sometimes referred to as substance use difficulties (SUDs), is the recurrent use of alcohol and/or drugs causing significant clinical and functional impairment (American Psychiatric Association, 2013). Men have higher prevalence of SUDs and are more likely to access SUD treatment than women, however, there is limited data available regarding gender and prevalence of DD (Torrens-Melich et al., 2021; United Nations Office on Drugs and Crime, 2024). Research suggests 70%-86% of people seeking professional support for drug or alcohol use experience additional mental health (MH) needs (Weaver et al., 2003).

Depression is arguably the most common comorbid MH condition with SUDs (Lai et al., 2015). There is debate regarding overlaps and differences between depression and SUDs, and whether they are independent or conditions with similar aetiologies (Davis et al., 2008). The self-medication hypothesis suggests some people use substances to self-medicate symptoms of psychiatric disorders such as depression (Khantzian, 1997; Turner et al., 2018). Alternatively, it is suggested depression symptoms develop as a consequence of SUDs (Agosti & Levin, 2006; Davis et al., 2008). Recovery from depression and/or SUDs is complicated by the presence of the other condition (Agosti & Levin, 2006). People with comorbid SUDs and depression have poorer treatment outcomes and more relapses than those with SUDs or depression alone (Buckman et al., 2018; Cridland et al., 2012). Their poorer outcomes may be influenced by multiple factors, including the complexity of comorbidity, societal inequalities, stigma, receiving poorer care, limited treatment access, low treatment engagement and attachment styles (Buckman et al., 2018; Lappan et al., 2020; Livingston &

Boyd, 2010; Public Health England [PHE], 2017; Schindler & Sack, 2015; Williams et al., 2021). Given the high rates of childhood trauma and social difficulties experienced by people with DD, attachment theory is likely to explain some of these difficulties (DOH, 2009; Tucci et al., 2010).

Brief Overview of Attachment Theory

Insecure attachment styles are associated with MH difficulties, although do not necessarily imply pathology (Adams et al., 2018). A person's attachment style, developed during infancy, is thought to influence how they regulate emotions as well as develop, maintain and experience close relationships (Ainsworth et al., 1978; Bowlby, 1977; Shaver & Mikulincer, 2002). See Cassidy (2016) for an overview of the development of attachment theory. Early attachment literature claimed four distinct attachment styles a child could develop. Infants with 'secure' attachment styles (developed through receiving consistent, responsive care from caregivers) are said to seek support from others and self-regulate emotions effectively, those with 'avoidant' attachment styles (developed through neglect or rejection) rely on themselves to regulate emotions, those with 'anxious/ambivalent' attachment styles (developed through intermittently met needs) depend highly on others for emotional needs, whilst those with 'fearful/disorganised' attachment styles (developed through fearful/frightening care) express opposing fear and desire for closeness (Ainsworth et al., 1978; Crittenden & Ainsworth, 1989; Main & Solomon, 1990).

Influenced by early attachment literature, and difficulties measuring childhood attachment retrospectively, adult attachment models have been developed (see Curran and Mehdikhani (2017) for further detail). Adult attachment styles are thought to be best captured by two dimensions (anxiety and avoidance), rather than distinct categories, as people can demonstrate a range of attachment strategies and relationships (Bartholomew & Horowitz, 1991; Brennan et a., 1998; Gillath et al., 2016). Similarly to early literature, adult attachment

anxiety is associated with reliance on others for emotional needs and rejection worries, whilst avoidance is associated with self-reliance and regulatory attachment behaviours (Bartholomew & Horowitz, 1991; Fraley & Shaver, 2000; Mikulincer et al., 2013). Attachment security is represented by low anxiety and avoidance (Fraley & Shaver, 2000). Pollard et al. (2020) argued models of attachment based on anxiety and avoidance, fail to capture disorganised/fearful attachments, which are particularly important for MH difficulties associated with high levels of childhood trauma, i.e. DD.

Attachment in SUDs, Depression and DD

Relational difficulties associated with insecure attachment can impact development of therapetuic relationships with professionals, which is an important factor for MH treatment engagement and outcomes (Arnow et al., 2013; Mikulincer et al., 2013). Adams et al. (2018) found differential MH treatment engagement, with securely attached people most likley to engage and initiate service contact, followed by anxiously attached and avoidantly attached in ascending order. Given these findings, attachment styles may partially account for low rates of treatment initiation and incompletion for people with DD, and subsequent poor outcomes (Buckman et al., 2018; Tsuang et al., 2003).

Schindler's (2019) review found a relationship between SUDs and insecure attachment. They suggested those with DD and insecure attachment likely use substances to cope with emotion regulation and relational difficulties (Schindler, 2019). Curran and Mehdikhani (2017) argue substances differ in physiological and psychological effects but all can up or down-regulate affect. Although literature is inconsistent regarding the most prevelant insecure attachment style or strategies within SUD populations, avoidance is most consistently reported and has strongest empirical link (Curran & Mehdikhani, 2017; Finzi-Dottan et al., 2003). The numbing effects of substances are considered an avoidant coping strategy (Schindler, 2019), and could partially explain difficulties with service engagement.

Insecure attachment in childhood is a risk factor for later SUDs (Schindler, 2019; Zhai et al., 2014). Although inconsistent, some literature suggests attachment insecurity may be predictive of SUD severity and duration (Schindler, 2019; Schindler et al., 2005; Thorberg et al., 2011).

Research suggests a further complex relationship between attachment, SUDs and comorbid MH needs (Schindler, 2019). Schindler et al. (2005) found fearful attachments associated with comorbid SUDs and MH in adolescents. However, research in this area is limited. None of the studies in Schindler's (2019) review specifically considered comorbid SUDs and depression. Development and severity of depression has also been associated with insecure attachment (Bifulco et al., 2006; Conradi & de Jonge, 2009). Conradi and de Jonge (2009) found people with insecure attachment to have increased likelihood of depression compared to those with secure.

There is currently no research comparing attachment styles of people with comorbid SUDs and depression to people with depression alone. Understanding the relationships between attachment, depression and comorbid substance use is important for understanding how to maximise treatment engagement, retention and outcomes for people with both conditions.

The current research primarily aimed to explore whether attachment styles differ in people with comorbid SUDs and depression compared to people with depression alone and controls. It also aimed to find out which insecure attachment style is most prevalent in DD, and whether attachment style is associated with current substance use or depression severity. It was hypothesised:

1. People with comorbid SUDs and depression will exhibit higher levels of insecure attachment styles (avoidant, anxious and disorganised/fearful) compared to those with

depression alone and controls, and individuals with depression alone will exhibit higher levels compared to the controls.

2. People with DD will have higher levels of avoidant attachment than anxious attachment.
3. Attachment style will be associated with current substance use and depression severity.

Method

Participants and Recruitment

Voluntary sampling was used, via advertisement online and within an addiction service. Participants were eligible if aged 18 or above, and able to read English well enough to participate. Participants were divided into groups based on responses.

For the main analysis participants were split into three groups:

- **Dual diagnosis:** Participants scoring 10 or more on the depression scale, and more than 16 and/or 8 on the alcohol and drug use scales respectively. Participants with alcohol and drug use difficulties were grouped together to encompass all SUDs as they are often comorbid (Schindler, 2019).
- **Depression only:** Participants scoring 10 or more on the depression scale, but less than 16 and 8 on the alcohol and drug use scales respectively. Additionally, they had to confirm no previous difficulties or treatment for SUDs.
- **Control group:** those scoring below the cut offs on the depression, and substance use scales. Additionally, they had to confirm no previous difficulties with or treatment for depression or SUDs.

For participants in the DD and depression only group, they had to confirm depression and/or SUDs was their current primary MH concern.

A total of 183 participants completed the study (N=183). Of these, 111 were eligible for the main analysis: 36 met DD criteria, 36 met depression only criteria and 39 met control criteria. Of the DD group, 7 had alcohol difficulties, 21 had drug difficulties and 8 had both. Substances currently used in the DD group (within past 3 months) included a mixture of central nervous system (CNS) depressants, stimulants, opioids and hallucinogenics (see appendix P). For the main analysis (a 3x2 mixed-model analysis of variance [ANOVA]), a minimum of 66 participants was needed for a 95% chance of detecting a medium effect size (p=.05) (for the interaction effect), according to G*Power.

All participants were included within secondary regression analysis. See table 3.1 for demographic information, with further details in appendix P. Reasons for participants not meeting main analysis criteria included previously having DD or depression, only having SUDs or having a primary MH need other than depression or SUDs.

Table 3.1

Demographic Information

Group/condition	Age	Gender Male (M), Female (F), Non-binary (NB)	Ethnicity	Currently receiving professional depression support	Currently receiving professional SUD support	Other reported MH needs (secondary)
Dual diagnosis	19-53 m=32	M: 8 F: 25 NB: 3	White: 30 Asian: 4 Black: 1 Mixed ethnicity: 1	19	12	Anxiety: 30 PTSD: 15 PD: 6 Bi-polar: 2 ED: 8 OCD: 3 ADHD: 5 DID: 1 ASD: 3
Depression only	18-59 m=28.47	M: 5 F: 25 NB: 6	White: 33 Asian: 2 Black: 1 Mixed ethnicity: 0	24	/	Anxiety: 25 PTSD: 8 PD: 3 Bi-polar: 1 ED: 4 OCD: 6
Control	26-64 m=35.9	M:7 F:32	White: 34 Asian: 2 Black: 2 Mixed ethnicity: 1	/	/	Anxiety: 5 ED: 1 OCD: 1
Participants not meeting criteria for main analysis (included in secondary regression tests)	18-71 m=33.35	M:19 F: 50 NB:3	White: 61 Asian: 1 Black: 2 Mixed ethnicity: 6 Other, Latino: 2	20	4	Anxiety: 31 PTSD: 13 Bi-polar: 5 OCD: 6 ADHD: 2 ED: 8 PD: 2

Abbreviations: post-traumatic stress disorder (PTSD), personality disorder (PD), eating disorder (ED), obsessive compulsive disorder (OCD), attention deficit/hyperactivity disorder (ADHD), autism spectrum disorder (ASD), dissociative identity disorder (DID)

Design and Materials

A quantitative cross-sectional survey was used, with a mixed between-subjects and within-subject design.

Advertisement materials (posters and social media posts), participant information sheet (PIS), questionnaires and the debrief were reviewed by people with lived experience of SUDs and/or depression. Their feedback was used to inform the materials and language used, as such an information video was made to accompany/as an alternative to the PIS (to support those with difficulty reading).

Measures.

***Demographics*.** Participants were asked their age, gender, ethnicity and about current and previous substance use, depression, other MH needs and professional support.

Patient health questionnaire-8 (PHQ-8; Kroenke et al., 2009). A valid and reliable 8-item self-report measure of depression severity (Kroenke & Spitzer, 2002; Kroenke et al., 2001). Scoring ranges 0-24, with scores of 5-9 suggesting mild depression, 10-14: moderate, 15-19: moderately severe and 20-24: severe (Kroenke et al., 2009). A score of 10 or more is clinically relevant, with a sensitivity and specificity of 88% for detecting major depression (Kroenke et al., 2009). Cronbach's alpha for the current study was .92.

Alcohol use disorders identification test (AUDIT; Babor et al., 2001). A 10-item self-report measure, with high internal consistency and test-retest reliability, assessing alcohol consumption and identification of problematic use and/or potential alcohol use disorders (Babor et al., 2001; Hays et al.,1995). Scoring ranges 0-40, with higher scores indicating more severe difficulties. Scores of 16-19 indicate high risk and 20 or more possible dependence (Babor et al., 2001). A score of 16 or more indicates referral to specialist treatment. Cronbach's alpha for the current study was .89.

Drug use disorders identification test (DUDIT; Hildebrand, 2015). A valid and reliable 11-item self-report measure assessing drug use and identification of problematic drug

use/drug use disorders (Hildebrand, 2015). Higher scores indicate more severe difficulties. Scoring ranges 0-44. Voluse et al. (2012) found a score of 8 or more critical for identifying drug use difficulties, with 90% sensitivity and 85% specificity. Cronbach's alpha for the current study was .92.

Experience in close relationships-revised (ECR-R; Fraley et al., 2000). A valid and reliable 36-item self-report measure assessing attachment style strategies, containing two subscales: avoidance (discomfort with intimacy/seeks independence) and anxious (fear of rejection and abandonment) (Fraley et al., 2000; Graham & Unterschute, 2015). Questions are answered on a 7-point scale from 1 (strongly disagree) to 7 (strongly agree). The anxiety subscale is comprised of questions 1-18 and avoidance subscale comprised of questions 19-36, with some items reverse scored. Total scores are averaged for each subscale. Higher scores indicate higher levels of that attachment style. Overall attachment insecurity is indicated by higher total scores and security indicated by low scores. For the current study it was adapted to include non-romantic relationships in the participant's life rather than just romantic, see appendix Q. Order was randomised for online participants. Cronbach's alpha for the current study was .95 for the anxiety scale, and .94 for avoidant.

Disorganised/fearful attachment subscale (DFAS; Pollard et al., 2020). A 12-item subscale assessing disorganised/fearful attachment, taken from the revised Psychosis Attachment Measure (PAM) (Pollard et al., 2020), see appendix R. Questions are answered on a 4-point scale from 0 (not at all) to 3 (very much). The total score is averaged, with higher scores indicating higher levels of disorganised/fearful attachment. The PAM was developed for people with psychosis-related difficulties, but the disorganised/fearful attachment subscale is relevant for those without, particularly those with high levels of childhood trauma. The subscale has high internal consistency, excellent test-retest reliability and good construct validity for the intended population (Pollard et al., 2020). Self-report

measures of disorganised/fearful attachments are limited, requiring further development and testing. Cronbach's alpha for the current study was .94.

Procedure

The study was advertised on social media (Facebook, Twitter and Instagram), including MH and SUD groups. It was also shared by addiction charities Change Grow Live (CGL), UK Smart Recovery and The Bridge Programme via social media and webpages. People could participate online by accessing the survey platform Qualtrics via weblink. Posters were used in CGL services and the lead researcher presented the research at therapeutic groups, with prior consent from attendees – people interested in participating could do so online or request a paper copy.

Subsequently participants read the PIS and/or watched the video, provided informed consent to partake, and completed the anonymous survey, before receiving a written debrief. A response was required for all items for the data to be included. Paper survey (n=6) data was manually inputted. Responses were exported to Microsoft Excel and SPSS for analysis.

Ethical Approval

Ethical approval was attained from an NHS Research Ethics Committee, ethics number: 23/WM/0100.

Data Analysis

Demographic information is presented using descriptive statistics. Participant characteristics (gender, age, ethnicity and PHQ-8 scores) were compared across groups and significant differences controlled for as appropriate. Required parametric assumptions were tested. A mixed-model analysis of variance (ANOVA) with a between subject factor of group and a within subject factor of attachment style (avoidant vs anxious), and an analysis of covariance (ANCOVA) with a between factor of group and within subject factor of attachment style (fearful/disorganised) were conducted to test the primary hypothesis.

Pairwise comparison post-hoc tests were conducted to determine the simple main effects and differences between individual groups and attachment styles (also testing the second hypothesis). Partial eta squared and Cohen's D were used to calculate effect sizes.

To test the third hypothesis, hierarchical multiple regression analyses were conducted to examine the relationship between the attachment subscales and current substance use (alcohol and drugs), and depression severity.

Results

Participant Characteristics

Gender

A chi-square test of independence was conducted between groups and gender (male and female). There was not a statistically significant association between group and gender, $\chi^2(9) = .682$, $p>.05$. Non-binary (NB) participants were excluded from this test due to their low numbers which led to an assumption violation (expected frequences were not greater than five, when NB was included).

Age

A Kruskal-Wallis H test was run to determine if there were differences in ages between the three groups. Distribution of ages were not similar for all groups, as assessed by visual inspection of a boxplot. The distributions of ages were statistically significant between groups $\chi^2(3)=14.76$, p.001. Post-hoc analysis (pairwise comparison with a Bonferroni correction) revealed statistically significant differences in age between the depression only (mean rank = 40.31) and control groups (mean rank = 68.60), adjusted $p<.001$. Ages were not significantly different between the DD (mean rank = 58.04) and depression only groups (adjusted p=.057), or the DD and the control groups (adjusted p=.464).

Ethnicity

A chi-square test of independence was conducted between group condition and ethnicity (participant groups were collapsed into 'white' and 'people of the global majority (POGM)' to run the test. However, all expected frequences were not greater than five, so it is not possible to accurately report the results.

Depression Scores

An independent-samples t-test was run to determine if there were differences in PHQ-8 scores between the DD and depression only group. There was not a statistically significant difference ($p>.05$).

Comparison of Attachment Styles Across Groups

Assumptions for a mixed-model ANOVA were satisfied. A mixed-model ANOVA found a statistically significant two-way interaction between the groups and attachment styles (anxious and avoidant), when age was controlled for, $F(2, 107)=3.208$, $p<.05$, partial $\eta^{2=}.057$. See table 3.2 for mean scores and standard deviation information.

There was a statistically significant difference in anxious attachment scores between groups (when age was controlled for), $F(3,107)=36.79$, $p<.001$, partial $\eta^2=.508$. Post-hoc tests demonstrated anxious scores were significantly greater in the DD group (Mean difference [MD]=2.242, SE=.252, $p< .001$, d=2.14) and depression only group (MD=2.121, SE=.259, $p< .001$, d=2.01) compared to the control. Anxious scores in the DD group were not significantly greater than the depression group (MD=.121, SE=.257, p=.638, d=.1).

There was a statistically significant difference in avoidant attachment scores between groups (when age was controlled for), $F(3,107)=23.422$, $p<.001$, partial $\eta^2=.396$. Post-hoc tests demonstrated avoidant scores were significantly greater in the DD group (MD=1.689, SE=.222, $p<.001$, d=1.689) and depression only group (MD=1.429, SE=.227, $p<.001$, d=1.429) compared to the control. Avoidant scores in the DD group were not significantly greater than the depression only group (MD=.260, SE=.226, p=.251, d=0.26).

An ANCOVA found that after adjustment for age, there was a statistically significant difference in fearful/disorganised attachment scores between groups F(2,107)=36.584, p<.001, η^2=.406) (see appendix S for assumption information). Post-hoc analysis revealed fearful/disorganised attachment scores were significantly greater in the DD (MD=1.221, 95% CI [1.588, .854], p<.001, d=2.009) and depression only groups (MD=.99, 95% CI [1.365, .614], p<.001, d=1.632) compared to the control group. Fearful/disorganised scores in the DD group were not significantly greater than the depression only group (MD=.231, 95% CI [-.142, .604], p=.404, d=.302).

Table 3.2
Descriptive Statistics

	Dual diagnosis (n=36)		**Depression (n=36)**		**Control (n=39)**	
	Mean (M)	**Standard deviation (SD)**	**M**	**SD**	**M**	**SD**
Anxious	4.78	1.15	4.7	1.17	2.5	.93
Avoidant	4.18	.99	3.92	1.08	2.49	.75
Fearful	1.513	.765	1.323	.763	.245	.392

Comparison of Avoidant and Anxious Attachment in the Dual Diagnosis Group

Post-hoc tests of the mixed-model ANOVA (simple main effects) found a statistically significant effect of attachment style for the DD group (when age was controlled for), F(1,34)=4.311, p<.05, partial η^2=.113. For the DD group, anxious scores were significantly higher than avoidant (MD=.599, SE=.191, p<.05, d=3.294).

Exploring Association Between Attachment Style, Substance Use and Depression Severity

For the main regression analyses all required assumptions were met. The fearful/disorganised attachment measure was omitted and analysed separately, as inclusion led to assumption violations (of the Durbin-Watson statistic and correlation with the anxious attachment measure) - see appendix T.

Prediction of Current Alcohol Use. A hierarchical multiple regression was run to determine if addition of PHQ-8 scores, DUDIT scores and age (covariates), and then attachment (anxious and avoidant) scores improved prediction of AUDIT scores over and above PHQ-8 scores, DUDIT scores and age alone. The attachment subscales were not significantly associated with AUDIT scores - see table 3.3 for full details on each regression model.

The full model of PHQ-8 scores, DUDIT scores, age and attachment scores (anxious and avoidant) to predict AUDIT scores was not statistically significant, R^2=.05, F(5,177)=1.81, p=.11, adjusted R^2=.02. The addition of attachment (anxious and avoidant) scores to the prediction of AUDIT scores (model 2) did not lead to a significant increase in R^2 of .004, F(2, 177)=.33, p=.72.

Prediction of Current Drug Use. Hierarchical multiple regression was run to determine if addition of PHQ-8 scores, AUDIT scores and age (covariates), and then attachment (anxious and avoidant) scores improved prediction of DUDIT scores, above PHQ-8 scores, AUDIT scores and age alone. The attachment subscales were not significantly associated with DUDIT scores.

The full model of PHQ-8, AUDIT scores and attachment (anxious and avoidant) scores to predict DUDIT scores was significant, R^2=.131, F(5,177)=5.34, p<.001, adjusted R^2=.11. The addition of attachment (anxious and avoidant) scores to the prediction of DUDIT scores (model 2) did not lead to a significant increase in R^2 of .01, F(2, 177)=.1.4, p=.32.

Prediction of Current Depression Severity. Hierarchical multiple regression was run to determine if addition of AUDIT scores, DUDIT scores and age (covariates), and then of attachment (anxious and avoidant) scores improved prediction of PHQ-8 scores over and above AUDIT scores, DUDIT scores and age alone. The anxious subscale was significantly associated with PHQ-8 scores, whilst the avoidant subscale was not.

The full model of AUDIT scores, DUDIT scores, age and attachment (anxious and avoidant) scores to predict PHQ-8 scores was statistically significant, R^2=.47, F(5,177)=31.85, p<.001, adjusted R^2=.46. The addition of attachment (anxious and avoidant) scores to the prediction of PHQ-8 scores (model 2) led to a further significant increase in R^2 of .32, F(2, 177)=54.41, p<.001.

Table 3.3: *Regression model details (anxious and avoidant)*

AUDIT Scores/Alcohol Use						
	Model 1			**Model 2**		
Variable	**B**	**Standard Error (SE)**	**β**	**B**	**SE**	**β**
Constant	6.368*	2.005		5.207*	2.533	
DUDIT	.192*	.07	.211	.186*	.07	.203
PHQ-8	-.001	.090	-.001	-.049	.115	-.043
Age	.021	.046	.034	.017	.047	.028
Anxious				.155	.563	.029
Avoidant				.332	.057	.053
DUDIT scores/Drug use						
Constant	-.976	2.165		-2.709	2.674	
AUDIT	.213*	.077	.194	.203*	.077	.186
PHQ-8	.354**	.091	.285	.286*	.118	.231
Age	.030	.049	.046	.019	.05	.029
Anxious				-.014	.589	-.002
Avoidant				.822	.594	.12
PHQ-8 scores/Depression Severity						
Constant	13.242**	1.4		.25	1.681	
DUDIT	.222**	.057	.275	.113*	.046	.14
AUDIT	-.001	.062	-.001	-.021	.049	-.024
Age	-.143**	.037	-2.65	-.085*	.03	-.158
Anxious				2.471**	.319	.531
Avoidant				.586	.327	.106

*Note. N=183. *P<.05, **p<.001*

Discussion

The current research primarily aimed to find out whether attachment styles differ in people with comorbid SUDs and depression (DD), compared to those with depression only and a control group. It also aimed to explore which attachment style is most prevalent in

those with DD and whether attachment style is associated with current substance use or depression severity.

In relation to the first hypothesis, people with DD and depression only were both found to have higher levels of insecure attachment (anxious, avoidant and disorganised/fearful) than the controls, however those with DD did not have significantly higher levels than those with depression only. Current findings support literature finding higher rates of insecure attachment in people with MH difficulties compared to those without (Adams et al., 2018). The finding of similar prevalence of all three insecure attachment styles between those with DD and depression only, suggests similar aetiologies and pre-disposing attachment-related factors underpin the difficulties in both groups. This provides evidence for the overlap between depression and SUDs (Davis et al., 2008). Furthermore, current findings suggest the poorer treatment outcomes and higher rates of relapse experienced by people with comorbid SUDs and depression, compared to depression only, as well as the low rates of treatment initiation and high droup-out for people with DD (Buckman et al., 2018; Tsuang et al., 2003), are not due to attachment style. Given the current findings, the first hypothesis was partially met.

Regarding the second hypothesis, people with DD had higher levels of anxious than avoidant attachment. Current findings contrast to literature suggesting SUDs and DD have strongest empirical links with avoidant attachment (Curran & Mehdikhani, 2017; Finzi-Dottan et al., 2003), as well as the current hypothesis. It is important to consider that due to the dimensional nature of attachment, people can still demontrate anxious attachment strategies alongside avoidant strategies, as well as fearful/disorganised and secure (Gillath et al., 2016).

In consideration of the third hypothesis, anxious attachment (but not avoidant) was associated with current depression severity, supporting previous attachment and depression

literature (Bifulco et al., 2006; Conradi & de Jonge, 2009). However, attachment styles were not associated with current substance use severity. It is important to note the current regression analyses were run on all participant data, including those without current SUDs or depression. Therefore, the specific association between attachment and substance use severity for people with DD is not captured and may still exist, as suggested by previous literature (Schindler, 2019). The current findings add to inconsistent findings within the SUD and attachment literature (Schindler, 2019).

In addition to the main findings, 67% of those in the depression only group were currently receiving professional support (i.e. prescribed medication or therapy) for depression compared to 53% in the DD group. This could suggest those with depression only are more likely to seek professional support whilst those with DD self-medicate with substances (Khantzian, 1997; Turner et al., 2018). However, further research and evidence is needed to support this theory. It is also important to consider that whilst a significant number of people in the DD group were also receiving professional support for depression, it is possible the positive impact of such support may be limited by the effects of substances, particularly those which are CNS depressants (Khanh, 2018). The current findings add a novel contribution to the literature which highlights a complex relationship between insecure attachment, SUDs and comorbid MH needs (Khantzian, 1997; Schindler, 2019).

Clinical and Research Implications

Given the current findings, MH and substance use services and clinicians should consider that those accessing their services (particularly those with depression and/or SUDs) have significantly high levels of insecure attachment (compared to those without these needs), and should adapt accordingly by providing attachment-informed care (Bucci et al., 2015). However, services and clinicians should not be concerned about insecure attachment being an increased barrier to creating positive attachment or therapeutic relationships with

people with comorbid SUDs and depression, as there is no significant difference in attachment presentation compared to those with depression only. This is important for clinicians to be aware of, particularly as people with DD face stigma and additional barriers to accessing services (PHE, 2017).

Treatment approaches for people with DD, and depression only, should consider the possible impact of insecure attachment. As suggested by Schindler (2019) it could be helpful for individual attachment needs to be assessed and used to inform treatment planning, alongside relevant MH and substance use information. Other strategies which can support therapeutic engagement and promote secure attachment for people with insecure attachments include services and professionals providing consistency, appropriate flexibility, clear expectations and emotional containment (i.e. through listening, empathy, warmth and attunement) (Bucci et al., 2015).

Findings suggest attachment style may not account for the differences in treatment outcomes, engagement and relapse rates of people with DD compared to those with depression only (Buckman et al., 2018; Cridland et al., 2012; Tsuang et al., 2003). Therefore it is important researchers and services continue to explore other possible contributing factors such as stigma, receiving poorer care, limited access to effective treatment and low treatment engagement (Lappan et al., 2020; Livingston & Boyd, 2010; PHE, 2017; Williams et al., 2021).

Strengths and Limitations

This is the first study to compare and explore attachment styles of people with comorbid depression and SUDs to those with depression only and a control. Therefore, this novel research adds to the limited literature, attempting to contribute to a better understanding of the complex relationship between attachment style and DD. The use of clinically relevant cut offs on the PHQ-8, AUDIT and DUDIT to inform the grouping of participants (in line

with formal diagnostic criteria), rather than relying on subjective self-report, is a further strength.

Given high prevalence of multiple comorbidities for people with DD, SUDs and MH needs (which can be a challenge for designing and facilitating research), the current study attempted to recruit a sample which was representative of the target population by including participants with multiple and additional MH needs (secondary to depression or SUDs). However, this may have had confounding effects on the findings. Furthermore, given the high prevalence of comorbid SUDs and poly-substance use the authors did not group participants based on the substances they reported using. However, as different substances have different psychological and physiological effects, and may interact with MH needs and attachment relationships differently, it may have been beneficial to do so. It could be helpful for future research to explore the relationship between specific SUDs (i.e. cannabis), depression and attachment.

Modification of the ECR-R questionnaire to also consider non-romantic relationships (as not everybody experiences romantic relationships, particularly people who experience high rates of isolation i.e. those with DD) may have led to reduced reliability and/or validity. The fearful/disorganised attachment subscale was included to capture the relevant attachment style which is not well captured by measuring attachment avoidance and anxiety only (Pollard et al., 2020). As this subscale was developed for people with psychosis, it may not be valid and reliable for the current populations (although internal consistency was found to be high). Further exploration of this subscale within different populations is required, particularly for populations with high rates of childhood trauma (Pollard et al., 2020).

It is a further limitation that participant groups were not matched for all characteristics, however, age was controlled for within the relevant analyses to mitigate the impact of this. It is also a limitation that it was not possible to accurately run statistical tests

(without violating a required assumption) to compare groups regarding participant ethnicity, or to include NB participants whilst comparing participant genders. Findings are further limited by the lack of diversity within participant characteristics. Of particular note is the high proportion of females who completed the current study (across all groups). Although data regarding prevalence of females with DD is limited, given SUDs are more prevalent in males (Torrens-Melich et al., 2021; United Nations Office on Drugs and Crime, 2024), the current findings may not be representative of the intended population and should be interpreted with this in mind. Furthermore, participants were mostly of white ethnicity, meaning findings may not be generalisable to the wider population.

Conclusion

In conclusion, the present study found no significant differences in insecure attachment styles between people with DD (comorbid SUDs and depression) and depression only, although both groups had higher levels of insecure attachment (anxious, avoidant and fearful/disorganised) than the control group. People with DD were found to have higher levels of anxious attachment than avoidant attachment. Additionally, anxious attachment was found to be associated with current depression severity but not substance use severity (across all participants). These findings add novel contribution to the literature, suggesting people who develop DD and depression only, experience similar pre-disposing attachment-related factors. Findings also suggest insecure attachment does not account for the poorer treatment outcomes and higher relapse rates for people with DD compared to those with depression only. However, all findings should be interpreted with caution given the limited diversity and representativeness within the current participant sample.

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Executive Summary of Theory Driven Research Project

Background

During infanthood, all people develop an 'attachment style' (or type of emotional/relational bond) to their caregivers, based on how their caregivers respond to their needs. This attachment style influences how they develop relationships with others and cope with difficult emotions, throughout childhood and adulthood. Insecure attachment styles (anxious, avoidant and fearful/disorganised) are associated with later mental health (MH) difficulties, whilst a secure attachment style may impart resilience from developing such difficulties. This study primarily investigated whether there are differences in attachment styles of people with substance use difficulties (SUDs) and depression (known as a dual diagnosis [DD]), compared to people with depression alone and a control group.

People with both conditions are vulnerable and have poorer treatment outcomes and increased relapse rates, compared to people with only depression or SUDs. This may be due to them finding it more difficult to engage with services/professionals, possibly impacted by attachment style. Understanding the relationship between attachment styles, SUDs and depression can help to understand how services/professionals can better support people with both conditions.

Research Questions

The current research aimed to answer the following questions:

1. Do attachment styles differ in people with comorbid SUDs and depression (DD) compared to people with depression alone and controls?
2. Which insecure attachment style is most prevalent in people with DD?
3. Is attachment style associated with current substance use or depression severity?

Method

The survey-based study was advertised online via social media (Facebook, Twitter and Instagram) and within a substance misuse service (Change Grow Live [CGL]). It was also shared by addiction charities CGL, UK Smart Recovery and The Bridge Programme via their social media and webpages. Participants were eligible to partake if they were aged 18 or above and could read the English language well enough to consent and participate.

People could participate online by accessing the survey platform Qualtrics via weblink, alternatively people accessing support in CGL services could request a paper copy. Those who wanted to partake: (1) read the participant information sheet or watched the information video, (2) consented to partake, (3) completed the anonymous survey, (4) received a written debrief.

The survey consisted of questions about the participant's background (i.e. age, ethnicity, gender and history of substance use, depression, professional support and other MH needs), an alcohol use questionnaire, a drug use questionnaire and three attachment subscales (exploring insecure attachment styles: anxious, avoidant and fearful/disorganised).

Participants meeting the main inclusion criteria were divided into three groups based on their answers, those not meeting these criteria were included within secondary analyses.

The main three groups were:

1. **Dual diagnosis** (people with depression and SUDs)**:** participants scoring above the given cut off on the depression scale as well as the alcohol and/or drug use scales.
2. **Depression only:** participants scoring above the given cut off on the depression scale and below the given cut offs on the alcohol and drug use scales. They also had to confirm no previous difficulties or treatment for SUDs.

3. **Control group:** participants scoring below the given cut offs on the depression, alcohol and drug use scales. They also had to confirm no previous difficulties with or treatment for depression or SUDs.

Participants in the DD and depression only groups, also had to confirm depression and/or SUDs was currently their main MH difficulty.

The survey data collected was statistically analysed to answer the research questions.

Results and Key Findings

A total of 183 participants completed the study (N=183). Of these, 111 were eligible for the main analysis: 36 met DD criteria, 36 met depression only criteria and 39 met control criteria. Of the DD group, 7 had alcohol difficulties, 21 had drug difficulties and 8 had both.

No significant differences in insecure attachment styles were found between people with DD and depression only, although both groups had significantly higher levels of insecure attachments (anxious, avoidant and fearful/disorganised) than the control group. People with DD had higher levels of anxious attachment than avoidant attachment. Additionally, anxious attachment was found to be associated with current depression severity but not substance use severity (across all participants). These findings add novel contribution to the literature, suggesting people who develop DD and depression only, experience similar pre-disposing attachment related factors but may cope with these in different ways (i.e. by self-medicating with substances). Findings also suggest insecure attachment does not account for the poorer treatment outcomes and higher relapse rates for people with DD compared to depression only.

Limitations

The current study attempted to recruit participants representative of people who access MH and SUD services, by including people with additional secondary MH needs. However, this may have caused bias within the results. Furthermore, it may have been

beneficial to divide DD participants based on the different substances they used, due to the differing physiological and psychological effects.

Two of the attachment subscales used in the study (anxious and avoidant) were modified to include consideration of non-romantic relationships (as not everybody experiences romantic relationships), which may have reduced their reliability and/or validity. Findings are also limited by the lack of diversity within participant characteristics (most identified as female and white), meaning they may not be generalisable.

Implications and Future Research

Given current findings, MH and substance use services and clinicians should consider that those accessing their support (with depression and/or SUDs) have significantly high levels of insecure attachment (compared to those without these needs), and should adapt accordingly by providing attachment-informed care/treatment. However, clinicians should not be concerned about insecure attachment being an increased barrier to creating therapeutic relationships with people with DD, as there is no difference in attachment presentation compared to those with depression only. This is important as people with DD face stigma and additional barriers to accessing services.

Findings suggest attachment style may not account for current substance use severity, or differences in treatment outcomes, engagement and relapse rates of people with DD compared to those with depression only. Therefore, it is important future research explores other possible contributing factors i.e. stigma and limited access to services.

Connecting Narrative

All of my research projects are underpinned by the exploration of attachment theory within disadvantaged populations. I did not intentionally plan to conduct three studies underpinned by this theory, but the research design process naturally drew me to this area of research. Throughout my clinical practice and experience of working in mental health, I have always found attachment theory to be an anchor in my work, placing particular importance on creating positive and secure therapeutic relationships with the people I work with. On reflection it is no surprise my research projects also followed this theme.

Systematic Review of the Literature

Learning of the limited research within the intellectual disability (ID) field and having previously enjoyed working as a healthcare assistant in an ID service, I was keen to conduct research in this area. I had experienced first-hand some of the challenges people with ID experience when creating trusting relationships with others, particularly healthcare staff, and was interested in learning about and evaluating interventions which could help reduce such challenges. I was also inspired by my external supervisor Dr Helen K Fletcher, whose passion regarding the ID and attachment field is infectious.

Having never conducted a systematic review before, undertaking this project taught me how to complete a structured and critical review of the literature. Although I found the learning process time-consuming and overwhelming at times, I was really proud of the final paper. At times, during the analysis and write-up phase, I regretted including both quantitative and qualitative research, as well as different participant groups (people with ID and carers), as it complicated some of the process. However, I'm glad I persisted as this allowed for a comprehensive evaluation of the available intervention literature.

Service Improvement Project

Given my interest in attachment theory and desire to experience working within social care services, I was excited to learn of a potential project within the Residential and Edge of Care Service during the course research fair. Collaborating with my supervisors to develop the scope of this project was a particularly enjoyable experience, as it incorporated a number of our shared interests.

Although this was my favourite project to conduct, it was also the most challenging. Throughout the process I learnt how to authentically engage children and young people (CYP) in research, particularly those who may be more mistrusting due to past relational trauma. By observing and modelling my external supervisor at the children's homes I learnt the importance of showing young people you are genuinely interested in them and their experiences, by spending time getting to know them and/or engaging with their interests prior to undertaking research. This helped to build rapport and hopefully make them feel more comfortable throughout the process. Despite the significant time and effort, I put into engaging CYP it was still difficult to recruit participants, especially those with exploitation experience. This was also made harder by there being a reduced number of CYP at the homes during the time I was undertaking the research. I had initially only planned to interview CYP, however, as it became evident it would be impossible to recruit the required sample size, we decided to also interview staff. It was stressful and time consuming to change the scope of the project mid-way through, however, the addition of the staff voice proved invaluable. I also found the process of sharing the findings and recommendations with the service managers particularly rewarding, as they expressed their gratitude and enthusiasm to take the recommendations forward. I am looking forward to conducting further service improvement projects throughout my career.

Theory Driven Research Project

Having lost a parent to alcohol addiction and fondly worked in an addiction service for two years, I always knew I wanted to conduct a project in the area of dual diagnosis. I have witnessed how people experiencing addiction are often stigmatised and blamed for their difficulties, despite the additional social and psychological challenges they may have faced throughout their life. These experiences fuelled me to explore a possible explanation for the poorer outcomes for this population (and of course, may have biased my interpretation of the findings).

Designing and undertaking this research really stretched my research skills. Applying for approval from the university and Health Research Authority (HRA) was particularly daunting as somebody with limited research experience. The process was time consuming, but I valued the great detail the study was evaluated under, as it increased my own confidence in the study and its value. Having never previously conducted statistical analysis, I was completely overwhelmed when it came to the analysis. However, with some valued guidance, and trial and error, I undertook the analyses independently and taught myself how to interpret the results. This was a massive achievement for me, and I still can't quite believe I now (kind of) understand statistics! If I could now go back and re-design elements of the project I would, but I am trying to view this as a positive sign of the research knowledge and skills I have now gained.

Current Relationship with Research

Although I found designing and conducting the above projects to be quite challenging at times, I am proud of the outcomes. Looking back, I did enjoy many aspects of undertaking the research and it really tested my problem-solving skills. It is surreal to look back on what I have learnt and achieved over the past three years. I am not in a rush to conduct more research in the near future, but I am definitely interested in supervising and/or supporting

other trainees or assistant psychologists to conduct research, particularly service improvement projects.

Reflections on Attachment Theory

Through conducting these three projects I have expanded my understanding of the complexities and nuances of attachment theory, and its implications for my clinical practice. However, given the vast literature and different branches of attachment theory (which I was previously unaware of), I still feel I have only just begun to scratch the surface.

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First of all, I would like to acknowledge and thank all of the people who generously took part in my research. As well as the Experts by Experience who helped to shape the project and materials into what they were. This thesis would not have been possible without you all.

I am extremely thankful for the wisdom, support and guidance shared with me by my research supervisors, who helped me achieve three diverse research projects with very little prior research experience, and helped to ground and encourage me when things did not run smoothly. I am also grateful for the support provided by my course Tutor, Matt Hotton. Knowing I could always go to him for advice when I was uncertain of anything throughout the research process (or training in general) was invaluable. As well as Dannielle Shore, who provided me with statistical support.

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I would like to give a heartfelt thanks to my Mum, Drew and my friends for their love and cheerleading throughout training. Thanks for always believing in me, celebrating my achievements and grounding me when I was stressed. And last but not least, I would like to thank my amazing course mates – without you, your wisdom, kindness and humour, I couldn't have finished this intense course. You will all be amazing Clinical Psychologists!

Appendices

Appendix A: Instructions for Authors - SLR

Manuscript Submission Guidelines: *Journal of Intellectual Disabilities*

Only manuscripts of sufficient quality that meet the aims and scope of *Journal of Intellectual Disabilities* will be reviewed.

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2.3 Acknowledgements

All contributors who do not meet the criteria for authorship should be listed in an Acknowledgements section. Examples of those who might be acknowledged include a person who provided purely technical help, or a department chair who provided only general support.

2.3.1 Third party submissions

N/A

2.4 Funding

Journal of Intellectual Disabilities requires all authors to acknowledge their funding in a consistent fashion under a separate heading.

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2.6 Research ethics and patient consent

N/A

2.7 Data

N/A

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Appendix B: Table of Additional Extracted Data – People with Intellectual Disabilities (SLR)

Table B.1

Additional Extracted Data (PWID)

Study (Author and year)	Title	Country	Conceptualisation of attachment	Detailed participant characteristics
Hoffman et al. (2019)	The effect of technology assisted therapy for intellectually and visually impaired adults suffering from separation anxiety: Conquering the fear.	Netherlands	Secure attachment-relationships (the bond between caregiver and receiver) help to regulate emotional needs and behaviour.	Gender: 5 males, 1 female. Ages: 27-56. Ethnicity: not reported. Severity of ID: moderate to mild. Additional diagnoses/needs: blind or visual impairment (VI) and separation anxiety (SA).
Jonker et al. (2015)	Caregiver-mediated therapy for an adult with visual and intellectual impairment suffering from separation anxiety.	Netherlands	Creating an emotional and trusted bond with a caregiver/attachment-figure, which supports emotion regulation (Bowlby, 1969).	Gender: male. Age: 27. Ethnicity: not reported. Severity of ID: moderate. Additional diagnoses/needs: VI and SA.
McInnis (2016)	Effectiveness of individual psychodynamic psychotherapy in disability psychotherapy.	UK	The emotional/affectionate bond between caregiver and infant/person, which support emotion regulation (Bowlby, 1988).	Gender: Male. Age: 28. Ethnicity: white British. Severity of ID: mild. Additional diagnoses/needs: none reported.
Pearson et al. (2019)	Teaching young adults with intellectual disabilities about early parent-child attachment behaviours using an educational DVD.	UK	The emotional/affectional bond between child/infant and caregivers (Bowlby, 1969).	Gender: 11 females, 14 males. Ages: 16-22 (mean 17.8 years). Ethnicity: not reported. Severity of ID: mild to moderate. Additional diagnoses/needs: none reported.

Pethica & Bigham (2018)	"Stop talking about my disability, I am a mother": Adapting video interaction guidance to increase sensitive parenting in a young mother with intellectual disability.	UK	Emotional bond between two people (caregiver-person). Secure attachment is associated with effective emotion regulation. Can be mediated by maternal sensitivity and reflective and reflective function (Ainsworth et al., 1974).	Parent. Gender: female. Age: not reported. Ethnicity: not reported. Severity of ID: mild. Additional diagnoses/needs: none reported.
Sterkenburg et al. (2008a) & Schuengel et al (2009)	(1) The effect of an attachment-based behaviour therapy for children with visual and severe intellectual disabilities. (2) Supporting affect regulation in children with multiple disabilities during psychotherapy: a multiple case design study of therapeutic attachment.	Netherlands	Being able to seek comfort in times of stress and explore the environment from an attachment figure/relationship (Bowlby, 1969).	Gender: 3 males, 3 females. Ages: 10-17. Ethnicity: not reported. Severity of ID: severe. Additional diagnoses/needs: blind or VI.
Sterkenburg et al. (2008b)	Developing a therapeutic relationship with a blind client with a severe intellectual disability and persistent challenging behaviour.	Netherlands	Being able to seek comfort in times of stress and explore the environment from an attachment figure/relationships (Bowlby, 1969).	Gender: Male. Age: 17. Ethnicity: not reported. Severity of ID: severe. Additional diagnoses/needs: blind.

Appendix C: Table of Additional Extracted Data – Caregivers (SLR)

Table C.1

Additional Extracted Data (Caregivers)

Study (Author and year)	Title	Country	Conceptualisation of attachment	Detailed participant characteristics
Birdsey et al. (2022)	Piloting the circle of security parenting group with parents of children with a learning disability: An exploratory case study.	UK	The relationship between parents/caregivers and infant/child which develops through parental attunement and sensitivity to needs (Bowlby, 1988).	Parents of PWID. Gender: 4 females. Ages: 30s-40s. Ethnicity: White British. Parents of: child with mild-moderate ID, aged 5-13, additional diagnoses/needs: 2x chromosomal syndrome, 1x ASD & ADHD, 1x sensory processing disorder.
Damen at al. (2011) & Schuengel et al. (2012)	(1) Effects of video-feedback interaction training for professional caregivers of children and adults with visual and intellectual disabilities. (2) Attachment representations and response to video-feedback intervention for professional caregivers.	Netherlands	The bond/relationship between caregivers and receivers which is facilitated through sensitive responsiveness (Ainsworth et al., 1978).	Professional carers (PCs) of PWID. Gender: 59 females, 13 males. Age: 20-58 (M=30). Ethnicity: not reported. PCs of: adults with moderate to severe ID and/or visual impairment. The study focussed on the relationship with 12 PWID: 7 males, 5 females, age: 13-54 (M=38), with moderate-severe ID, additional diagnoses/needs: VI.
Johnson et al. (2017)	Increasing day service staff capacity to facilitate positive relationships with people with severe intellectual disability: evaluation of a new intervention using multiple baseline design.	Australia	Based on the relationship model for building positive relationships with PWID (Johnson et al., 2012). It incorporates attachment-related concepts i.e. recognising the individual, sharing the moment and connecting.	PCs of PWID. Gender: not reported. Age: between 21 to over 50. Ethnicity: not reported. PCs of: adults with moderate to severe ID. The study focussed on the relationship with 5 PWID, gender: not reported, age: 24-52 (M=40.68), with severe-profound ID, additional diagnoses/needs: none reported.

Muddle et al. (2021)	Talking with parents of children with learning disabilities: parents' ideas about the circle of security parenting programme.	UK	The relationship with parents/caregivers. Secure attachment is present when an infant/child feels able to explore their environment and seek comfort from them as a secure base (Ainsworth et al., 1978).	Parents of PWID. Gender: 6 females. Age: not reported. Ethnicity: none reported. Parents of: child with moderate-severe ID, aged 5-14 (mean=9.33), additional diagnoses/needs: 3xASD, 2x sensory processing disorder, 2x genetic disorder, 1x ADHD, 1x epilepsy
Vandesande et al. (2023)	Piloting attachment psychoeducation provided to parents of children with severe disabilities: testing the feasibility of a digital micro-intervention.	Belgium	The emotional/affectional bond between child/infant and caregivers (Bowlby, 1969).	Parents of PWID. Gender: 12 females, 4 males. Age: females M= 40.78, males M= 43.3. Ethnicity: not reported. Parents of: children with severe-profound ID, aged <10, additional diagnoses: none reported.
Wingerden et al. (2019)	Effectiveness of m-learning HiSense APP-ID in enhancing knowledge, empathy, and self-efficacy in caregivers of persons with intellectual disabilities: a randomized controlled trial.	Netherlands	The relationship between parent/caregiver and infant/child/person. Secure attachment is developed through sensitive and responsive caregiving and can facilitate socio-emotional functioning and coping.	PCs of PWID. Gender: 72 females, 28 males. Age: 18 to 35+. Ethnicity: Western European=81, Asian=3, African=2, Latin American=1, Other=5, not stated=1. PCs of: adults with mild-moderate ID, age: not reported, additional diagnoses/needs: none reported.

Appendix D: Mixed Methods Appraisal Tool Quality Questions and Criteria (SLR)

Table D.1

MMAT Quality Questions and Criteria

Category of study designs	Methodological quality criteria	Responses		
		Yes	No	Can't tell
Screening questions (for all types)	S1. Are there clear research questions?			
	S2. Do the collected data allow to address the research questions?			
	Further appraisal may not be feasible or appropriate when the answer is 'No' or 'Can't tell' to one or both screening questions.			
1. Qualitative	1.1. Is the qualitative approach appropriate to answer the research question?			
	1.2. Are the qualitative data collection methods adequate to address the research question?			
	1.3. Are the findings adequately derived from the data?			
	1.4. Is the interpretation of results sufficiently substantiated by data?			
	1.5. Is there coherence between qualitative data sources, collection, analysis and interpretation?			
2. Quantitative randomized controlled trials	2.1. Is randomization appropriately performed?			
	2.2. Are the groups comparable at baseline?			
	2.3. Are there complete outcome data?			
	2.4. Are outcome assessors blinded to the intervention provided?			
	2.5 Did the participants adhere to the assigned intervention?			
3. Quantitative non-randomized	3.1. Are the participants representative of the target population?			
	3.2. Are measurements appropriate regarding both the outcome and intervention (or exposure)?			
	3.3. Are there complete outcome data?			
	3.4. Are the confounders accounted for in the design and analysis?			
	3.5. During the study period, is the intervention administered (or exposure occurred) as intended?			
4. Quantitative descriptive	4.1. Is the sampling strategy relevant to address the research question?			
	4.2. Is the sample representative of the target population?			
	4.3. Are the measurements appropriate?			
	4.4. Is the risk of nonresponse bias low?			
	4.5. Is the statistical analysis appropriate to answer the research question?			
5. Mixed methods	5.1. Is there an adequate rationale for using a mixed methods design to address the research question?			
	5.2. Are the different components of the study effectively integrated to answer the research question?			
	5.3. Are the outputs of the integration of qualitative and quantitative components adequately interpreted?			
	5.4. Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?			
	5.5. Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?			

Appendix E: Table of Initial Quality Appraisal Discrepancies (SLR)

Table E.1

Initial Quality Appraisal Discrepancies

Study (Author and year)	Quality criteria	Lead author initial rating	Independent reviewer initial rating	Main discussion points	Agreed rating
Hoffman et al., (2019)	4.3. Are the measurements appropriate?	No	Yes	Reviewers discussed whether not having a specific social anxiety measure meant study measurement was not appropriate (the measures used were valid and/or reliable). As the Author's stated the intervention reduced "social anxiety" it was decided that not having a specific social anxiety measure was not appropriate	No
Jonker et al., (2015)	4.4. Is the risk of nonresponse bias low?	Can't tell	Yes	The lead author noted that imputation was used in the analysis, but the paper did not state how many data points were imputed.	Can't tell
Wingerden et al., (2019)	2.4. Are outcome assessors blinded to the intervention provided?	No	Can't tell	The lead author initially noted that participants in the experimental condition were informed of the condition once assigned (study measures were self-report). The independent reviewer noted the paper did not state whether the assessors supporting participants to complete the self-report questionnaires were blinded to the condition of participants at all data collection points.	Can't tell

Appendix F: Instructions for Authors - SIP

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Appendix G: Further Information About the Service Staffing Structure (SIP)

The service was managed overall by a Corporate Parenting Manager and a Service Manager. Each of the three homes had a Registered Team Manager and Assistant Team manager. The two shorter-term/assessment homes each had one Senior Practitioner, one Advanced Practitioner and 14 Senior/Specialist Family Support Workers. The longer-term home had three Advanced Residential Childcare Workers and nine Residential Childcare workers. A total of 50 staff members worked directly with the CYP across the homes at the time of the interviews, all of whom were invited to take part.

Appendix H: Interview Schedule for CYP (SIP)

1. What do the staff at the home do with/for you?
2. What words would you use to describe what the staff do?
3. What's it like staying at the home?
4. How does it feel to be supported by the home staff?
    a. What's it like?
5. Does it seem like they're helping you?
    a. How comes?
6. What was it like when you first got to the home?
    a. Do you feel the same or differently about it now?
7. What do you like about what staff do for/with you?
8. What do you not like about what staff do for/with you?
9. What's the best and worst bit about being at the home or being supported by the staff?
10. What's it like trying to get on with new staff?
    a. Was/is it easy or hard to talk to them or get to know them? Why?
    b. What helped or made it more difficult?
11. Have you made any good connections with staff?
    a. How/why did that happen?
12. How do staff/the home make you feel safe?
13. What could they do to make you feel safer?
14. Is there anything that makes it difficult for you to accept/use the assistance you can get from staff/home?
15. Is there anything that makes it easier?
16. Is there anything you would like the staff to do differently?
17. Is there any other help/support you would like from the home or staff?
18. What choices do you get to make about your care?

   a. Do you get any?

19. Do you understand the plans for your care?

   a. Who has talked to you about this and has that been helpful?

20. If you were in charge of the home and staff what changes would you make or what rules would you have?

Appendix I: Interview Schedule for Staff (SIP)

1. What have you found to be helpful in building trusting relationships with the CYP at the home?
2. What are the challenges of engaging CYP who come into the home?
3. What skills do you think staff need to help engage them?
4. What do you think are the main barriers for CYP to engage with the staff/home?
5. In what way do you think their past experiences (i.e. with their birth family, abuse, neglect or child exploitation) impact their experience of receiving care from staff/the home?
6. Have you noticed any differences in your experience of working with CYP who have experienced child exploitation (compared to those who have not)?
    a. If yes, in what ways?
7. Do you think it's harder to reduce risk for CYP who have experienced exploitation compared to those who have not?
    a. If yes, in what way?
8. Do you feel confident and equipped to adequately support CYP who have experienced exploitation and to talk to them about their experiences?
    a. If yes, what has supported you to feel equipped?
    b. If no, what support could help you to feel more equipped?
9. Given all that you have said, in answer to the previous question – is there anything you think could be done better, to support CYP to create therapeutic care-based relationships with staff and increase feelings of safety for the CYP?
    a. Do things need to be done differently for CYP who have been exploited?
    b. If yes, in what way?
10. Please share anything you would like to know more about regarding child exploitation.

11. Do you have any final comments or thoughts that you would like to share?

Appendix J: Coverage of Themes Across the Data (SIP)

Table J.1

Coverage of Themes Across CYP Data

	Number of participants represented by each subtheme	Number of extracts relevant to each subtheme
CYP theme 1: The push and pull of relationships		
"S*ometimes they care too much":* Relationships with the residential staff	5	54
"I*t's not my mum's, so I have mixed feelings":* Relationship to the home	5	26
"Y*ou know what they've gone through, so you kinda know how they feel":* Peer relationships	4	15
"Y*ou've got to understand like, although you don't live with your parents, they're still your parents":* Birth family relationships	4	13
"M*e and my social worker don't get along":* Relationship to social worker	2	4
CYP theme 2: What the CYP value		
"It's good because you always know they're gonna help ya": Being taken care of (physical and emotional needs)	5	26
"T*hings are always miscommunicated, everything in this household is": C*ommunication and consistency	3	12
"Internet for everything": Material requests	4	7

Table J.2
Coverage of Themes Across Staff Data

	Number of participants represented by each subtheme	Number of extracts relevant to each subtheme
Staff theme 1: Supporting all CYP open to the residential edge of care service		
"Every child's journey is different": The importance of understanding the YP's experience and getting to know them.	6	26
"*The best thing we can do for our young people is offer safety, nurturing an understanding":* Building trusting relationships	7	42
"*They don't trust anyone*": Barriers to engagement and relationships	7	42
"*They are young people who have been through significant trauma each and everyone of them":* Trauma and attachment informed care	7	34
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Appendix K: Additional Quotes (SIP)

Table K.1

Additional Quotes From CYP

CYP theme 1: The push and pull of relationships	
1a) "S*ometimes they care too much":* Relationships with residential staff	*"Doing stuff with them, like going out and activities. Because really, you see a side of them you don't normally see in the house because normally they're like a lot stricter in the house, but like when they're actually doing something with you or like out the house you sort of see a sort of funny side to them."* – YP3 *"They just do what they can do, the best."* – YP4 *"I love all of them. They're quite, they're so nice."* – YP1 "'*Cause they help you out whenever you need it. Say if you wanna go out for a walk, they take you for a walk*." – YP4 "*I don't know, at first, I thought they were just like. I thought they were just there because they wanted, like it's a job, they want money, stuff like that. And they're just there to do paperwork, stuff like that. But the longer I was here, I've realised that they're not here for the money. They're here to help these kids and they actually try to get along with us and make our lives better while we're here*." – YP5 "*Sometimes they care too much. Some of them can care too much which can be annoying…."* – YP3

1b) "I*t's not my mum's, so I have mixed feelings":* Relationship to the home	"*UM, it's fun. But at the same time it's not my mum's, so… Uh, I have, like, mixed feelings. But if it's for now, I'll like put up with it because it's quite nice*." – YP1 "*Like since I moved here, my life's just got a lot better to be honest. My social life's got better, my independence skills have got better, just a bit of everything*." – YP5 "*It's just a care home isn't it. What do you expect? It's nicer than most homes. It's better than being with your parents*." – YP3 "*My mum always used to say that it was like a bad place to be in care so to make sure we didn't playup. So we always thought it was like a prison kind of. And, like, really messed up and like, not fun to be in. But although it's not what I expected, I'm glad it's better than what I expected, I guess. Yeah*." – YP1 "*One of the good things about living in a care home is like they won't compromise on safety."* – YP3
1c) "Y*ou know what they've gone through, so you kinda know how they feel":* Peer relationships	"*Urm. Taking most of the children's feelings into consideration. Yeah, because Liam, the manager. He, well. Most of these kids, well all of them. I get along with all of them, of course, but most of them are very alike to me. So I can tell he picks kids that are alike so they get along*." – YP1 "*Just like, living with other kids, you don't know what the other kids are like do ya."* – YP1 "*Umm the other boys because I thought they'd be mean*." – YP4

1d) "Y*ou've got to understand like, although you don't live with your parents, they're still your parents":* Birth family relationships	*"You've got to understand like, although you don't live with your parents, they're still your parents. Not that I think of my dad as a parent".* – YP3 *"And the worst thing is probably that, erm, my siblings aren't like, here, so I can't talk to them as freely."* – YP1 *"Say you fell out with your mum, you can pick if you wanna see her next week. [….] : It's good cause, if you're going back to your mums, like me, after you've just fallen out with her, you're still gonna be in a bad mood with each other".* – YP4
1e) "M*e and my social worker don't get along":* Relationship to social worker	"*It's up to my social worker more than anything else, so and because of the fact that she's sometimes difficult to deal with […] She's never. She's just really aloof. Like she's never around. Like she doesn't really text or contact my keyworkers much.*" – YP1

CYP theme 2: What the CYP value	
2a) "It's good because you always know they're gonna help ya": Being taken care of (physical and emotional needs).	*"It feels nice, like, because like my mum obviously used to do that. But it's nice that they actually try and make me feel. I guess, uh. I don't know what is like, just like supported I guess."* – YP1 *"It's good because you always know they're gonna help ya."* – YP4
2b) "T*hings are always miscommunicated, everything in this household is":* Communication and consistency	"*Um, they they're quite good at, like getting stuff done. Like if you ask them something, they're most likely, you know, like my key workers have always never, like, failed really when it when I came to like ask something they like just do it and I'm never, like I don't think I've ever been disappointed in one of them so."* – YP1 *"Things are always miscommunicated. Everything in this household is."* – YP3
2c) "Internet for everything": Material requests	*"I would raise pocket money. Everything else is going up in price, except our money."* – YP3 *"The Wi-Fi, just to make it a little bit longer."* – YP1 *"Internet for everything."* – YP2

Table K.2

Additional Quotes from Staff

Staff theme 1: Supporting all of the CYP on the residential edge of care	
1a) "Every child's journey is different": The importance of understanding the YP's experience	*"I would say especially, don't come in with all these notions or a preconception of these children. Very often the work that I've done isn't what's on paper, it isn't the description of the child that I meet."* – S1

and getting to know them.	*"I mean, again, that is about lived experience of children and considering what, you know that individualized approach. That we need to consider that with all children, not just children that have been exploited."* – S4 *"Every child's journey is different, actually."* – S4
1b) "*The best thing we can do for our young people is offer safety, nurturing an understanding":* Building trusting relationships	*"Children in my opinion, are hypervigilant to transparency to about who you are. Their radar will tune to your yeah, to your integrity, to your honesty, to your… erm who your true character is. So, what I've always tried to do is be true to myself."* – S1 *"Honesty. Genuinely, just be honest with kids. If you can't tell them something, tell them you can't tell them."* – S2 *"I think that the best thing we do for our young people is offer them safety, nurturing and an understanding that if they're speaking, we'll listen. Which will then in turn develop them to feel that they can open up and in a safe way and how they do it is how, you're led by how the child does it."* – S3 *"Oh, time, definitely time. It takes a while to build up that trust. And I think just spending quality time with the kids, having fun, doing nice activities where it's not some sort of "intervention" or key working session or you're not discussing anything difficult or anything like that, just actually just going out and having fun and having a laugh."* – S5
1c) "*They don't trust anyone*": Barriers to engagement and relationships	*"I think the children are coming in with a lot of disappointment. They're coming in with a lot of rejection. They're coming in with broken promises. Talk of change and they've been let down many, many times. I absolutely get the cynicism and the guardedness to say "why am I gonna trust you with my life?"""* – S1

	"A lot of our young people have had inconsistent care and just aren't ready for the consistency and the boundaries and it to go through all of us." – S2 *"A lot of them want to just like not accept that they're in that situation or they're scared."* – S3 *"I think all of the young people, especially if they've been through a number of placement moves, each move just makes them less likely to trust. Why should they bother getting to know somebody, 'because in two months this could be over. What's the point in investing? What's the point in allowing yourself to feel something towards that person? Because before you know it's going to be over and it's all going to be your fault."* – S5 *"I think those that have been exposed to trauma of all sorts of kinds, that we deal with, the difference I would say with sexual exploitation, drug exploitation, criminal exploitation is they are more fearful. They are more guarded for sure. I would say, much more complex in terms of trying to move them forward."* – S7
1d) "*They are young people who have been through significant trauma each and everyone of them":* Trauma and attachment informed care	*"There's also something that I found paradoxical about receiving care. Actually, we are the absolute polarized opposite of some of the things that they've experienced. And we do that shamelessly, but there is a measure. We do also, I think we do sometimes in our wanting to do so much we have to be mindful of our position. It's almost like giving somebody too much too soon. This has to be dripped and proportionate."* – S1 *"You know, I think a lot of them feel rejected by their birth families. You know, some of the young people that we have here have been voluntarily placed in care by their families. Which leaves them feeling completely abandoned. The people that you know were meant to love them and care for them forever are no longer doing that. So, why*

	would they believe us when we say that we love them and care for them." – S5 *"I think what happens is, we pick children up too late and then the trauma is already, very, very embedded, uh and they've experienced an awful lot."* – S5
Staff theme 2: Supporting CYP with experience of exploitation	
2a) "*It's all around identity and feeling accepted":* The push and pull of exploitation	*"What you're dismissing and being negative about is the bits that have built up, that they've been told build up their character, that make them somebody. So, I can… I get it that you know "I've got in my community, I've got perceived status. I've got wealth. I've got this, I've got respect." I'm going in there challenging that by my actions. I'm not outright calling you, you know, you're worthless, you're doing…. but what I am inadvertently doing is saying "none of those things are real". That's a big thing for a person, a teenager to take, especially one that's been built into that illusion of this "this is my persona", and it's not… the people have done their work very well."* – S1 *"There are so many [risks] there are lots, but this is one that sits there very nicely alongside and actually it generates around being in care as well because of that vulnerability."* – S1 *"Because it is a culture that they are completely absorbed in and the whole message it… well… my understanding is the whole message they get from the adults that are piling them with all this stuff are "you can't trust you, can't trust professionals. You can't trust the police. You can't trust your parents. You can't…". You know."* – S3 *"What I have found, I would say for all the children we have had exploitation, is that they've pulled other children in the home into their behaviours. So not in terms of selling drugs or doing that side*

	of it. But in terms of other behaviours that they've, they share. Just disruptive behaviours really. I wouldn't say that they've even particularly pulled children off with them to go missing. But it's the disruptive behaviours in the house, like just staying up all night, smoking in the bedrooms, barricading themselves in the lounge, being rude and disrespectful to staff, smashing up things, umm haveing fights. All those kind of things, actually really influence the dynamics. And you find that a lot of, depending on the child, but at least one of the children, if not all of them, then become scared of them. And it's kind of like, "do I join them or do I not?" and actually a majority of the time they join them because it's safer in their opinion, to be with them than against them. And so that's really difficult because you then have almost like a gang culture in your household and until, unfortunately, until you remove that person, it's very difficult to come out of that." – S6
2b) "We're behind the curve": Prevention, early identification and early intervention	*"Now, if you're not picking up on those small things, your story and your narrative is fragmented. You kind of, it's writing on a piece of paper and passing it to the next that adds to the next line to that story that adds the next line to that story, or recognizes that that makes sense."* – S1 *"For me, the bit that underpins everything is prevention itself. […] Equip a child with knowledge and the awareness, and that space, social awareness and all those skills. If you can you do that before. If I had no inkling that there was CSE, the work you could be doing with a child anyway. You're doing all those things, those protective behaviors pre, so actually if it did come along, you'd know what you were looking at. So I'm a big fan. I hate for, for, any conversation to be "you know, we're waiting for it to happen", you know. Ohh, so we're now doing it now we're already in that process, OK? So wouldn't it be a good education for any child that we recognise as vulnerable on our radar, that we do that work anyway? So it should be universal."* – S1

"I don't think we're quick enough. I think around the digital side of things, we've been really poor. To be honest. And I don't know if even as society we've kept up enough as to how much things have changed." – S2

"I think obviously they've [the police] got their different thresholds and they're not the same as ours. So how quickly they respond to things, I think leaves us feeling a bit stuck in then what we can do." – S5

"I think you know thresholds could be lowered. If you know, interventions could start early without concrete evidence and things like that, it would do a lot of good, but obviously I understand why that can't happen." – S5

"Parents have been screaming for years, but because they're [exploiters] very clever at how they develop the young people by keeping them local to start with, it's really hard for professionals to then actually identify and then step in and become involved." – S3

"I think when they're out in the community, these children, I think some of the parents are left without the skill set for too long to be able to try and manage what's going on for the children, and sometimes it's not always about their lack of willingness to parent children, it's about lack of capacity and we've already talked a little bit about that. So I think that that's an issue." – S7

"I think it's got out in the news more recently, like I think more recently it's becoming more publicised. But I still think it would be useful for parents to have the training at quite a young age because I mean, even 8-year-olds are being exploited so. I think it would be really good for parents to have, you know, there to be leaflets or

	something around exploitation for parents to have that the school give out when they do an exploitation class with the children. Umm, just so they know what to look out for as well and where to seek help." – S6 *"As part of our pre-admission, for instance, if they haven't already got a [exploitation] screening tool we do them anyway and it isn't because we necessarily think that they're being exploited, but we want to rule it out as opposed to in. But we have a lot of children that come to our attention now that are clearly involved in exploitation of one kind or another and have been existing out in the Community like that for a period of time without a screening tool having been completed before they even come to our attention."* – S7
2c) "*There should be much more definition and understanding*": What is exploitation and how do we evidence it?	*"I think there should be much more definition understanding."* – S1 *"Just in so much as we have a lot of conversations, but it's quite hard to capture those conversations on an evidence base. But at the same time you don't want a tick box exercise."* – S2 *"I genuinely don't know because I think my realization is we're all aware of the titles. We're all aware of what it should look like or what our young people may have experienced. But actually, for each young person, it's very individual."* – S3
2d) "I always observe and take from other people": Staff learning from each other and experience	*"I said I've had a lot of colleagues that have had serious experience in it. Personal experience with it, and I've learned a lot over years and I've kind of honed that into how I see CSE."* – S1 *"A lot of it is support from colleagues. I've been in the service quite a long time now and we're very, very good for when these conversations are happening. You're going, "no, no idea, I've never done that in my life", and they [colleagues] go "well come with me for this conversation" and we learn a lot from each other by just*

kind of informal mentoring. Really. And then afterwards going "How do you think that went? Did you think about… or…." and actually reflecting upon what the conversation was and thinking actually, "if I was doing that again, I'd..."" – S2

"I think having a baseline measure would help us to understand kind of where we're at. I think that more training, but realistic training, not just the "this is the county line, this is where it runs from this city to this city. This is… you're looking for expensive gifts. You're looking at…" you know that very tick box stuff we know. Kind of a 5 minute whistle stop tour of that sort of training and then actually "how would you deal with this situation? How have you dealt with it? Let's share experience. Let's share how we're having these conversations… You know, the child who's really not engaging in your home, how have you got them to engage?" as more of a learning, bringing lots of different people together, to share their experiences so we can learn from each other." – S2

"I've worked in services for a long time. So I think experience, and actually I was a practitioner within the field at the stage that Operation Bullfinch happened. So actually, our CDE world is just really a follow on from that and that. We've increased awareness. You know things happen, which then results in people going out and getting further information where they need to. So, I think experience leads into that, but also ensuring that I update myself on any new guidance or legislation that comes out." – S4

"I mean you can learn, I suppose, through kind of role modelling in terms of seeing your colleagues and how they do it and how they approach it. So you could take tips from others. But I don't think you could do training in terms of let's do some role play and let's try… I don't think that would work." – S6

2e) "Once you know, it's too late": Staff hopelessness and anxiety	*"I do worry… my worry around that is the longevity of how much can I do and what are the pull factors when you leave me?"* – S1 *"Because county lines is just countrywide now, that I reckon, if you were in Scotland and you're suppliers were in London that they would find a way to get you to then be running in Scotland. I just, I believe it's so embedded in them that especially for the young that like, so they're choosing quite vulnerable young children while they're still living at home who are sorry searching out for those role models that world that excitement. They then whisk them and get them into it, and by the time for a lot of them, by the time that any professionals are available to be involved, they're already too deep into it."* – S2 *"You know what I mean? By the time we work with the kids, they've already crossed so many barriers that bringing them back is, you know, not an easy thing for us to be able to do."* – S3 *"I mean my sample is very limited. So erm, but from what I have experienced, uh, those children that have experienced exploitation just tend to be so much more secretive. I feel like you can't connect with them. It seems a lot less genuine. I think they're much more mistrustful of you, and probably because we're much more mistrustful of them. I think you're second guessing what they're doing, they're second guessing what you're doing and it's kind of a vicious cycle. I think there's always that. I guess probably on both sides that "oh, I don't want to connect because this is going on and it's likely they're not going to be able to stay here because it's not safe for them". Uh. I think staff wise, I think you feel quite vulnerable and quite anxious, uh. Because there's only so much you can do to try and keep that young person safe, especially in the regulations that we have, you can't stop that young person going out. You can't ground them. You can't do those things that you might*

	do if you were their parent and they were living at home with you. You can't take that phone away. I think you feel quite powerless in that situation. So yeah, I think it's you just don't feel you know them as well if they're experiencing exploitation." – S5
2f) "*There's no narrative around some of the information that's provided*": Information sharing and multi-agency working	*"You would have, I think you'd have a better oversight with a smaller group, and then you've gotta think about staffing structures. We're a big team now. Big teams are great, but they come with a challenge of communication. Now, if the first thing I'd say about CSE and CCE, anything in those grooming processes, is about noticing the small things. The devil is in the detail. The messages will all be there, it's whether you see them. We are a big house."* – S1 *"I think better multi-agency working uh, I think especially from the police side would be supportive. I think obviously they've [the police] got their different thresholds and they're not the same as ours. So how quickly they respond to things, I think leaves us feeling a bit stuck in then what we can do."* – S5 *"I mean it's not support, but I think the issue that we have in our home is just kind of issues around communication and consistency. You might be off shift for like 2 days and you come, you come back and you're trying to catch up and it's, you know, you could have missed so much in those two days. I came back and a child's moved out and there's a police investigation ongoing, and it's only been two days. Umm, so it's quite hard to kind of uh, you know, keep tabs on everything and keep track of everything. And erm, you know, six different people might have spoken to a police officer over the course of four days, like, and each time you get told the information it's been filtered through another person. So, it's all kind of being watered down. And I think that is a particular struggle for our service with the shift changes and staff changes."* – S5

2g) "*They need to be part of the plan*": Intervention, breaking the cycle	*"The most successful one I've seen is to change locality. It's children who've been picked up and moved to really quite remote places. No social media access, nothing."* - S2 *"They need to know that it's a long-term commitment. And they need to be part of the plan, and actually come up with what the rules, boundaries and expectations should look like. They should never be told to them, because they're being so independent in this world that the minute you take that away from them, you've lost them."* – S3 *"I don't know. I mean, I do think, you know, I know that it's kind of banded around about "ohh, they just need a circuit break" but I don't think they particularly work either, because you're kind of like you're taking them away from their family home or their networks and everything that's going on. You're putting them in another place for like 16 weeks. Whatever they decide to do for the circuit break. And then you're just replacing them right back into what hasn't changed. I mean, the environment, the area hasn't changed during that time. So it's like how much work can you realistically do with a child in 16 weeks for them to be able to return home. But I know by moving a child to a different area, there's exploitation everywhere. So if you've got that kind of, you're still vulnerable, aren't you, so wherever you go, you're gonna be identified as vulnerable, and you're potentially gonna get caught up in another group."* – S6 *"We don't shy away from taking children with exploitation and I know that there might be that feeling with some professionals, and probably the exploitation team, that kind of nobody will touch their children, nobody will offer placements because they seem so risky, and everything like that. But there's a bigger picture to it and that's what needs to be understood. It's you know, it's not about us thinking we can't manage their risk or not wanting to support them. It's actually about the other children that they're gonna be placed

alongside. And we can't, you know, we need positive outcomes for them as well and it's already their home. So to bring in another person that we know, could really disrupt the other children, then as a manager, you're not going to do that. And that's why it's really difficult. Yes, they do need support and I, you know, I really feel for those children that do need a placement because it must be so tough when people really aren't coming forward to take them. And we need to look at other ways where we can support them within children's homes. But, yeah. I think you're looking at smaller homes as well. I mean, we're a 6 bed, I think with children of exploitation it needs to be just two, two children." – S6

Appendix L: Service Response (SIP)

Findings and recommendations were presented to the service manager and lead consultant clinical psychologist for the homes, via presentation facilitated by the lead researcher and clinical psychologist from the homes (who supervised the project). The outcomes were well received, and the project praised. The service manager commented that the cohort of children who access the homes has changed over recent years, with an increase in complexity of needs, including increased prevalence of past or present exploitation. They highlighted there was a need to support staff to feel confident in the tools they have, to work with children at this stage in their life and create a sense of pride within the role they can play to support them – which could be facilitated via the recommended expert by experience training and reflective practice. The service noted that the recommendations were practical and could be easily implemented with the creation of an exploitation working-group.

Appendix M: Lay Summary for Young People (SIP)

Summary of Service Improvement Project Findings for Young People

Background information:

There is little research exploring the experiences of children and young people living in residential homes. Without speaking to the young people themselves, we cannot understand their experiences or what support they think is helpful or unhelpful.

The project:

Young people currently living at the Residential and Edge of Care (REoC) homes were invited to share their opinions and experiences of the homes during an interview with Ruby Ramsden (Trainee Clinical Psychologist, University of Oxford). **Five young people took part.** Interviews happened between February and June 2023. This project was supervised by Andy Glossop (Clinical Psychologist, REoC).

REoC wanted to find out:

1. How young people experience the support provided by REoC
2. How things could be improved to support all young people

Summary of findings:

- Young people were mostly positive about the care received and relationships with staff.
- Relationships with peers, birth families and social workers were also highlighted as important.
- Young people valued communication and consistency.
- Young people wanted increased internet access and a better internet connection.

Recommendations were made to REoC based on these findings.

Thank you to everyone who took part!

Appendix N: Lay Summary for Staff (SIP)

Summary of Service Improvement Project Findings for Staff

Background information:

There is limited research exploring the experiences of children and young people (CYP) living in residential homes and/or with experience of child exploitation. There is also limited research exploring experiences of staff working in residential homes. CYP receiving such support are vulnerable and may experience difficulties developing trusting relationships or feelings of safety with staff/services. Additionally, those with exploitation experiences are likely to still experience push/pull factors towards exploitative relationships, which may be a further barrier to engagement. Without speaking to the CYP themselves, and the staff who support them, we cannot truly understand their experiences, or the facilitators and barriers to this support.

The project:

CYP and staff from the Residential and Edge of Care (REoC) homes were invited to share their opinions and experiences of the homes during an interview with Ruby Ramsden (Trainee Clinical Psychologist, University of Oxford). Interviews happened between February and June 2023. This project was supervised and overseen by Andy Glossop (Clinical Psychologist, REoC).

REoC wanted to find out:

- How CYP experience the support provided by REoC
- How staff experience supporting CYP
- How things could be improved to support all CYP
- Whether things needed to be done differently to better support CYP with experience of exploitation

Who took part:

- 5 CYP who lived at the homes
- 7 staff members who worked there

Summary of findings:

- CYP were mostly positive about the care received and relationships with staff.
- Relationships with peers, birth families and social workers were also highlighted as important.
- CYP valued communication and consistency.
- CYP wanted increased internet access and a better internet connection.
- Staff suggested all CYP require individualised support with a focus on building trusting relationships.
- Staff expressed hopelessness at being able to effectively disrupt exploitation once started, but shared that their confidence supporting exploited CYP increased via experience and learning from peers.
- Staff said there needs to be better prevention, identification, intervention and communication around exploitation.

Recommendations:

Based on the findings, the following recommendations were made:

- For staff training courses on child exploitation to include and/or be co-produced by people with lived experience of exploitation and living in care homes.
- For CYP with exploitation experience to be involved in future research and service development.
- To facilitate staff reflective practice sessions focussing on their work with child exploitation (ran by a Clinical Psychologist).
- To review the service exploitation screening-tool and its use, and ensure it adequately captures all forms of child exploitation.
- Liaison with the local youth justice and exploitation team and police, to enquire about "mapping" of local intelligence.
- For CYP with exploitation experience to be offered longer-term placements, where possible.
- For parents/carers to be provided with information and resources about child exploitation.
- If inconsistencies in practice and communication are reported to use current systems to review and ensure this is improved.
- An exploitation working-group could help to push these recommendations forward.

Thank you to everyone who took part!

Appendix O: Instructions for Authors - TDRP

Manuscript Submission Guidelines: *International Journal of Mental Health and Addiction*

Papers should be submitted under one of the following categories: Letters to the Editor; Regular articles; Review Articles; Letters of law; Brief reports; Clinical case studies; Commentaries; Book reviews; News updates (research, education and clinical).

Submission is a representation that the manuscript has not been published previously and is not currently under consideration for publication elsewhere.

Manuscript Style

- All pages should be typed in 12-point Times New Roman font and numbered (including pages containing the title, author name and affiliation footnotes, abstract, acknowledgments, references, tables, and figure caption list).
- A title page is to be provided that includes the article title, author's name (no degrees), author's affiliation, and suggested running head. The affiliation should comprise the department, institution (usually university or company), city, and state (or nation) and should be typed as a footnote to the author's name. The suggested running head should be less than 80 characters (including spaces) and should comprise the article title or an abbreviated version thereof. For office purposes, the title page should include the complete mailing address, telephone number, and e-mail address of the one author designated to review proofs.
- An abstract is to be provided, preferably no longer than 150 words. A list of 5-6 key words is to be provided directly below the abstract. Key words should express the precise content of the manuscript, as they are used for indexing purpose.
- Papers should be no more than 6,000 words. Sexist or racist language should not be used. Colloquial or highly specialized language should be avoided whenever possible. Statistics are acceptable but must be explained in simple terms.

Illustrations

Tables should be numbered (with Roman numerals) and referred to by number in the text. Each table should be typed on a separate page. Center the title above the table, and type explanatory footnotes (indicated by superscript lowercase letters) below the table.

References

The International Journal of Mental Health and Addiction follows the reference style provided in the Publication Manual of the American Psychological Association (APA). For detailed information on APA style, please consult the APA style website.

Conflict of Interest

When authors submit a manuscript, they are responsible for disclosing all financial and personal relationships that might bias their work. To prevent ambiguity, authors must state explicitly whether potential conflicts do or do not exist. Each author must indicate whether or not they have a financial relationship with the organization that sponsored the research. For each source of funds, both the research funder and the grant number should be given.

Conflict of interest statements should be present on every manuscript before the References section. The statement should mention each author separately by name. Recommended wording is as follows: *Author X, Author Y and Author Z declare that they have no conflict of interest.*

Informed Consent
For studies with human subjects, please include the following statement before the References section:

'All procedures followed were in accordance with the ethical standards of the responsible committee on human experimentation (institutional and national) and with the Helsinki Declaration of 1975, as revised in 2000 (5). Informed consent was obtained from all patients for being included in the study.'

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All authors are requested to include information regarding sources of funding, financial or non-financial interests, study-specific approval by the appropriate ethics committee for research involving humans and/or animals, informed consent if the research involved human participants, and a statement on welfare of animals if the research involved animals (as appropriate).

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• Free text: *All authors contributed to the study conception and design. Material preparation, data collection and analysis were performed by [full name], [full name] and [full name]. The first draft of the manuscript was written by [full name] and all authors commented on previous versions of the manuscript. All authors read and approved the final manuscript.*

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Research involving human participants, their data or biological material

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Consent to Participate

For all research involving human subjects, freely-given, informed consent to participate in the study must be obtained from participants (or their parent or legal guardian in the case of children under 16) and a statement to this effect should appear in the manuscript.

Appendix P: Additional Demographic Information (TDRP)

Table P.1

Additional Demographic Information

Group/condition	Self-report current depression/low mood	Self-report previously receiving a diagnosis or professional support for depression/low mood	Self-report current alcohol use difficulties	Self-report current drug use difficulties	Self-report previous experiencing SUDs or receiving professional support for substance misuse in the past (alcohol and/or drugs)
Dual diagnosis	34	30	8	16	22
Depression only	35	34	/	/	/
Control	5 (did not meet clinical threshold)	/	/	/	/
Participants not meeting criteria for main analysis (included in secondary regression tests)	28	53	5	11	33

Table P.2

Participants' Reported Substance Use

Group/condition	DD	Depression	Control	Participants not meeting criteria for main analysis (included in secondary regression tests)
Alcohol	C: 25 P: 6 N: 5	C: 24 P: 7 N: 5	C: 34 P: 3 N: 2	C: 42 P: 17 N:13
Cannabis	C: 25 P: 6 N: 5	C: 3 P: 11 N: 33	C: 2 P: 15 N: 22	C: 17 P: 40 N:15
Amphetamines	C: 3 P: 18 N: 15	C: 0 P: 3 N:33	C: 0 P: 7 N: 32	C: 0 P: 22 N:50
Cocaine	C: 9 P: 16 N: 11	C: 0 P: 3 N: 33	C: 0 P: 12 N: 27	C: 8 P: 26 N:38
Crack cocaine	C: 1 P: 5 N: 30	C: 0 P: 0 N: 36	C: 0 P: 0 N: 39	C: 1 P: 5 N: 66
Heroin	C: 0 P: 3 N: 33	C: 0 P: 0 N: 36	C: 0 P: 0 N: 39	C: 0 P: 4 N: 67
Fentanyl	C: 1 P: 1 N: 34	C: 0 P: 1 N: 35	C: 0 P: 0 N: 39	C: 0 P: 2 N:70
Hallucinogenics	C: 5 P: 13	C: 0 P: 2	C: 1 P: 8	C: 15 P: 13

	N: 18	N: 34	N: 30	N: 44
Ketamine	C: 4 P: 11 N:21	C: 0 P: 1 N: 35	C: 0 P: 5 N: 34	C: 6 P: 12 N: 54
Ecstasy	C: 8 P: 15 N: 13	C: 0 P: 4 N: 32	C: 0 P: 10 N: 29	C: 7 P: 27 N: 38
Opiate substitute medication (illicit or not as prescribed)	C: 1 P: 5 N: 30	C: 0 P: 0 N: 36	C: 0 P: 0 N: 39	C: 2 P: 6 N: 64
Painkillers (illicit or not as prescribed)	C: 6 P: 17 N: 13	C: 6 P: 2 N: 28	C: 1 P: 6 N: 32	C: 2 P: 21 N: 50
Benzodiazepines	C: 2 P: 10 N: 24	C: 1 P: 0 N: 35	C: 0 P: 3 N: 36	C: 0 P: 12 N: 60
Sleeping tables (illicit or not as prescribed)	C: 5 P: 5 N: 26	C: 2 P: 2 N: 32	C: 0 P: 2 N: 39	C: 2 P: 9 N: 61
Steroids (illicit or not as prescribed)	C: 1 P: 1 N: 34	C: 0 P: 0 N: 36	C: 0 P: 0 N: 39	C: 0 P: 3 N: 69
Other prescription medication (illicit or not as prescribed)	C: 4 P: 4 N: 28	C: 3 P: 0 N: 33	C: 0 P: 3 N: 36	C: 2 P: 20 N: 50

Abbreviations: currently - in the last 3 months (C), past - over 3 months ago (P), never (N)

Appendix Q: Modified Experience in Close Relationships - Revised (ECR-R) Measure (TRDP)

We all differ in how we relate to other people. This questionnaire lists different thoughts, feelings and ways of behaving in relationships with others.

Thinking generally about how you relate to key people in your life, respond to each statement by circling a number to indicate how much you agree or disagree with the statement.

There are no right or wrong answers.

	Question	**1= strongly disagree, 4= neither agree nor disagree, 7= strongly agree**						
1	I am afraid I will lose their love.	1	2	3	4	5	6	7
2	I often worry they will not want to stay with me.	1	2	3	4	5	6	7
3	I often worry they don't really love me.	1	2	3	4	5	6	7
4	I worry they won't care about me as much as I care about them.	1	2	3	4	5	6	7
5	I often wish their feelings for me were as strong as my feelings for them.	1	2	3	4	5	6	7
6	I worry a lot about my relationships.	1	2	3	4	5	6	7
7	When they are out of sight, I worry they may become close to someone else.	1	2	3	4	5	6	7
8	When I show my feelings for others, I'm afraid they will not feel the same about me.	1	2	3	4	5	6	7
9	I rarely worry about them leaving me.	1	2	3	4	5	6	7
10	They make me doubt myself.	1	2	3	4	5	6	7
11	I do not often worry about being abandoned.	1	2	3	4	5	6	7
12	I find that others don't want to get as close as I would like.	1	2	3	4	5	6	7
13	Sometimes people change their feelings about me for no apparent reason.	1	2	3	4	5	6	7
14	My desire to be very close sometimes scares people away.	1	2	3	4	5	6	7

15	I'm afraid that once a person gets to know me, they won't like who I really am.	1	2	3	4	5	6	7
16	It makes me mad that I don't get the affection and support I need from them.	1	2	3	4	5	6	7
17	I worry I won't measure up to other people.	1	2	3	4	5	6	7
18	They only seem to notice me when I'm angry.	1	2	3	4	5	6	7
19	I prefer not to show them how I feel deep down.	1	2	3	4	5	6	7
20	I feel comfortable sharing my private thoughts and feelings with them.	1	2	3	4	5	6	7
21	I find it difficult to allow myself to depend on them.	1	2	3	4	5	6	7
22	I am very comfortable being close to them.	1	2	3	4	5	6	7
23	I don't feel comfortable opening up to them.	1	2	3	4	5	6	7
24	I prefer not to be too close to others.	1	2	3	4	5	6	7
25	I get very uncomfortable when they want to be very close.	1	2	3	4	5	6	7
26	I find it relatively easy to get close to them.	1	2	3	4	5	6	7
27	It's not difficult for me to get close to them.	1	2	3	4	5	6	7
28	I usually discuss my problems and concerns with them.	1	2	3	4	5	6	7
29	It helps to turn to them in times of need.	1	2	3	4	5	6	7
30	I tell them just about everything.	1	2	3	4	5	6	7
31	I talk things over with them.	1	2	3	4	5	6	7
32	I am nervous when they get too close to me.	1	2	3	4	5	6	7
33	I feel comfortable depending on them.	1	2	3	4	5	6	7
34	I find it easy to depend on them.	1	2	3	4	5	6	7
35	It's easy for me to be affectionate with them.	1	2	3	4	5	6	7
36	They really understand me and my needs.	1	2	3	4	5	6	7

Appendix R: Fearful/Disorganised Attachment Subscale (Pollard et al., 2020) (TDRP)

We all differ in how we relate to other people. This questionnaire lists different thoughts, feelings and ways of behaving in relationships with others.

Thinking generally about how you relate to key people in your life, **please use a tick to show how much each statement is like you**.

There are no right or wrong answers.

		Not at all (0)	A little bit (1)	Quite a bit (2)	Very Much (3)
1	I feel frightened in close relationships.				
2	When I try to get close to someone sometimes I shut down and find it difficult to think or move.				
3	I find close relationships overwhelming.				
4	I often freeze when I try to get close to someone.				
5	I want close relationships, but being close makes me feel frightened.				
6	I want to be close to others but I often find myself pulling away when I am.				
7	Sometimes I am confused by my feelings towards others.				
8	When I form close relationships I lose sense of who I am.				
9	I find people I am in close relationships with to be unpredictable in their actions and behaviours.				
10	When I'm stressed I want to contact close others but I am frightened of their response.				
11	I often get hurt in close relationships.				

Appendix S: Additional Statistics information for ANCOVA (TDRP)

Assumptions of ANCOVA (Fearful/disorganised)

There were 3 outliers within the Control Group data, as assessed by inspection of a box-plot. The outliers were inspected and considered genuinely unusual data points and retained for analysis. The assumption of approximate normality was met for the DD and Depression only Group, but not the Control Group, as assessed by visual inspection of Normal Q-Q plots. As the one-way ANCOVA is fairly robust to deviations from normality, the planned test was run.

Appendix T: Results of Hierarchical Multiple Regression Tests (Fearful/Disorganised)

For the regression analyses exploring the prediction of current substance use (alcohol and drugs), and current depression severity, with fearful/disorganised attachment scores as the independent variable (IV), all required assumptions were met.

Prediction of AUDIT Scores/Alcohol Use

A hierarchical multiple regression was run to determine if the addition of PHQ- 8 scores, DUDIT scores and age (covariates), and then of attachment style (fearful/disorganised) scores improved the prediction of AUDIT scores over and above PHQ-8 scores, DUDIT scores and age alone. The fearful/disorganised subscale was not significantly associated with AUDIT scores - see Table T.1 below for full details on each regression model (regarding fearful/disorganised attachment).

The full model of PHQ-8 scores, DUDIT scores, age and attachment style (fearful/disorganised) to predict AUDIT scores was not statistically significant, R2=.051, F(4,178)=2.416, p=.051, adjusted R2=.03. The addition of attachment style (fearful/disorganised) scores to the prediction of AUDIT scores (Model 2) did not lead to a statistically significant increase in R^2 of .006, F(1, 178)=1.21, p=.272.

Prediction of DUDIT Scores/Drug Use

A hierarchical multiple regression was run to determine if the addition of PHQ-8 scores, AUDIT scores and age (covariates), and then of attachment style (fearful/disorganised) scores improved the prediction of DUDIT scores over and above PHQ-8 scores, AUDIT scores and age alone. The fearful/disorganised subscale was not significantly associated with DUDIT scores.

The full model of PHQ-8 scores, AUDIT scores, age and attachment style (fearful/disorganised) to predict DUDIT scores was statistically significant, R^2=.138, F(4,178)=7.098, p<.001, adjusted R2=.12. The addition of attachment style

(fearful/disorganised) scores to the prediction of DUDIT scores (Model 2) did not lead to a statistically significant increase in R^2 of .018, F(1, 178)=3.67 p=.057.

Prediction of Current Depression Severity

Hierarchical multiple regression was run to determine if addition of AUDIT scores, DUDIT scores and age (covariates), and then of attachment (fearful/disorganised) scores improved prediction of PHQ-8 scores over and above AUDIT scores, DUDIT scores and alone. The fearful/disorganised subscale was significantly associated with PHQ-8 scores.

The full model of AUDIT scores, DUDIT scores, age and attachment (fearful/disorganised) scores to predict PHQ-8 scores was statistically significant, R^2=.398, F(4,178)=29.43, p<.001, adjusted R^2=.385. The addition of attachment (anxious and avoidant) scores to the prediction of PHQ-8 scores (model 2) led to a further significant increase in R^2 of .248, F(1, 178)=73.38, p<.001.

Table T.1

Regression Model Details (Fearful/Disorganised)

AUDIT scores/Alcohol use						
		Model 1			Model 2	
Variable	B	Standard Error (SE)	β	B	SE	β
Constant	6.368*	2.005		6.069*	2.022	
DUDIT	.192*	.07	.211	.18*	.071	.197
PHQ-8	-.001	.09	-.001	-.065	.107	-.057
Age	.021	.046	.034	.022	.046	.036
Disorganised/ fearful				1.027	.932	.101
DUDIT scores/Drug use						
Constant	-.976	2.165		-1.417	2.161	
AUDIT	.213*	.077	.194	.196*	.077	.179
PHQ-8	.354**	.091	.285	.233*	.11	.187
Age	.03	.049	.046	.033	.048	.05
Disorganised/ fearful				1.85	.966	.167
PHQ-8 scores/Depression Severity						
Constant	13.242**	1.4		8.197**	1.32	
AUDIT	-.001	.062	-.001	-.032	.053	-036
DUDIT	.222**	.057	.275	.105*	.05	.131

Age	-.143**	.027	-.265	-.092*	.032	-.172
Disorganised/ fearful				4.734**	.553	.531

*Note. N=183. *P<.05, **p<.001*

Appendix U: Research Approval Letter (TDRP)

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03 July 2023

Dear Miss Ramsden

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**A comparison of attachment styles in people with comorbid substance misuse and depression, depression alone and healthy controls.**
IRAS project ID:	**320396**
REC reference:	**23/WM/0100**
Sponsor	**University of Oxford / Research Governance Ethics and Assurance**

I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?
HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report