

# Attachment Representation and Sensitivity: The Moderating Role of Posttraumatic Stress Disorder in a Refugee Sample

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*It has been hypothesized that adult attachment representations guide caregiving behavior and influence parental sensitivity, and thus affect the child's socio-emotional development. Several studies have shown a link between posttraumatic stress disorder (PTSD) and reduced parental sensitivity, so it is possible that PTSD moderates the relationship between insecure attachment representations and insensitivity. In this study symptoms of PTSD (Harvard Trauma Questionnaire), parental sensitivity (Emotional Availability Scales), and attachment representations (Attachment Script Assessment) were assessed in 53 parents who were asylum seekers or refugees. Results showed that when parents were less able to draw on secure attachment representations, symptoms of PTSD increased the risk of insensitive parenting. These findings suggest that parental sensitivity is affected not just by attachment representations, but by a conjunction of risk factors including symptoms of PTSD and insecure attachment representations. These parents should therefore be supported to establish or confirm secure models of attachment experiences, to facilitate their ability interact sensitively and form a secure relationship with their children.*

**Keywords:** Attachment Representations; Trauma; Posttraumatic Stress Disorder; Sensitivity; Refugee

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## INTRODUCTION

It is well-established that a healthy parent–child relationship is important if children are to prosper in their development. Bowlby (1973) developed attachment theory to explain the relationship between parent and child from a biological perspective. Bowlby proposed that, with age and cognitive development, sensorimotor representations of

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attachment experiences give rise to internalized mental representations, that is, working models of the world and significant persons in it. Adult attachment representations reflect mental representations of past and present attachment experiences (Main, Kaplan, & Cassidy, 1985). These attachment representations have an important function, namely to provide a personal framework to guide behavior and expectations in present relationships and during the development of new relationships (Coppola, Vaughn, Cassibba, & Costantini, 2006). It has been suggested that adult attachment representations guide caregiving behavior, determine parental sensitivity and thereby the child's socio-emotional development (Main et al., 1985; Van IJzendoorn, 1995).

Caregiving representations have been shown to be related to adult attachment representations (George & Solomon, 1996; Slade, Belsky, Aber, & Phelps, 1999) and observed parenting behavior. There is also extensive evidence that parents with a "secure state of mind" are more sensitive (Biringen, Matheny, Bretherton, Renouf, & Sherman, 2000; Slade, Grienemberger, Bernbach, Levy, & Locker, 2005; Trapolini, Ungerer, & McMahon, 2008). Such parents are more willing and able to perceive their children's actions correctly and to respond to them in a prompt, contingent, and appropriate way. In general, attachment security helps an individual to attend less to his or her own needs, and shift attention to other behavioral systems, such as caregiving. Parental sensitivity is one of the key mechanisms in an effective parent-child relationship and an important precondition for development of attachment security in the child (Ainsworth, Blehar, Waters, & Wall, 1978; De Wolff & Van IJzendoorn, 1997; Van IJzendoorn, 1995).

Various studies have shown that trauma-related psychological disturbances and, more specifically, posttraumatic stress disorder (PTSD) can affect parenting. Parents with symptoms of PTSD perceive their relationship with their child as poorer than those without symptoms of PTSD (Jordan et al., 1992; Lauterbach et al., 2007; Samper, Taft, King, & King, 2004; Van Ee, Sleijpen, Kleber, & Jongmans, 2013); they also perceive their child as having a more difficult temperament and experience more parenting stress (Davies, Slade, Wright, & Stewart, 2008; Holditch-Davis et al., 2009; McDonald, Slade, Spiby, & Iles, 2011) than parents without symptoms of PTSD. It has been observed that mothers with more symptoms of PTSD were less sensitive and responsive (Feeley et al., 2011; Schechter et al., 2010; Van Ee, Kleber, & Mooren, 2012). The available data amount to convincing evidence for the impact of trauma on parenting and hence, children.

For decades theory and research on trauma and attachment have developed relatively independently (Stovall-McClough & Cloitre, 2006). This study contributes to our understanding of the relationships and interactions among attachment representations, PTSD, and caregiving behavior (sensitivity) in a high-risk sample (asylum seekers and refugees). As the development of attachment representations precedes refugee trauma, and both these factors are related to parenting sensitivity, symptoms of PTSD may moderate the relationship between attachment representations and caregiving behavior. A chronic sense of being under threat and difficulty with reflective thinking may affect the way parents think and feel about and behave toward their children (Slade, 2005). In addition, they may interfere with parents' capacity to consider their children's perspective and interpret their thoughts and feelings correctly (Kosslyn, 2005). Together with intense fear, sadness, and anger, this can lead to degradation of parents' capacity to respond sensitively to their children and their ability to serve as a secure attachment for them (Lieberman & Knorr, 2007); in other words, this group of parents is more likely to display insensitive parenting behavior. The role of parental symptoms of PTSD as a moderator of the relationship between attachment representations and sensitivity has not been studied before.

## METHODS

### Procedure

The sample for this study was recruited via Centrum '45, the Dutch national institute for the treatment of trauma resulting from war, persecution, and violence, and via regional centers for asylum seekers in the Netherlands. At Centrum '45, counselors informed eligible participants about the research project and asked if they would consent to be approached by research assistants. At regional centers research assistants working with interpreters approached eligible participants to tell them about the project. If they were willing to participate, a research date was set. All parents came with their child for 1 day to Centrum '45 or a designated area within the center. Before testing started final written, informed consent was obtained. Participants were aware that they could withdraw their consent at any time and that their anonymity was guaranteed. An interpreter was present throughout the day. When questionnaires were not available in the language required, items were translated during the session. Participants received 25 euros and their traveling expenses were reimbursed. The study was approved by the Medical Ethics Committee of the Medical Centre, Leiden University, the Netherlands.

### Participants

To study the effects of trauma at the extremes of the distribution a sample of both asylum seekers, refugees, as well as their children was chosen. Asylum seeker and refugee parents (mothers and fathers) were eligible for the study if they had suffered a traumatic experience and had a preschool child, born in the Netherlands. Asylum seekers and refugees with severe mental retardation, addictions, or psychosis were excluded. As traumatization of the child has its own effect on parent-child interaction, dyads were excluded when children themselves had experienced traumatic experiences. Exclusion criteria were checked with the Mini International Neuropsychiatric Interview (Overbeek, Schruers, & Griez, 1999) and an interview to assess the child's lifetime trauma exposure history. In this interview, parents were asked to report exposure to potential traumatic experiences such as accidents, hospitalization, and violent events throughout the life of their child.

Eighty eligible parents consented to be part of the study, but 10 participants refused to take the Secure Base Scripts (SBS) test as they considered it too difficult. One participant was excluded from the analyses because of problems with translation and the results were therefore unreliable. Four participants had too much missing data on the Harvard Trauma Questionnaire (HTQ) to be useful in analyses. In 12 cases both father and mother participated; to avoid dependency in the data we included only data from the mothers of these children, as the mother is usually the primary caregiver. The final sample therefore consisted of 53 participants.

Independent samples *t*-tests and chi square tests of associations were performed to test whether participants who refused to complete the SBS differed significantly from participants who completed this assessment. Participants with missing scores on the SBS had spent significantly fewer years in the Netherlands before the study,  $t(15.44) = -2.76$ ,  $p = .04$ , and had completed lower levels of education,  $\chi^2(4, 73) = 15.10$ ,  $p < .01$ ; in fact, most had not received any education at all or had completed only a few years of primary school. Participants with missing scores on the SBS did not significantly differ in age, gender, country of origin, or refugee status (having a residence permit or not) from participants who did complete the SBS.

The sample consisted of 30 mothers, 23 fathers, 21 girls, and 32 boys. The mean age of the parents was 30.86 years ( $SD = 7.37$ ), the mean age of the children was 28.04 months

( $SD = 9.62$ ). The families had fled from all over the world (Africa: 35.8%, Middle East: 35.8%, South and Eastern Asia: 11.3%, Eastern Europe and Balkan: 7.5%, Russia and former Russia: 7.5%, South America: 1.9%) to the Netherlands from 3 months to 17 years ( $M = 6.80$ ,  $SD = 4.75$ ) before the study. Of all the parents, 31 had received a residence permit (58.5%), and 24 parents and their children (44.4%) lived in an asylum center. Of all the parents, 16.3% had little or no education, 20.4% had finished primary school, 18.4% had finished secondary school, 10.2% had finished vocational education and 34.7% held a professional or university qualification.

## Measures

### *Symptoms of PTSD*

Traumatization of parents was measured with the HTQ (Mollica, Caspi-Yavin, Bollini, & Truong, 1992). The questionnaire consists of a list of 20 traumatic experiences and a 30-item trauma symptom list. The first 16 items are derived from the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition (DSM-IV, American Psychiatric Association, 2002), criteria for PTSD and measure of the severity of PTSD symptoms. The other 14 items describe symptoms related specifically to refugee trauma. The HTQ asks participants which traumatic experiences they experienced, witnessed, or heard of. It also asks participants to rate the degree to which particular PTSD symptoms have bothered them in the past week on a Likert scale from 1 (*not at all*) to 4 (*extremely*). A cut-off score of 2.5 on this scale has been used in several studies to identify clinically significant PTSD (Mollica et al., 1992). Standard versions of the HTQ are available in many languages. For a small minority of the participants the HTQ was not available in the required language. In this case qualified interpreters translated the questions in session. The scores of these four participants did not significantly differ from other participants.

The psychometric properties of the HTQ are adequate to very good across cultures and valid for the measurement of symptoms of posttraumatic stress (Kleijn, Hovens, & Rodenburg, 2001). In a review of instruments used in studies of refugees, the HTQ was found to be statistically reliable and valid in multiple studies across diverse traumatized populations (Hollifield et al., 2002). In the current study, despite the use of different languages, internal consistency of the 30-item symptom list was high (overall Cronbach's  $\alpha = .92$ ; intrusion  $\alpha = .84$ , avoidance  $\alpha = .79$ , arousal  $\alpha = .82$ , refugee trauma items  $\alpha = .89$ ). The mean score on the 30-item DSM-IV posttraumatic stress symptoms was used in the analyses.

### *Attachment scripts*

Attachment scripts of parents were measured with the SBS (Waters & Rodrigues-Doolabh, 2004). The narrative-attachment instrument uses a word-prompt method to assess participants' awareness of and access to a secure attachment script. Evidence for the convergent validity of the SBS comes from the fact that SBS scores show substantial association with Adult Attachment Interview coherence ( $r$  ranging from .50 to .60). It has been suggested that secure attachment scripts provide the foundation for attachment representations (Bakermans-Kranenburg, 2006; Bretherton, 1991; Waters & Waters, 2006). The SBS instrument has been used across different sociocultural groups (Coppola et al., 2006; Vaughn et al., 2007; Verissimo & Salvaterra, 2006; Waters & Waters, 2006).

Parents completed the SBS by responding to word-prompts that provided outlines for six different stories. Each outline included three columns of four words and the outlines were presented one at a time. Parents were asked to use the outline to produce a story. They were told that the stories would be recorded using an audio-recorder and that they could start a story again if they wanted. Of the six word-prompt outlines presented, two

were filler stories and four were attachment-related: two parent-child oriented lists (*Baby's Morning* and *Doctor's Office*) and two adult-couple oriented lists (*Troubles at Work* and *The Accident*).

Narratives were coded on a seven-point scale for the extent to which they were organized around a secure attachment script. A secure attachment script is one in which there is a bid for help, the bid is recognized and help is offered, the help is useful in overcoming the problem, and the situation ultimately returns to normal. Narratives that show this structure clearly were coded 7; narratives that lacked this structure completely were coded 1. Following common practice, a composite score derived by averaging the scores across all four stories was used in the analysis.

All scripts were scored by the first author, who has been trained by Harriet Waters to score the SBS reliably. A sample of 10 randomly selected cases was also scored by Harriet Waters. Inter-rater reliability for the SBS was established by computing Intraclass Correlation Coefficients (ICC) for the four attachment-related stories in this sample. Within-story rater agreement was high (ICC ranging from .84 to .91). Inter-rater agreement for the composite score was also high (ICC = .97). The internal consistency of the composite score was good (Cronbach's  $\alpha$  = .80).

### *Sensitivity*

Sensitivity of parents toward their children was measured with the Emotional Availability (EA) scales, fourth edition (Biringen, 2008). EA is defined as the degree to which the individual expresses emotions and is responsive to the emotions of others. Optimal EA enhances secure-attachment behavior (Biringen, 2000). The EA scales assess four dimensions of parental EA to the child and two dimensions of the child's EA to the parent. The parental dimensions are sensitivity, structuring, nonintrusiveness, and nonhostility; the child dimensions are responsiveness to the parent and involvement with the parent. For the purposes of the present study we only used scores on the parental sensitivity dimension of the EA scale because this dimension was of specific relevance to our hypotheses. The score for this dimension ranges between 1 and 7 with higher scores indicating higher parental sensitivity. A sensitive adult displays balanced, positive, and genuine affect, clarity of perceptions, and appropriate responsiveness, and there is a mutual delight in interacting. An insensitive adult displays negative affect, harshness, or passive disinterest, and may show neglectful or abusive behavior.

In this study, parents and children were videotaped during a 15-minute play session. Parents were instructed to play with their children and the available toys as they liked. During this unstructured play, parent and child were alone in the room. Two trained raters, who were unaware of the maternal history of trauma or level of symptoms, independently coded the videotaped sessions. Inter-rater reliability, computed for a randomly selected 30% of the videotapes, was high (sensitivity: ICC = .89).

### **Statistical Analyses**

Statistical analyses were performed using SPSS version 20.0 (Armonk, NY: IBM Corp.). Preliminary analyses on the variables of interest were performed to ensure no violation of the assumptions of normality, linearity, and homoscedasticity. Hierarchical regression analysis was used to test whether attachment scriptedness was associated with parental sensitivity to the child and whether this association was moderated by PTSD symptom level. To test the moderating effect of PTSD symptom level we computed the interaction between the standardized SBS scores and PTSD symptom level. The interaction term was added to a regression model together with the covariates parental gender and age, the



standardized independent variable (i.e., attachment scriptedness), and the moderator PTSD symptom level. Then the significance of the interaction term was tested. A significant interaction term would indicate that the association between attachment scriptedness (independent variable) and parental sensitivity (dependent variable) was moderated by PTSD symptom level. Simple slope analysis (Preacher, Curran, & Bauer, 2006) was used to test whether the slope for the regression of parental sensitivity on attachment scriptedness was significant at low (1 standard deviation below the mean of the moderator), intermediate (mean of the moderator), and high (1 standard deviation above the mean of the moderator) levels of the moderator (PTSD symptom level).

RESULTS

Descriptive Statistics

Table 1 gives an overview of means and standard deviations for the number of traumatic experiences, PTSD symptoms, secure attachment scripts, and sensitivity toward the child as observed within the interaction. Means did not differ significantly between mothers and fathers (all *p*-values > .05). On average, participants had experienced or witnessed about 11 traumatic experiences. The most common experienced traumatic experiences were lack of water or food (48.1%), unnatural death of a family member (44.4%), forced separation from family members (53.7%), imprisonment (44.4%), torture (46.3%), being threatened with torture (50.9%), and nearly dying (55.6%). The mean PTSD symptom level was at the boundary between a normal and clinical range. Fifty-one percent of participants had symptoms sufficient for a clinical diagnosis of PTSD and 49% had subthreshold scores. Mean SBS scores provide continuous data; a score below 4 indicates a general absence of a secure attachment script in the narratives. In our sample 69.8% of the scripts reflected lack of awareness of and access to a secure attachment script, 18.9% of the scripts reflected weak awareness of and access to a secure attachment script, and 11.3% reflected strong awareness of and access to a secure attachment script.

Associations Between PTSD Symptoms, Attachment Scriptedness, and Sensitivity

Parental sensitivity toward children was significantly negatively associated with PTSD symptom level (*r* = −.42, *p* < .01), indicating that increased levels of parental sensitivity are associated with decreased PTSD symptoms. There was a significant positive association between parental sensitivity and attachment scriptedness (*r* = .32, *p* < .05), suggesting that increased awareness and access to a secure attachment script is associated with increased levels of parental sensitivity toward their children. Attachment scriptedness was not significantly associated with PTSD symptoms.

TABLE 1  
*Descriptive Statistics for Mothers, Fathers, and the Total Sample of Parents*

	Father ( <i>N</i> = 12)		Mother ( <i>N</i> = 41)		Total sample ( <i>N</i> = 53)		Range
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	
PTSD symptoms	2.48	0.80	2.37	0.70	2.40	0.72	1–4
Attachment scripts	3.02	0.48	3.19	1.03	3.15	0.94	1–7
Parental sensitivity	4.58	1.51	4.24	1.56	4.32	1.54	1–7

TABLE 2  
*Associations Between Attachment Scripts (SBS), Posttraumatic Stress Disorder (PTSD) Symptoms, and Parental Sensitivity*

	<i>B</i>	<i>SE B</i>	$\beta$	$\Delta R^2$	$R^2$
Step 1				0.01	0.01
Constant	4.61	0.47			
Gender	−0.38	0.54	−0.10		
Age	−0.06	0.23	−0.04		
Step 2				0.11*	0.12*
Constant	4.67	0.45			
Gender	−0.45	0.51	−0.12		
Age	−0.03	0.22	−0.02		
SBS	0.51	0.21	0.33*		
Step 3				0.27**	0.39**
Constant	4.74	0.41			
Gender	−0.54	0.47	−0.15		
Age	−0.04	0.20	−0.03		
SBS	0.44	0.19	0.29*		
PTSD symptoms	−0.61	0.19	−0.40**		
Step 4				0.10*	0.49*
Constant	4.55	0.39			
Gender	−0.22	0.46	−0.06		
Age	0.01	0.19	0.01		
SBS	0.41	0.18	0.27*		
PTSD	−0.53	0.18	−0.34**		
SBS × PTSD symptoms	0.54	0.20	0.33*		

Dependent variable: parental sensitivity, \* $p < .05$ , \*\* $p < .01$ ,  $\Delta R^2$  = change in  $R^2$  compared to previous step.

**Moderation of the Association Between Attachment Scriptedness and Parental Sensitivity by PTSD Symptom Level**

Table 2 presents the results of the hierarchical regression analysis that was employed to test whether the association between attachment scriptedness and parental sensitivity was moderated by PTSD symptom level. We controlled for the effects of parental age and gender on parental sensitivity by adding them to the model in step 1. There was no significant contribution of parental gender and age to variation in parental sensitivity. To test whether attachment scriptedness contributed independently to variance in parental sensitivity it was added to the model in step 2. There was a significant positive association between attachment scriptedness and parental sensitivity, indicating that increased levels of awareness and access to a secure attachment script is associated with higher degrees of parental sensitivity. Attachment scriptedness accounted for 11% of the variance in parental sensitivity. To be able to test an interaction the main effect of the moderator needs to be added to the regression model before the interaction is added. Therefore to test whether the association between attachment scriptedness and parental sensitivity was moderated by symptoms of PTSD the interaction between attachment scriptedness and PTSD symptom levels, the moderator variable, PTSD symptom level, was added to the model in step 3, and accounted for 27% of the variance in parental sensitivity. The interaction between attachment scriptedness and PTSD symptom level was added in step 4. The interaction effect was significant and accounted for 10% of the variance in parental sensitivity, suggesting that the association between attachment scriptedness and parental sensitivity was moderated by PTSD symptom level. The effect size of the total  $R^2$  is 0.76 and post hoc achieved power is 0.99.

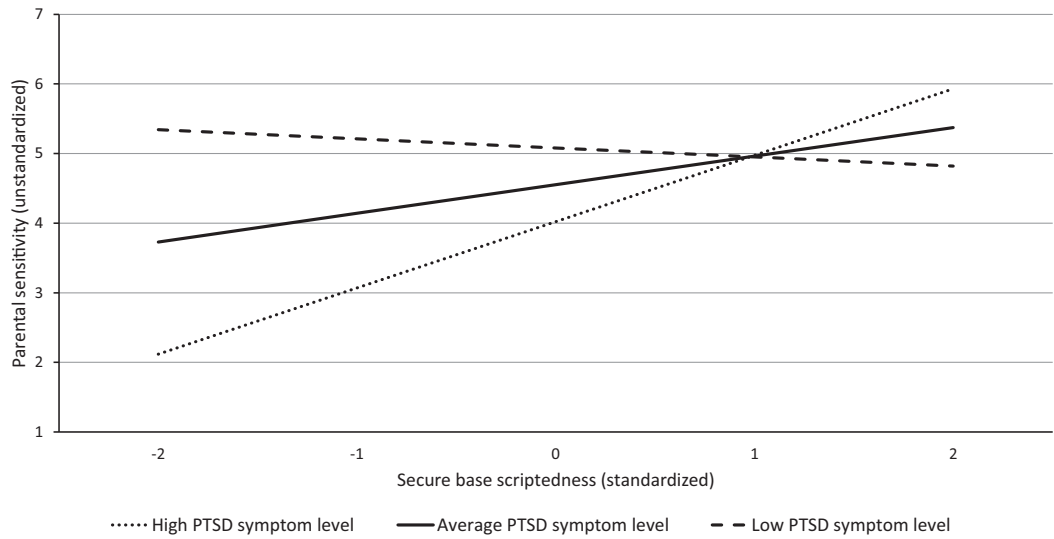


FIGURE 1. Association between attachment scripts and parental sensitivity as a function of posttraumatic stress disorder symptom level.

In Figure 1, the association between attachment scriptedness and parental sensitivity is presented as a function of the PTSD symptom level. Lines represent the association between attachment scriptedness and parental sensitivity for high PTSD symptom levels (1 standard deviation above the mean PTSD symptom level in the sample), low PTSD symptom levels (1 standard deviation below the mean PTSD symptom level in the sample), and intermediate PTSD symptom levels (mean PTSD symptom level in the sample). It can be seen that the association between attachment scriptedness and parental sensitivity was stronger at higher PTSD symptom levels. Simple slope analysis indicated a significant positive association between attachment scriptedness and parental sensitivity for parents with high ( $b = 0.95$ ,  $p < .01$ ) and intermediate ( $b = 0.41$ ,  $p < .05$ ) PTSD symptom levels, but a nonsignificant association for parents with low PTSD symptom levels ( $b = -0.13$ ,  $p = .64$ ). This indicates that parental sensitivity was negatively influenced by lower levels of attachment scriptedness for parents with intermediate or above intermediate PTSD symptom levels but not for parents with lower PTSD symptom levels.

DISCUSSION

Working models of attachment can be defined as knowledge structures that guide behavior in particular contexts, including caregiving relationships (Bakermans-Kranenburg, 2006). Symptoms of posttraumatic stress, such as a continuous reactivation of trauma and a state of fear, may amplify negative working models. As parents with insecure attachment representations and more symptoms of PTSD can be less sensitive toward their children, we hypothesized that symptoms of PTSD can moderate the relationship between parental attachment representations and sensitivity.

In line with previous research, secure attachment representations are underrepresented in this clinical sample (Bakermans-Kranenburg & Van IJzendoorn, 2009). An insecure attachment has been postulated to be a risk factor for mental health problems; however, no causal relationship has yet been established. Some studies associated PTSD with higher



attachment insecurity (Mikulincer, Ein-Dor, Solomon, & Shaver, 2011; Solomon, Dekel, & Mikulincer, 2008; Stovall-McClough & Cloitre, 2006). However, studies in veteran samples did not find an association between attachment insecurity and PTSD, but did find an association between attachment insecurity and unresolved trauma and loss (Harari et al., 2009; Nye et al., 2009). Our study is the first study in a nonveteran sample that failed to find an association between symptoms of PTSD and attachment representations.

Although we found a significant relationship between sensitivity and attachment representations, the association is modest. The low variability in the higher range of scores on the attachment scripts—as expected in a group exposed to extreme trauma—within a small heterogeneous sample with participants from many cultural backgrounds may account for the relative weakness of the association. Furthermore, levels of parental sensitivity have been shown to be negatively affected by daily stresses (Belsky, Woodworth, & Crnic, 1996; Crnic & Low, 2002; Phelps, Belsky, & Crnic, 1998; Van IJzendoorn, Bakermans-Kranenburg, & Mesman, 2008) and asylum seekers and refugees are exposed to a variety of daily stresses such as the asylum procedure, housing, financial strains, and acculturation demands.

Of particular importance is the finding that symptoms of PTSD moderate the relationship between parental attachment representations and parental sensitivity. There is only a weak relationship between awareness of and access to secure attachment scripts and sensitivity in parenting in parents who report low levels of PTSD symptoms. However, when parents cannot draw on secure attachment representations, a high level of PTSD symptoms increases the risk of insensitive parenting. These findings suggest that parental sensitivity is affected not just by attachment representations but by the conjunction of risk factors such as symptoms of PTSD and insecure attachment representations. However, Sagi-Schwartz et al. (2003) showed that Holocaust survivors who were able to protect their children from their traumas as children did not differ from the comparison group in symptoms of PTSD, attachment representations, and maternal behavior. Longitudinal studies are needed to further explore vulnerability and resilience in populations who have experienced severe trauma. These results suggest that there should be more integration of attachment and trauma research; this might shed further light on the interaction between attachment, trauma, and its consequences for parenting behavior.

Whilst this study makes a relevant and original contribution to attachment research through its structured and intensive observations of asylum seeker and refugee parents and their children, it also suffers from limitations. Firstly, the design was cross-sectional and so the data provide no evidence on causality. The parents' attachment representations developed before the symptoms of PTSD developed, so from an ontogenetic perspective we consider the attachment representations to be the determining factor and the symptoms of PTSD to be a moderating factor. However, this interpretation should be confirmed in longitudinal studies. Secondly, the participants came from diverse cultural backgrounds. Although we used instruments that have been validated in samples from multiple cultures, they are not necessarily valid for the specific culture of all our participants. Thirdly, the asylum seekers and refugees who took part in the present study are members of a specific group considered to be at risk for clinical disturbance as a result of traumatic experiences and forced migration; this may limit the generalizability of our results. Whether our findings generalize to asylum seekers and refugees outside the Netherlands or to other at-risk populations is a subject for future research.

We deem our results to be of clinical importance. In a high-risk population of traumatized parents, it is important, on one hand, to treat this traumatization. PTSD, as a single predictor, had a large negative effect on sensitivity. On the other hand, in a population of traumatized parents, it is important to assess the attachment representations of both children and parents. Insecure attachment representations combined with a high level of

PTSD symptoms increase the risk of insensitive parenting, so traumatized parents need to be supported to confirm, re-establish, or develop secure models of the world and significant others, in order to facilitate their ability to interact sensitively with their child and offer the opportunity for secure attachment. The therapeutic alliance and the establishment of a secure attachment can be of crucial importance in the treatment of (complex) PTSD (Charuvastra & Cloitre, 2008; Van der Kolk, 1989). It is precisely via this therapeutic relationship that a parent can establish or confirm secure attachment representations. Thus, risks of insensitive parenting can be decreased, and the child's development is indirectly influenced.

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