Attachment styles, traumatic events, and PTSD: a cross-sectional investigation of adult attachment and trauma

Maja O’Connor* and Ask Elklit

Department of Psychology, University of Aarhus, Denmark

The aim of the present study was to examine the association between post-traumatic stress disorder (PTSD) and adult attachment in a young adult population. A sample of 328 Danish students (mean age 29.2 years) from four different schools of intermediate education level were studied by the Harvard Trauma Questionnaire (HTQ), the Revised Adult Attachment Scale (RAAS), the Trauma Symptom Checklist (TSC), the Crisis Support Scale (CSS), the Coping Style Questionnaire (CSQ), and the World Assumption Scale (WAS). Attachment styles were associated with number of PTSD symptoms, negative affectivity, somatization, emotional coping, attributions, and social support. The distribution of attachment styles in relation to PTSD symptoms could be conceived as uni-dimensional.

Keywords: adult attachment; traumatic events; posttraumatic stress symptoms; protective factors; risk factors

Introduction

During the last few decades it has been recognized that theory originally designed to describe attachment patterns between mother and child is also relevant in understanding adult relationships and psychopathology (Sroufe, 2005). Attachment style in adulthood is related to the adult experience of romantic love and mental models of self (Hazan & Shaver, 1987). The field of adult attachment has developed greatly over recent years (Fraley & Shaver, 2000) and is currently influential in areas of personality and social psychology including social cognition (Stein, Jacobs, Ferguson, Allen, & Fonagy, 1998). It has been suggested that stressful attachment-related events such as the unresolved loss of a loved one can lead to a number of symptoms, including those of Posttraumatic Stress Disorder (PTSD; Fearon & Mansell, 2001). Bowlby (1953) identified a number of negative life events that would be expected to influence the stability of attachment: the death of a parent, foster care, parental divorce, chronic and severe illness of parent and child, single parent, parental psychiatric disorder, drug and alcohol abuse, and child experience of physical or sexual abuse. Weinfeld, Sroufe, and Egeland (2000), among others, in a study of a high-risk sample provided evidence that attachment continuity was jeopardized by child maltreatment, maternal depression, and family functioning in early adolescence. Quite similar findings are reported as risk factors for PTSD in a meta-analysis by Brewin, Andrews, and

*Corresponding author. Email: maja@psy.au.dk

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Valentine (2000) who concluded that general childhood adversity predicted PTSD more consistently than e.g., did gender and age at trauma. Psychiatric history, reported childhood abuse, and family psychiatric history had more uniform predictive effects.

A search in PsycINFO (August 2006) revealed only a few studies examining the relationship between adult attachment and PTSD based on self-report inventories. Two studies had male participants, such as former prisoners of war or victims of torture, who had experienced extreme stress (Dieperink, Leskela, Thuras, & Engdahl, 2001; Kanninen, Punamaki, & Qouta, 2003). Two studies had female participants investigating CSA survivors and women who attended a clinic for early pregnancy termination (Allanson & Astbury, 2001; Anderson & Alexander, 1996), with findings, in general, indicating a secure attachment style to be associated with decreased number of PTSD symptoms and insecure attachment styles to be associated with enhanced number of PTSD symptoms when exposed to traumatic experiences. Two studies had both genders as participants. Miller (2000) assessed 31 parents of childhood leukemia survivors and found that secure attachment was associated with less posttraumatic symptoms and dysphoria, while fearful and dismissive attachment styles were associated with an increased level of posttraumatic symptoms. Waldinger, Schulz, Barsky, and Ahern (2006) tested whether insecure attachment mediated the link between childhood trauma and adult somatization in a sample of 101 couples. For women fearful attachment fully mediated this link, but for men both childhood trauma and insecure attachment were independent predictors of adult somatization.

Lazarus and Folkman (1984) proposed that cognitive factors such as coping styles and cognitive schemas or attributions mediate response to traumatic experiences in the direction that problem-centered coping generally is more effective in dealing with traumatic stress that emotional coping. A recent literature review gave evidence to the Lazarus and Folkman theory (Agaibi & Wilson, 2005). Furthermore, it has been found in recent studies that high levels of emotional coping style and low levels of problem-focused or rational coping style preceding a traumatic event predicted PTSD (Gil, 2005; Nielson, 2003), and that chronic PTSD in war veterans was associated with basic assumptions such as lower levels of self-worth and beliefs about the benevolence of other people (Dekel, Solomon, Elklit, & Ginzburg, 2004). In addition to basic assumptions (Janoff-Bulman, 1992), availability of social support is likely to be perceived differently by individuals with various attachment styles as these styles (Bartholomew, 1990) are defined by some authors as positive and negative working models of self and others. In their empirical and theoretical review, Sarason and Duck (2001) conclude that cognitive components, such as locus of control, schemata, and working models, are some of the personality variables influencing social support.

The term negative affectivity refers to a mood dimension and reflects a general tendency to react to and have a negative perspective on the surrounding world and oneself (Krog & Duel, 2003). Negative affectivity can both be seen as a state and a personality factor or trait similar to neuroticism (Krog & Duel, 2003). Schnurr and Vielhauer (2005) described negative affectivity/neuroticism as a likely risk factor for PTSD because the personality dimension reflects a sensitivity to negative stimuli. Shapinsky, Rapport, Henderson, and Axelrod (2005) found a strong positive correlation between negative affectivity and PTSD measures, and a substantial variance in PTSD was accounted for by trait characteristics such as negative affectivity. Significant associations between PTSD and negative affectivity were also found by e.g., Bennett, Owen, Koutsakis, and Bisson (2002), Feldner, Lewis, Leen-Feldner, Schnurr, and Zvolensky (2006), and Monson, Price, Rodriguez, Ripley, and Warner (2004). To the best of the authors’ knowledge, no research on the relationship between attachment style and PTSD in a general population sample and no research on the associations between attachment, PTSD, and coping styles has been published.
**Adult attachment**

The adult attachment theory by Hazan and Shaver (1987) was further developed by Bartholomew and colleagues (Bartholomew, 1990; Bartholomew, Cobb, & Poole, 1997; Griffin & Bartholomew, 1994) by describing a connection between attachment and models of self and others resulting in a two-dimensional model of adult attachment based on self-report inventories. Collins and colleagues (Collins, Cooper, Albino, & Allard, 2002; Collins & Feeney, 2000, 2004; Feeney & Collins, 2001, 2003) likewise based on self-report data derived the same four attachment styles from two dimensions: (1) the combined measures of closeness and dependency and (2) anxiety. These dimensions are comparable to the model of self and others based on the dimensions of dependency and avoidance originally described by Bartholomew (Bartholomew, 1990; Griffin & Bartholomew, 1994).

**The current study**

In the present study the definition of psychological trauma and the diagnostic criteria for PTSD in the DSM IV (American Psychiatric Association, 1994) is used (First, Frances, & Pincus, 2002). The aim of the study is to examine whether attachment security is related to (1) post-traumatic symptomatology and (2) several other closely linked aspects of social and psychological functioning believed to be implicated in the development of and/or maintenance of PTSD, namely negative affectivity and somatization. A secondary aim is to test whether attachment security is associated with post-traumatic symptomatology independently of these PTSD-related social and psychological factors.

**Method**

**Sample**

A total of 328 students (65% female) with a mean age 29.2 years ($SD = 11.63$; range = 15–61 years) participated in the study. The participants came from four different schools of intermediate education level (nurses’ aids, two types of social workers, and craftsmen). The schools were selected for their predominantly young student populations, the majority of which have a non-university background. Traumatic experiences ad modum Kessler, Chiu, Demler, and Walters (1995) were investigated.

**Procedure**

Data collection was based on questionnaires. The first author introduced the study to the participants and was available for clarifying questions while the participants filled out the questionnaire. Participation was voluntary. The response rate was 94%.

**Measures**

**Harvard Trauma Questionnaire**

The Harvard Trauma Questionnaire (HTQ) part IV (Mollica, Caspi-Yavin, Bollini, & Truong, 1992) measures the severity of PTSD symptomatology and can be used for an estimate of the PTSD diagnosis. The HTQ consists of 30 items (4-point Likert scale; $1 =$ not at all, $4 =$ very often). Sixteen items relate to the three core clusters in PTSD in DSM-IV: avoidance (7 items), reexperiencing (4 items; one item contains two related
symptoms), and hypervigilance (5 items). The A2 criterion (the experience of horror or helplessness) of the DSM-IV diagnosis (First, Frances, & Pincus, 2002) was assessed separately. Only scale items \( \geq 3 \) on HTQ were considered for a PTSD diagnosis. The scale has been shown to be both reliable and valid (Bach, 2003). The HTQ self-report measure of PTSD had 88% concordance with interview based estimates of PTSD (Mollica et al., 1992).

In the present study, participants chose the most traumatic event experienced in their lifetime. On the basis of the chosen event, each participant first answered HTQ retrospectively in relation to their reaction in the time immediately after the stressful event (Lifetime, LHTQ), then subsequently answered HTQ in relation to their current reaction (CHTQ). The internal consistencies, as measured by Cronbach’s alpha, of the subscales in this study were excellent for LHTQ, with avoidance (\( \alpha = .82 \)), reexperiencing (\( \alpha = .84 \)), hypervigilance (\( \alpha = .76 \)), LHTQ total (\( \alpha = .95 \)), and good for CHTQ, with avoidance (\( \alpha = .71 \)), reexperiencing (\( \alpha = .74 \)), hypervigilance (\( \alpha = .67 \)), and CHTQ total (\( \alpha = .93 \)).

Revised Adult Attachment Scale

The Revised Adult Attachment Scale (RAAS) is an 18-item self-report scale, on which participants rate statements about how they function and feel in a relationship with a partner, someone close, and people in general (5-point Likert scale; 1 = not at all characteristic, 5 = very characteristic). The scale is two-dimensional; (1) items on closeness and dependency are merged into one dimension (\( \alpha = .73 \)) (Collins, 1995, unpublished research note) and (2) an anxious attachment dimension (\( \alpha = .73 \)).

Attachment styles corresponding to Ainsworth’s three original attachment patterns (secure, anxious-ambivalent, and avoidant) can be generated based on the RAAS (Collins & Read, 1990; Stein et al., 1998). A fourth attachment pattern corresponding to a fearful style was also included (Collins & Feeney, 2004). The categorical attachment styles are distributed by values on the dimensions of “close-dependency” and anxiety; e.g., secure attached scores high on the close-dependency dimension and low on the anxious dimension. High is defined as being above the midpoint on the 5-point scale, and low as below the midpoint. Scores exactly on the midpoint are normally excluded from the sample (Collins, 1995, unpublished research note).

In the present study, 12.8% (\( n = 42 \)) had missing values and 8.2% (\( n = 27 \)) had midpoint scores and were therefore excluded from the sample leaving a new \( N \) of 259. Sixty-six percent (\( n = 188 \)) had a secure attachment style, 8.2% (\( n = 27 \)) had a preoccupied attachment style, 8.7% (\( n = 25 \)) had a dismissive attachment style, and finally 6.6% (\( n = 19 \)) had a fearful attachment style.

Trauma Symptom Checklist — Revised

The Trauma Symptom Checklist — Revised (TSC-R) consists of 23 items and measures a number of general distress symptoms on a 4-point Likert scale (1 = never, 4 = always). The TSC-R yields specific scores for negative affectivity and somatization. Krog and Duel (2003) identified the two subscales based on a factor analysis of 4152 cases from 16 studies of trauma populations in which the original TSC (Briere & Runtz, 1989) was used. The TSC-R subscales have good internal consistency reliability and factorial and criterion validity (Krog & Duel, 2003). The internal consistencies of the subscales as measured by Cronbach’s alpha were acceptable to very good (somatization \( \alpha = .65 \), negative affectivity \( \alpha = .83 \); TSC total \( \alpha = .85 \)).
Crisis Support Scale
The Crisis Support Scale (CSS) measures social support after a traumatic event. The seven items (7-point Likert scale; 1 = never, 7 = always) relate to perceived available support, practical help, emotional support, contact with others in a similar situation, ability to express thoughts and emotions related to the event, the degree to which one feels let down, and general satisfaction with social support (Joseph, Andrews, Williams, & Yule, 1992). The scale has good psychometric properties (Elklit, Pedersen, & Jind, 2001). The internal consistencies of the subscales in the present study were good (Present CSS α = .73; Past CSS α = .83).

Coping Style Questionnaire
The Coping Style Questionnaire (CSQ) originally consisted of 60 items (4-point Likert scale; 1 = never, 4 = always) measuring four coping styles; rational coping, emotion-focused coping, avoidance coping, and detached coping (Roger, Jarvis, & Najarian, 1993). In this study, 37 items loading significantly, both in the original study and in a replication study (Elklit, 1996), on the four factors (cut-off point 0.30) were used. The internal consistencies of the subscales in this study were good to acceptable with the exception of detached coping (rational coping α = .70; emotion-focused coping α = .75; avoidance coping α = .65; detached coping α = .43). The latter was excluded from this study.

World Assumptions Scale
The World Assumptions Scale (WAS) is a 32-item self-report scale that examines the participants’ cognitive schemes about self and the world. Items are scored on a 6-point Likert scale (1 = strongly disagree, 6 = strongly agree). The internal consistency of the subscales has previously been found to range from α = .48 – .82. (Elklit, Shevlin, Solomon, & Dekel, 2007). In the present study the internal consistency ranged from α = .43 – .70. Only subscales self-control (α = .69) and benevolence of the world (α = .70) showed satisfactory internal consistency, therefore only these scales were used in the present study.

Data analysis
The distribution of the data is presented as percentages, means, and standard deviations. Nominal variables were compared using χ². Correlations were estimated with Pearson’s correlation coefficient. Attachment styles were analysed in relation to all scales using a one-way ANOVA. Multiple linear regression analysis was used to assess the effect of independent variables on the LHTQ total scores. A 0/1 (no/yes) coding was used for dichotomous variables. The analyses were performed by means of SPSS-PC, version 13.0.

Results
The average duration of the participants’ education was 12.7 years (SD = 2.5; range 7–24). Forty-eight percent were single and lived alone, 20% were cohabiting, 26% were married and lived together with a partner, and 6% were divorced. The average time of living together with a partner/spouse was 11.3 years (SD = 10.5). Thirty-nine percent
of the participants had children. The average number of children was 2 (SD = 0.9; range 1–5).

The average number of lifetime traumatic experiences was 1.5 (SD = 1.4). Seventy-seven percent had been exposed to at least one traumatic experience such as bereavement (53%; n = 174), threat of violence (15%; n = 49), actual violence (10%; n = 32), accident (14%; n = 47), shock because of significant others being exposed to a traumatic event (14%; n = 47), fire (4%; n = 14), witnessing a person being killed or injured (9%; n = 28), rape (2%; n = 8), childhood sexual abuse (3%; n = 11), childhood physical abuse (4%; n = 14), or severe childhood neglect (7%; n = 23).

Lifetime PTSD prevalence was estimated to 18.9% for all subjects (37.3% for all exposed subjects who answered the HTQ); current PTSD rate was estimated to 4.6% (11.9% for the exposed subjects who answered the HTQ). Missing data were not imputed. There was an overrepresentation of young males who had missing data in the various psychological scales particularly at the end, but not in the demographic or event questions. As young males with a medium level of professional education are not well represented in attachment and trauma research, we decided to keep them in the study. Those not reporting any traumatic experiences were excluded in the following analyses.

**Associations between attachment styles and the psychosocial variables**

The relationships between attachment styles and the independent variables were analysed by means of one-way ANOVAs (Table 1). None of the attachment styles were associated with level of trauma exposure (data not shown). Secure attachment was significantly associated with low levels of lifetime and current number of PTSD symptoms, negative affectivity, somatization, and emotional and avoidant coping, but with high levels of perceived previous and present social support, rational coping, and a more favorable attribution of benevolence of the world.

Preoccupied attachment was only associated with a high level of emotional and a low level of rational coping. Dismissive attachment was associated with high levels of lifetime and current number of PTSD symptoms, negative affectivity, and somatization and low levels of benevolence of the world and perceived present support. Fearful attachment presents almost the same pattern as dismissive attachment with the exception that fearful attachment was not related to the intrusion subscales, a low level of perceived previous social support, and high levels of emotional and avoidant coping.

**Regression analysis**

A stepwise linear regression analysis was carried out using the Lifetime HTQ (LHTQ) total score as the dependent variable. The aim was to generally develop a model of the best predictors of trauma symptoms and see whether attachment can be justifiably considered to add unique information (i.e., whether it is independent of the other factors considered). Demographic variables were entered first followed by trauma related variables, personality related variables third, and social support variables last. The final model included six variables that explained 54% of the total LHTQ score (Table 2).

The correlation between Lifetime HTQ and Current HTQ was \( r = .76 \). Lifetime HTQ was predicted by (female) gender (gender accounted for 16% of the variance), rape experience, feeling of helplessness in relation to the traumatic event (helplessness was rated independently of the HTQ), high degree of fearful attachment and of emotional coping,
and lack of perceived sympathy and social support at the time after the traumatic experience (Table 2).

**Discussion**

The present study attempted to clarify whether PTSD symptomatology and other psychosocial factors were associated with adult attachment security. The results of the

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**Note:** *p < .05; **p < .01; ***p < .005; ****p < .0005.
study provide evidence that the number of PTSD symptoms was associated with certain attachment styles. A negative correlation between secure attachment and all subscales of current and lifetime HTQ was found, suggesting that secure attachment may have a protective effect on the development of PTSD. The results are in accordance with a study of former male political prisoners in which secure attachment was found to be protective in relation to development of PTSD following physical torture (Kanninen et al., 2003).

No significant pattern appeared in the associations between preoccupied attachment style and number of PTSD symptoms, whereas the fearful and the dismissive attachment styles showed a positive relationship with number of PTSD symptoms on both current and the lifetime measures of HTQ. The pattern of associations between number of PTSD symptoms and secure attachment on the one hand and fearful and dismissive attachment styles on the other was inverted. The level of associations indicates that secure attachment may be a more salient factor than fearful and dismissive attachment. The regression analysis showed that one particularly attachment style, the fearful, could explain part of the variation of the PTSD symptomatology. This finding is similar to a finding by Fraley, Waller, and Brennan (2000) that measures of the insecure attachment styles are more reliable and therefore stronger predictors than measures of secure attachment. As expected, fearful and dismissive attachment styles were linked to poor psychological adjustment on a variety of parameters in the present study. The present findings showed significant associations between fearful attachment and low levels of perceived social support and emotional and avoidant coping styles. Dismissive attachment was unrelated to coping and past social support and was less strongly associated with the negative affectivity and somatization than fearful attachment. Dismissive attachment was associated with less favorable assumptions about the benevolence of the world. The latter attribution has previously been associated with poor psychological outcome (Janoff-Bulman, 1992).

The use of avoidant and especially emotional coping has been previously associated with increased psychological distress (Böðvarsdottir & Elklit, 2004; Ireland, Boustead, & Ireland, 2005). The results of the current study are in line with these findings. Furthermore, fearful attachment was found to correlate strongly and dismissive attachment moderately with the TSC subscales of somatization and negative affectivity. A search on PsycINFO (August 2006) revealed no publications on studies combining the TSC and attachment style. The results are, however, comparable to results from related studies finding a positive correlation between insecure attachment styles (especially the fearful type) and somatization, hypochondria, or subjective body complaints (Ciechanowski, 2003).

Table 2. Hierarchical multiple regression analysis to predict present number of lifetime PTSD symptoms (LHTQ).

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<td>Emotional coping</td>
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<td>Past sympathy</td>
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Note: Step 1: $F = 24.9; R^2 = .16; p < .005$. Step 2: $F = 19.53; R^2 = .23; p < .0005$. Step 3: $F = 21.05; R^2 = .34; p < .0005$. Step 4: $F = 25.24; R^2 = .48; p < .0005$. Step 5: $F = 21.03; R^2 = .50; p < .0005$. Step 6: $F = 19.9; R^2 = .54; p < .0005$. 
Walker, Katon, & Russo, 2002; Schmidt, Strauss, & Braehler, 2002; Wayment & Vierthaler, 2002). In line with the present results, one study found a positive correlation between fearful attachment and negative affectivity (Wearden, Lamberton, Crook, & Walsh, 2005). Negative affectivity has previously been found to share the same underlying structure as neuroticism (Meyer & Shack, 1989). The results from the present study are therefore in line with related studies finding a positive correlation between neuroticism and insecure attachment styles (Howell Rolston, 2003; Moreira et al., 1998; Wolfgang, 2005).

Demographic variables, with the exception of gender, were unrelated to traumatization in the current study. The finding of a higher number of PTSD symptoms reported by women remained significant after controlling for social support, emotional coping, fearful attachment, and feeling of helplessness or horror in relation to traumatic events. This is in line with previous research (Kessler, Chiu, Demler, & Walters, 2005; Kessler, Sonnega, Bromet, & Hughes, 1995; Krog & Duel, 2003). Of interest is the fact that women, in spite of the higher number of PTSD symptoms, reported more satisfying social support and more positive attributions than men. The possibility of attachment security being confounded with trauma exposure was not supported in the present study.

This study has several limitations. First, the study is cross-sectional and retrospective. Furthermore, the number of persons with fearful attachment was relatively small. Self-report measures may, in the light of different results found between self-reported adult attachment versus adult attachment interviews, not fully capture the underlying organization of attachment representation. The focus of this study has been limited to identifying associations between adult attachment in romantic and close relationships and PTSD. While this focus is appropriate when studying relationships between attachment style and processing of traumatic events experienced in adulthood, it may not be the most appropriate choice for studying relationships involving traumatic events experienced in childhood. Finally, the population is only representative of a segment of the Danish population. Generalizations to other populations should therefore be made with caution.

Despite the limitations, one strength of the study was that it consisted of an understudied population representative of a social stratum without a university background. Hence the studied population represents a different population than that found in many studies of young college populations. In addition, this study supports the hypothesis that the number of PTSD symptoms is associated with attachment styles in a younger adult population of intermediate education level not selected for being a survivor of a traumatic event, and the results are consistent with results from traumatic populations (Allen, Huntoon, & Evans, 1999; Dieperink et al., 2001; Kanninen et al., 2003). The findings provide further evidence that fearful and dismissive attachment is linked to high levels of psychological distress while secure attachment is linked to low levels of psychological distress. This suggests that attachment style may be an important interpersonal dimension in relation to traumatic experiences and reactions.

Sixty-six percent of the valid population was classified as securely attached. This figure is fairly high compared to prior findings on other types of non-traumatized populations (Bartholomew & Horowitz, 1991). Age, class, and cultural differences in the populations investigated may be the reason for the various results, as could technicalities such as the number of midpoint exclusions (8.7%; \( n = 27 \)).

The inverse relationship between secure versus fearful and dismissive attachment styles found in this study opens an interesting discussion. The preoccupied attachment style was hardly associated with the dependent variables. These results could suggest a type of linear
relationship between the four attachment styles and scores on most dependent variables; a linear relationship with secure attachment at one end followed by preoccupied, then dismissive, and lastly fearful attachment (Table 2). The results are in opposition to Collins’ (1996) findings that preoccupied persons report exaggerated levels of negative emotion, compared to avoidant/dismissive persons.

Is this merely a coincidental result caused by a relatively small population of fearfully attached individuals or is it possible that attachment could be conceived as uni-dimensional rather than bi-dimensional? Fraley and Brumbaugh (2004) investigated stability across time based on uni-dimensional attachment security in contrast to the bi-dimensional attachment styles described by Bartholomew (Bartholomew & Horowitz, 1991; Griffin et al., 1994), and Collins (1996). Thus, in line with Fraley and Baumbaugh (2004), this study may indicate that attachment could be conceived as a uni-dimensional, high/low security dimension. Furthermore, the study indicates that attachment may be an intermediate factor in relation to psychological trauma in the direction that a high degree of secure attachment could be a protective factor, whereas preoccupied exhibits a neutral middle ground, while fearful and dismissive attachment are risk factors in relation to specific types of abuse and psychological distress.

A number of questions need to be addressed in future research. The current study gave evidence that attachment is an important factor in relation to trauma. Attachment can be viewed as a subjective, interpersonal dimension in relation to psychological trauma, supplementing well-known psychological measures such as coping and personality styles, when investigating the possible effects of personality in relation to traumatic experiences and reactions. While secure attachment style seems to serve as a protective factor and fearful and dismissive attachment styles represent risk factors in the development of traumatization following a traumatic experience, new preventive interventions may be at hand. As the study is correlational, we have no knowledge about causality. Attachment security may as well be the result of traumatic events that cause destabilization of existing attachment styles, as it may moderate or mediate the effects of traumatization. Inclusion of attachment measures in prospective studies of PTSD and inclusion of PTSD measures in prospective studies of attachment need to be taken into consideration in future research to better understand the relationship between PTSD and adult attachment. Furthermore, additional work is needed to understand the nature of dimensions of attachment across gender, age, socioeconomic status, trauma type, and culture.

References


