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TITLE: AN EXPLORATION OF THE RELATIONSHIP BETWEEN THE THERAPIST ATTACHMENT STYLE AND THE EFFICACY OF THERAPY

THESIS SUBMITTED IN PARTIAL FULFILMENT OF THE REQUIREMENTS OF THE HIGHER DIPLOMA IN COUNSELLING AND PSYCHOTHERAPY

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ABSTRACT

The current study is done using a desk-based research approach, using secondary resources taken from library books and online academic journals. It explores attachment theory and applies it to the therapeutic space to determine the impact of therapist attachment styles on the therapeutic alliance and outcome. Attachment theory can indeed be overlaid onto the therapeutic alliance to help provide a meaningful measure of its efficacy. While the results varied it was found that the therapist attachment styles impacted the alliance and outcome both positively and negatively. But it was also noted that different clients would be affected differently depending on the therapist attachment style. It also led to the question of what place does reflective thinking have in the process and what is it's effectiveness.

Chapter 1: INTRODUCTION

Psychodynamic therapy places importance on the interpersonal relationship between the client and therapist, the client's inter-psychic relationship and how both evolve in the therapeutic space. What plays out in this space is destined to repeat itself in current external relationships and is a by-product of relationships and experiences that have occurred in the past. Within psychodynamic literature the word 'psyche' means thoughts, feelings and spirit and 'psychodynamic' refers to how the psychic is experienced as constantly changing and evolving rather than being static (Jacobs, 2017). As such, aspects of all relationships are both internal and external to us; how we perceive the other and how that person relates to us. Our internal psychical relationship of thought, feeling and spirit does not necessarily have to be related to our feelings towards someone else; nor do they have to be prompted by someone else; they can be about ourselves, or parts of ourselves. These internal aspects are formed in the early years of child development via the external relationship with our primary care-givers and how we perceive that relationship (Jacobs, 2017, p. 6). The relationship with our care-givers; how they communicated with us being the external facet, how we perceive this, being the internal facet and what we may have wished for, being the fantasy. These relationships are instrumental in shaping us.

Bowlby's (2005, p. 112) attachment theory focuses on the real-life experience between parent and child and away from fantasy. This developmental theory defined the interpersonal relationship between the infant and the primary care-giver, who is also called the attachment figure, and is usually the mother. Through this relationship the child learns characteristic patterns of relating to the mother; which in turn is used as patterns of behaviour throughout the individual's lifespan, and with others. Depending on how well the child bonds with the attachment figure, the

quality of the attachment is believed to have implications on how that individual will succeed in holding and maintaining secure and loving relationships into adult life.

Individuals usually seek help from a therapeutic encounter at times of distress within their lives and it is at such times of stress, that the attachment system, learned in childhood is triggered in adults. Understanding and knowing this system plays a central role in guiding the therapeutic relationship. Bowlby likened the therapeutic encounter to the attachment relationship whereby the therapist helps the client reconstruct a working model of himself and his attachment figures so that "he becomes less under the spell of forgotten miseries and better able to recognize companions in the present for what they are" (Bowlby, 2005, p. 155). In other words, the therapeutic environment should be a safe space to allow the client to explore themselves and their interpersonal environment. Feeling safe is when exploration can begin.

Chapter 2: ATTACHMENT THEORY - FOUNDATION

Bowlby's conviction that it's the real relationships which we have as children that shape us, led to his attachment theory. Being marginalized by his psychoanalytical piers, his theory fell into the hands of academic researchers. Here it was developed and enhanced to establish a robust theory on developmental psychology. The below exploration follows that path that links it to the therapeutic space and the development of the relationship between therapist and client.

The attachment behavioral system is designed by evolution; it is genetically programmed. Bowlby, (2005, pp. 136–137) noted that this behavioural system is evident in three kinds of behavior. Firstly, the child attempts to maintain proximity to the attachment figure via seeking and monitoring the whereabouts of the attachment figure. Secondly, the attachment figure is used as a secure base from which to explore the world. The exploratory behavioral system is intimately related to the attachment system for only when a child feels safe will exploration begin. Finally, in times of perceived danger or alarm the attachment figure is used as a safe haven – a "stronger and/or wiser person" to turn to for safety and comfort. While proximity is important, secure attachment requires reassurance of safety and on-going emotional availability of the care-giver. Bowlby recognized that the care-giver can be physically close but emotionally unavailable thus attachment is not defined by proximity but rather by emotional responsiveness. This attachment drive is significant across the life-span of an individual; it is a human need, which exists not only in infancy and childhood but throughout one's life. It is the essence of being the social beings that we are; to communicate, to be with one another, to listen and to be heard. People who are partnered and who have good friends live longer than those who are isolated.

While the drive to attach is genetic; it is the quality of attachment, based on the everyday interactions with the parents, that shapes the child's emotional state. What is critical, is how the

child feels towards the care-giver and their appraisal of the care-givers availability. Through the "*Strange Situation*" test it was discovered that the innate attachment system is mailable and the different individual attachment styles depends on the difference of care-giving received (Ainsworth, Blehar, Waters, & Wall as cited in Wallin, 2015). Three distinct patterns of behaviour were observed, that the children exhibited when their mothers returned to them in the "*Strange Situation*". The emotional security of the child could be determined from these behavioral patterns. To summarise, a secure child has equal access to his/her impulses and can display a full range of emotions; to which their mothers are capable of responding to. The child can explore when desired and seek security when required. The dyad is capable of full emotional exchanges. This flexibility and resilience is due to the mother being attuned to her child (Wallin, 2015). By being attuned the mother is mirroring the child in both an accurate and marked manner (Wallin, 2015). She can resonate with the child and give back to the child, the child's own emotions which allows the child to discover and understand his own emotions. The avoidant child seems blasé to an intrinsically alarming environment. Apparent distress can be misconstrued as calm; yet his/her heart rate is as high as a secure child's, upon their mother's departure and their cortisol level are greater than the secure infants. Their mothers are rejecting of emotional behavior and are emotionally unavailable and uncomfortable with physical contact. These children seem to be learning to suppress emotionality in general, and particularly to suppress negative feelings. The ambivalent child was too pre-occupied to play and too distressed to actively search for comfort when his/her mother returned. Ambivalent infants seemed to be learning that negative emotions get attention; that these are the 'valid' emotions in the relationship. Finally, discovered by Main and Solomon (as cited in Wallin, 2015), disorganized children, perceived their mother as a safe haven and source of threat which is a biological paradox and later in life these children are at a higher risk of psychopathology.

What begins as a biological drive evolves into what Bowlby called "*Internal Working Models*" (IWM); which is an internalized mental model or schema which allows us to create generalizations and summaries of past experiences. We learn from the past, how we were received and mirrored by our attachment figure, is what we expect in the future and we apply such knowledge directly to the present. At best the internal models are open and flexible to change as new information becomes available. Insecure models are more rigid and inflexible. These adaptive models born in childhood, are in effect a type of rule-book which operates both in the conscious and the unconscious, so many people are unaware of their own patterns of behavior. They are behavioural and communicative rules which eventually become strategies that determine how we access our attachment-related feelings, emotions and memories. They are part of our defense mechanism, which was initially required to adapt to the parents' own attachment style. What was perceived as good was kept in and what did not work was made redundant.

The IWM was reconceived as "structured processes serving to obtain or limit access to information" (Main et al as cited in Wallin, 2015, p. 34). She developed the "*Adult Attachment Interview*" (AAI) which is a narrative assessment of an adult's "state of mind with respect to attachment" (Siegel, 1999, p. 78). Through the discourse in the AAI interview the individual would reflect internal process and patterns of behavior. It highlights functioning of feelings and behaviors, attention, memory and cognition. "The internal working models will be related not only to individual differences in patterns of nonverbal behavior but also to patterns of language and structures of mind" (Main et al as cited in Wallin, 2015, p. 34). The classifications of each of these adults correlate with the infant attachment strategy. The autonomous adult, reflective of the secure child, would present as coherent, valuing of attachment and objective regarding any particular event or relationship. The dismissing adult, reflective of the avoidant child, would present as

dismissing of attachment-related experiences and relationships. The preoccupied adult, reflective of the ambivalent child, would present as being preoccupied with or by past attachment relationships and experiences. The unresolved adult, reflective of the disorganized child, would present with striking lapses in monitoring and reasoning when discussing abuse or loss. (For further detail please refer to Appendix 1 (Wallin, 2015, p. 33)). The AAI classification of the parents predicted with 75% accuracy the "*Strange Situation"* outcome of their children with regards to security versus insecurity (Main et al as cited in Wallin, 2015, p. 32). The reverse has also shown to be true. The child's attachment style is specific to each parent and corresponds with each parents own AAI classification (Siegel, 1999, p. 82). It thus proved the intergenerational transmission of attachment styles from parents to children to be something other than just biology or genetics. It also implies that the AAI ratings are tenacious and stable across time. Main, posited that the reason for this is because children learn the terms in which they are 'allowed to' interact with parents on an emotional level, they in effect mold to their models. As they grow into parents themselves they invite the same response from their children, often unconsciously, so as to maintain their own rigid patterns of emotional responses and behaviour (Main as cited in Wallin, 2015, p. 39). As such a character trait displayed by an individual may not be a trait that the individual was born with, but rather a state of mind that is repeatedly reinforced over time through interactions with their attachment figures. From these interviews, Main was able to derive that parents' mode of communication ultimately impacted the child's non-verbal behaviour in their "*Strange Situation"*. Where Ainsworth had observed a pattern in the secure child, being confident in their attachment figure's responsiveness as having freedom to explore; Main noted that the autonomous adult had the mental freedom to explore memories, thoughts and emotions in a coherent manner. It follows, that many of us maintain outdated attachment behavioural patterns,

learnt in the non-verbal realm of infanthood which are accessed and expressed both verbally and non-verbally in adulthood.

Despite there being a strong link between the AAI and the "*Strange Situation"* findings Ijzendoorn (as cited in Wallin, 2015, p. 39) discovered a transmission gap, which was a break in the cycle of transmission of insecure attachment from one generation to another. The cause of this Main theorized to be due to an ability she called metacognitive monitoring which is the ability to step outside our experience and remain with it at the same time (Main as cited in Wallin, 2015). It allows the individual to critique ones' own thoughts. Fonagy (2001) through his research on the theory of mind stretched this concept to include how adults ponder mental states in general and also the mental states of others.

While, psychanalytical theory originally saw the emotional bond between mother and child as secondary to the oral drive; Bowlby saw the infant's need for a secure base to be paramount in the drive for attachment. Here, the mother needed to understand the cause of the distress and be able to cope with it, to be able to alleviate it for the child. Where the mother could not meet the child's needs, they would be dismissed, or the mother would become over-involved. Fonagy (2001) from a psychoanalytical persuasion, saw the attachment drive as secondary; the primary function via the attachment bond, is that the infant learns to generate mental representations of the world, which include relational representations. It is within this attachment relationship that children learn that they have a mind of their own, through which they can mediate the world. To take a step back, if the mother can think about the child in terms of the child's own thoughts, feelings and desires while simultaneously, accessing her own thoughts, feelings and desires in relation to the child; then secure attachment can be transmitted through the generations, regardless of the adult's own attachment style. Here the mother is able to recognize the child's intentional

stance before the infant is aware of their own intentional stance and as such, gives the child the capacity to conceive of the conscious and unconscious mental states of the child and others. This capacity allows the adult to respond not just to observable behaviour but also to the underlying wishes and beliefs of another individual; it gives behaviour a meaning. This capacity being very reminiscent of insight and empathy. Fonagy et al (as cited in Fonagy, 2001) linked this capacity of being able to recognise another's emotion and intentional stance with those being able to reflect on their own and their care-giver's mental state in the AAI. Fonagy et al (as cited in Fonagy, 2001) found that mothers in a relatively high-stress group of adults characterized by single-parent families, parental criminality, unemployment, overcrowding, and psychiatric illness would be more likely to have securely attached children if their reflective function was high. Broadly speaking, it is this strength of the capacity to mentalise that can potentially allow adults whose own childhood experience of attachment was problematic, to raise children to be securely attached (Fonagy, 2001).

This capacity for intersubjectivity and the attachment drive are different but complementary systems (Wallin, 2015). The attachment drive gives rise to exploration once a deemed safe haven is available to the child. The secure adult has an ability to think, feel and act with openness and has a capacity to communicate with flexibility, which is driven from a felt sense of security. Intersubjectivity is driven by the need to know and be known by others. It promotes psychical intimacy and belonging. It allows an individual to experience another as a real person, rather than an object in their own psychical world. That person can be valued as a separate psychical being, with their own thoughts, needs and desires which may be very different. Through dialogue this separateness can be explored and respected rather than a need to dominate or submit as if the other is an object in our psychical world.

A key aspect of the dialogue is the concept of collaborative communication (Karlen Lyons-Ruth as cited in Wallin, 2015). The care-giver should learn as much as possible about what the child feels, needs and wants. When there is a disruption where the child's needs are not met, the care-giver should instigate a repair. Doing so, builds the child's expectation as to what is open communication and also teaches the child the essence of communication. Also, there should be the freedom for the child to protest against limits set. It gives the care-giver a chance to recognize the intentional stance of the child. This ability to provide repair to rupture is key to emotional development.

The need for emotional connection and comfort is an evolutionary drive, so it can not be ignored. As such unmet needs are repressed or defended against. The insecure attachment strategies are examples of these where consciously the dismissing adults see themselves as strong and complete, projecting their vulnerabilities and needs into others (Wallin, 2015). The preoccupied adults seem vulnerable to feelings of distress and can loose autonomy in a relationship and could eventually push a partner away. (Wallin, 2015).

Attachment research has proved that the unconscious experience is central to a person's emotional health and wellbeing. Bowlby (as cited in Bucci, Seymour-Hyde, Harris, & Berry, 2016), equated the therapeutic interaction to the attachment relationship, where the therapist acts as the attachment figure and provides a secure base in which the client can safely explore themselves and their interpersonal environment. There is also a recognition that the therapist involvement will result in enactments that highlight both therapist and client's vulnerabilities and the challenge is to turn these exact enactments into opportunity for growth and healing.

Chapter 3: ATTACHMENT IN THE THERAPEUTIC SPACE

The most important factor in any talk-therapy is the relationship with the therapist (Jacobs, 2017). This relationship is made up of the real relationship, the working alliance and transference (Jacobs, 2017; Meissner, 2007). The real relationship reflects aspects of both parties that reflect their existence in the world outside; how they function in the real world (Meissner, 2007). Ligiero and Gelso (2002) describes the working alliance as being made up of three constituent parts. These include the task, bond and goals each of which play a role in defining the quality and strength of the alliance. The goal(s) must be agreed upon, be achievable and realistic. The therapist and the client must agree on the tasks that are to be performed in order to achieve those goals. Essentially, the working alliance is the conscious component of the relationship and the transference is the unconscious aspect of the relationship.

There is an empirically established relationship between the working alliance and psychotherapy outcome, regardless of the modality of therapy (Martin, Garske, & Davis as cited in Bucci et al., 2016). As such importance is placed on the working alliance, it is important to understand what role the therapist plays in this dyad. An emotional bond must be struck between the dyad. Initially, Freud (1912) recommended that the therapist retain an "emotional coldness" which would be advantageous to both parties. This would not be considered appropriate in the light of psychodynamic therapy today. However, there is accuracy if the emotional coldness is interpreted as a form of absence, as in giving the client space to develop his or her own story and associations. This space is an essential part of communication. In doing so, the therapist now has an opportunity to monitor his or her own affect and emotional responses. As communication continues the transference and the counter-transference is evoked and can be worked on. In tuning into these emotional responses, the therapist can pick up any counter-transference that has been

created. The transference is based on significant relationships of the client, usually, but not exclusively, from early childhood relations with parents and other care-givers, which the client inevitably transfers onto the therapist (Jacobs, 2017; Ligiéro & Gelso, 2002; Meissner, 2007). It includes the thoughts, feelings and fantasies around these relationships but also the defences against them (Goldstein & Goldberg, 2008). Essentially it triggers the attachment system. Kernberg (as cited in Goldstein & Goldberg, 2008), defined countertransference as the "unconscious reaction to the (client's) transference". It is the joint-creation from both therapist and client. Initially thought to be counter-productive and seen as a barrier to perceiving the client clearly. It is now understood that this type of countertransference is a subjective transference which is indeed unhealthy as it relates to the therapist's own unresolved conflicts and anxieties, especially if they remain undetected (Kiesler as cited in Ligiéro & Gelso, 2002). Objective countertransference, on the other hand, is a therapist's reaction to the client's maladaptive behaviour (Kiesler as cited in Ligiéro & Gelso, 2002). This can be productive once the therapist becomes aware of it. It should be acknowledged once it is appropriate to do so, as in the feedback will benefit the client. Where there is overt disagreement or misunderstanding in any aspect of the working alliance the therapist needs to be able to acknowledge it and work through it – it is this form of rupture and repair which is necessary to allow change to occur in therapy (Safran and Muran as cited in Smith, Msetfi, & Golding, 2010). It is the collaborative communication described by Karlen Lyons-Ruth (as cited in Wallin, 2015). Where it remains unacknowledged there is a possibility of countertransference behaviour, which can take many forms. The therapist may become withdrawn from the dyad or start to avoid aspects of the client's material (Ligiéro & Gelso, 2002). It may also take the form of agreeing with or being over-supportive to the client, engaging in too much self-disclosure; to the point where it is beneficial to the therapist and not the client (Ligiéro & Gelso, 2002). This eventually damages the

working alliance as it over-serves the client's needs without working with the client's conflicts. This behaviour is analogous to that of the dismissing or pre-occupied mother.

It was stated that client and therapist interpersonal characterises are the strongest predictors for clinical outcomes (Norcross as cited in Bucci et al., 2016). Meissner (2007) reported that the alliance alone accounted for nearly 25% of the variance in treatment outcome. Where it fails Meissner (2007) proposed that it was due to insecure attachment either by protectively retreating or becoming overinvolved with the clients' anxiety and distress. It was also noted that insecure attachment styles tend to reinforce insecure attachment patterns whereas secure therapist tend to counteract them (Meissner, 2007).

In their systematic literature review, of eleven other studies, (Degnan, Seymour-Hyde, Harris, & Berry, 2016) found a positive correlation between therapist attachment security and the quality of the working alliance, in relation to both qualified and trainee psychotherapists. It was considered that the attachment-related behaviours were more critical in the forming of the working alliance while the developing of goals and working through the task were deemed to be more important later in the therapy. (Dunkle and Friedlander as cited in Degnan et al., 2016). While it is important to retrieve results from student therapists (Ligiero & Gelso as cited in Degnan et al., 2016) pointed out that they have limited experience in objectively creating the alliance any may be less open or aware of their own levels of attachment insecurity. Ligiéro & Gelso (2002) in their study on countertransference did not concur, but rather reported that there was no significant relationship between therapist attachment style and ratings of the overall working alliance by either therapist or supervisor. A similar outcome was noted with client rated and therapist rated working alliance. (Bucci et al., 2016). This however, includes the task and goals and is not solely focused on the created

bond. Ligiéro & Gelso (2002) concluded that the therapist did not see the client as an attachment figure, so their attachment style was not activated during the sessions.

It is interesting to note that in the same study, Ligiéro & Gelso (2002) noted that levels of therapist insecure attachment were not related to negative countertransference behaviours but levels of therapist secure attachment were inversely related to negative countertransference. They also noted that countertransference behaviour may cause the therapist to distort the emotional bond he or she has with the client but not the agreed upon goals or tasks. While not naming countertransference as the cause, it was noted in another study that high therapist attachment, being either avoidance or anxious impedes the therapist's perception of their client. (Degnan et al., 2016). This is also supported, but in particular when client symptoms were higher (Bucci et al., 2016).

What is interesting in these findings, is that yes, there is some indecision as to whether a therapist secure attachment has an impact on the working alliance. However, I am comparing a literature review of eleven studies with two other independent studies. While, those studies stating that therapist attachment style does not affect working alliance there is evidence that strongly suggests that the therapist perception of the client is impacted by whether there is a therapist secure attachment or not, which can impact on the countertransference.

Degnan et al. (2016) found a positive correlation between therapist attachment security and outcome of therapy. Specifically, therapists with higher attachment security had greater success with clients reporting greater interpersonal distress pre-therapy. It implies that more securely attached therapists were better able to meet the needs of the more severely impaired clients thus improving alliance and outcome.

There have been many studies done on how attachment styles of the therapist may complement the style of the client. The results are wide ranging and conflicting. Looking first at

avoidant attachment in therapists, Tyrell, Dozier, Teague and Fallot in their 1999 study (as cited in Bucci et al., 2016) found that more avoidant attachment clients works better and achieves better outcomes with therapists who are less deactivating and vice versa. The findings from Wiseman & Tishby, (2014) partially supported these findings where therapists low in avoidance were treating clients high in avoidance, the results were positive. However, the study found that where both therapist and client were low in avoidance the client symptoms were likely to decrease to a greater extent than compared to contrasting matches. Both studies confirmed that results were hampered when both client and therapist were both high avoidant. Interestingly, the study by Wiseman & Tishby is based on student therapists using psychodynamic therapy. Also, it is important to note that the therapists always reported lower anxiety and avoidance ratings than their clients.

Whereas, (Marmarosh et al., 2014) did not support the findings on the avoidant scale but rather found that clients with opposite intensities on the dimensions of the attachment anxiety scale worked well together. Their results also indicated that therapist with greater attachment anxiety may not be helpful for clients with greater attachment anxiety. The study also suggests that therapist attachment anxiety might have a positive relationship with the alliance, when dealing with clients with low attachment anxiety, in the early stage owing to the therapist overly focusing on the maintaining a positive relationship, but it may get eroded over time. Such a positive start does not exist where both therapist and client are classified as high anxiety attachment.

Clients with a more insecure attachment with highly preoccupied and disorganised features found more dismissing therapist as more satisfying (Petrowshi et al as cited in Bucci et al., 2016). However, it should be noted that this study uses a measure of attachment security dissimilar to other methods, so may skew results. Bernier & Dozier, 2002 (as cited in Wiseman & Tishby, 2014) found that dissimilar interpersonal orientations of the client and therapist were optimal for the

process and the outcome of psychotherapy. It is thought to be due to therapist being able to challenge the client's rigid and maladaptive interpersonal strategies and stops the therapists colluding with client (Eagle & Wolitzky as cited in Wiseman & Tishby, 2014) Unfortunately, the combination of client high attachment anxiety and counsellor high to moderate attachment avoidance predicted lower levels of client perceived session depth (Romano et al as cited in Wiseman & Tishby, 2014).

Many studies reviewed used different measure and scales when looking at therapist global attachment patterns. Recent studies have asserted that a two continuous dimensions model, measuring avoidance and anxious is best for assessing adult self-reported attachment (Brennan et al as cited in Smith et al., 2010). Both dimensions look how the individual behave in relation to attachment and score the individual in relation level of security in attachment. The avoidance scale measures the individual's comfort of being close and depending on others. The anxiety scale measures the individual's fear of being rejected and being abandoned in times of need. Where possible, throughout my review of the literature I have relayed this information in terms of this scale of anxiety and avoidance.

Chapter 4: CONCLUSION

There is much research in the area and it is clear from the research that the quality of the therapeutic process can be viewed in context of attachment theory. The relational aspect of therapy is essential. It is upon this which therapy is built.

The current study investigated whether the therapist attachment style would impact the outcome of therapy. There does not appear to be a definitive answer, however, it was interesting to note that majority of studies point towards there being some level of impact; in particular, when working with more symptomatic clients or when the therapist ratings of insecure attachment, be it avoidant or dismissive, were high. In most cases, securely attached therapists experienced less problems being able to emotionally connect with their clients and repair ruptures as they occur.

With this in mind, it is important that each therapist understands their own attachment style, in particular trainee therapists, as they may not be fully aware. This can be explored in personal therapy.

Where the therapist is not securely attached; the process can still be successful where there is a strong capacity to self-reflect and through mentalising. Researchers suggest that this is the reason for transmission gaps between insecure adults and secure children. In both these cases, if not all, supervision may allow for this process to take place. Some of the studies reviewed stated that therapists were under supervision, but not all. It would be interesting to explore if there is a correlation between supervision, therapist attachment style and therapy outcome. Further research would have to be done in this area to determine this.

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Appendix

Adult state of mind with respect to attachment	Infant strange situation behavior
Secure/autonomous (F)	Secure (B)
Coherent, collaborative discourse. Valuing of attachment, but seems objective regarding any particular event/relationship. Description and evaluation of attachment-related experiences is consistent, whether experiences are favorable or unfavorable. Discourse does not notably violate any of Grice's maxims.	Explores room and toys with interest in preseparation episodes. Shows signs of missing parent during separation, often crying by the second separation. Obvious preference for parent over stranger. Greets parent actively, usually initiating physical contact. Usually some contact maintaining by second reunion, but then settles and returns to play.
Dismissing (Ds)	Avoidant (A)
Not coherent. Dismissing of attachment-related experiences and relationships. Normalizing ("excellent, very normal mother"), with generalized representations of history unsupported or actively contradicted by episodes recounted, thus violating Grice's maxim of quality. Transcripts also tend to be excessively brief, violating the maxim of quantity.	Fails to cry on separation from parent. Actively avoids and ignores parent on reunion (i.e., by moving away, turning away, or leaning out of arms when picked up). Little or no proximity or contact-seeking, no distress, and no anger. Response to parent appears unemotional. Focuses on toys or environment throughout procedure.
Preoccupied (E)	Resistant or ambivalent (C)
Not coherent. Preoccupied with or by past attachment relationships/experiences, speaker appears angry, passive, or fearful. Sentences often long, grammatically entangled, or filled with vague usages ("dadadada," "and that"), thus violating Grice's maxims of manner and relevance. Transcripts often excessively long, violating the maxim of quantity.	May be wary or distressed even prior to separation, with little exploration. Preoccupied with parent throughout procedure; may seem angry or passive. Fails to settle and take comfort in parent on reunion, and usually continues to focus on parent and cry. Fails to return to exploration after reunion.
Unresolved/disorganized (U)	Disorganized/disoriented (D)
During discussions of loss or abuse, individual shows striking lapse in the monitoring of reasoning or discourse. For example, individual may briefly indicate a belief that a dead person is still alive in the physical sense, or that this person was killed by a childhood thought. Individual may lapse into prolonged silence or eulogistic speech. The speaker will ordinarily otherwise fit Ds, E, or F categories.	The infant displays disorganized and/or disoriented behaviors in the parent's presence, suggesting a temporary collapse of behavioral strategy. For example, the infant may freeze with a trance-like expression, hands in air; may rise at parent's entrance, then fall prone and huddled on the floor; or may cling while crying hard and leaning away with gaze averted. Infant will ordinarily otherwise fit A, B, or C categories.