ATTACHMENT PATTERNS, COPING, EMOTIONAL PROCESSING AND THERAPY ALLIANCE IN RECOVERY FROM TRAUMA

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Abstract

This study investigated the role of personality factors, coping and attachment in torture survivors' recovery, thus enhancing both attachment and trauma theories. The participants were Palestinian political ex-prisoners who were victims of human-rights abuse (the number of participants ranging from 36 to 176) from the Gaza strip. The findings revealed that in the natural course of recovery, avoidance symptoms were common when the trauma was still fresh, and at that time, relying on problem-focused coping was beneficial. However, in the long run, emotion-focused coping was related to successful recovery. Moreover, attachment was triggered in dangerous circumstances and was related to different ways of reacting in the aftermath of trauma. First, individuals with different attachment patterns differed in their strengths and vulnerabilities depending on whether the torture was psychological and interpersonal or physical. Secure individuals coped better with exposure to physical torture than to psychological torture, while insecurity was associated with increased levels of both psychological and somatic symptoms in exposure to physical torture. Secondly, we studied the emotional processing of traumatic memories. Secure men had a balanced emotional profile involving both cognitive and affective responses despite the severity of trauma exposure. Preoccupied men, in turn, showed intensive affective and behavioral responses, which heightened during extreme stress, while dismissive men showed intensive cognitive and low-intensity affective responses despite the degree of exposure. Thirdly, although there were no differences in early therapy alliance, the development of alliance during the therapy followed different paths for different attachment groups. The secure trauma patients' pattern of alliance was the most even, while that of the preoccupied patients showed the most fluctuation. The pattern of alliance for dismissive patients, in turn, grew towards being more negative. In sum, both personality and the significance of the trauma need to be considered when helping victims of human-rights abuse.

Kidutus traumoista toipuminen: kiintymysmallien, selviytymisstrategioiden, emotionaalisen prosessoinnin ja terapeuttisen allianssin merkitys

Tiivistelmä

Tutkimus keskittyi persoonallisuustekijöiden (kiintymysmallien ja selviytymisstrategioiden) merkitykseen kidutustraumoista toipumisessa kiintymys- ja traumateorioiden näkökulmista. Tutkimuksen osallistujat olivat palestiinalaisia vapautettuja vankeja, jotka olivat tulleet kidutetuiksi vankeusaikanaan (36 – 176 osallistujaa tutkimuskysymyksestä riippuen). Tutkimme selviytymisstrategioiden yhteyttä hyvinvointiin luontaisessa toipumisprosessissa. Tutkimuksessa havaittiin, että luontaisessa toipumisprosessissa välttämisoireet olivat ensi alkuun tyypillisiä. Tällöin ongelmakeskeiset selviytymisstrategiat olivat yhteydessä parempaan hyvinvointiin. Kuitenkin pitkällä tähtäimellä tunnesuuntautuneet selviytymisstrategiat olivat hyödyllisempiä. Tutkimme myös sitä miten eri kiintymystyylit aktivoituvat traumaattisissa tilanteissa ja millaisiin reagointitapoihin ne ovat yhteydessä. Ensinnäkin eri kiintymysmallin omaavat henkilöt erosivat heikkouksissaan ja vahvuuksissaan riippuen siitä oliko kidutustrauma luonteeltaan fyysistä tai psyykkistä eli vuorovaikutuksessa tapahtuvaa. Turvallisesti kiintyneet miehet selviytyivät paremmin fyysisestä kuin psyykkisestä kidutuksesta, kun taas turvattomasti kiintyneet miehet reagoivat niin psyykkisin kuin fyysisin oirein tullessaan kidutetuiksi fyysisin keinoin. Lisäksi tutkimme traumaattisten muistojen emotionaalista prosessointia ja niiden yhteyksiä kiintymysmalleihin. Turvallisesti kiinnittyneiden miesten emootioiden käsittely oli tasapainoista, sisältäen niin kognitiivista kuin tunnepitoista trauman prosessointia kidutuksen määrästä riippumatta. Ristiriitaiset miehet näyttivät sen sijaan turvautuvan intensiiviseen tunnepitoiseen prosessointiin ja toiminnallisiin reaktioihin, mitkä vahvistuivat entisestään äärimmäisissä stressiolosuhteissa. Etäännyttävästi kiinnittyneet miehet vuorostaan prosessoivat muistojaan intensiivisen kognitiivisesti ja välttäen tunnepitoista prosessointia riippumatta trauman määrästä. Lopuksi tutkimme terapeuttisen allianssin eli yhteistyösuhteen yhteyttä kiintymysmalleihin. Vaikka terapian alussa eri kiintymystyylin omaavat ryhmät eivät eronneet toisistaan, oli allianssin kehittymisessä selkeästi oma kulkunsa kiintymysmallista riippuen. Turvallisesti kiintyneiden miesten allianssin kehitys oli tasaisin, kun taas ristiriitaisesti kiintyneiden miesten allianssissa näkyi suurimpia vaihteluita. Etäännyttävästi kiintyneiden miesten allianssi sen sijaan kehittyi negatiivisempaan suuntaan. Tutkimuksen tulokset korostavat persoonallisuuden tekijöiden huomioimisen merkitystä suunniteltaessa ihmisoikeusrikkeiden uhrien kuntouttamista.

Kiitokset

Haluan kiittää seuraavia henkilöitä, joiden tuki on ollut merkittävä väitöskirjaprosessin aikana. Ennen kaikkea haluan kiittää työni ohjaajaa professori Raija-Leena Punamäkeä, joka on yhdeksän vuoden ajan ollut eläytyvän väsymätön kannustaja ja tuki. Hänen taitoihinsa kuuluu tiukan, mutta rakentavan kritiikin antaminen myönteisessä hengessä. Hän on onnistunut välittämään innostuksen tieteellisiin kysymyksiin kulttuurien ja tiederajojen yli. Erityisen ihailtavaa on hänen kykynsä ja kiinnostuksensa tutkimustietojen saattamiseen kliinikoiden käyttöön heti uusien analyysien valmistuttua.

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List of original publications

Article I
Kanninen, K., Punamäki, R.L., & Qouta, S. (2002). The relation of appraisal, coping efforts, and acuteness of trauma to PTS symptoms among former political prisoners. *Journal of Traumatic Stress*, 15, 175-165.

Article II
Kanninen, K., & Punamäki, R.L. Qouta, S. (2003). Personality and trauma: Adult attachment and posttraumatic distress among former political prisoners. *Peace and Conflict: Journal of Peace Psychology, 9, 97-126,*

Article III
Kanninen, K.,Qouta, S., Punamäki, R.L. (2003). Adult attachment and emotional responses to traumatic memories among Palestinian former political prisoners. *Traumatology*, 9, 15-26.

Article IV
Kanninen, K., Salo, J., & Punamäki, R.L. (2000). Attachment patterns and working alliance in trauma therapy for victims of political violence. *Psychotherapy Research, 10,* 435-449.

The articles are referred by their Roman numerals in the text

INTRODUCTION

Although we wish there were new political winds blowing, forbidding all organized violence, we are confronted with the fact that human psychology has not changed. Humans will continue to fight and destroy with even more destructive means. Despite numerous international declarations, torture and ill-treatment remain a major problem. According to the latest reports, Amnesty International listed 100 countries known for some form of human-rights violation in the previous year. Lately, the news has made the problem more visible in the aftermath of the "legalized treatment" of Iraqi soldiers, for example. Torture is defined as a typical man-made trauma where another human being deliberately causes the victim psychological and physical suffering in an attempt to achieve political, economic or social objectives. Psychological torture is a complex form of interpersonal trauma that involves humiliation, threats, and fright. Physical torture causes intolerable pain through measures such as beating, burning, and stretching. Its special features, that victims have no objective control over the situation and are confronted with unpredictable horrors inflicted by fellow-humans, add to its complexity.

Post-traumatic stress disorder (PTSD), together with other anxiety disorders and depression, is the most common mental disorder in the aftermath of severely traumatic events (Saraceno, Saxena & Maulik, 2002). DSM-IV diagnostic criteria (1994) for PTSD defines traumatic events as involving physical injury or threat to an individual's integrity, and include responses of helplessness or horror, and symptoms of re-experiencing, avoidance and hyperarousal. Other traumatic reactions may include somatic symptoms, feelings of shame, guilt, anger, emotional numbing, memory problems, and even brain alterations. Psychosocial problems also seem to occur, and include alienation, substance abuse, vocational incapacity, and problems in intimate relationships (Pitman, 1994; Basoglu & Mineka, 1992; Ramsay, Gorst-Unsworth & Turner, 1993; Keane, Albano & Blake, 1992; Kozaric-Kovacic, Folnegovic-Smalc, Skrinjaric & Szajnberg, 1995).

It has become clearer in recent years that the PTSD syndrome is more than a simple extension of normative stress response (McFarlane, 1997). In many individuals (depending on the type of trauma), the acute stress symptoms typically abate within weeks following the traumatic event. In other words, there is some truth behind the saying of time healing wounds. In some individuals, however, PTSD symptoms first emerge months or even decades after the trauma, and in others there may be a life-long pattern of oscillating between active PTSD and remitted symptoms (McFarlane, 1997; Amir, Kaplan & Kotler,

1996; Roth & Cohen, 1986; Weisaeth, 1993). Thus, there is a great need to develop effective treatment methods, and to understand what takes place in natural recovery.

Focusing on human aggression should nevertheless not overshadow the fact that humans also care for others, and also wish to repair and restore them (Volkan, 2004). Professionals worldwide work with victims of torture and ill-treatment, strive to understand their experiences, and try to find suitable methods and establish guidelines for treatment. The aim throughout our study was to help them in their search for methods, as well as to furnish them with knowledge that would be useful in their work.

Appraisal and coping in recovery from trauma

Earlier theoretical thinking on trauma showed traces of the simplistic stimulus-response model. It was common to assume that the more traumatic experiences the person had been exposed to, the more suffering she/he would endure. Research indeed shows that the nature of trauma influences the severity of PTSD. It seems that man-made trauma has more severe consequences than natural catastrophes. For instance, more than half of torture victims (Allodi, 1985; Hougen, Kelstrup, Petersen & Rasmussen, 1988), and 32% to 80% of rape victims (Breslau, Davis, Andreski & Petersen, 1991; Kilpatrick, Edmunds & Seymour, 1992), suffer from PTSD, whereas only 4% of the victims of hurricanes, volcanic eruptions and floods do so (McMillen, North & Smith, 2000; Norris, 1992). Furthermore, studies undertaken at multiple sites have confirmed that torture is a particularly threatening form of abuse, resulting in greater levels of psychiatric morbidity (Basoglu, Jaranson, Mollica & Kastrup, 2001, Shrestha et al, 1998), even when other forms of human-rights violations and trauma are taken into account (Silove, Steel, McGorry, Miles & Drobny, 2002).

Yet, not all victims of torture continue to suffer, and some even blossom after release. According to the transactional model, various person- and environment-related factors mediate the impact of trauma on mental health (Folkman & Lazarus, 1991), and their influence may be stronger than the sole trauma exposure. In facing trauma, individuals evaluate how relevant, harmful, and controllable the event is. The appraisals further influence the choice of coping efforts to either alter the stressful reality (problem-focused coping) or to regulate their emotional reactions (emotion-focused coping). Appraisal and coping efforts, together with social resources, determine whether an experience is associated with suffering or with recovery (Lazarus, 1991).

Earlier research has shown that appraising a situation as controllable is often associated with problem-focused coping (Mikulincer, Florian & Weller, 1993) and fewer post-traumatic symptoms, (Fairbank, Hansen & Fitterling, 1991), while appraising it as uncontrollable (Mikulincer & Solomon, 1989) and threatening (Mikulincer et al, 1993) is related to the use of emotion-focused and distancing coping strategies. Problem-focused coping has been generally found to be more effective than emotion-focused coping in alleviating stress reactions (Blake, Cook & Keane, 1992; Conway & Terry, 1992; Fairbank et al, 1991; Mikulincer et al, 1993; Solomon, Mikulincer & Avitzur, 1988; Solomon, Mikulincer & Benbenishty, 1989).

However, when coping is seen as a process that changes according to the nature of the situation and time elapsed since the trauma, using flexibly alternating strategies may be associated with better adjustment (Folkman, 1984; Lazarus, 1985, Lazarus & Folkman, 1984; Mattlin, Wethington & Kessler, 1990; Punamäki, Quota & El Saraj, 1997; Roth & Cohen, 1986). Folkman and Lazarus (1991) further suggested that emotion-coping strategies may promote well-being temporarily, but they are not successful in the long run because they do not improve the problematic situation. In contrast, Suls and Fletcher (1985) concluded in their review that a person's general, stable, avoidant style (activity oriented away from the threat) was superior at alleviating stress in the short term, but non-avoidant styles were better in the long run. The effectiveness of coping has been studied widely, but mostly in experimental, non-trauma settings with college students, and without follow-ups. No conclusions regarding the effect of the passage of time can be drawn for trauma groups on the basis of earlier studies. Therefore, the first contribution of this study lies in the fact that it was carried out in the context of real-life trauma, and took the passage of time since the traumatic event into account. Furthermore, we could find no studies investigating the different paths through which appraisal, coping and symptoms are related.

Consequently, the first aim of the study was to find optimal ways of appraisal and coping when torture survivors are recovering from their multifaceted traumas. We focused on the different paths through which appraisal and coping efforts mediate between traumatic experiences and post-traumatic symptoms. Furthermore, we wanted to investigate the effect of time on optimal coping.

The role of attachment in recovery from trauma

There is some tension in the field of trauma research between those who prefer to normalize the status of victims and those who prefer to define PTSD as a psychiatric illness. McFarlane (1997) emphasizes the fact that PTSD is not a normal response to abnormal experience, because many studies have shown the existence of risk factors other than trauma as predictors. Thus, there has been a growing interest in identifying so-called vulnerability factors that may lie behind its development.

The published literature on the role of personality and familial aspects of PTSD is small in extent and inconclusive. According to one study on the family history of veterans and prisoners of war, two thirds of individuals with PTSD have a family history of psychopathology, primary alcoholism, anxiety, and depression (Davidson, Swartz & Storck, 1985). Meanwhile other studies have found no differences from the controls except for greater familial anxiety (Davidson, Smith & Kudler, 1989), or then a family history of mental illness has been found to correlate only weakly with PTSD (Speed, Engdahl & Swartz, 1989). Data from studies on civilian populations at risk from PTSD are varied as well, but a family psychiatric history (McFarlane, 1988; Breslau, Davis & Andreski, 1991; Davidson, Hughes & Blazer, 1991) has been shown to form a premorbid risk factor. All in all, it seems that vulnerability factors are important within a certain range of trauma severity: it takes proportionately more trauma to produce PTSD in less predisposed individuals. In other words, extreme levels of trauma may bring out PTSD in the hardiest (Connor & Davidson, 1997).

Nevertheless, considering the great individual differences in recovery, we took the question of personality seriously. The role of personality factors has become a common explanation for differences in recovery rates and it is always referred to as an important factor (e.g., Horowitz, 1979; Miller, 1992; Shalev & Yehuda, 1998, Wilson, 1989; Somerfield & McCrae, 2000). However, empirical studies are scarce. In accordance with modern cognitive and analytical thinking, we maintain that personality is formed in early interaction, and we thus decided to use attachment theory as a dynamic model for investigating the role of personality in recovery from trauma.

Early experiences are internalized as attachment patterns that reflect the way a person has learned to value him- or herself and his or her own needs, and either to trust or not to trust relationships with others and the world (e.g., Bowlby, 1973; Ainsworth, 1979). Three main attachment patterns (secure-autonomous, insecure-dismissive and insecure-preoccupied) in adulthood have been identified (Main & Goldwyn, 91; Crittenden,

1997). Secure-autonomous individuals have, as children, experienced their attachment figures as available and consistently responsive. They generally hold positive schemas about themselves and the world, and are confident of other people's benevolent intentions (Crittenden, 2000; Main, 1996). Insecure-dismissive persons, in turn, have experienced their attachment figures as unavailable, unresponsive or insensitive, and have thus learned to minimize emotional expression and to avoid closeness. Finally, insecure-preoccupied individuals have experienced their caregivers as inconsistent and unpredictable: they have learned to heighten their emotional expression to get maximum protection from their caregivers and to minimize cognitive processing (Crittenden, 1995, Crittenden, 1997).

Clinical studies have predicted a general vulnerability among persons with insecure attachment in developing psychological problems. Van IJzendoorn and Bakermans-Kranenburg (1996) found in their meta-analyses that insecure and unresolved classifications were clearly overrepresented in pathological samples. Thus, secure attachment seems to provide some kind of protective armor. Some specific associations have also been found. Dismissive individuals are more likely to be diagnosed with psychological disorders in which the distress tends to be minimized, such as substance abuse and somatic symptoms. In contrast, individuals with preoccupied attachment patterns are more likely to be diagnosed with psychological disorders reflecting high levels of subjective distress (Fonagy, Leigh, Steele, Steele, Kennedy & Mattoon, 1996; Rosenstein & Horowitz, 1996; Mikulincer, Florian & Weller, 1993; Cole-Detke & Kobak, 1996; Mikulincer & Orbach, 1995) and relationship problems (Pianta, Egeland & Adam, 1996). Moreover, there is evidence that their adult attachment pattern determines the vulnerability to PTSD among victims of childhood abuse (Alexander, Anderson, Brand, Schaefer, Grelling & Krez, 1998; Muller, Sicoli & Lemieux, 2000) and rape (Thelen, Sherman & Borst, 1998).

Furthermore, attachment patterns are triggered and crystallized in dangerous and threatening circumstances (Bowlby, 1973; Crittenden, 1997; Mikulincer, Florian & Weller, 1993), and the role of attachment in traumatic conditions is thus of particular interest. The activation of attachment may explain why trauma victims uniquely perceive, interpret and experience physical and psychological torture. The studies conducted by Mikulincer and his colleagues (Mikulincer et al, 1993; Mikulincer, 1988; Mikulincer, Horesh, Eilati & Kotler, 1999) are informative in showing how individuals with different attachment patterns react differently depending on the amount of danger (military violence) they have

been exposed to: insecure persons, especially dismissive persons, were found to be particularly vulnerable to distress when they lived in a dangerous area, whereas in less dangerous areas the difference in symptoms between the attachment patterns was less evident.

There have been no previous studies on the relationship between attachment and torture. However, we can speculate that the person-trauma interaction may be more complex in extreme conditions such as torture. The results of earlier studies suggest that different torture methods cause different symptoms: psychological torture has been found to be associated with intrusive symptoms, and physical torture with somatic and avoidance symptoms (Carlson & Rosser-Hogan, 1994; El Sarraj, Punamäki, Salmi & Summerfield, 1996; Turner & Gorst-Unsworth, 1990). Crittenden (1997) emphasizes that each attachment pattern forms within a strategy that has been the most adaptive solution to the circumstances in which the person has been raised. For example, insecure-preoccupied individuals would be differently prepared to deal with psychological torture than secure-autonomous persons in that their expectations about the relationships and the benevolence of the world are in better accordance with the deception, cruelty and humiliation that are characteristic of psychological torture.

Thus, the second aim of this study was to examine whether attachment patterns functioned either as protective armor or as vulnerability factors in the face of different forms of trauma.

Attachment and the processing of trauma-related memories

Horowitz (1993) described recovery from trauma as a struggle between the intrusive re-experiencing and suppression of painful, shameful and frightening memories. Trauma victims often show biased and discrepant emotional processing of their trauma-related experiences, and exposure seems to distort the synchronization between affective, cognitive and behavioral levels of emotional experience. For example, a study among Palestinian trauma survivors suffering from post-traumatic stress symptoms (PTS) showed that their emotional processing was dominated by behavioral urges to act, intensive negative feelings and a low level of meta-evaluation (Näätänen, Kanninen, Quota & Punamäki, 2002). Recovery from trauma, in turn, could be seen as the successful integration of fragmented and biased emotional experience into one's life history (Litz, Orsillo, Kaloupek & Weathers 2000; Foa, Steketee & Rothbaum, 1989; Horowitz, 1997).

We were interested in how survivors with different attachment patterns emotionally processed their traumatic memories.

Contemporary theories of emotion conceptualize emotional experience as a "gestalt", where emotions are seen to reflect different levels. Thus, emotional experience involves cognitive appraisals (Frijda, 1986; Lazarus, 1991), behavioral urges to act (Frijda, 1986), accompanied feeling states (Larsen & Diener, 1991), physiological arousal (Scherer, 1993), and meta-evaluation (Mayer & Stevens, 1994, Greenberg, 1996). Furthermore, intensity of arousal and valence, which ranges from a positive to a negative emotional state, have been regarded as basic dimensions of emotion (Russell, 1980). Emotions are seen as an integral part of person-environment transactions that contribute to adaptation (e.g., Scherer, 1993).

We could not find any empirical studies on the relationship between attachment patterns and the multilevel processing of trauma-related emotions. I will now, therefore, review earlier studies on attachment that are relevant in terms of emotions. Firstly, in the context of cognitive appraisal of the self, the world and others, secure-autonomous individuals generally have more balanced, coherent and positive views of both themselves and others than insecure individuals (Collins & Read, 1990; Feeney & Noller, 1990; Mikulincer, 1998a; Mikulincer, 1995; Collins, 1996; Simpson, Rhodes & Nelligan, 1992). Secondly, on the behavioral level of emotional expression, secure-autonomous individuals generally deal more constructively with their anger than preoccupied persons, who are generally more impulsive and get into conflicts more easily (Mikulincer, 1998b; Collins, 1996; Collins & Read, 1990, Simpson, Rholes & Phillips, 1996). Thirdly, as far as valence is concerned, a secure-autonomous attachment pattern is generally associated with more positive, and insecure patterns with negative feeling states. In addition, dismissive individuals tend to minimize their affects, while preoccupied individuals express the most intensive negative feelings (Feeney, Noller & Hanharan, 1994; Pianta, Egeland & Adam, 1996; Collins, 1996; Mikulincer & Orbach, 1995; Rosenstein & Horowitz, 1996; Salzman, 1996). Both Dozier and Kobak (1992) and Mikulincer (1998b) reported an attachment-specific discrepancy between subjectively reported feeling states and physiological levels of emotional experience: dismissive individuals have been found to deny feelings of distress despite responding with intensive physiological activation.

Crittenden (1997) related different attachment categories to different strategies for managing cognitive (in terms of learned contingencies) and affective (in

terms of safety and comfort-related) information. She describes how secure individuals can make use of both affective and cognitive information and use them in balanced ways, while dismissive individuals are "defended against affect", mainly detaching themselves from others and from negative affect. Preoccupied individuals, in turn, are "defended against cognition", and thus rely mainly on affective information and strategies.

Studies on emotional processing after trauma have usually been conducted in laboratory settings comparing trauma victims with or without PTSD, often in hypothetical situations, and have mainly used one of two levels of emotional experience. The situation with attachment studies was similar. Our study contributed in that it was conducted in a community setting using a multilevel approach: trauma survivors with different attachment patterns were asked to think about their real-life traumatic experiences.

Consequently, the third aim of this study was to investigate how secure and insecure individuals differed in their emotional processing of trauma-related memories, and whether the processing was associated with the severity of the trauma in an attachment-specific way.

Attachment and therapy alliance

There are no disagreements among either clinicians or empiricists about whether trauma therapy is needed or not. Empirically investigated psychosocial treatments for PTSD include cognitive-behavioral, behavioral, EMDR, and psychodynamic therapies (see reviews by Wilson, Friedman & Lindy, 2001; Foa, Keane & Friedman, 2000; Marshall, Stein, Liebowitz & Yehuda, 1996). Furthermore, psychological treatments have been found to be more effective than medication in a meta-analysis (van Etten & Taylor, 1998). The burning question in the field of therapy research since the 90s has been, "What works and for whom?" (Fonagy & Roth, 1996). We were interested in the role of attachment ("whom") in forming a therapeutic relationship ("what") in trauma therapy.

Living through traumatic experiences scatters a person's actual security. As a result, the inner sense of safety, or the illusion of it, is destroyed. Establishing safety is a primary issue in the therapeutic relationship. Trauma therapists have stated strongly that no therapeutic work can succeed if safety has not been adequately secured both outside and within the therapeutic treatment situation (e.g., Herman, 1992; Allen, 1995). Being able to speak in detail about traumatic experiences in the context of a safe and supportive relationship, and thus to overcome avoidance and re-experience trauma-associated affects, are considered the key mechanisms of efficacy across trauma therapies (Marshall

et al, 1996). We approached the question of a safe haven in therapy relationships by exploring the alliance that survivors with different attachment patterns developed with their therapists.

A positive working alliance has been acknowledged as one of the greatest contributors to successful therapy outcome regardless of the treatment approach (Horvath & Luborsky, 1993; Horvath & Symonds, 1991). The working alliance is generally viewed as the reality-based part of the relationship (Bordin, 1979; Gelso & Carter, 1994; Greenson, 1967; Luborsky, 1976), which reflects the client's and the therapist's agreement on the therapeutic goals and tasks, and the bond between them (Horvath & Symonds, 1991). Earlier studies have brought out the fact that a client's interpersonal and intrapersonal capacities contribute to the formation of a positive alliance (see the meta-analyses of Horvath & Luborsky, 1993). These capacities, in turn, are affected by the client's pre-existing internal models of him- or herself and others in relationships, and are formed in early interaction with caregivers, in other words through attachment. Mallinckrodt, Coble and Gantt (1995) found that female clients with the poorest working alliance tended to characterize their fathers as intrusive and controlling, while positive maternal bonds were associated with a good working alliance. Dolan, Arnkoff and Glass (1993), in turn, found that secure attachment was associated with a good working alliance, while a dismissive attachment pattern was associated with poor agreement on goals. Furthermore, autonomous and dismissive individuals have been found to profit more from therapy than preoccupied clients (Fonagy et al, 1996).

Moreover, it seems that early alliance is a better indicator of therapy outcome than alliance in the middle or late sessions (Horvath & Symonds, 1991). There is controversy in terms of how and whether the alliance changes during the course of the therapy: some researchers suggest that it follows a linear pattern (Klee, Abeles & Muller, 1990; Kivlighan & Shaughnessy, 1995; Piper, Boroto, Joyce, McCallum & Azim, 1995), some argue that it follows a high-low-high pattern (Mann, 1973; Golden & Robbins, 1990, Horvath & Marx, 1990), and others maintain that it remains quite stable Gomes-Swartz, 1978; Hartley & Strupp, 1983; Marmar, Weiss & Gaston, 1989; Morgan, Luborsky, Crits-Cristoph, Curtis & Solomon, 1982). Most of these studies have not taken the client's interpersonal capacities into account, which may partly explain the controversial results. There have been no previous studies on the relationship between alliance and attachment in the torture or PTSD context.

The final questions addressed in this study concerned how early alliance differed between attachment patterns, whether the development of alliance followed a different pattern in different attachment groups, and which attachment group benefited most from the therapy.

Summary of the research questions:

How do different appraisal and coping efforts mediate between trauma and recovery from multifaceted traumas? (I)

What is the effect of time on optimal coping? (I)

Are attachment patterns protective or vulnerability factors in the face of extreme forms of trauma? (II)

How do secure and insecure individuals differ in their emotional processing of trauma-related memories? (III)

How are emotional responses activated in response to high or low trauma among traumatized men with different attachment patterns? (III)

Are attachment patterns related to therapeutic alliance at the beginning of the trauma therapy? (IV)

How does alliance develop in different attachment groups during the therapy? (IV)

How is attachment related to the success of the therapy? (IV)

METHODS

Participants

Article I

The participants were 103 Palestinian men from the Gaza Strip. They were randomly sampled from a list of ex-prisoners in a local human-rights organization. All of them had been imprisoned during the first Intifada, the national uprising for independence in 1987-1993. Most of them had been freed according to the Oslo peace agreement between Israel and the Palestinian Liberation Organization (PLO) signed in Washington in September 1993. International, Israeli and Palestinian human-rights organizations (Amnesty international, 1989; Middle East Watch, 1990; B´Tselem, 1994; Cohen & Collan, 1991a, 1991b; Al haq, 1988) have documented that ill-treatment, abuse and torture were commonly used in interrogating Palestinian prisoners during the Intifada. The men participated in the study in 1997, which was a relatively stable and peaceful time in the Gaza Strip.

Article II

The participants were 176 Palestinian men, of whom 103 were the same as in the study reported in Article I, 50 were participating in rehabilitation programs (Article 4), and 23 had been detained but not imprisoned.

Article III

The participants consisted of 103 ex-prisoners (Article I) and 50 patients from rehabilitation programs (Article IV)

Article IV

The participants were 50 self-referred Palestinians, of whom 48 had been political ex-prisoners and 2 had been detained. Half of them chose individual (n =25) and the other half group therapy (n = 25) at local mental-health clinics in Gaza and the West Bank. The duration of the therapies was from 10 to 12 months.

Procedure

The fieldwork was conducted in cooperation with the Palestinian ex-detainees' rehabilitation programs and local mental-health clinics (the Gaza Community Mental Health Programme (GCMPH). A male field worker approached the ex-prisoners in their

homes. The visits lasted about one-and-a-half hours. All the participants, except one, filled out the questionnaires themselves. The refusal rate was zero, apparently because the interviewing took place in the homes, the field worker was a trusted person in the community, and the major political parties accepted the fieldwork

Measures

A short description of the measures is given in the following. Detailed information is provided in the articles.

Appraisal and coping (I) The items for the appraisal and coping questionnaires were selected from the measures introduced by Frijda, Kuipers and ter Schore (1989) and Smith (1991). The participants were instructed to think about their prison experiences, and to estimate how well each item described their appraisal and urges to act, ranging from 0 (nothing at all) to 10 (extremely well). The detailed scale was adapted from Borg (1982). The subscales were formed according to the earlier research and theory (Basoglu & Mineka, 1992; Fairbank, Hansen & Fitterling, 1991; Lazarus, 1991; Lazarus & Folkman, 1984). The appraisal sum scores were *control, harm and loss,* and *relevance*, and the coping sum scores were *emotion-focused coping* and *problem-focused coping.*

Torture and ill-treatment experiences (I, II, III). The participants were asked whether they had been exposed to 30 common interrogation methods, either (0 = never, 1= sometimes, 2= very often). A sum score was formed for all the items, and also separately for *psychological and physical torture and ill-treatment*. It was further dichotomized to indicate *low-trauma and high-trauma groups*. *Acuteness of trauma* was indicated by the time that had elapsed since release from prison.

Post-traumatic symptoms (I, II, IV) The 30-item Harvard Trauma Questionnaire (HTQ; Mollica & Caspi-Yavin, 1991) was used to assess post-traumatic symptoms (PTS). Sixteen items are derived from the DSM-III-R criteria for PTSD, and 14 items from clinical experience. The participants were asked to rate them all on a four-point scale (0 = does not suffer at all, 4 = suffers severely). Sum scores for *vigilance, intrusion* and *avoidance* were formed.

Somatic symptoms (II) A list of 31 items was used to assess typical complaints of torture victims (Allodi, 1985). The participants were asked to rate them on a three-point scale (1 = not at all, 3 = frequently). Sum scores were formed for *general symptoms, psychosomatic symptoms, diversified aches and pains*, and *stomach problems*.

Attachment measure (II, III, IV) There are two approaches in the research on adult attachment, which differ in conceptualization and assessment procedure (Bartholomew & Horowitz, 1990; Collins & Read, 1990, 1996; Feeney, Noller & Hanharan, 1994; Hazan & Shaver, 1987; AAI; Crittenden, 2000; George, Kaplan & Main, 1985; Main & Goldwyn, 1991). It was not possible to use existing attachment measures requiring the taping of interviews due to the special socio-political situation in Gaza. Taped material would have caused too much suspicion. On the other hand, we were also interested in developing more time-costly methods for measuring attachment, and we thus created a written adaptation of the Adult Attachment Interview. In comparison with forced-choice descriptions of behavior in current intimate relationships, this was a more dynamic method for assessing unique ways of remembering childhood relationships and processing emotionally loaded experiences. The participants were asked to describe their childhood relationships with their parents, their responses to distress and loss, and how they thought their childhood had affected their adult personality. We formed 30 sum variables comprising the quality of childhood experiences (what is remembered) and the processing of these memories (how experiences are remembered) based on the coding system devised by Main and Goldwyn (1991). We wanted to examine the attachment patterns from empirical and quantitative perspectives, and therefore used a cluster analysis to identify groups of participants with similar combinations of attachment-related experiences and states of mind.

Cluster 1 participants (47%) represented the *Secure-Autonomous Attachment Pattern.* They differed significantly from the men in Clusters 2 and 3 in describing more loving, and less rejecting and less over-involving mothers, having more semantic and episodic memories of their mothers, and in describing parent-child relationships from the child's perspective. The responses were coherent and lacked anger and derogation. They differed from the men in Cluster 3 in seeking more familial and less extra-familial support, and from those in Cluster 2 in showing less denial of distress and withdrawal in responding to rejection, separation, and upsets.

Cluster 2 participants (37%) represented the *Insecure-Dismissive Attachment Pattern.* They described their mothers as rather neutral, and as showing minimal love and involvement, and rejection. They dealt with distress through denial and withdrawal and sought little parental attention and consolation. They were derogative and devalued the importance of their childhood, and were incoherent in their descriptions. They reported fewer episodes, and their memories evoked less narrative quality and feelings. Compared

to those in Cluster 3, these men described their parental relationships as less mutual and less involving of feelings.

Cluster 3 participants (16%) represented the *Insecure-Preoccupied Attachment Pattern.* They experienced their parents as highly unloving, over-involving and neglectful, and their mothers as rejecting. When distressed, they sought attention and support from both parents and others. They described their parental relationships as mutual and full of feelings. Their memories had a rich narrative quality, but at the same time were incoherent and full of anger.

Intensity and valence of emotional responses (III) This measurement is based on the multilevel theory of emotional experience, involving cognitive appraisal, behavioral urges to act, subjective feeling states, and meta-evaluation (Frijda, Kuipers & ter Schore, 1989; Smith, 1991; Lazarus, 1991). The participants were instructed to think about their prison experience, and to estimate how well each item described their present thinking (appraisal), feelings and urges to act, ranging from 0 (nothing at all) to 10 (extremely well). The detailed scaling was adapted from Borg (1982). As our focus was on intensity and valence rather than on the content of cognitive appraisal, we formed two15-item sum scores indicating *negative and positive valence in appraisal*. With a view to investigating the participants' subjective feeling states, we asked them to estimate the intensity of 28 different states drawn from the circumplex model of emotions (Larsen and Diener, 1992; Russell, 1980). Again, two sum scores were constructed indicating negative and positive valence. The first (11 items) combines activated, inactivated and general pleasant feelings, and the second (11 items) combines activated, inactivated and general unpleasant feelings. A sum variable of 15 items was also constructed to describe action readiness. Lastly, a meta-evaluation sum variable was constructed using three items.

Working alliance (IV) The working alliance inventory (WAI; Horwath & Greenberg, 1989) was used to investigate the alliance the participants who attended therapy formed with their therapists. The participants filled out the questionnaire after the third session, in the middle of the therapy, and after the second-to-last session. A 1-5 scale was used for responses (1= never, 5= always). The items were modified for group-therapy use so as to be in relation to both the group and the counselor. A sum score was formed of the 27 items.

Translation of measures The questionnaires were translated into Arabic from English by a bilingual psychologist and independently back-translated by a bilingual social worker. Both English and Arabic measures were then checked by the GCMHP research

group . The Arab-language reports of attachment histories were likewise translated and back-translated into English. The torture and ill-treatment list was translated for the purpose of epidemiological study in Gaza (El Sarraj, Punamäki, Salmi & Summerfield, 1996).

RESULTS

A short overview of the main results is given in the following section. Detailed information is provided in the articles.

How do different appraisal and coping efforts mediate between trauma and PTS? (I)

A path analysis was conducted in order to study the mediating effects of appraisal and coping between trauma and PTS. The results substantiated both direct and appraisal- and coping-mediated paths. The direct associations were symptom-specific: torture and ill-treatment had a direct association with intrusion, and recent release from prison with avoidance symptoms. The mediated model revealed that the acuteness of trauma was associated with PTS via appraisal and coping efforts: men who had recently been released were more likely to appraise their experiences as harmful and involving loss. This, in turn, was associated with emotion- and problem-focused coping efforts. Both types of coping efforts were associated with PTS, albeit differently: the men using the former suffered more from vigilance and intrusive symptoms, whereas those using the latter showed more avoidance symptoms.

What is the effect of time on optimal coping in recovery from torture and ill-treatment? (I)

The analyses revealed that the effectiveness of coping depended on the acuteness of the trauma. Emotion-focused coping was associated with a higher level of PTS among those who had been recently exposed to trauma, and with a low symptom level, when a longer time had elapsed. In contrast, problem-focused coping was associated with a lower level of PTS among the men who had recently been released, and with a high level among those who had been released for a longer time.

Are attachment patterns protective in the face of multifaceted traumas? (II)

The results showed that the protective role of attachment depended on the nature of the trauma. Among the insecure (both dismissive and preoccupied) men, exposure to a high

level of physical torture and ill-treatment was associated with an increased level of PTS and somatic symptoms. On the other hand, exposure to psychological torture and ill-treatment was associated with an increased level of somatic symptoms among the secure-autonomous, but not the insecure participants.

How do individuals with different attachment patterns differ in their emotional-response profiles? (III)

The analyses substantiated the supposition that the cognitive-emotional profiles were attachment-specific. The emotional profile of the secure-autonomous men differed from both insecure patterns in their capacity to combine both cognitive and affective responses: their stable, moderate and comprehensive emotional responses involved both. This indicates an ability to integrate the painful memories without being either overwhelmed or numbed by them. Contrary to expectations, the secure men did not show a high level of meta-evaluation.

The emotional profile of the insecure-dismissive men was characterized by a high intensity of cognitive and meta-evaluative responses and by a low intensity of affective responses: this suggests the over-regulation of the affective domain of emotions.

The insecure-preoccupied men showed a high intensity of affective and a low intensity of cognitive and meta-evaluative responses, and an intensive behavioral urge to act, indicating under-regulated cognitive responses and heightened affective distress in their emotional profiles.

How are emotional responses activated in response to high or low trauma among men with different attachment patterns? (III)

The results supported the activation hypothesis. The secure-autonomous men showed moderate levels of affective and cognitive responses despite exposure to severe trauma, while exposure to severe trauma was associated with intensive affective responses and a behavioral urge to act in the insecure-preoccupied men. The insecure-dismissive participants were biased towards intensive cognitive responses independently of the severity of the trauma exposure.

How are attachment patterns related to the success of the therapy? (IV)

The analyses showed that attachment per se was not related to the success of the therapy.

Are different attachment patterns related to how therapeutic alliance is formed at the start of the trauma therapy? (IV)

The results revealed that there were no differences in early alliance between the attachment groups.

Are there differences in how the therapeutic alliance develops for different attachment patterns during trauma therapy? (IV)

The analyses showed that the development of alliance during therapy followed different patterns across the attachment groups. It dropped in the secure-autonomous individuals in the middle of therapy, and had increased back to its initial level by the end. Similarly, it decreased steeply in the preoccupied individuals in the middle of the therapy, and then increased even more steeply at the end. By way of contrast, it was approximately the same for the dismissive individuals at the beginning and in the middle of the therapy, and then it decreased at the end.

DISCUSSION

This study investigated the role of personality factors, coping and attachment, on torture survivors' recovery, thus enhancing both attachment and trauma theories. The main results showed, first, that neither emotion- nor problem-focused coping was directly related to better mental health in the aftermath of traumatic events. Optimal coping was time-dependent. Secondly, attachment was triggered in dangerous circumstances and individuals with different attachment patterns reacted in unique ways depending on the severity of the traumatic events. It was found that secure attachment did not always function as protective armor in the face of complex traumas. Thirdly, the trauma survivors exhibited attachment-specific emotional processing in dealing with traumatic memories: the autonomously attached were truly balanced in their way of processing their trauma memories by both cognitive and affective means. Fourthly, although attachment per se was not related to the success of the therapy or to early alliance, the development of alliance followed different paths for individuals with different attachment patterns.

Appraisal, coping and the effect of the passage of time on recovery

Our findings overall are well in line with the transactional model (Lazarus & Folkman, 1984), meaning that various person- and environment- related factors mediate the impact

of trauma on mental health. In the first article we examined how appraisal and coping efforts mediated between traumatic events and recovery. The path model revealed that the men who had recently been released from prison were more likely to appraise their experience as harmful and involving loss. This was further related to both emotion-focused and problem-focused coping efforts, but neither type was directly related to better recovery. The timing of the coping efforts turned out to be important: we found that symptoms of avoidance were common when the traumatic experiences were still fresh. In the natural course of recovery, problem-focused (rational and behavioral) efforts were adaptive at that time. However, concentrating on "changing the external" by practical arrangements was no more beneficial in the long run; when a longer time had elapsed after the imprisonment, emotion-focused coping, and "changing oneself", were related to better recovery.

The fluctuations in symptoms and coping efforts supported the notion that coping is fluid and fluctuates according to changes in the external situation and the subject's inner needs (Horowitz, 1986; Lazarus, 1993). In Horowitz's view, both approach and avoidance strategies are needed in dealing with stress before the process of working through gets started. Avoidance stops the processing of traumatic memories becoming too painful, and approach strategies help the victim to integrate the trauma. Meanwhile, oscillation between the two is normal.

Understanding a trauma survivor's appraisal and coping efforts is important in trauma therapy. Empirical studies have shown that the number of victims who successfully process trauma increases with the passage of time, but there seems to be little or no spontaneous recovery after six months (Foa, 1995; Rothbaum, Foa, Murdock, Riggs & Walsh, 1992). In this respect, the saying that "time heals all wounds" is not fully accurate. Furthermore, beginning with Janet and Freud and continuing into present conceptualizations, trauma theorists have postulated that emotional engagement with the traumatic memory is a necessary condition for the successful processing of the events and subsequent recovery. Our results concur with that, while suggesting the additional need for avoidance strategies in the natural recovery process. At the risk of sounding like naïve empiricists, we might suggest that if a trauma victim gets "stuck" in excessive emotion regulation, he or she may benefit from a push towards reappraisal of the traumatic memories. Both clinical and empirical studies have suggested that experiencing oneself as being able to control the anxiety, being a successful "coper", seems to be the turning point

for the beginning of recovery (e.g., Foa , 1997; Alloy & Abrahanson, 1979; Basoglu & Mineka, 1992).

The results contrast with those emphasizing the general superiority of problem-focused coping (Blake et al, 1992; Mikulincer et al., 1993; Solomon et al., 1989), and postulating that emotion-focused coping is unsuccessful in the long run (Folkman & Lazarus, 1991). The difference may be explained by the specific circumstances of our study. Torture is likely to demand strong defenses and emotion regulation to protect the victim's well-being. Focusing on practical arrangements and distancing oneself emotionally may match with the real-life situation (poor economic circumstances, no work and large families to support) that the political prisoners face when returning home. Thus, it only seems natural that they place much emphasis on solving that side of their reality. Yet, our results also showed that focusing only on the realities may prevent survivors from assimilating their traumatic experiences.

Attachment and vulnerability to trauma

According to trauma theorists, PTSD reflects a post- stress biological sensitization due to pre-existing risk factors (e.g., Yehuda, 1997), such as childhood trauma (e.g., Glaser, 2000; Van der Kolk et al., 1996). In the same vein, earlier research results have basically indicated that secure persons (characterized by safe parenting) are protected, and insecure persons vulnerable in conditions of traumatic stress. Our finding is that this general view does not apply to the complex person-trauma interaction that is characteristic of torture and ill-treatment: attachment-specific vulnerability was triggered and crystallized in exposure to life-endangering experiences of torture. The secure-autonomous and insecure victims differed in their strengths and vulnerabilities depending on whether the torture was psychological and interpersonal or physical. More specifically, the secure-autonomous attachment pattern was protective following exposure to severe *physical* trauma, whereas insecure attachment was not, and on the other hand the secure-autonomous men were more vulnerable to PTSD and somatic symptoms than the insecure-preoccupied men following exposure to severe *psychological* trauma.

The reasons behind these findings can only be speculated upon, but it is apparent that psychological and physical torture vary in terms of what they mean to secure and insecure victims. Another popular idea among trauma theorists is that the successful processing of a traumatic experience requires adjustments in core schemas, that is in beliefs about the world and about oneself (e.g., Horowitz, 1986, Janoff-Bulman, 1985).

This process is apparently different for men with different attachment patterns. It seems likely that autonomously attached torture survivors experience a great mismatch between abuse by their fellow men (albeit the enemy) and their inherent view of other human beings as trustworthy, the world as benevolent and the self as invulnerable. These men could deal more successfully with physical torture that was of a less interpersonal nature. This finding concurs with Crittenden's (1997) descriptions of secure-autonomous individuals being "naively secure", in that they cope better with dangers that do not originate from human relationships. For the insecure-preoccupied men, in turn, psychological torture may not have provided the same dramatic mismatch between previous core schemas and experiences of torture: it may have only confirmed what they knew from before, that people cannot be trusted. This may have provided them with protective armor in this cruel interpersonal situation. The insecure-dismissive men also "managed well" in facing psychological torture, although the underlying dynamics may have been different from those in the case of the preoccupied men. The numbing of true affect to facilitate rational thought is a characteristic defensive strategy of dismissive men (Crittenden, 1997), yet this strategy did not protect them from somatic suffering as a response to physical torture. This finding concurs with the repression model (Horowitz et al., 1993) in that distancing oneself from one's own feelings and from other people is often related to somatization. The dismissive survivor's "body remembers" when no words are found (Kirmayer, Robbins & Paris, 1994).

Attachment and emotional responses to traumatic memories

Our findings provide evidence of attachment-specific ways of processing trauma-related memories. The emotional-response profile of the dismissive men was characterized by a high intensity of cognitive responses and a low intensity of affective responses, despite the severity of the trauma exposure. This indicates an over-regulation of affective, and over-reliance on cognitive domains of emotion. In Crittenden's terms (1997), dismissive individuals trust cognitions and distrust emotions (defended against affect), or according to Liotti (1991/1995), their affective and episodic schemas are segregated from the cognitive and semantic ones. These results are in line with Florian and Mikulincer's (1997) earlier findings.

The emotional-response profile of the preoccupied men is a mirror image. The high intensity of affective and low intensity of cognitive responses indicate that they under-regulated their cognitive responses, in other words they distrusted cognitive information

and relied predominantly on affective responses. Moreover, they responded to traumatic memories with an intensive behavioral urge to act, which may indicate dependency upon procedural rather than semantic models for regulating emotions (Liotti, 1991/1995). These findings are well in line with Crittenden's thinking (1997), and with earlier results obtained by Florian and Mikulincer (1998). This emotional-response profile was heightened when these preoccupied men had been exposed to a high level of torture and ill-treatment.

The secure men differed decisively from those with insecure attachment patterns in their ability to combine both cognitive and affective responses despite the severity of trauma exposure. Their stable, moderate and comprehensive emotional-response profiles indicate an ability to integrate the painful memories without being either overwhelmed or numbed by them. Again, the results confirmed Crittenden's theory in terms of how individuals with autonomous attachment are "balanced" in their use of both cognitive and affective modalities.

Furthermore, it is interesting to compare these results with Foa's suggestion (1997), that it is the holding of extremely rigid views (such as "I am totally invulnerable" or "The world is extremely dangerous") that renders an individual less adept at processing traumatic events. It seems that men with autonomous attachment patterns could approach their traumatic memories with more flexibility, in other words they could combine both channels of processing (cognition and emotion). Thus, in theory, these men should have the most adaptive pattern in the long run.

Knowledge about attachment-specific processing is advantageous for therapists who seek to help patients to change, and who therefore need to know how they react to and process their traumatizing experiences, which possibly maintain their distress. Trauma theorists such as Foa (1997) have suggested that, according to the organization-elaboration hypothesis, traumatized individuals whose experiences seem confused and fragmented need special help with creating a clear narrative organization, which in turn is associated with successful recovery (Foa, Molnar & Cashman, 1995). At the same time, trauma theorists also emphasize the fact that emotional engagement is a prerequisite for the successful processing of trauma-related memories (Horowitz, 1986; Foa, 1997). Our results provided some refinement to trauma theory in emphasizing the role of personality in understanding the different reactions. We agree with Jellema (2000), who suggested that the therapeutic process should be different for different attachment categories. She pointed out that therapeutic interventions for dismissive patients should involve accessing previously dismissed affect, while preoccupied patients will need to develop cognitive, i.e.

causal understanding. Furthermore, preoccupied patients may benefit from methods of emotion regulation. We also suggest that understanding the patient's attachment strategies may be useful in tuning into his or her habitual style of processing emotionally painful material. This is inline with both attachment theory and cognitive analytical thinking as advocated by Ryle, who suggests that some patients may require cognitive help to develop emotional security (Jellema, 2000).

Attachment and therapeutic alliance in trauma therapy

Our findings demonstrate the importance of clients' attachment patterns in trauma therapy, in particular how attachment is related to different patterns of development in alliance. The fact that attachment per se was not related to the success of the therapy was unexpected, because earlier results with general therapy populations have indicated that preoccupied clients benefit less from therapy than patients with other attachment classifications (Fonagy, 1996). The interesting finding was that, although early alliance did not differ between the different attachment groups, its development followed different patterns.

We might speculate that the similarities in early alliance could reflect the notion that it is predominantly dominated by the therapist's actual, reality-based behavior (Luborsky, 1976), whereas the fact that alliance followed different paths for different attachment patterns could reflect the later phases imposing more requirement on the patients, as their old, possibly neurotic ways are challenged (Horvath & Luborsky, 1993). Furthermore, although alliance seems to be a pantheoretical construction, the context of trauma therapy poses a special challenge for its development. Torture survivors have experienced a trauma of an interpersonal nature. The relationship between the tortured and the torturer has been described as extremely close and intimate, and themes of power and dependency dominate (Bustos, 1992). The same themes are bound to recur in the therapeutic relationship. As a result of their horrific experiences, torture survivors generally have impaired capacity for forming trusting relationships (Pope & Garcia-Peltoniemi, 1991). We might speculate that the similarities in early alliance could also be a reflection of these interpersonal trauma marks.

Alliance in the autonomous patients stayed on almost the same level throughout the therapy, except for a small decline in the middle. This evenness could be explained in terms of the characteristics of autonomously attached individuals: they have been described as cooperative and self-reflective (Crittenden, 1998), which may make it

easier for them to receive new information about themselves and to enter into a reciprocal relationship with the therapist than for patients with other attachment strategies.

The preoccupied patients showed a more strongly fluctuating high-low-high alliance pattern. Preoccupied individuals have been described as being likely to get themselves and others entangled in distorted and fluctuating affects, as confusing the present focus on past feelings states, and as having difficulties in forming stable relationships (Crittenden, 1998). Their tendency to "go with the flow" may show in deteriorating alliance when more sensitive matters are brought up in the therapy. On the other hand, strong emotional involvement was reflected in their highly positive evaluation of the therapeutic relationship at the end of the period.

The dismissive individuals followed a middle-middle-low alliance pattern. Both the focused nature of the trauma therapy, as well as their general tendency to prefer a "cognitive" style of processing, may enable such patients to concentrate on trauma-related matters, which may delay confrontation with their interpersonal procedures. They have a tendency to distance themselves from emotional and distressing information, and to deny their emotions (Crittenden, 1998). This may also be related to their negative evaluation of the therapeutic relationship at the end of the therapy in an attempt to minimize its importance.

Trauma therapy is by its nature "more focused", the goal being to help patients to process their traumatic memories and to restore their previous levels of functioning. Both the focus and the fact that the trauma is caused by a specific as well as horrific event(s) may take attention away from the individual differences in the therapeutic process. An understanding of how insecure attachment may affect the therapeutic relationship may help the clinician to predict what type of challenges may emerge. Like van der Veer and van Waning (2004), we emphasize the fact that the therapist's task of providing a "secure base", from which the client can safely explore his or her inner and outer realities is of crucial importance in work with victims of human-rights abuse. As Liotti (2004) summarizes it, treatment in which attention is first given to stabilizing the therapeutic relationship before proceeding to the trauma work has been made necessary by widespread clinical observations that trauma-centered therapies that are often highly effective for simple types of PTSD can exacerbate rather than resolve patients' difficulties in complex PTSD.

Critical remarks

The findings of this study must be considered within the context of its limitations. I will first comment on the limitations from the research point of view and then go on to discuss some clinical caveats. First, the identification of three attachment patterns was based on a modified AAI method. Because this method was created specifically for this study, the results are not directly comparable to those that have been obtained using AAI or different questionnaire methods. Secondly, in an ideal research design, the attachment patterns would have been assessed before the traumatic event took place. Thirdly, it is important to note that this study focused on male torture survivors within a particular cultural context, the Middle East. There is emerging evidence of cultural specificity in attachment patterns (Waters et al, 2000). We must also remember that Palestinians have been experiencing ongoing trauma for three generations, and thus, theoretically, they could individually be considered to be "unresolved" in their attachment. A study by Sagi, van IJzendoorn, Joels, & Scharf (2002) showed, for example, that a great percentage of Holocaust child survivors still exhibited signs of unresolved mourning as adults.

Moreover, the greater-than-expected rates of dismissive attachment could also be interpreted to reflect a change in attachment patterns towards the dismissive in an attempt to adapt to situational demands. Trauma victims have been found to use excessive affect regulation characterized by repression, emotional numbing and denial (Horowitz et al., 1993), which is reminiscent of dismissive individuals' response styles and emotional processing. Finally, the findings of this study need to be interpreted with caution because of the retrospective, correlational, and cross-sectional settings. All in all, there is a need for replication in other cultural contexts, with both sexes and with longitudinal designs.

From the viewpoint of trauma therapists, the need to use "reductive classificatory methods as attachment" (Leiman, 1999) is a relevant question. Certainly, the uncritical use of any labeling methods is counterproductive in therapeutic work. One advantage of cognitive analytical therapy (see e.g., Ryle & Kerr, 2002) lies in the use of reformulations that are "bespoke tailored" to the individual patient. In terms of research, however, it may be a limitation in that important distinctions between groups of patients can be obscured. As our results clearly show, there was substantial clinical relevance in identifying the underlying attachment patterns. It may not be necessary to concentrate great efforts on identifying "the true attachment patterns in a scientifically acceptable way"

in everyday clinical use: indeed, the dismissal of and preoccupation with affect may be best conceived of as strategies rather than categories (Jellema, 2000).

This question is also relevant in terms of "scientific trends".The treatment of clients with PTSD seems to be conceptualized in recent publications as the implementation of techniques based on empirical evidence. The medicalized understanding of the reality of trauma victims can be greatly distorted if the patient is seen as his presented symptoms (PTSD). In the worst-case scenario, this would imply that all trauma patients need exactly the same kind of treatment, which in turn would mean that the patient would not get heard and would not get better! van der Veer and van Waning (2004) write beautifully on how knowledge and technique, at best, could be seen as a "carrier wave" that makes it possible for a message of love and hope to be transmitted by the therapist and received by the client. A systematic approach may be a start, but in the end every treatment is a unique interpersonal endeavor.

Finally, as researchers we need always to be aware of the possibility that the findings in this study could be misused by interrogators aiming at maximizing their impact. Needless to say, we would dearly hope for consciousness of the harmful effects of both psychological and physical torture, and for a monitoring and sanctioning system that would apply to mental-health professionals working in security, military, and public sectors.

Summary

This study focused on improving interventions with victims of human-rights abuse. Our findings suggest that trauma therapy should be "bespoke tailored" to fit the victim's personality, and should encompass both cognitive and emotional processes. Critics of this kind of "individualist" approach demand concentration on material and economic help, and emphasize the resilience of survivors of military violence (Summerfield, 1997). Their argument is implicitly based on the idea that the more severe the trauma (such as torture) and the more ideologically committed the victim is, the less room there is for individual differences in responding to and recovering from atrocities.

Our observations emphasize the opposite: people respond in a diversity of ways in life-threatening situations. Personality with its strengths and vulnerabilities tends to activate and crystallize in situations of danger and threat. Some personality structures are especially salient because they serve successful recovery. Attachment-specific cognitive-emotional processing of trauma-related memories and different therapy processes are good examples of that.

The evidence from Gaza suggests that both personality (attachment) and the meaning of the trauma need to be considered, *especially* with victims of human-rights abuse. Yet, each torture survivor has his or her own unique reality and goes beyond the call for tailored individualized "meetings". We did not want to create more "prisons" to limit clinicians' and researchers' thinking. Our intention was rather to provide information and understanding that is relevant for work with trauma survivors.

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