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Profiles of Irish Survivors of Institutional Abuse with Different Adult Attachment Styles

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ABSTRACT

Two hundred and forty seven survivors of institutional abuse in Ireland were classified with the Experiences in Close Relationships Inventory as having fearful (44%), preoccupied (13%), dismissive (27%) or secure (17%) adult attachment styles. The group with the secure adult attachment style had the most positive profile, while the most negative profile occurred for the fearful group in terms of DSM IV diagnoses and scores on the Trauma Symptom Inventory, the Global Assessment of Functioning Scale, the World Health Organization Quality of Life 100 scale, and the Kansas Marital Satisfaction Scale. The profile of the preoccupied group was more similar to that of the fearful group. The profile of the dismissive group was more similar to that of the secure group.

INTRODUCTION

Historically, following the foundation of the Republic of Ireland early in the 20th century, the Catholic church played a major role in Irish society. This included providing educational, correctional and health services for much of the population through its schools, reformatories and hospitals. In response to many allegations of institutional abuse within such institutions that came to media attention at the close of the 20th century, the Commission to Inquire into Child Abuse (CICA) was set up by the Irish Government. The research described in this paper was commissioned by CICA.

In a previous paper, we reported the overall characteristics of the 247 adult survivors of institutional abuse who participated in our research project (Carr, Submitted). Participants had spent an average of 10 years living in institutions before the age of 16. Almost all said they had been physically abused and about half reported being sexually abused while living in institutions. Over four fifths of participants at some point in their life had met the DSM IV (American Psychiatric Association, 2000) diagnostic criteria for an anxiety, mood, substance use, or personality disorder. On the Experiences in Close Relationships Inventory using Brennan, Clark and Shaver's (1998) SPSS algorithm, only 16.59% of cases were classified as having a secure adult attachment style. The rates for fearful, dismissive and preoccupied adult attachment styles were 44.13%, 26.72% and 12.55% respectively. This present paper is concerned with the adjustment of adults with different attachment styles, who suffered institutional abuse in childhood within the context of Irish religiously-affiliated residential reformatories and industrial schools.

In defining institutional abuse, Gallagher (1999), has proposed that this type of abuse is perpetrated by adults working within the context of institutions serving children in the community including residential care centres, schools, reformatories, churches, and recreational facilities which may be managed by either secular or religious organizations. Wolfe, Jaffe et al. (2003) extend this definition by pointing out that institutional abuse is typically an ongoing process rather than an isolated incident, within which an abuse of power occurs, and which may involve physical, sexual or emotional maltreatment.

Bowlby (1969,1973,1980, 1988) argued that an institutional upbringing and child maltreatment compromise the development of secure attachment to caregivers. This in

turn, places individuals at risk for the development of insecure attachment styles and psychopathology in adulthood. Past research on children has shown that there is an association between problematic care-giving (including institutional upbringing and child maltreatment) on the one hand, and attachment insecurity and psychopathology on the other (e.g., Greenberg, 1999; Maclean, 2003; O'Connor, Marvin et al., 2003; Rutter, 2006). Studies of adults' have shown that both the coherence of adults' narratives about their early attachment experiences (as assessed by the Adult Attachment Interview (Hesse, 2008; Main, Hesse, & Goldwyn, 2008), and adult attachment styles in romantic relationships (as assessed by self-report questionnaires (Brennan, Clark & Shaver, 1998)), are associated with non-optimal child-rearing experiences and psychopathology (e.g., Agrawal, Gunderson et al., 2004; Brennan & Shaver, 1998; Dozier, Stovall, & Albus, 1999; Fonagy, Leigh et al., 1996; Fortuna & Roisman, 2008; Fossati, Feeney et al., 2003; Meyer, Pilkonis et al., 2001; Muller, Lemieux & Sicoli, 2001; Riggs, Paulson et al., 2007; Schindler, Rainer et al., 2005; Ward, Lee & Polan, 2006). In contrast, secure attachment in childhood and adulthood is typically associated with a history of involvement in supportive and sensitive care giving relationships (Cairns, 2002; Mikulincer & Shaver, 2007).

The finding that not all survivors of childhood adversity show problematic adjustment, has led to the investigation of protective factors which promote resilience (Luthar & Zelazo, 2003), and some such research has been conducted on the effects of institutional upbringing. In a longitudinal study of children reared in institutions during their preschool years, Hodges and Tizard (1989) found that at 16 years these young people were more likely than matched normal controls to have psychological problems, and difficulties making and maintaining close peer relationships. Children who were adopted by high functioning parents with whom they developed strong, stable relationships, had better outcomes than those reunited with their biological parents after placement in residential care. The biological parents of these children were disadvantaged, had mental health problems and had difficulty offering stable parenting relationships. Thus, placement with high functioning adoptive parents was a protective factor for these children who spent their early years in institutional care. Rutter, Quinton and Hill (1990) found that men and women raised in institutions showed significant psychological problems and difficulties making and

maintaining relationships in adulthood. However, where stable supportive marital relationships were formed, better overall psychological adjustment occurred. Thus, formation of a stable marital relationship was a protective factor which promoted resilience for these cases.

Research on the adjustment of adult survivors of institutional abuse with different attachment styles has not previously been reported in the literature. The aim of the present study was to fill this gap in our knowledge by profiling subgroups of adult survivors of institutional abuse with fearful, preoccupied, dismissive and secure adult attachment styles on measures of current psychopathology, and current psychosocial adjustment. Within this context, psychopathology was assessed with structured clinical interviews for DSM IV axis I and personality disorders (SCID I and II, First, Spitzer et al., 1996, 1997) and the Trauma Symptom Inventory (TSI, Briere, 1996). Psychosocial adjustment was evaluated with the World Health Organization Quality of Life Scale 100 UK (WHOQOL 100, Skevington, 2005) and the Global Assessment of Functioning Scale (GAF, Luborsky, 1962) and the Kansas Marital Satisfaction Scale (KMS, Schumm, Paff-Bergen et al., 1986). These instruments were selected so as to assess key areas of psychopathology and psychosocial functioning with both interviewer rated (SCID and GAF) and self-report instruments (TSI, WHOQOL 100 UK, and KMS). We expected survivors of institutional abuse with insecure adult attachment styles to have greater psychopathology and poorer psychosocial adjustment. In contrast, we expected a secure adult attachment style to be a protective factor associated with resilience, and for securely attached survivors of institutional abuse to show less psychopathology and better psychosocial adjustment.

METHOD

Participants

The participants were 247 adult survivors of institutional abuse recruited through CICA, a statutory body established by the Irish Government in 2000 to investigate and report on institutional abuse in religiously affiliated reformatories and industrial schools. All people who attended CICA before December 2005 and who reported institutional abuse were

invited to participate in the study unless their whereabouts was unknown; they were resident outside Ireland and UK; they previously stated they did not want to participate in a research project; they previously stated they did not want to be contacted by CICA; they were known to be deceased; or they were known to be in poor health or to have a significant disability. The overall exclusion rate was 26%. The response rate for the study was 26%. Approximately 20% of CICA attenders participated in this study. The sample included almost equal numbers of males (54.7%) and females (45.3%), with a mean age of 60 years (SD = 8.33; Range = 40 – 83 years). Participants had spent an average of 5.4 years (SD=4.55) living with their families before entering an institution and on average spent 10 years (SD=5.21) living in an institution. It had been 22-65 years since they had suffered institutional abuse.

Ninety nine percent of participants reported that they had experienced physical abuse, serious enough to mention in answer to questions about the most severe form of physical institutional abuse they had experienced. Forty one percent reported that being assaulted to lead to medical attention was the most severe form of physical institutional abuse to which they had been exposed. For 30% it was being hit to leave bruises; for 20.6% it was being assaulted to lead to cuts; and for 5.7% it was being hit without being bruised. The average age when the most severe form of physical institutional abuse began was 8.50 years (SD = 3.72) and the average duration was 6.74 years (SD = 4.42).

Fifty one percent of participants reported that they had experienced sexual abuse, serious enough to mention in answer to questions about the most severe form of sexual institutional abuse they had experienced. Twenty two percent reported that fondling and masturbation was the most severe form of sexual institutional abuse they had experienced. For 18.6% it was oral, anal or vaginal penetration. For 6.9% it was attempted oral, anal or vaginal penetration. For 3.2% it was non-contact sex, for example, exposure. The average age when the most severe form of sexual institutional abuse began was 10.73 years (SD = 2.87) and the average duration was 2.83 years (SD = .99).

In terms of adult adjustment, 81.78% of participants at some point in their life had met the diagnostic criteria for a DSM IV anxiety, mood, alcohol or substance use, or personality disorder. Thirty four percent of participants were retired; 24% were

unemployed; 27% were unskilled or semiskilled; and the remaining 15% had skilled or professional jobs. Forty nine percent had never passed any state, college or university examination. Fifty five percent were married or in a long term cohabiting relationship, and the mean duration of such relationships was 31.10 years (SD = 10.73 years). In terms of mental health, educational and socio-economic factors, as a group, participants in this study were poorly adjusted compared with the general population, but were probably better adjusted than other CICA attenders, and other survivors of institutional abuse, since older cases in poor health or with significant disabilities and who were homeless were excluded.

Instruments

Participants were interviewed with a standard assessment protocol which elicited information on demographic characteristics and history of institutional experiences, and also contained the instruments described below.

Experiences in Close Relationships scale (ECR)

The 36-item ECR is a reliable and valid instrument for assessing adult romantic attachment style and yields scores on interpersonal anxiety and interpersonal avoidance dimensions (Brennan et al., 1998). On the basis of scores on these two dimensions, using Brennan et al.'s SPSS algorithm, cases were assigned to four adult attachment style categories: secure, fearful, dismissive and preoccupied. Seven point response formats were used for all ECR items ranging from 1=disagree strongly to 7=agree strongly. The ECR was developed from a pool of over 600 items identified in a review of 14 self-report measures of adult attachment. The avoidance and anxiety factors were identified by factor analyses, so there is good evidence for the construct validity of the scale. Internal consistency and inter-rater reliability coefficients above .9 were obtained in the present study for scores on ECR anxiety and avoidance scales.

Structured Clinical Interview for Axis I Disorders of DSM IV (SCID I)

SCID I (First et al., 1996) modules for assessing DSM IV (American Psychiatric

Association, 2000) anxiety, mood and substance use disorders were used in this study, since past research suggests that these are the main axis I disorders shown by adult survivors of child abuse. The presence of both current disorders and past (or lifetime) disorders were assessed. Diagnoses were reliably made with inter-rater reliabilities all exceeding .7.

Structured Clinical Interview for DSM IV Personality Disorders (SCID II)

SCID II (First et al., 1997) modules for assessing DSM IV (American Psychiatric Association, 2000) antisocial, borderline, avoidant and dependent personality disorders were used in the present study, since previous research suggests that these are the main axis II personality disorders associated with adult survival of child abuse. With the SCID II, only current (but not past) personality disorders were assessed. Diagnoses were reliably made with inter-rater reliabilities exceeding .9.

Trauma Symptom Inventory (TSI)

The 100 item TSI is a reliable and valid instrument which evaluates posttraumatic symptomatology (Briere, 1996). Four point response formats ranging from 0 = never to 3 = often were used for all items. The TSI yields scores a total score and scores for ten clinical scales. Internal consistency and inter-rater reliability coefficients above .9 were obtained in the present study for scores on all TSI clinical scales. The pattern of results for subscale scores were similar to those of total scores, so only the latter are reported below.

World Health Organization Quality of Life Scale 100 UK (WHOQOL 100 UK)

The UK version of the WHOQOL 100 is a reliable and valid 102 item instrument which yields an overall quality of life score along with scores for 6 domains and 24 facets (Skevington, 2005). For all items, response are given on five point Likert scales. The domains are physical well-being; psychological well-being; level of independence; quality of social relationships; quality of the environment; and quality of spiritual life. Because a similar pattern emerged for all domains, only analyses of total scores are reported below. Internal consistency and inter-rater reliability for the WHOQOL 100 total score and

subscales were above .9 in the present study.

Global Assessment of Functioning Scale (GAF)

The GAF is a reliable and valid rating scale for recording a global judgement about a person's overall psychological, social, and occupational functioning, excluding impairment due to physical or environmental factors (Luborsky, 1962). It is included in DSM-IV-TR as the Axis V assessment and forms part of the SCID. In the present study interviewers gave a single rating from 1–100. Inter-rater reliability of the GAF was .9.

Kansas Marital and Parenting Satisfaction Scales (KMS)

The 3 item KMS (Schumm et al., 1986) is a reliable and valid measure of the quality of marital or long-term cohabiting relationships. Seven point response formats were used for all items ranging from 1=extremely dissatisfied to 7=extremely satisfied. In the present study internal consistency and inter-rater reliability co-efficients above .9 were obtained for the KMS.

Procedure

The study was designed to comply with the code of ethics of the Psychological Society of Ireland and ethical approval for the study was obtained through the UCD Human Research Ethics Committee. Between June and December 2005, a team of 29 interviewers, all of whom had psychology degrees, conducted face-to-face interviews of about 2 hours duration at multiple sites in Ireland (N=126) and the UK (N=121). Participants were reimbursed for travel and subsistence. Protocol data were not used for clinical or litigation purposes. Inter-rater reliability of all protocol scales was assessed for 52 cases.

RESULTS

Classification of cases into adult attachment categories

Using Brennan et al's (1998) ECR SPSS algorithm to assign cases into adult attachment categories, 109 (44%) were classified as fearful, 31 (13%) as preoccupied, 66 (27%) as dismissive, and 41 (17%) as secure.

Analytic strategy

In Tables 1-3 the statistical significance of intergroup differences was determined with chi square tests for categorical variables and one-way ANOVAs for continuous variable. In all analyses p values were set conservatively at $p<.01$ to reduce the probability of type 1 error. Where chi square tests were significant at $p<.01$, group differences were interpreted as significant if standardised residuals in table cells exceeded an absolute value of 2. Scheffe post-hoc comparison tests for unequal cell sizes were conducted to identify significant intergroup differences in those instances where ANOVAs yielded significant F values. Pearson product moment correlations were used to evaluate relationships between continuous variables, while point biserial correlations were computed to evaluate the relationship between continuous and dichotomous variables.

Insert Table 1 about here

Demographic and historical characteristics

From Table 1 it may be seen that the four groups differed significantly on marital status and number of children. Significantly more members of the secure group were still married or cohabiting with their first partner compared with the other three groups. Compared with the other three groups, significantly more members of the preoccupied group were married or cohabiting in a second or later long-term relationship and they also had significantly more children. The four groups did not differ significantly on gender, age, socio-economic status, or years spent with their current partner. The four groups did not differ significantly in the number of years spent with families before entering institutions, number of years spent living in institutions, reasons for entering institutions and whether institutions were managed by nuns, brothers or priests.

Insert Table 2 about here

Psychopathology

From Table 2 it may be seen that overall rates of current and lifetime DSM IV axis I disorders; current mood disorders; current anxiety disorders; lifetime alcohol dependence; and personality disorders were significantly lower for the secure group compared with the fearful or preoccupied groups. Also overall rates of current DSM IV axis I disorders; current anxiety disorders; lifetime alcohol dependence; and personality disorders were significantly lower for the dismissive group compared with the fearful or preoccupied groups. From Table 3 it may be seen that on the TSI, which assess trauma symptomatology, compared with the fearful and preoccupied groups, the mean scores of the secure and dismissive groups were significantly lower.

Insert Table 3 about here

Psychosocial adjustment

From Table 3 it may be seen that on the WHOQOL 100 UK and the GAF, the mean scores of the secure and dismissive groups were significantly higher than those of the fearful and preoccupied groups. On the KMS the mean score of the secure group was significantly higher than those of the fearful and dismissive groups.

Summary profiles

Summary profiles of the 4 groups are given in Table 4. The group with the secure adult attachment style had the most positive profile, while the most negative profile occurred for the fearful group. The profile of the preoccupied group was more similar to that of the fearful group. The profile of the dismissive group was more similar to that of the secure group.

Correlational analyses

In addition to the comparative group analyses, correlational analyses were conducted to evaluate the relationship between ECR dimensions and indices of current functioning, because of the evidence supporting the validity of dimensional approaches to conceptualizing attachment styles (Brennan et al., 1998; Fraley & Waller, 1998). These are given in Table 5. There were significant ($p<.01$) correlations between the ECR interpersonal anxiety dimension and the following variables: the total number of current and lifetime axis I disorders and personality disorders on the SCID I and II ($r = .37$), the TSI total score ($r = .58$), the WHOQOL 100 UK total score ($r = -.49$), and the GAF rating ($r = -.28$). The correlation between the ECR interpersonal anxiety dimension and the KMS total score was not significant. There were also significant ($p<.01$) correlations between the ECR interpersonal avoidance dimension and the following variables: the total number of current and lifetime axis I disorders and personality disorders on the SCID I and II ($r = .26$), the TSI total score ($r = .22$), the WHOQOL 100 UK total score ($r = -.26$), the GAF rating ($r = -.23$) and the KMS total score ($r = -.38$). There was a significant point biserial correlation between ECR interpersonal avoidance and the dichotomous variable 'married or cohabiting in first long term relationship' ($r = -.27$). The correlation between this variable and ECR interpersonal anxiety was not significant. These correlational analyses show that ECR interpersonal anxiety and avoidance dimensions were significantly correlated with all indices of psychopathology and psychosocial adjustment used in the analyses, with only two exceptions. Interpersonal anxiety was not significantly correlated with marital satisfaction or stability.

The dependent variables in this study were conceptually inter-related. To assess the significance, strength and direction of these relationships, correlations between dependent variables were conducted. These are given in Table 5. There were large and significant ($p<.01$) correlations between the total number of current and lifetime axis I disorders and personality disorders on the SCID I and II, the TSI total, the WHOQOL 100 UK total, and the GAF rating. In absolute values, these correlations ranged from .45 to .69. As expected there was a positive correlation between the number of diagnoses and the TSI total; and negative correlations between these two variables and the WHOQOL 100 UK total, and

the GAF rating. There were smaller, but significant ($p<.01$) correlations between the KMS and the TSI total, the WHOQOL 100 UK total, and the GAF rating, which ranged, in absolute values, from .18 to .32. As expected there was a negative correlation between the KMS and the TSI total; and positive correlations between the KMS and the WHOQOL 100 UK total, and the GAF rating. There were significant positive point biserial correlations between the dichotomous variable 'married or cohabiting in first long term relationship' and both the WHOQOL 100 UK total ($r = .21$) and the KMS ($r = .80$).

DISCUSSION

In support of our main hypothesis, we found that the secure group had the most positive profile. The most negative profile occurred for the fearful group. The profiles of the other two groups fell between these two extremes. The profile of the preoccupied group was more similar to that of the fearful group, while the profile of the dismissive group was more similar to that of the secure group. Adult survivors of institutional abuse with secure adult attachment styles had less psychopathology and showed better psychosocial adjustment with respect to quality of life, global functioning, marital satisfaction, and marital stability. Surprisingly, this positive overall adjustment was unrelated to the number of years spent in the family of origin before institutional entry and the number of years spent in an institution. Adult survivors of institutional abuse with fearful adult attachment styles had more psychopathology and showed poorer psychosocial adjustment in terms of quality of life, global functioning, marital satisfaction, and marital stability. In reporting these analyses it is acknowledged that ECR data are usually rendered on a continuum, but in order to comment on sub-groups among our sample, in particular those survivors classified as having a secure adult attachment style, we chose to render the data in a categorical form. However, consistent with these typological analyses, correlational analyses showed that ECR interpersonal anxiety and avoidance dimensions were significantly correlated with all indices of psychopathology and psychosocial adjustment used in the study, with only two exceptions. Interpersonal anxiety was not significantly correlated with marital satisfaction or stability. Correlational analyses also showed that, as expected, there were moderate to strong correlations between measures of psychopathology and psychosocial adjustment

used in this study. Overall, these results suggest that a secure adult attachment style may be a protective factor in promoting resilience in adult survivors of institutional abuse, while an insecure attachment style may be a risk factor for problematic adjustment. However, this conclusion must be tempered with the caveat that no firm conclusions may be drawn about causal links between adult attachment style, psychopathology and psychosocial adjustment. Statistically significant relationships between attachment style on the one hand, and psychopathology and psychosocial adjustment on the other, were found in the current study. However, it is not possible to determine whether a secure attachment style led to less psychopathology and better psychosocial functioning, or visa versa, or whether there was a reciprocal relationship between variables within these domains.

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Insert Table 4 about here

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Comparison with past research

This is the first study to profile the adjustment of Irish survivors of institutional abuse with different adult attachment styles. However our results are consistent with those of studies of adults which have shown that insecure attachment in childhood and in adult romantic relationships is associated with non-optimal child-rearing experiences and psychopathology (e.g., Agrawal, Gunderson et al., 2004; Brennan & Shaver, 1998; Dozier, Stovall, & Albus, 1999; Fonagy, Leigh et al., 1996; Fossati, Feeney et al., 2003; Meyer, Pilkonis et al., 2001; Muller, Lemieux & Sicoli, 2001; Riggs, Paulson et al., 2007; Schindler, Rainer et al., 2005; Ward, Lee & Polan, 2006).

The finding in the current study, that those with secure adult attachment styles showed less psychopathology and better psychosocial adjustment is consistent with the growing international empirical literature supporting this finding (Mikulincer & Shaver, 2007).

The finding that more participants with a secure adult attachment style were in stable first martial or cohabiting relationships, and were better adjusted is consistent with the finding of Rutter et al. (1990), that well adjusted survivors of institutional living were in stable marriages, and that marital stability may be a protective factor promoting resilience in adult survivors of institutional living. It is noteworthy that although groups with secure and preoccupied adult attachment styles did not differ in levels of marital satisfaction, significantly more participants with secure adult attachment styles were in their first marital or cohabiting relationship. Therefore a secure adult attachment style is more strongly associated with relationship stability than relationship quality.

The proportions of cases which fell into the 4 attachment style categories were not vastly dissimilar to those found in studies of trauma survivors and mental health service patients, where commonly more cases fall into the fearful category than any other. For example, Allen, Coyne & Huntoon (1998) in a study of trauma survivors found 68% had a fearful adult attachment style, and Riggs et al. (2007) in a study of psychiatric inpatients found 58% of her sample were fearful.

An important issue is the degree to which survivors of institutional abuse with secure adult attachment styles, resembled the normal population. On the GAF, the clinical cut-off score below which moderate or severe psychological symptoms are shown is 70. In round numbers, the mean score for the secure group of 69 was far closer to this cut-off point than the mean scores of all three insecure groups which ranged from 52-61 and were indicative of significant problems with global functioning. For the TSI total score, averaging across general population norms for males and females over 55, the clinical cut-off raw score is 97. This is equivalent to a T score of 65 which is 1.5 standard deviations above the mean. TSI total scores above 97 indicate clinically significant trauma symptoms. In round numbers, the mean score of the secure group of 60 fell well below this cut-off point. In contrast the mean scores of the fearful and preoccupied groups which were 177 and 119 respectively fell above the TSI clinical cut-off score and were indicative of clinically significant trauma symptoms. Norms for the WHOQOL 100 UK and KMS are unavailable and so normative comparisons cannot be made with data from the present study for these

instruments. However, it is possible to put the rates of psychological disorders in the four attachment categories in Table 2 in context, by making comparisons with prevalence rates for current mood and anxiety disorders in Europe with reference to data from Alonso et al. (2004), and in the USA with reference to data from Kessler, Chiu et al. (2005). Comparisons may also be made with prevalence rates of personality disorders in Europe based on Torgersen and colleagues' (2001) study in Norway and a USA study by Grant et al. (2004). Using data from these representative community samples, and rounding percentages to whole numbers the following comparisons may be drawn. For current mood disorders, prevalence rates in Europe and the USA ranged from 4-10%. In the present study, for the group with a secure adult attachment style, the rate of 12% was far closer to this norm, than the rates of 18-36% shown by groups with insecure adult attachment styles. For current anxiety disorders, prevalence rates in Europe and the USA ranged from 6-18%. In the present study, for the group with a secure adult attachment style, the rate of 22% was far closer to this norm, than the rates of 27-61% shown by groups with insecure adult attachment styles. For personality disorders, prevalence rates in Europe and the USA ranged from 13-15%. In the present study for the group with a secure adult attachment style, the rate of 12% fell within this norm, whereas the rates of 19-44% shown by groups with insecure adult attachment styles were above the norm. These comparative results suggest that survivors of institutional abuse in our study who developed secure adult attachment styles, as a group, showed rates of common psychological disorders closer to population norms than survivors with insecure attachment styles. This suggests that a secure adult attachment style may be a protective factor promoting resilience in adult survivors of institutional abuse. Furthermore, those with fearful or preoccupied adult attachment styles, in the present study, were the most vulnerable, showing rates of psychopathology that were 2 to 3 times higher than in the normal population, suggesting that these attachment styles are significant risk factors.

Limitations

The non-representativeness of the sample, the retrospective nature of the childhood data, and the fact that some participants were applying for compensation were the principal

limitations of this study. Participants were a self-selected group who volunteered for the study in response to an invitation from CICA and this limits the results' generalizatbility. Recollections of institutional abuse and other life events may have been influenced by participants' current mental health and psychological adjustment. A prospective longitudinal study, of a randomly chosen representative sample would have been methodologically (though not ethically) preferable to the retrospective design we used. Some participants were applying for compensation and this may have affected the validity of self-report data, possibly elevating the level of self-reported childhood institutional adversity and current psychopathology. However, because none of the protocol data were used for legal purposes, the tendency for participants seeking compensation to do this may have been somewhat reduced. On the positive side, ours is the largest study of its kind to date and the only such study conducted within an Irish context.

Interpretation and implications

The results of the present study show that secure and insecure adult attachment styles are associated with quite different levels of adult psychopathology and psychosocial adjustment. The mechanisms or processes underpinning these associations should be the focus of further research in this area.

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Table 1. Demographic and historical characteristics

Variable	Categories		Group 1 Fearful	Group 2 Preocc	Group 3 Dismis	Group 4 Secure	χ^2 or F	Group Diffs
			N=109 44.13%	N=31 12.55%	N=66 26.72%	N=41 16.59%		
Gender							8.21	NS
	Male	f	54.00	23.00	32.00	26.00		
		%	49.50	74.20	48.50	63.40		
	Female	f	55.00	8.00	34.00	15.00		
		%	50.50	25.80	51.50	36.60		
Age in years							2.79	NS
		M	58.35	61.16	61.46	61.49		
		SD	8.10	8.12	8.23	8.72		
Years with family before institution							1.42	NS
		M	5.13	6.95	5.36	5.03		
		SD	4.31	5.13	4.66	4.45		
Years in institution							1.93	NS
		M	10.38	8.13	9.86	10.85		
		SD	5.20	5.14	5.03	5.33		
Reason for entering institution (N=241)							17.85	NS
	Illegitimate	f	16.00	7.00	15.00	10.00		
		%	15.09	24.14	22.73	25.64		
	Put in by authorities for petty crime	f	21.00	13.00	15.00	9.00		
		%	19.81	44.83	22.73	23.08		
	Put in because parents could not provide care	f	55.00	7.00	22.00	15.00		
		%	51.89	24.14	33.33	38.46		
	Put in because parent(s) died	f	14.00	2.00	14.00	5.00		
		%	13.21	6.90	21.21	12.82		
Institution management							12.91	NS
	Nuns	f	61.00	10.00	34.00	16.00		
		%	55.96	32.26	51.52	39.02		
	Brothers/ Bros+ Priests	f	26.00	17.00	19.00	15.00		
		%	23.85	54.84	28.79	36.59		
	Nuns + Bros/Priests/Other	f	22.00	4.00	13.00	10.00		
		%	20.18	12.90	19.70	24.39		
Current socio-economic status (N=241)							15.54	NS
	Unemployed	f	34.00	6.00	15.00	5.00		

Table 2. Frequency of psychological disorders

Disorders		Group 1 Fearful N=109	Group2 Preoccupied N=31	Group 3 Dismissive N=66	Group 4 Secure N=41	χ^2	Group diffs
Any DSM IV Axis I disorder (lifetime or current)	f	96.00	28.00	49.00	28.00	11.71**	1=2>4
	%	88.10	90.30	74.20	68.30		
Any DSM IV Axis I disorder (current)	f	71.00	21.00	24.00	12.00	25.56***	1=2>3=4
	%	65.10	67.70	36.40	29.30		
Any DSM IV mood disorder (current)	f	40.00	9.00	12.00	5.00	12.50**	1=2>4
	%	36.70	29.00	18.20	12.20		
Any DSM IV anxiety disorder (current)	f	66.00	19.00	18.00	9.00	31.10***	1=2>3=4
	%	60.60	61.30	27.30	22.00		
Alcohol dependence (lifetime)	f	33.00	14.00	9.00	10.00	11.97**	1=2>3=4
	%	30.30	45.20	13.60	24.40		
Any Personality Disorder	f	48.00	8.00	13.00	5.00	20.03***	1=2>3=4
	%	44.00	25.80	19.70	12.20		

Note: Adult attachment styles were based on ECR (Brennan, Clark & Shaver, 1998). Fearful = high anxiety and high avoidance. Preoccupied = high anxiety and low avoidance. Dismissive = high avoidance and low anxiety. Secure = low anxiety and low avoidance. Diagnoses were made with the SCID I (First et al., 1996) and SCID II (First et al., 1997). Psychological disorders do not represent mutually exclusive categories and so percentages within and across groups sum to more than 100%.. f = frequency. Where chi square tests were significant at $p<.05$, group differences were interpreted as significant if standardised residuals equalled or exceeded an absolute value of 2.00. **$p<0.01$. ***$p<0.001$.

Table 3. Trauma symptoms, quality of life, global functioning, and marital satisfaction

Variable		Group 1 Fearful N=109	Group 2 Preocc N=31	Group 3 Dismiss N=66	Group 4 Secure N=41	F	Group diffs
Trauma symptom Inventory total (N=247)	M	177.78	119.51	66.06	60.29	33.27***	1=2>3=4
	SD	43.61	46.35	39.57	42.66		
WHOQoL 100 UK Total (N=247)	M	84.85	84.55	97.77	104.53	23.44***	1=2<3=4
	SD	14.70	16.56	15.54	13.78		
Global assessment of functioning (N=235)	M	52.17	56.10	61.18	69.73	12.44***	1=2<3=4
	SD	20.74	19.32	21.11	17.97		
Kansas Marital Satisfaction (N=136)	M	6.96	13.61	7.65	15.27	10.07***	1=3<4
	SD	8.32	8.50	8.38	8.99		

Note: Adult attachment styles were based on ECR (Brennan, Clark & Shaver, 1998). Fearful = high anxiety and high avoidance. Preocc = preoccupied, high anxiety and low avoidance. Dismis = dismissive, high avoidance and low anxiety Secure = low anxiety and low avoidance.. N = number of cases. M = mean. SD = Standard deviation. F values are from one-way analysis of variance and inter-group differences are based on Scheffe post hoc tests for comparing groups with unequal Ns. ***p<0.001.

Table 4. Summary profile of survivors of institutional abuse with different adult attachment styles

	Group 1 Fearful	Group2 Preoccupied	Group 3 Dismissive	Group 4 Secure
Psychopathology				
Any Axis I disorder (current or past)	++	++	+	-
Any Axis I disorder (current)	++	++	-	-
Any mood disorder (current)	++	++	+	-
Any anxiety disorder (current)	++	++	-	-
Alcohol dependence (past)	++	++	-	-
Any personality disorder	++	++	-	-
Trauma symptoms	++	++	-	-
Psychosocial adjustment				
High quality of life	-	-	++	++
High global functioning	-	-	++	++
Marital satisfaction	-	+	-	++
Demographic factors				
With first long-term partner	-	-	-	++
More than 4 children	-	++	-	-

Note: Adult attachment styles were based on the Experience in close relationships inventory SPSS algorithm in Brennan, Clark & Shaver (1998). Fearful = high anxiety and high avoidance. Preoccupied = high anxiety and low avoidance. Dismissive = high avoidance and low anxiety. Secure = low anxiety and low avoidance. ++ = The group had the highest level of this attribute in situations where 2 or 3 of the groups differed from each other. + = The group had a lower level of this attribute than a group marked ++. - = The group had the lowest level of this attribute compared with the other groups.

Table 5. Correlations between variables

Variable	ECR Anxiety	ECR Avoidance	Total No SCID I & II Diagnoses	TSI total	WHOQoL 100 UK	GAF	KMS
ECR Avoidance	**.29**	-	-	-	-	-	-
Total no. SCID I & II diagnoses	**.37**	**.26**	-	-	-	-	-
TSI Total	**.58**	**.22**	**.65**	-	-	-	-
WHOQoL 100 UK total	**-.49**	**-.26**	**-.58**	**-.69**	-	-	-
GAF	**-.28**	**-.23**	**-.52**	**-.45**	**.46**	-	-
KMS	-.11	**-.38**	-.11	**-.19**	**.32**	**.18**	-
Married or cohabiting in first long term relationship	-.08	**-.27**	-.08	-.14	**.21**	.03	**.80**

Note: ECR = Experiences in Close Relationships Inventory.. SCID I = Structured Clinical Interview for Axis I Disorders of DSM IV. SCID II = Structured Clinical Interview for DSM IV Personality Disorders. TSI = Trauma Symptom Inventory. GAF = Global assessment of functioning scale. WHOQOL 100 UK = World Health Organization Quality of Life 100 UK. KMS = Kansas Marital Satisfaction Scale. Correlations in bold are significant at $p < .01$. N = 247 for all variables except GAF where N=235 and KMS where N = 136.