ATTACHMENT PATTERNS AND WORKING ALLIANCE IN TRAUMA THERAPY FOR VICTIMS OF POLITICAL VIOLENCE

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We examined the development of alliance in therapy in different attachment groups in a naturalistic setting. The participants were 36 self-referred Palestinian political ex-prisoners, who were victims of torture and ill treatment and had sought psychotherapy. Their therapy lasted for 10–12 months. The analyses showed that the development of alliance during therapy followed different patterns across the attachment groups. Yet early alliance did not differ between the groups. For the autonomous individuals, alliance dropped in the middle of therapy, and increased back to its initial level by the end. Similarly, for the preoccupied individuals alliance decreased steeply in the middle of the therapy, and then increased even more steeply by the end. In contrast, for the dismissing individuals, alliance was approximately the same at the beginning and in the middle of the therapy, and then it decreased at the end.

Positive working alliance has been acknowledged as one of the greatest contributors to successful therapy outcome. It has been proposed as a common, pantheoretical factor that could account for positive therapy outcome regardless of the treatment approach (Horvath & Luborsky, 1993; Horvath & Symonds, 1991). Working alliance is generally viewed as a reality-based part of the therapeutic relationship (Bordin, 1979; Gelso & Carter, 1994; Greenson, 1967; Luborsky, 1976; Horvath & Symonds, 1991). From a cognitive perspective, alliance consists of agreeing on both the tasks and goals of the therapy and establishing a personal bond (Bordin, 1979; Horvath & Greenberg, 1989). However, it has been suggested that the therapeutic relationship is also affected by the more unconscious, dysfunctional interpersonal schemas that the client brings into the therapeutic situation, and which are reactivated during therapy (Gelso & Carter, 1994; Luborsky, Cris-Cristoph, Alexander, Margolis, & Cohen, 1983).

Earlier studies have pointed out that a client’s interpersonal and intrapersonal capacities contribute to the formation of positive alliance (see meta-analyses by Horvath & Luborsky, 1993). Clients who develop weak or negative alliances are characterized by difficulties in maintaining social relationships (Mallinckrodt, 1991;
Moras & Strupp, 1982), poor past family and current relationships (Kokotovic & Tracey, 1990; Mallinckrodt, 1991), a low quality of object relations (Piper, Azim, Joyce, & McCallum, 1991; Ryan & Cicchetti, 1985), hostile-dominant problems (Muran, Segal, Samstag, & Crawford, 1994), and poor intrapsychic flexibility, and they are also not psychologically minded (Ryan & Cicchetti, 1985). Our aim in this study was to examine how clients’ attachment patterns, or, in other words, their preexisting mental schemas of others and themselves in relationships, affect the formation of alliance.

Attachment theory provides an object-relational theoretical basis for understanding how the client’s pretreatment characteristics, or interpersonal schemas, influence the formation of alliance (Bowlby, 1988). The formation of therapeutic alliance is affected by individuals’ capacities for reciprocal interaction, which, in turn, are affected by their preexisting internal working models of themselves and others in relationships formed in early interaction with a caregiver. Thus, childhood relationships play a mediating role in the client’s capacity to enter into a therapeutic relationship (Bowlby, 1988). Although attachment patterns have been found to be fairly continuous from childhood to adulthood under stable conditions (van IJzendoorn & Bakermans-Kranenburg, 1997; van IJzendoorn & Bakermans-Kranenburg, 1996), they have also been shown to be dynamic in reaction to the environment and new relationships (Bowlby, 1973; Crittenden, 1997).

The concept of attachment has been approached mainly by using two different measures: a self-report measure that taps conscious attitudes about relationships, devised by Hazan and Shaver (1987); and an Adult Attachment Interview (AAI; George, Kaplan, & Main, 1985), in which the participant’s way of processing and integrating memories of parental caregiving, the “current state of mind,” is analyzed (Main & Goldwyn, 1985–1994). Although the measures use different approaches, a study using both methods has indicated that they share a common core which is established in childhood (Bartholomew & Shaver, 1998). Three different attachment patterns have been identified: autonomous (secure, according to Hazan and Shaver, 1987), dismissing (avoidant), and preoccupied (anxious-ambivalent) attachment patterns (Crittenden, 1998; Hazan & Shaver, 1987; Main & Goldwyn, 1985–1994). For consistency and simplicity, the terminology presented by Crittenden is used in this article.

Autonomous individuals are characterized by coherence and integration (Crittenden, 1998; Main, 1991), and they easily achieve proximity, trust, and mutuality in intimate relationships (Collins & Read, 1990; Feeney & Noller, 1990; Hazan & Shaver, 1987; Simpson, 1990). Dismissing individuals often have either derogative or idealized attitudes about their childhood. They may also have a hard time recalling early memories of childhood interaction with their parents (Main, 1991). They tend to find their relationships problematic and dislike intimate self-revelation (Collins & Read, 1990; Feeney & Noller, 1990; Hazan & Shaver, 1987; Mikulincer & Nachson, 1991; Simson, 1990). Preoccupied individuals appear enmeshed in their relationships, and mix current with past ones. They may still exhibit anger towards their caregivers (Crittenden, 1998; Main, 1991). Their relationships are often characterized by jealousy, seeking out of symbiotic feelings and passion, and difficulty maintaining long-lasting relationships (Collins & Read, 1990; Feeney & Noller, 1990; Hazan & Shaver, 1987). These attachment behavior patterns are likely to be repeated in new relationships, including the therapist-client relationship (Bowlby, 1988). In this study, our first objective was to examine how early working alliance differs between attachment patterns.

So far we have been able to find only a few empirical studies on the specific relationship between attachment and alliance. Mallinckrodt, Coble, and Gannt (1995)
found that female clients with the poorest working alliance tended to characterize their fathers as intrusive, controlling, and unwilling to permit autonomy. Positive mother bonds, in turn, were associated with a good working alliance. Dolan, Arnkoff, and Glass (1993) showed that clients with a secure attachment pattern formed good alliances in terms of agreement on tasks and goals. Clients with an avoidant attachment pattern, in turn, achieved poor agreement on goals. In this study we expected the autonomous individuals to form the most positive, and the preoccupied individuals to form the poorest working alliances.

The second aim of our study was to determine whether the development of alliance during therapy follows a different pattern in different attachment patterns. To our knowledge, there are no empirical data on that relationship. Luborsky (1976) has suggested that alliance is a dynamic rather than a static entity that is responsive to the changing demands of therapy. Horvath and Luborsky (1993) suggested a two-phase model of the development of alliance. The first type of alliance is more evident at the beginning of the therapy, in sessions 1–5, and is based on the patient’s experience of the therapist as supportive and himself as a recipient of support. During this period, the main goal is to establish satisfactory levels of collaboration and trust. The second critical phase of alliance is more typical later on, when the initial impressions are supplanted by the more cognitive components of the alliance, and the therapist starts challenging the client’s old dysfunctional patterns. The possible weakening of alliance needs to be addressed. Thus, the model implies that there may be ruptures in alliance at different times for different reasons (Horvath & Luborsky, 1993). Mann (1973) described a similar trend in time-limited therapy. According to his model, alliance follows a high-low-high pattern over time.

So far studies have indicated that early alliance seems to be a better predictor of outcome than alliance in the middle and late sessions of therapy (Horvath & Symonds, 1991), but the empirical evidence about the pattern of change has been controversial. Horvath and Marx (1990) argued that there is systematic fluctuation within individual treatment dyads, and research shows some evidence for Mann’s model of a high-low-high development pattern of alliance (Golden & Robbins, 1990; Horvath & Marx, 1990). However, some studies have found support for a linear pattern (Klee, Abeles, & Muller, 1990; Kivlighan & Shaughnessy, 1995; Piper, Boroto, Joyce, McCallum, & Azim, 1995), indicating that alliance becomes more positive over time. Others, in turn, have indicated that its strength remains stable during the course of therapy when averaged across cases (Gomes-Swartz, 1978; Hartley & Strupp, 1983; Marmor, Weiss, & Gaston, 1989; Morgan, Luborsky, Crits-Cristoph, Curtis, & Solomon, 1982). These controversial results may be explained by clients’ different interpersonal characteristics and capacities, which have not been taken into account in most of the studies. Piper and colleagues’ study (1995) provides partial support for this. Although the pattern of change was linear for both low and high quality of object relations, the pattern of change in alliance was more important for the outcome of the therapy for clients with a poor quality of object relations.

Insecure attachment types seem to show some tendency toward a low quality of object relations. To meet the second objective of our study, and in line with Piper et al. (1995), we thus hypothesized that the changes in the pattern of alliance would be greater for those with insecure attachment patterns than for autonomous individuals. Insecure individuals generally have a history of poor interpersonal relationships, and meet new relationships, such as with their therapist, with apprehension. The evolvement of a positive alliance may take a longer time, or the individual may be more reactive, experiencing either improvement or deterioration, in comparison
to secure types. In contrast, autonomous individuals may initially form the alliance more easily and show less fluctuation during therapy.

There is some research showing associations between attachment patterns and therapy outcome. Fonagy et al. (1996) found that autonomous and dismissing individuals may utilize therapy better than preoccupied individuals. Research by Dolan, Arnkoff, and Glass (1993) also supported this result. Accordingly, our final aim was to study the relationship between attachment patterns and therapy outcome.

Although alliance seems to be a pantheoretical construction, the context of trauma therapy may pose a special challenge for its development. Our sample consisted of men who had been exposed to torture and ill treatment, and who suffered from posttraumatic stress (PTS) symptoms. The formation of alliance in trauma therapy could be hypothesized to be of special significance, because the clients had experienced trauma of an interpersonal nature, and their internal models of others as trustworthy have been forced to undergo a real challenge and reworking (Bustos, 1992). A natural consequence of exposure to torture is difficulty in forming trusting relationships. It has even been said that “nothing is more important for the professional than addressing the issue of trust” (Pope & Garcia-Peltoniemi, 1991 p. 270).

However, our previous results have supported the necessity of taking a person–environment view when looking at the effects of trauma on an individual (Kanninen & Punamäki, in press). We found that torture survivors with different attachment patterns were differently vulnerable to PTS, depending on the degree of the interpersonality in the nature of the trauma. Insecure survivors were highly vulnerable to PTS when facing physical torture, while autonomous individuals were vulnerable to psychological torture. Apparently, autonomous individuals found psychological torture a highly shattering experience, because it produced a mismatch between the abuse and their earlier experience of humans as trustworthy and of the world as benevolent. Accordingly, we wanted to further explore the importance of attachment in a trauma context, and the role it may play in the therapy relationship.

Alliance has been traditionally considered a therapeutic concept belonging to individual therapy. The concept of cohesion, coming from group therapy, comes close to alliance. Cohesion has been defined in several different ways. It may be seen as acceptance among group members and a sense of belonging in the group (Bloch, Reibstein, Crouch, Holroyd, & Themen, 1979), as a feeling of being united (Yalom, 1985), or as therapeutic alliance between an individual and the group. There may also be several different types of cohesion, such as individual-level and group-level (Aveline, 1999). We decided to test the concept of alliance in a group context and defined it as an individual’s alliance with the group.

In sum, we had three objectives. First, we examined the relationship between the client’s attachment pattern and early working alliance. Second, we investigated how alliance develops over time in different attachment patterns. Third, we examined the relationship between the attachment pattern and the therapy outcome.

METHOD

PARTICIPANTS

The participants were 50 self-referred Palestinian male clients (mean age 31 years, SD = 7.1), who sought consultation at local mental-health clinics in Gaza and the
West Bank. The sample consisted of consecutive referrals for therapy in three months starting from May, 1998. The clients had themselves chosen whether to have individual \((n = 25)\) or group therapy \((n = 25)\). All the patients who were approached agreed to take part in the study.

All the participants except two were political ex-prisoners, detained during the Intifada, the national uprising for independence in 1987–1993. Most of them were freed in 1993–1997 under the terms of the Oslo peace agreement between Israel and the Palestinian Liberation Organization (PLO). Their prison sentences varied from 1 month to 15 years. Thirty percent had spent more than three years in prison. They had been imprisoned from 1 to 15 times, the median being twice. The majority reported having been victims of torture and ill treatment.\(^1\) For instance, 62% reported frequently having been beaten on their feet and hands, 42% having been beaten on their sexual organs, and 37% having been kept in isolation. Eleven percent had suffered from electric shocks.

Fifty-two percent lived in refugee camps, 26% in towns, 18% in villages, and 4% in resettled areas (housing projects for former camp residents). The education level of the participants varied from primary school (10%) to university (22%). About a third (32%) were professionals, 20% were blue-collar workers, 2% were entrepreneurs, 2% were policemen, and 8% were students. Others did not join the labor force. At the time, 72% of the participants were unemployed. Twenty-two percent of the men regarded their economic status as good, 48% as poor, and 28% as extremely bad. Seventy-six percent were either married or engaged, 6% were either separated or widowed, and 18% were single.

The participants filled out the attachment, PTS, and somatic-symptom questionnaires before the therapy. No information is available on the diagnostic assessments of these patients by the clinics.

THERAPY AND THERAPISTS

Half of the group were in individual therapy and half in group intervention. The clients in individual therapy were seen by seven male therapists. One therapist had six patients, two had five patients each, three had two patients, and one had three patients. All of the therapists had received trauma-related specialization training at the Copenhagen Rehabilitation Centre. Five counselors (four men and one woman), educated at local universities, led the group therapy sessions. Each group had five participants. The duration of both individual and group interventions was between 10 and 12 months. The clients were seen on a weekly basis in both formats.

The clinics provide care for victims of military violence and torture in the aftermath of military occupation. Intervention has a multidimensional approach; it includes both victim and family, provides for social services, and avoids procedures reminiscent of the torture. The groups function as “mutual support groups” which concentrate on validating the individuals’ personal traumatic experiences.

\(^1\)International (Amnesty International, 1989), Israeli (B’Tselem, 1994), and Palestinian (Al Haq, 1988) human rights organizations have documented evidence that psychological pressure, ill treatment, abuse, and torture were commonly used in interrogating Palestinian prisoners during the Intifada. Human rights violations have continued after the Peace Agreement between Israel and the PLO (B’Tselem, 1998).
MEASURES

Attachment patterns. The paper-and-pencil attachment measure used is based on the AAI (George, Kaplan, & Main, 1985). The participants were given booklets with instructions: first, to describe their childhood relationship with their mothers, and, on the next page, with their fathers, by giving five adjectives and illustrative examples of each adjective. On the following pages, they were asked to describe what had happened when they were upset, ill, felt rejected, or experienced loss as children, and what they did when they experienced distress in both childhood and adulthood. Finally, they were asked how they thought their upbringing had affected their adult personality, and why they thought their parents had behaved in the way they had.

We applied the Main and Goldwyn (1985–1994) scoring system to quantify the report. Coding was based on transcripts of the responses to open questions. The basic assumption in the AAI is that attachment patterns in adulthood are organized around the individual’s characteristic ways of processing emotional and cognitive information. Therefore, conceptually meaningful sum-scores were formed from the material in three different areas: (1) Childhood memories: The following categories of childhood memories were formed, based on all the answers provided by the respondents—unloving mother, unloving father, parental pressure for achievement, parental over-involvement, unresolved parental loss, and unresolved parental abuse. (2) Coherence of the answers: The following categories were identified—overall coherence, current anger, derogation, idealization, and mixing politics with childhood. An overall incoherence score was formed by summing up all the different violations in accordance with Grice’s (1975) maxims: quality (being truthful and giving evidence), quantity (being succinct and yet complete), relation (being relevant and perspicacious), and manner (being clear and orderly). Derogation scores involve devaluing childhood experiences and belittling parents. The current-anger sum-score involves blaming and accusing parents and exaggerating their small offenses. The idealization sum-score is based on exaggerating good parental qualities without giving evidence and idealizing parental responsibilities. (3) Dealing with distress: The following categories were formed separately for the childhood and adulthood responses to dealing with distress: aggression, self-reliance, attention seeking, seeking family support, seeking support from outside the family, and withdrawal.

Reliability of attachment variables. A separate sample of 50 reports was scored by an independent coder to study interrater reliability. The Kappa values (for the categorical variables) reached the recommended (Fleiss, 1981) levels (.70–.80), except for paternal involvement (.40). The Pearson correlation coefficients (for continuous variables) were acceptable (.70–1.00), except for idealization of parental responsibilities \( r = 0.37 \). All the attachment reports were rated by the first author. A detailed reliability analysis and a scoring key with a detailed explanation and examples of the categories are available from the authors.

Cluster analysis (Ward’s method and Euclidian distance) was used to identify different groups of participants with similar combinations of variables, i.e., attachment patterns. Clustering was run with the standardized sum-scores of the attachment variables, coded on childhood memories, coherence of the answers, and dealing with distress. The sum-scores were chosen on the basis of both the theory and their discriminating function in an earlier study (Kanninen & Punamäki, in press).
The three obtained clusters were named: (1) autonomous individuals \( n = 18 \), (2) dismissing individuals \( n = 12 \), and (3) preoccupied individuals \( n = 6 \). The fourth group, consisting of five persons, was called “unclassifiable” due to missing information. This group was left out of subsequent analyses. The autonomous individuals were typified by positive childhood memories, succinct storytelling, and coping with difficulties by seeking support rather than by withdrawal. The dismissing individuals were characterized by derogativeness and negative memories of their childhood, for example. They coped by withdrawal. The preoccupied individuals had experienced the most parental loss, pressure, and abuse. They had the most negative memories, and still expressed anger toward their parents. They regarded themselves as self-reliant.

**Working Alliance Inventory.** The Working Alliance Inventory (WAI; Horvath & Greenberg, 1989) has two parallel self-report measures (one for the client and one for the counselor). We used a 27-item version with a 1–5 Likert scale for the responses (1 = never, 5 = always). The participants filled it out after the third session, in the middle (during the fifth or sixth month), and after the second to last session of the therapy (between the 10th and 12th month). Only the client’s scores were used in this study, because earlier results have shown that the patient’s appraisal of the alliance has the strongest association with outcome (Horvath & Symonds, 1991). The WAI contains three subscales, reflecting agreement on goals, tasks, and bond. We were interested in the alliance as a whole, and only used the sum-scale. Horvath and Greenberg (1989) obtained good overall internal consistency estimates (alpha of .93 for the client scale). Reliability estimates (Cronbach’s alpha) using the present sample and the first measurement were .83 for the sum-scale. For group therapy use, the items were modified so that they were in relation to both the group and the counselor.

We checked the possible relation of the WAI sum-score to pretreatment symptom levels and to the amount of torture and ill treatment the participants had experienced, but no associations were found. Significant Pearson correlations were found between the working alliance scores at all three measurement times: the beginning and middle of the therapy \( r = .51 \ [N = 43], \ p = .001 \); the middle and end of the therapy \( r = .44 \ [N = 36], \ p = .008 \); and the beginning and the end of the therapy \( r = .42 \ [N = 36], \ p = .011 \).

**OUTCOME MEASURE**

PTS was assessed using the Harvard Trauma Questionnaire (HTQ; Mollica & Caspi-Yavin, 1991). The 30-item list consists of 16 symptoms derived from the Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R) criteria for post-traumatic stress disorder (PTSD) and 14 derived from clinical experience with trauma survivors. The latter category includes, for instance, feelings of shame, guilt, and being betrayed. The participants were asked to indicate to what extent they had suffered from each of 30 symptoms during the previous six months. The scale was a 4-point Likert scale: 0 = not at all; 1 = a little; 2 = quite a bit; and 3 = extremely. This symptom scale has demonstrated adequate levels of reliability and criterion validity among Arab populations (Staehr, Staehr, Behbehani, & Bojholm, 1993). Mollica et al. (1992) have shown sufficient criterion validity of HTQ in differentiating between PTS patients and nonpatients.

Sum-scores for intrusion, avoidance, and vigilance were formed, as suggested theoretically (McNally, 1992; Mollica & Caspi-Yavin, 1991). Intrusion included items
such as recurrent thoughts and having nightmares, while avoidance consisted of avoiding activities which reminded the person of the traumatic events, for example. Vigilance, in turn, included items such as the feeling of going crazy and difficulty in concentration. The reliabilities for these scales were .43 (intrusion), .88 (avoidance), and .90 (vigilance). In addition, a sum-score of all the items was formed (reliability .96). The choice of a dimensional (rather than categorical) approach to PTSD was made to facilitate the statistical analyses and to avert potential inaccuracies in specifying caseness because of the lack of a threshold score for diagnosing PTSD among Palestinian men. Multivariate analyses of variance on three pretreatment HTQ dimensions showed differences across the attachment patterns, Roy’s largest root $F(3,30) = 3.25, p = .035$, indicating that those with an autonomous attachment pattern had lower levels of PTS symptoms than those with the two insecure patterns. (Univariate analyses and post-hoc tests were not significant, however.)

TRANSLATION OF MEASURES

The HTQ was translated into Arabic by members of a research group in the Rehabilitation Center for Torture Victims in Copenhagen. The attachment measure was translated into Arabic from English by a bilingual psychologist and independently back-translated by a bilingual social worker. Both the English and Arabic versions were translated and back-translated by the research group in the Gaza Community Mental Health Program.

RESULTS

The number of participants was reduced to 36 for the final analyses. Five persons had missing attachment data, five persons from to the unclassified attachment group were left out, and four persons in group therapy had not filled out the alliance questionnaires.

The analysis of variance showed that there were no differences between attachment patterns in the levels of early alliance. We then examined how therapeutic alliance had developed in the course of the therapy, and whether this development differed according to the attachment patterns. We conducted a $3 \times 3$ univariate approach repeated measures analysis of variance with time (at the beginning, middle, and end of therapy) as a within-subject effect and attachment pattern (autonomous, dismissing, and preoccupied) as a between-subjects effect on the alliance sum-score. The analysis yielded a significant effect for time, Hyunh-Feldt $F(2,52) = 4.03, p = .024$, indicating that there were changes in alliance over time. There was also a significant Time $\times$ Group interaction effect, Hyunh-Feldt $F(4,52) = 3.09, p = .023$, indicating that the attachment patterns exhibited different patterns of alliance development over time. Table 1 shows the mean values for alliance at the three measurement times for the three attachment patterns.

We then calculated the linear and quadratic trends in alliance change over time within each attachment pattern, in order to isolate the source of the significant Time $\times$ Group interaction. We compared these trends across attachment patterns by performing orthogonal polynomial contrasts that tested for the differences between them. In the linear trend, the only significant difference was found between the dismissing and preoccupied attachment patterns, $F(1,15) = 6.87, p = .021$. In the quadratic trend, there were significant differences between the autonomous and the dismissing at-
attachment patterns, $F(1,22) = 5.31, p = .031$, as well as between the dismissing and preoccupied patterns, $F(1,13) = 6.26, p = .026$, but not between the autonomous and preoccupied patterns.

The results thus show that, when considered over time as a linear pattern, the development of alliance becomes more positive for preoccupied and more negative for dismissing individuals. However, as Figure 1 shows, this linear trend does not reflect the development of alliance very well when all three measurement times are taken into account. The initial level of alliance was found to be approximately the same in all attachment groups, but the pattern of alliance development differed in each one. For the autonomous individuals, the level of alliance dropped in the middle
of therapy, and increased back to the initial level by the end. The development of alliance followed a similar quadratic trend among the preoccupied individuals: The level decreased rather steeply in the middle of the therapy, and then increased even more steeply by the end. By way of contrast, the level of alliance among the dismissing individuals was approximately the same at the beginning and in the middle of the therapy, and then decreased by the end.

Our final aim was to study the relation between attachment pattern and the outcome of the therapy. The outcome variable was residualized change score calculated by regressing pretherapy HTQ sum-score onto posttherapy HTQ sum-score. The analysis of variance yielded no significant differences between the attachment patterns.

DISCUSSION

The results demonstrate the importance of clients’ attachment patterns in interventions with adults exposed to severe trauma and suffering from posttraumatic symptoms. Literature on both attachment and alliance may shed some light on why individuals with different attachment patterns showed different patterns of development in their perceptions of alliance. The results are in accordance with Crittenden’s (1998) descriptions of how individuals, based on their inner expectations, differ in their functioning in interpersonal relationships, and with Luborsky’s (1976) descriptions of the different phases of alliance.

Luborsky (1976) saw alliance as a dynamic entity. At the beginning of the therapy, early alliance may be dominated by the therapist’s actual behavior, such as whether the therapist seems caring and supportive. Thus, it seems natural that perceptions of alliance were quite similar among the patients, regardless of their attachment classification. However, later phases of therapy impose different requirements on the patient’s ability to form an alliance when the therapist challenges the old neurotic patterns (Horvath & Luborsky, 1993; Luborsky, 1976). The client may experience a loss of trust, and this may reactivate the old dysfunctional patterns, thus weakening the alliance.

The autonomous patients showed almost the same level of alliance throughout the therapy, although there was a small decline in the middle. The middle period, being the new critical phase, was thus reflected in the level of alliance, but the autonomous individuals then balanced their perception of it with the previous level. Autonomous individuals have been described as people who usually form a cooperative relationship in an interview situation. They are self-reflective and aware of their mental strategies (Crittenden, 1998). Accordingly, new information and requirements for reciprocity in the therapeutic relationship did not throw them out of balance and did not harm the therapeutic alliance.

The development of alliance among the preoccupied individuals resembled that of the autonomous individuals, in that there was a high-low-high pattern. However, the changes were more drastic, and at the end of the therapy perceptions of alliance among the preoccupied individuals became clearly more positive than it was among the autonomous individuals. The stronger fluctuation in the high-low-high pattern may reflect both inability to work on a more cognitive level, and difficulty in forming stable relationships. Preoccupied individuals have been described as being likely to involve others in regulating their distorted and fluctuating affects and to maintain an entangling present focus on past feeling states (Crittenden, 1998). Their tendency
to “go with the flow” may show in deteriorating alliance when more sensitive matters or problems in the therapeutic relationship 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 therapy.

In contrast to the other groups, the dismissing individuals had the same level of subjective experience of alliance in the middle of the therapy as at the beginning. By the end, their perception of the alliance had become more negative. The focused nature of trauma therapy may enable the dismissing patients to concentrate on trauma-related matters, which then delays confrontation with their interpersonal patterns. Dismissing individuals have been described as being persons who are usually more comfortable working on a cognitive level. They have a tendency to distance themselves from an interviewer in an unconscious attempt to reduce the risk of being made aware of distressing information (Crittenden, 1998). Furthermore, deterioration in the alliance may be related to difficulties with the prospective separation, and thus these men coped by distancing themselves and hiding behind their negative evaluation of the relationship with the therapist.

In summary, our results show that the changes in alliance were greater for the insecure, especially those with a preoccupied attachment pattern, than for the autonomous individuals. Although the attachment patterns differed in the development of alliance, attachment per se was not related to the success of the therapy. This differs from previous results obtained by Fonagy et al. (1996), which pointed out that preoccupied persons usually gain less from attending psychotherapy than persons with other attachment patterns.

We would like to emphasize the fact that the importance of attachment organization was only shown when we looked at the pattern of alliance development across different attachment groups. If we had only compared initial differences in alliance between the attachment groups, or concentrated on the development of alliance in the trauma group as a whole, the results would have looked very different. The alliance scores of the attachment groups did not differ statistically at the beginning of the therapy, and the change as averaged across the groups would have shown a misleadingly strong high-low-high pattern for all of the participants. This may explain why the results of previous studies have been controversial. Our study emphasizes the need to include personality variables as explanatory factors in such research settings.

The results have clinical relevance. Although trauma therapy by its nature is “more focused” therapy, in which the goal is to restore the person’s previous level of functioning, the therapeutic relationship is of primary importance as it is in other types of therapy (Bustos, 1992). In attachment terms, the therapist’s task is to provide the patient with a “secure base” (positive alliance), from which the patient can safely explore both “inner” and “outer” realities (Bowlby, 1988). How this task can be accomplished varies, depending on the client’s attachment pattern. Thus, an understanding of how insecure attachment may influence the specific patterns that are likely to appear in the therapeutic relationship may help the clinician in planning and timing the interventions.

Some caution may be warranted in interpreting the results of our study. First of all, both the sample and the group sizes were small. Ideally, the therapeutic setting (group versus individual treatment) would have been included as a covariate. This would have allowed us to draw firmer conclusions about the role of attachment and the effects of treatment setting on therapeutic alliance. Secondly, the “manipulation” of the concept and measurement of alliance in a group context may be criticized.
Furthermore, the results apply to specific trauma groups and cannot be directly generalized to other populations. Torture, because of its interpersonal nature, has probably caused extra difficulties in forming a trusting relationship. A natural consequence of exposure to torture is that a person’s ability to experience trust has been damaged. However, it is also important to note here that neither torture nor pretreatment symptom levels affected the clients’ ability to form an alliance with the therapist/counselor. Moreover, our method only considered the major attachment pattern classifications, and the issue of “unresolved trauma” was not addressed. This unresolved status may have further implications on treatment outcome.

REFERENCES


Zusammenfassung

Résumé
Nous avons investigué le développement de l’alliance en thérapie dans des groupes d’attachement différents, dans un setting naturaliste. Les participants étaient 36 ex-prisonniers politiques palestiniens venus eux-mêmes en psychothérapie comme victimes de tortures et de mauvais traitements. Leur thérapie était d’une durée de 10-12 mois. Les analyses ont montré que le développement de l’alliance au cours de la thérapie a suivi des patterns différents à travers les groupes d’attachement. L’alliance précocement n’a pas varié entre les groupes. Pour les individus autonomes, l’alliance a baissé au milieu de la thérapie pour retrouver son niveau initial à la fin. De façon similaire, elle a baissé en flèche chez les sujets préoccupés au milieu de la thérapie, pour remonter encore plus en flèche à la fin. Par contre, chez les sujets détachés, elle était à peu près comparable au début et au milieu, pour baisser à la fin.

Resumen
Hemos investigado, con encuadre naturalista, el desarrollo de la alianza terapéutica en grupos de diferentes tipos de apego. Los participantes fueron treinta y seis palestinos expresoerinos políticos, que fueron víctimas de tortura y maltrato y buscaron psicoterapia por sí mismos. Su terapia duró entre diez y doce meses. Los análisis mostraron que el desarrollo de la alianza durante la terapia siguió diferentes patrones en los grupos de apego. Sin embargo, la alianza temprana no difirió entre ellos. Para los
individuos autónomos, la alianza cayó al promediar la terapia y aumentó a su nivel inicial hacia el final. En forma similar, para los individuos “dependientes”, decreció bruscamente al promediar la terapia y luego aumentó aún más bruscamente hacia el final. En contraste, entre los individuos “rechazantes”, la alianza fue aproximadamente la misma al comienzo y al promediar la terapia y decreció al final.