Medical Research Archives

European Society of Medicine

OPEN ACCESS

Published: August 31, 2023

Citation: Evans G, and McTiernan K, 2023. An Investigation of an Attachment Formulation Workshop within a Specialist Autism Inpatient Service, Medical Research Archives, [online] 11(8). https://doi.org/10.18103/mra.v11i8.4271

DOI
https://doi.org/10.18103/mra.v11i8.4271

ISSN: 2375-1924

CASE REPORT

An Investigation of an Attachment Formulation Workshop within a Specialist Autism Inpatient Service

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ABSTRACT

Background: There is a dearth of research regarding the process of attachment within autistic individuals. There is also an emerging emphasis to attend directly to clients' mental health and recovery.
Case report: This case report details an attachment intervention with a client, presenting with behaviors that challenged within a specialist inpatient autism service. It was hypothesized that attachment was partially underpinning the behavior that challenged. This was further explored by: undertaking a notes review, interviewing the direct care team, formulating within the multidisciplinary team, delivering a Psychology attachment formulation workshop as well as by meeting regularly with the client. The workshop involved facilitating staff to integrate: Crittenden's dynamic-maturational attachment model with the client's experience whilst utilizing a CBT framework. This resulted in identifying that the client was presenting with the strategy of 'aggression and feigned helplessness', which emerged within a context encompassing: physical health issues, intellectual disability as well as trauma. Formulating resulted in an enhanced understanding of attachment and the client within the team. Interventions directly addressing attachment were devised in order to further mange the behavior that challenged, particularly in relation to family interactions as well as changes to the staff.
Conclusion: This case report demonstrates the clinical utility of an attachment formulation workshop within a specialist autism service. It would therefore be informative to undertake similar research within autism services.

Keywords: Autism, intellectual disability, attachment, mental health, formulation workshop, inpatient service.

Case report

CW was admitted to a specialist inpatient service for autistic people with intellectual disabilities. Autism is defined by issues in social communication and social interactions within multiple contexts in conjunction with restricted repetitive patterns of behaviour or interests. Indicators must be apparent early in the developmental period and cause significant impairments in functioning[1]. The occurrence of autism within children is between 1-2% and intellectual disability is noted to co-occur[2]. This cohort of clients can present with complex psychosocial difficulties which can manifest as behaviour that challenges[3]. CW displayed significant behaviours that challenge including: aggressive threats of violence, throwing items, hitting staff, attempting to bite staff, advancing towards staff in an aggressive manner with arms raised, punching walls and inserting items into her ears. There was at least one high risk incident occurring per day. In accordance with NICE guidelines[3] the initial response was to implement a behaviour support plan. This involved: setting out a high ratio and consistent staff team, scheduling interactive times with staff, structuring CW's day and creating a low stimulus environment. CW was placed as the sole occupant of a four bedroomed ward, with a minimum of three staff assigned to assist in meeting CW's activities of daily living. CW was relatively stable within eighteen months, evidenced by a reduction in the recordings of high-risk incidents to ten per month.

Clinical observation

It was observed and hypothesized that attachment issues were partially underpinning the behaviour that challenged. For instance, CW presented as highly anxious when her mother cancelled appointments or when there were changes to the staff. CW found this emotion difficult to regulate which manifested in aggressive behaviours. CW stated 'I can't help it'. This hypothesis was further explored by: undertaking a notes review, interviewing the direct care staff and by analysing the observational data that was recorded on the unit.

Notes review

In considering the factors which influenced the development of CW's internal working model. Early in life CW became ill, experienced seizures and was hospitalized. CW's parents separated before she was two years of age and CW was estranged from her father. There is a maternal history of severe mental health issues as well as alcohol abuse issues. CW's mother remarried and there were inconsistent relationships between CW and her siblings. Reportedly, CW witnessed domestic abuse between her mother and stepfather. CW was diagnosed with epilepsy and a moderate intellectual disability during middle childhood. A subsequent assessment noted CW's capacity to undertake activities independently.

CW displayed aggression towards herself and other people since childhood. It is noteworthy that CW previously poured a kettle of water onto herself when emotionally dysregulated. CW was expelled from a specialist inclusive learning centre as a result of high levels of aggressive behaviour, which included attempting to strangle another pupil. CW first presented to mental health services with aggression and cutting behaviour at the age of ten and underwent intervention. CW was re-referred when she was fifteen years of age, after threatening her mother with a knife. As a young adult CW was admitted to a respite service, after physically assaulting her mother. On discharge, issues continued within the relationship and CW was admitted to forensic services. CW continued to present with physical aggression and was segregated from other people. CW later received a diagnosis of autism. It was also noted that CW's mother caused significant anxiety, agitation, and conflict. For instance, CW's mother was observed to be at times highly verbally abusive towards staff and CW on the phone. CW was subsequently transferred to an inpatient autism service, where she maintained weekly telephone contact and monthly visits from her mother. CW's mother acknowledged that she could not manage to care for CW and suggested for staff to remain vigilant and consistent in their approach.

Interviews

CW's direct care team was interviewed utilizing the Challenging Behaviour Interview[4]. Staff highlighted that 'she becomes quite distressed when visits and telephone calls from her mother are cancelled or end'. Staff felt uncertain in manging this. Occasionally, staff responded by redirecting CW's attention towards an independent activity. This escalated CW's expression of anger, evidenced by increased shouting. At other times staff immediately withdrew from CW and intermittently checked on CW. One nurse reflected on how when this occurred, CW would advance towards staff with a mood chart expressing her emotions. This resulted in further staff disengagement. An analysis of the observational data indicated that the aggressive behaviours occurred more frequently when appointments were cancelled or when there were changes within the staff.

The multidisciplinary team reviewed how CW's attachment strategies created within the relationship with her mother were being re-enacted

within interactions with staff. Attachment issues may therefore be partially underpinning the behaviour that challenged. The clinical observations of the multidisciplinary team aligned with this view. There is an emerging emphasis to attend to attachment when working with autistic clients with an intellectual disability[5]. This was previously not addressed within CW's care plan. It was agreed for Psychology to facilitate an attachment formulation workshop with staff with the aim of (1) providing information on attachment (2) developing an explanation of the presenting problem and its maintenance within the context of CW's attachment style and (3) increasing staffs' understanding of CW in order to facilitate CW's emotional regulation and to reduce the behaviours that challenged.

Prior to the attachment workshop, the direct care team completed the Motivation Assessment Scale [6] and attributed the aggressive behaviours of advancing towards staff mainly to attention seeking. The Controllability Beliefs Scale[7] was also administered. Weiner[8] highlights that when carers believe that the clients' challenging behaviour is internally controlled, carers are less likely to offer help. The score on this measure indicated that staff believed that the aggressive behaviour was not within CW's control. A three-hour attachment formulation workshop was then facilitated with ten staff involved in CW's care. This included an occupational therapist, nursing staff as well as nursing assistants. Participants' ages ranged from 18 to 45 years with the years in the service ranging from 18 months to eight years. The multidisciplinary team, CW and staff consented to undertaking this work as well as to the writing of this de-identified case report. The service confirmed consent for this information to be published.

Intervention

Formulation involves combining: psychological theory, evidence, the clinician's experience with the client's experience in order to explain the development and maintenance of problems and to guide intervention[9]. It therefore provides a reflective space for staff to consider whether cognitions and behaviours are maintaining the problem and to facilitate insight in order to become more attuned to clients. The workshop was underpinned by Crittenden's dynamic-maturational model of attachment[10]. However, it is noteworthy that Psychology has a solid research base in relation to attachment[11,12]. This construct is central to the emergence of therapeutic relationships and to the delivery of expert intervention. However, there is a dearth of research specifically investigating attachment within autistic people. Questions are also raised in relation to if attachment differs within autistic people as a result of how social communication is undertaken. Nevertheless, the emerging evidence indicates that autistic individuals do have secure attachments[13]. Moreover, all people require attachment at some point in life and this increases in importance when vulnerabilities present. For instance, when difficulties decrease levels of functioning. However, the features of autism overlap with other presentations, including attachment issues, social anxiety and obsessive-compulsive issues. There can therefore be challenges in differentiating between such presentations when they co-occur and greater sensitivity in measurement maybe required[14].

Crittenden's theory postulates that attachment consists of three components (a) a unique enduring and affectively charged relationship (b) an adaptive strategy for protecting oneself and (c) a pattern of information processing that underpins the strategy[15]. According to the model, danger and the instinct to have children drives the organization of human behaviour and, people strive to survive and to remain safe[16]. Attachment strategies emerge during childhood, when children are dependent on their attachment figure and modify their interactions in order to meet their needs for: safety, comfort, proximity and predictability[17]. The latter of which is particularly important for autistic people, as high levels of predictability are required so as to ensure emotional regulation. This primary relationship influences the development of the child's internal working model and results in the blueprint for understanding relationships[18]. Staff were facilitated to reflect on how attuned parenting enables children to develop a: sense of safety, stability and self-worth. Moreover, when a child's inner world is responded to, children can internalise this and develop a greater capacity to understand their own needs as well as the feelings of other people[19]. Conversely unattuned parenting can impede children's: emotional, physical and neurological development[20]. However, Crittenden[15] emphasises that the development of attachment strategies is a complex and fluid process which is responsive to changes in dynamics. Moreover, people can change strategies within different contexts. Accordingly, 'Type A' strategies gives preference to cognition above affect, 'Type B' strategies integrates both cognition and affect, whereas 'Type C' strategies emphasises affect whilst omitting cognition[21]. This theory was combined with the collated data, in order to construct the following 5P formulation with participants.

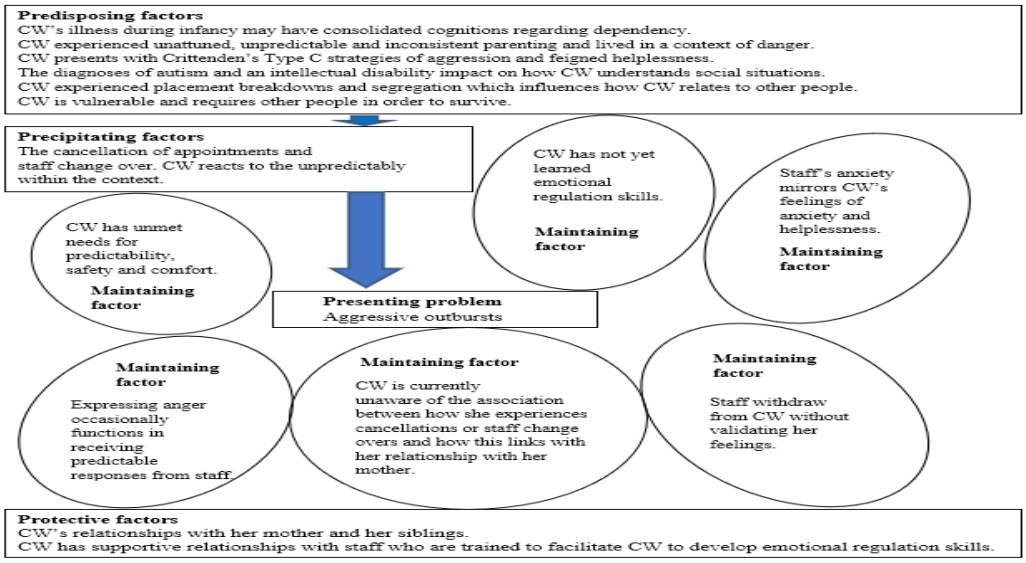

Figure 1: 5P Formulation

In reviewing the factors which predisposed CW to aggressive outbursts. CW's illness during infancy may have consolidated cognitions regarding her dependency on her attachment figure in order to survive. This may have exacerbated CW's anticipatory anxiety regarding the return of her caregiver. CW also experienced unattuned, unpredictable, and inconsistent parenting and witnessed domestic abuse. This has probably influenced how CW perceives the world and other people[22]. CW therefore lived in a context of danger which impacted on the meeting of her needs. CW's diagnoses further affects how she understands social situations. Moreover, CW experienced multiple school and placement breakdowns whereby she was consistently segregated from other people due to verbal and physical aggression, including placement within seclusion. These experiences have probably influenced how CW relates to people and may have negatively impacted on the development of CW's communication skills.

CW presents with the 'Type C strategies' of aggression and feigned helplessness[16]. This is associated with individuals who process information through the limbic structures and who have learned to focus on their own feelings and worldview in order to survive[10]. Such individuals often seek and require physical input in order to regulate emotions. This attachment strategy is associated with contexts where there is limited predictability and where individuals have deduced that neither other people nor temporal order are reliable sources of information[23]. Consequently, causal conclusions are not inferred[23]. CW has learned that when she feels anxious, exaggerated anger increases the probability of a more predicable response from her mother who has been experienced as unpredictable[24,25]. Thus, displaying anger functions in attaining predictable care from caregivers[26]. CW fears breaking contact with her mother, as she cannot predict her return. People presenting with this strategy often attempt to maintain control and the caregiver's presence by consistently communicating unsolvable problems, including changing the source of ailments[17].

CW may experience the cancellation of appointments and changes within staff as highly unpredictable events and as breaking contact with her caregiver, whom CW requires in order to survive. This triggers a sense of danger and anxiety within CW, who attempts to meet her need for predictability, safety and comfort from caregivers by expressing anger. This anger may also function in keeping CW's unmet needs and overwhelming sense of threat to self, outside of her awareness[23]. The level of aggression displayed may therefore relate to the perceived intensity of threat and felt helplessness of the person to protect oneself[23].

In examining the factors which were maintaining the emotional issue, firstly at the time of the intervention, CW presented with a limited understanding of the association between how she perceived cancellations or changes within staff and how this linked with her attachment strategy. Secondly, CW could not contain or regulate the anxiety that she experienced. It is noted that inconsistent parenting can negatively impact on the capacity to regulate emotions[27]. Expressing anger also occasionally functioned in CW receiving predicable care from staff. Staff reflected on how their anxiety mirrored CW's feelings of anxiety and helplessness. Staff too became conscious of the unpredictability within responses as well as how withdrawing from CW without validating her feel-

ings triggered an escalation of the aggressive behaviours. Moreover, as an autistic person CW has an even greater preference for routine and predictability and becomes highly distressed when this does not occur. An awareness also emerged regarding the presence of CW's unmet needs for predictability, safety and comfort, which due to vulnerabilities CW cannot meet for herself. This will be a lifelong vulnerability within CW, whereby CW will continuously require other people in order to survive.

Interventions directly addressing attachment were set out. This centred on continuing with providing a safe and predicable therapeutic environment[26] and reinforcing positive interactions between CW and her mother. It was suggested for staff to calmly sit with CW when appointments are cancelled and to wait for the anxiety to dissipate. It is more effective to facilitate a person's level of distress to reduce before conversing, as additional information can exacerbate the stress response[28]. Staff were advised to acknowledge and to normalise CW's feeling of anxiety and to verbalise the events surrounding the cancellation of appointments. This could enable CW to feel understood and in control[16]. Thus, staff would model containing and transforming maladaptive affect into language[15]. This may facilitate CW to remember the event which could assist CW in regulating her emotions when in similar situations[15]. Individuals with Type C strategies are predisposed to remaining in a victim role and thus it can be beneficial to facilitate a cognitive understanding in order to empower the person to gain ownership of events[23]. There was also a predictability within staff changeover, as it was a routine event and it was suggested to communicate this to CW. Staff continued to schedule individual interactive sessions with CW. This aimed to reduce CW's tendency to engage in aggressive and self-injurious behaviour as her needs for predictability, safety and comfort were met. Further adapted cognitive behavioural therapy for emotional regulation was recommended. This therapy can be effective with individuals with Type C strategies[26]. It was set out for this process to include continuing to support CW to utilize her mood chart on a daily basis in order to gain emotional literacy skills and to attain a sense of control in relation to her feelings. This may assist in ensuring that CW's emotional expression was not restricted exclusively to anger. It can also be beneficial for individuals with Type C strategies to be supported to learn how to consider the perspectives of other people[26]. It was emphasised that successful implementation of the interventions would require consistent delivery by the team.

Results

Staff completed qualitative feedback following the workshop. This highlighted that reviewing CW within Crittenden's attachment paradigm facilitated perceiving CW from a different perspective and attending to her mental health. Participants gained insight in relation to how CW may interpret cancellations. An understanding also emerged regarding the unmet needs underpinning CW's display of aggression. One nurse commented on the neurodevelopment of the brain and its link with CW requiring physical input for emotional regulation. Whereas, another participant reflected on how formulating enabled her to connect with and to understand CW within a complex history. This resulted in an awareness that CW was previously in a context which was not adjusted to her, which resulted in the emergence of behaviours that challenged. The attachment formulation was shared with CW, who noted that interactions and cancellations by her mother impacted on her mental health. It may have been informative to have interviewed CW's mother. This could have resulted in information regarding the personal meaning of CW's birth and how intergenerational attachment styles conflict or otherwise, which in turn could guide intervention[15]. Another limitation is that the results pertain to one client within one service and so further research is required in order to generalize the findings.

Conclusion

To conclude, CW presented with attachment issues, which can be understood within the context of her life experiences. There was added complexity present with the diagnoses of autism and an intellectual disability. Staff feedback indicated that the workshop resulted in an increased knowledge of attachment and resulted in gaining insight into the psychological processes which were partially underpinning the behaviour that challenged. CW continued to remain in the safe and predictable environment of the inpatient setting. An opportunity therefore presented, where staff with their acquired knowledge could be an attachment figure for CW[15]. This would involve staff becoming increasingly attuned to CW and mentalizing as well as containing CW's experience of anxiety whilst providing a safe space for reflection[26]. This could potentially assist CW: to increase her personal awareness, to regulate her emotions and to further increase her level of functioning[15].

Conflict of Interest: The authors have declared no conflict of interest.

Funding: This research did not receive any funding.

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