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## AAI predicts patients' in-session interpersonal behavior and discourse: a "move to the level of the relation" for attachment-informed psychotherapy research

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There is currently little empirical evidence regarding how patients' attachment patterns manifest in individual psychotherapy. This study compared the in-session discourse of patients classified secure, dismissing, and preoccupied on the Adult Attachment Interview (AAI). Rather than focusing on content or form alone, this study analyzed how patients' discourse elicits and maintains emotional proximity with the therapist. The AAI was administered to 56 patients prior to treatment and one session for each patient was rated with the Patient Attachment Coding System (PACS) by four independent raters, blind to patients' AAI classification. Significant differences were found in the discourse of patients with different attachment patterns. Namely, secure and preoccupied patients showed more contact-seeking behavior than dismissing patients, who avoided emotional proximity more, while preoccupied patients resisted therapists' help more than did secure and dismissing patients. These results suggest that the different attachment patterns may have distinctive manifestations in the psychotherapy process that can be tracked by external observers.

**Keywords:** attachment; psychotherapy; AAI; adult attachment; clients' variables; psychotherapy research

### Introduction

In the past two decades, an internationally thriving area of research has focused on investigating the hypothesis that individual differences in adult attachment, which are related to ways of engaging in close relationships and to attitudes toward seeking and receiving help (Mikulincer & Shaver, 2007; Rholes & Simpson, 2004), impact psychotherapy in distinct ways. Existing research has shown a fairly substantial link between attachment patterns and such clinical variables as the therapeutic alliance (Diener & Monroe, 2011), outcome (Folke, Daniel, Poulsen, & Lunn, submitted; Levy, Ellison, Scott, & Bernecker, 2011), psychiatric diagnosis (Dozier, Stovall-McClough, & Albus, 2008; Fonagy et al., 1996), and many others (see Daniel, 2006; Obegi & Berant, 2009; Slade, 2008; Steele & Steele, 2008).

However, little is known about aspects of in-treatment interpersonal behavior and discourse that are specific to the different attachment classifications (Obegi & Berant, 2009). Are the ways in which dismissing patients idealize their experiences with their caregivers in the Adult Attachment Interview (AAI; Main, Goldwyn, & Hesse, 2002)

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similarly reflected in their engagement with the therapist? Are secure patients as coherent in psychotherapy as they are in the AAI? Do preoccupied patients become as entangled with their therapist as they are thought to be in their close relationships? There remains a relative lack of empirical evidence that existing knowledge on attachment patterns can be extended to the therapeutic context, and many clinicians still seem to believe that attachment patterns “cut too broad a swath” (Eagle, 2006, p. 1092) to be very useful in clinical work.

More research on the in-session correlates of the different attachment patterns is needed. In this study, we attempted to identify in-session differences related to the three main organized attachment patterns (secure, dismissing, preoccupied) by analyzing patients’ discourse as an attachment behavior. In doing so, we assume that discourse can serve distinct interpersonal functions, including eliciting and maintaining emotional proximity, comfort, and reassurance from a caregiver, which are the defining features of attachment behavior (Ainsworth, Blehar, Waters, & Wall, 1978). For example, emotional proximity tends to increase when one asks for help or expresses distress in various ways.

We hypothesize that when discourse is assessed as a means of regulating emotional proximity, rather than analyzed for its form or content alone, it is possible to predict the recurrence of certain discursive patterns with distinct interpersonal functions based on patients’ attachment classification. We also hypothesize that differences in these discursive patterns will be consistent with the predictions of attachment theory regarding the three main organized patterns of attachment. In particular, secure patients might be able to express distress, and ask for and accept help; by contrast, dismissing and preoccupied patients, fearful that the therapist will be unavailable if they become too close or too distant, might adopt different discursive strategies that manipulate the therapeutic dialogue and help maintain a tolerable emotional proximity to the therapist.

So far, research in adult attachment has primarily relied on mental representations and defense mechanisms related to attachment that emerge in interviews or projective tests in order to infer underlying attachment organizations, with less emphasis on how attachment actually manifests in adult relationships (see e.g., Creasey, 2002; Roisman, Madsen, Hennighausen, Sroufe, & Collins, 2001; Simpson, Winterheld, Rholes, & Oriña, 2007). Since patients usually seek therapy because they need help, in this article we propose that psychotherapy can be used not only to study how patients make sense of and represent their attachment-related experiences, but also as an ideal context in which to observe *in vivo* adult attachment behaviors and dynamics in patients’ discourse.

We begin with a review of the relevant literature followed by an explanation of the theoretical framework underlying our approach and a detailing of the development and procedures of the Patient Attachment Coding System (PACS), which we used to investigate the interpersonal function of patients’ discourse. The results are reported along with excerpts of coded session transcripts. We conclude with a discussion of the implications of our results and possible future developments.

### ***Literature on clinical correlates of attachment patterns***

The first study that attempted to investigate differences between patients with different attachment patterns in a treatment setting was conducted by Dozier (1990). The results showed that, in a population of institutionalized adults with psychiatric disorders, attachment security was associated with greater compliance with the treatment program and avoidance was associated with poorer use of treatment and rejection of treatment providers. This finding was replicated later on populations of institutionalized adolescents

and mothers in home-visiting and group interventions (Heinicke & Levine, 2008; Korfmacher, Adam, Ogawa, & Egeland, 1997; Teti et al., 2008; Zegers, Schuengel, van Ijzendoorn, & Janssens, 2006). Thus, there is evidence that attachment security has an impact on the ways in which clients participate in treatment contexts, a key preliminary step in investigating the manifestations of attachment in psychotherapy. However, these studies investigated clients' conduct as assessed based on relatively long periods of frequent contact, and it is not yet clear how their results would translate into specific behaviors in any given session of individual psychotherapy.

Other authors have considered in-session correlates of the different attachment patterns within the framework of the AAI, assuming that the discursive differences that emerge in the interview would manifest similarly in psychotherapy, as both the AAI and psychotherapy challenge patients to express and organize their emotional and interpersonal experience (Ammaniti, Dazzi, & Muscetta, 2008; Bowman & Safran, 2007; Holmes, 2001; Muscetta, Dazzi, De Coro, Ortu, & Speranza, 1999; Samstag et al., 2008; Wallin, 2007). For example, Holmes (2001) maintains that patients' narrative expression in the AAI is reflected in the stories patients tell in psychotherapy, and argues that secure patients' narratives are more coherent and balanced, dismissing patients' narratives are overly succinct and unemotional, while preoccupied patients are overwhelmed by their experiences and struggle to fit them into clear narratives. In a similar vein, Wallin (2007) proposes that the ways in which the self and the caregivers are represented in the AAI shape the patient's interactions with the therapist. Wallin claims that dismissing patients are emotionally restricted and maintain either a disparaging or idealizing view of the therapist. Preoccupied patients, on the other hand, are overwhelmed by their dependence on the connection with the therapist, as shown by either exaggerated helplessness or angry desperation.

Few studies have tried to put these claims to the test. This is an important task, since the narrative markers that are used in the AAI to identify attachment organizations might be specific to the protocol and interpersonal context of the interview (Daniel, 2009, 2011). Where the AAI interviewer focuses exclusively on a query into attachment experiences, both the therapist's activity and the range of topics discussed in psychotherapy may differ considerably. Therefore, the discursive features of the AAI might not transfer meaningfully to the psychotherapy context (much in the same way that they do not transfer, for example, to interviews addressing work-related experiences; Crowell et al., 1996).

Westen, Nakash, Thomas, and Bradley (2006) devised the Attachment Questionnaire and showed that, in clinicians' judgment, AAI-like narrative characteristics of their patients' discourse seemed to be associated with patients' modes of interpersonal behavior in ways that were consistent with attachment theory. To date, however, the measure has not been validated with any other measure of attachment, and the single-informant rating procedure may have caused clinicians' judgments on patients' interpersonal patterns to be influenced by their judgments about their narratives and vice versa (see Eagle, 2006).

In a recent study, Daniel (2011) has for the first time systematically compared the in-session discourse of dismissing and preoccupied patients, who had been independently assessed on the AAI, focusing on some discursive variables that are related to the different AAI classifications (e.g., verbal productivity and narrative initiative). Results showed that preoccupied patients talked more, had longer speech turns, and initiated more narrative sequences than dismissing patients, who were more likely to be silent during sessions. Although the study was limited to insecure patients, these results have great importance in showing that patients with different AAI classifications speak in psychotherapy in different ways. However, the clinical implications of these differences remain unclear.

### *Theoretical framework of this study*

To advance the study of attachment in clinical contexts, we tried to integrate the focus on the in-session behavioral correlates of the different attachment patterns with the fine-grained analysis offered by a focus on the in-session discourse, going beyond the analysis of linguistic form and content to investigate empirically the way in which discourse enacts the attachment behavioral system. While toddlers try to ensure the availability of their attachment figures by attempting to maximize physical proximity, adults are able to make predictions about the accessibility and responsiveness of their significant others and to actively foster closeness using *language* (Bowlby, 1969/1982).

We then referred to the ideas of some prominent analytic philosophers of language such as Austin (1962). In contrast with earlier views that maintained that language “represents” or “stands for” things or meanings, Austin claimed that language always has a pragmatic function, and cannot be considered as representation alone; language is used to *do* things as well as to *assert* things (Austin, 1962). According to Austin, while the traditional views on language as representation apply to *descriptive* or *constative* utterances (which describe the world and can therefore be true or false e.g., *It is raining*), other utterances which he termed *performative* (e.g., *I promise to do this*) are best understood as ways of doing something rather than ways of asserting anything, since the action that they carry out (e.g., promising) is completed simply by uttering the sentence aloud.

Austin arrived at the conclusion that most utterances, even the descriptive ones, are actions insofar as they are expressed in a context in which they deploy a function, and he proposed to take the *speech act* (the act that is performed in making an utterance) as the primary unit of analysis. With this theoretical framework, the enactment of attachment in psychotherapy might be studied by focusing on the function of patients’ discourse in regulating emotional closeness to the therapist, and by possibly identifying distinct types and categories of speech acts that deploy this function in different ways. In the remainder of this article, we will refer to these speech acts as *attachment discursive behaviors*.

Since it is likely that engagement in psychotherapy inherently activates the attachment behavioral system (Dozier & Bates, 2004), regardless of whether the patient–therapist relationship is considered an attachment at any point in treatment (a long-debated question in the literature; Allen, Stein, Fonagy, Fultz, & Target, 2005; Mallinckrodt, 2010; Mikulincer & Shaver, 2007; Parish & Eagle, 2003; Slade, 2008), psychotherapy might provide a context in which to observe patients’ attachment discursive behavior and to identify systematic differences in patients’ discourse.

In adapting a pragmatic approach to the study of attachment discursive behavior, one cannot rely on the assumption that the goals of the discourse are known by, or at least potentially accessible to, the speaker. According to attachment theory (Bowlby, 1980; Bretherton & Munholland, 2008), attachment behavior is oriented by a set of internal “maps” of the self and the environment (i.e., Internal Working Models) that are excluded from awareness, especially in the case of insecure attachment. Consequently, if discourse can be considered to mediate the attachment system, it is likely to do so without one’s awareness of its goals, in a constant adjustment of homeostasis. This adjustment might operate especially through indirect speech acts (Searle, 1975), or indirect attachment discursive behaviors, in which the intention of the speaker differs from what is said literally. For example, in most situations, emotional support from the listener can be as effectively elicited by expressing distressing emotions as it is by making a direct request. Providing a closed explanation for negative feelings or downplaying a distressing

experience ends up blocking any reassurance from the listener; complaining endlessly about recurring problems while ignoring offers of support implicitly pushes the listener to try harder; and so on.

### ***Development of the Patient Attachment Coding System***

The Patient Attachment Coding System (PACS; Talia & Miller-Bottomo, 2012) was developed in order to investigate differences in patients' attachment discursive behavior. The PACS was initially devised based on an in-depth qualitative analysis of 16 psychotherapy session transcripts, two for each of eight patients who had been independently assessed with the AAI. Patients came from a counseling facility in Padua (Italy), where they received supportive psychodynamic psychotherapy. Three of these patients were classified as secure, two were classified as dismissing, and three as preoccupied; no patients were classified unresolved with respect to loss or trauma.

The verbatim transcripts of these sessions were scrutinized for the emergence of attachment discursive behaviors that seemed to be specific to the discourse of secure, dismissing, and preoccupied patients. This analysis yielded three lists of around 40 items each (e.g., "patient readily interprets his difficulties"; "patient explicitly asks for help"). We then checked our lists with the AAI classification of the patients, and used our knowledge of the classification to refine the lists in a recursive process that entailed repeated reading of the sessions and informal discussions with expert clinicians.

However, the approach of identifying a one-to-one correspondence of each given item to a single classification seemed to lead to the exclusion of many items that were associated with more than one classification but nonetheless appeared to deploy a distinct attachment behavioral function (for example, asking for help appeared in the discourse of both secure and preoccupied patients). Therefore, we tried to organize our items according to their probable attachment-related function, and matched each item to one of the four Interactive Behavior Scales used to code the Strange Situation<sup>1</sup> (Ainsworth et al., 1978). For instance, we matched the item "The patient criticizes a significant other" (present in both the "secure" and "preoccupied" lists) with the Proximity Seeking scale, because in criticizing a significant other the patient conveys present distress and implicitly asks for support; we matched the item "The patient provides a minimal response" with the Avoidance scale because in giving overly succinct responses, the patient minimizes the possibility of contact. When uncertain about the function of a given item, we tried to look at the effect that it had on the therapeutic dialogue. For example, if the patient narrated a problematic situation in detail, the therapist would usually try to provide support; if the patient took an extremely long speech turn, the therapist would have little chance to intervene. In so doing, we proceeded in keeping with the long-standing principle in ethology that, in a large number of individuals, the function of a behavior is the same as its predictable outcome (Bowlby, 1969/1982). This method also allowed us to go beyond the observations of the initial qualitative analysis and to think creatively about other possible discursive behaviors that might have had similar functions, according to our experience and our knowledge of the psychotherapy literature.

In this way, we obtained three scales (Contact Seeking, Avoidance, and Resistance<sup>2</sup>) to be rated according to the presence of the related items. Given the frequency of indirect discursive behavior in adult discourse, we decided to rate direct and indirect discursive behaviors on independent subscales, and grouped the items of each main scale under two subscales. Finally, a number of subscales were divided with their items redistributed to ease the coding process, and we arrived at the final version of the instrument with three scales and nine subscales.

### **Restatement of hypotheses**

We hypothesized that: (1) there would be significant differences in patients' attachment discursive behavior assessed via the PACS scales across the different AAI classifications. Since the PACS scales were devised with regard to the Interactive Behavior Scales, we referred to the expected ratings of these scales for each attachment category in the Strange Situation coding system (Ainsworth et al., 1978) to make the additional following hypotheses:

- (2) Secure patients will show higher ratings on the Contact Seeking scale compared to dismissing patients;
- (3) Dismissing patients will show higher ratings on the Avoidance scale compared to both secure and preoccupied patients;
- (4) Preoccupied patients will show higher ratings on the Resistance scale compared to both dismissing and secure patients, and higher ratings on the Contact Seeking scale compared to dismissing patients.

## **Methods**

### **Participants**

This study sample consisted of 56 participants who received individual weekly psychotherapy, 20 from Padua, Italy (not including the patients from the initial qualitative analysis), where patients received supportive psychodynamic psychotherapy, and 36 from New York, where patients were treated with Brief Relational Therapy (Safran & Muran, 2000). Cases were selected based on availability of archival data previously collected for other studies. In both subsamples, the AAI was administered to each patient prior to therapy. For each patient, we selected one session from the first to the fifth sessions based on random selection when data availability allowed (3.6% session one, 17.8% session two, 25% session three, 25% session four, and 28.6% session five).

In terms of AAI classifications, in the Padua subsample eight patients were classified secure (40.0%), eight dismissing (40.0%), and four preoccupied (20.0%). In the New York sample, nine patients were classified secure (25%), 14 dismissing (39%), and 13 preoccupied (36%). Although some of the patients were given an Unresolved classification ( $N = 8$ , 14.3%), given our focus on the three main organized attachment patterns, in grouping these patients we only factored in their secondary classification. "Cannot Classify" patients were not included in the sample.

In the Padua and New York subsamples, females were 75% and 69.5%, respectively. The mean age of the Padua subsample was 23.5 years,  $SD = 2.7$ , and the mean age of the New York subsample was 37.3 years,  $SD = 12.1$ . The mean level of education was 16 years ( $SD = 0.79$ ) in the Padua subsample and 17.5 ( $SD = 1.6$ ) in the New York subsample. While the Padua subsample was uniformly Caucasian, the racial composition of the New York subsample was as follows: 75% Caucasian, 11.1% African American, 5.5% Hispanic, 2.7% Asian, and 5.5% failed to specify. In the Padua subsample, 20% of the patients had an Axis I diagnosis and no patients had an Axis II diagnosis. In the New York subsample, 77% of the patients received an Axis I diagnosis and 31% of the patients received an Axis II diagnosis; 27% of the patients received both Axis I and Axis II diagnoses.

The patients were placed in three different groups according to their AAI classification: Secure ( $N = 17$ , 30.3%), Dismissing ( $N = 22$ , 39.4%), and Preoccupied ( $N = 17$ , 30.3%). No significant differences were found among the groups concerning age ( $F(2,$



53) = 1.883,  $p = .162$ ), education ( $F(2, 53) = .145, p = .866$ ), or gender ( $\chi^2(2, N = 56) = 2.977, p = .226$ ). No significant differences were found among the groups concerning Axis I diagnosis ( $\chi^2(2, N = 56) = .317, p = .853$ ) or Axis II diagnosis ( $\chi^2(2, N = 56) = .086, p = .958$ ).

The 48 psychotherapists were trainees in the second, third, or fourth year of their graduate clinical training. In the New York subsample, 80.5% of the therapists were women, while all of the therapists were women in the Padua subsample.

## Measures

### *The Adult Attachment Interview*

The Adult Attachment Interview (AAI; George, Kaplan, & Main, 1996) is a one-hour long, semi-structured interview consisting of 20 questions that ask about childhood experiences with caregivers and their effects. The coding system of the AAI (Main et al., 2002) is designed to reveal speakers' "state of mind with respect to attachment" by assessing whether or not speakers' responses are coherent and collaborative, mainly based on the form and manner of their narratives and on the extent to which generalized descriptions of attachment experiences are supported by specific memories. Each interview is assessed for the following categories: Secure/Autonomous (F), Dismissing (Ds), Preoccupied (E). A fourth category, Unresolved/Disorganized (U), can be assigned in conjunction with one of the three other classifications.

Three certified AAI coders<sup>3</sup> scored a total of 14 AAIs from the New York subsample. The first author<sup>4</sup> recoded these AAIs to check inter-rater reliability ( $k = .81$ ), and coded an additional 12 AAIs from this sample. Two certified coders<sup>5</sup> scored all of the AAIs from the Padua subsample, resolving disagreements with consensus. The first author recoded a random sample of 10 of these AAIs to check inter-rater reliability ( $k = .85$ ).

### *The Patient Attachment Coding System*

The Patient Attachment Coding System rates patients' attachment discursive behavior in verbatim transcripts of psychotherapy sessions. When rating with the PACS, in order to delineate the overall tendencies of the patient's attachment discursive behavior in the session, a score is given on three main scales. The *Contact Seeking* scale rates discursive behaviors that tend to increase emotional proximity and the likelihood of receiving support from the therapist. The *Avoidance* scale rates discursive behaviors that tend to decrease emotional proximity. The *Resistance* scale rates discursive behaviors that tend to thwart the therapist's attempts to support patients and to make sense of their experience. Each main scale has three subscales. The nine subscales are rated based on the occurrences of 50 different markers of attachment discursive behaviors listed and described in a 30-page manual (Talia & Miller-Bottome, 2012). The markers are grouped under the nine subscales so that each marker can contribute to the rating of one subscale only. Table 1 provides a brief overview of the coding system,<sup>6</sup> and short descriptions of one marker for each subscale given as examples.

Rating a session with PACS takes approximately 90 minutes. When applying PACS to a psychotherapy transcript, the session is rated as a whole without segmenting the text beforehand, similar in this regard to the AAI coding procedure. The rater first reads the transcript all the way through, marking any number of discursive markers as they occur. On average, 20 to 40 occurrences of one or more types of discursive markers in any given

Table 1. Brief overview of the Patient Attachment Coding System.

Scale	Subscale	Example of one subscale marker	Transcript example
<b>Contact Seeking</b>	<i>Help</i> : patient asks for help, directly eliciting closeness.	<i>Patient makes a request regarding the therapeutic tasks in terms of his or her needs (scored from 3 to 5).</i>	P: <u>Yeah can we talk through a plan. Cause this is what I need. I think I need a plan.</u>
	<i>Gratitude</i> : patient shows appreciation for the therapist and the treatment, which works to maintain closeness.	<i>Patient expresses appreciation for the ongoing activities and the objectives that have been set out in therapy (scored from 3.5 to 5.5).</i>	P: <u>I really like the idea that we're gonna try to understand this, 'cause it's what blocks me when I'm with other people.</u>
	<i>Disclosure</i> : patient expresses distress in various ways, implicitly inviting closeness.	<i>Patient reports actual distressing emotions (such as anger, sadness, fear) experienced in the here and now (scored from 3 to 7).</i>	P: <u>And he goes, he tells me this thing, I don't remember, like – that I have to accept him the way he is. He always reasons like that ... I'm so upset about it.</u>
<b>Avoidance</b>	<i>Direct Avoidance</i> : patient directly responds to the therapist's interventions in ways that discourage emotional closeness.	<i>After a therapeutic intervention, the patient responds very briefly and then becomes silent for at least several seconds before the therapist speaks or the patient changes topic.</i>	T: <u>well right, so, so you feel like you need your own space ... you're not ready for the feelings that come with it?</u> P: <u>yeah [15 sec].</u>
	<i>Downplaying</i> : patient downplays any implied distress, minimizing any cue for help or support.	<i>The patient laughs or chuckles directly after referring to or recounting a negative or emotionally distressing experience.</i>	P: <u>– um – yeah, I had a horrible trip with my parents (chuckles).</u>
	<i>Releasing</i> : patient conveys self-sufficiency, preempting any offers of support and connection.	<i>Patient disqualifies a complaint, negative feeling, or disclosure by stating that: (a) he/she does not have the right to complain, (b) that there is no use in complaining, (c) he/she has no authority to make a judgment.</i>	P: <u>I don't know. I don't know what to do ... I shouldn't even complain, I have all these good things going for me, so.</u>

(continued)

Table 1. (Continued).

Scale	Subscale	Example of one subscale marker	Transcript example
<b>Resistance</b>	<i>Direct Resistance</i> : patient overrides the therapist's activity and responds in ways that are unrelated to the therapist's interventions.	<i>After a therapeutic intervention, the patient stays focused on his/her distress without responding to the therapist's intervention in any way.</i>	T: That's why I think, well I don't know if you feel proud of yourself but I am proud that you're dealing with it. You know? Facing it. P: I don't know what happened, I have no idea what – <u>what is happening inside of me so badly.</u>
	<i>Involving</i> : patient persuades the therapist into joining and recognizing his/her point of view alone.	<i>Patient quotes someone as having the same opinion that he or she has, "building the case" for the patient's point of view/experience in a problematic situation.</i>	P: I mean he has problems with aggression. <u>Even his mother says that.</u>
	<i>Merging</i> : patient conveys his/her thoughts and feelings leaving no room for contradiction or challenge.	<i>Patient discusses an experience by quoting a purportedly past occurrence of thinking to him or herself.</i>	P: I was like "maybe I still like him maybe I don't but like that's not a good reason not to be friends. And <u>not to explain to someone.</u> "*

Notes: In this table, the three main scales are listed alongside brief descriptions of their related subscales. An abbreviated description of one of the discursive markers associated with each of the subscales is provided, in addition to an example of the marker taken from an actual psychotherapy session transcript (underlined text indicates a discursive marker).

\*The patient uses this discursive strategy instead of stating definitively what her feelings or intentions in the situation were. This can work to avoid responsibility in the present for what her thoughts and feelings were in the past, and to preempt any possible challenge to her perspective from the therapist.

session are found. Next, the rater assigns a rating to the nine subscales by assessing the frequency and intensity of the discursive markers belonging to each subscale. Finally, the ratings of the nine subscales are collapsed in groups of three onto the related PACS main scale by picking the highest score out of the three and raising it up to one point depending on the score of the other two. Scales and subscales are rated from one to seven in .5 increments, in a continuum where “1” indicates the absence of the related markers, and “7” represents a pervasive presence.

The criteria listed in the manual for scoring a given marker refer to features such as the type of action enacted in the discourse (e.g., thanking the therapist), the topic of the passage (e.g., upset feelings), the syntactic features of the passage (e.g., long paratactic structures, incomplete sentences), the relation between the passage and either a therapist intervention or another part of the patient’s discourse which directly precedes it (e.g., abrupt change of topic), or a combination of any of these. A given marker can be assigned to a single word, a part of a phrase, a phrase, or a paragraph, as long as the passage of the text meets the criteria specified in the manual. For example, the discursive marker “Minimizing” (described in the manual as “The patient tries to downplay any implied negative experience or personal distress by claiming that what has been expressed is normal, unimportant, or has had only minor effect on him/her”) can be assigned to a word (e.g., “Whatever,” if it directly follows the reference to the negative experience), a short sentence (e.g., “but – well, that’s just life”), or to a whole paragraph (e.g., one in which the patient describes how little the problem under discussion has affected him or her). A given marker can be assigned to any continuous passage of the text, so long as the specified criteria are met throughout; if the passage is interrupted by a therapist intervention, by another marker, or by non-coded text, it is then possible to code the marker again. In the manual, there are numerous examples from patient transcripts provided for each marker, along with a number of other criteria that help to rule out phrases or passages that do not qualify for coding. In some cases, once a marker has been assigned, it is given a score for its intensity, according to additional criteria present in the manual.

### ***Procedure***

The psychotherapy sessions were transcribed verbatim, following most of the transcription standards of the AAI (George et al., 1996), in addition to the transcription of chuckling and crying. The sessions were coded by four raters (Rater I, the first author; Rater II, a post-undergraduate level research assistant; Rater III, a psychotherapist in training; and Rater IV, an expert clinician); only Raters I and IV had undergone AAI training. The first author led 10 three-hour training sessions. The first three trainings focused on a detailed reading of the PACS coding manual. In the next three trainings, raters were guided in coding three “sample” sessions. These trainings stressed the importance of memorizing the criteria for each discursive marker in order to reliably identify them in patients’ discourse, and emphasized that general stylistic features should not be taken into account when assigning ratings to a transcript. After these trainings, raters were given five training transcripts that were then reviewed in up to four additional meetings. Once preliminary reliability on these transcripts was judged to be satisfactory, the raters proceeded to code the sessions from the study sample.

Raters I and II used PACS to code 14 and 22 sessions, respectively, from the New York sample; Raters III and IV coded 10 sessions each from the Padua subsample. All raters were blind to the AAI classifications. Rater I recoded a selection of the sessions coded by Raters II, III, and IV to measure inter-rater reliability.

Table 2. Single measures intraclass correlation coefficient for scales and subscales.

	Rater I and II	Rater I and III	Rater I and IV
Help	.93**	.80**	.85**
Gratitude	.87**	.74*	.84**
Disclosure	.76*	.80**	.88**
<b>Contact Seeking</b>	<b>.87**</b>	<b>.74*</b>	<b>.90**</b>
Direct Avoidance	.77*	.85**	.88**
Downplaying	.85**	.78*	.82**
Releasing	.88**	.84**	.88**
<b>Avoidance</b>	<b>.84**</b>	<b>.89**</b>	<b>.87**</b>
Direct Resistance	.97**	.87**	.76*
Involving	.84**	.92**	.89**
Merging	.97**	.82**	.80**
<b>Resistance</b>	<b>.91**</b>	<b>.84**</b>	<b>.90**</b>

Note: \*\*Significant for  $p < .001$ , two-tailed; \*Significant for  $p < .01$ , two-tailed.

## Results

The single measures intraclass correlation coefficient was calculated between Rater I and the other raters for each main scale and subscale (see Table 2) on a total of 30 sessions (10 different sessions for each pair). The scores on the PACS scales did not appear to be normally distributed, so we decided to perform non-parametric tests. We then ran three different Kruskal-Wallis tests (one for each scale of the PACS), which revealed that, in accordance with our hypothesis (1), the mean ratings for the three groups differed significantly for each scale. Next, we ran *post-hoc* analyses with the Mann-Whitney test to examine hypotheses (2), (3), and (4). Results are shown in Table 3.

As predicted, secure patients were significantly more likely to show higher ratings on the Contact Seeking scale than dismissing patients. Surprisingly, secure patients were also significantly more likely to show higher ratings on this scale than preoccupied patients. Dismissing patients, as hypothesized, were significantly more likely than both secure and preoccupied patients to show higher ratings on the Avoidance scale. Preoccupied patients, again as hypothesized, were significantly more likely than both secure and dismissing patients to have higher ratings on the Resistance scale. In addition, preoccupied patients were significantly more likely to engage in Contact Seeking than dismissing patients, even if only with a moderate effect size.

## Examples

In the following are three transcripts excerpts taken from our sample, which will provide an illustration of how attachment discursive behaviors manifest in patients' actual discourse and are coded with the PACS. The portions of the text that are coded as discursive markers are underlined. The first excerpt is from a session with a secure patient, Maddy, a 28-year-old woman in therapy to work on her feelings of inadequacy and dependence in her close relationships.

P: My father is basically self-absorbed. He never changes, it's always the same story.

T: It sounds like he never asks about how you are.

P: He never asks about me (cries). I wish things were different.

In this passage, Maddy's capacity to maximize emotional proximity with the therapist by openly expressing her distress is captured by several discursive markers scored on the

Table 3. Results of the comparisons between the patients grouped according to their AAI classification for each scale.

	F ( $N = 17$ )		Ds ( $N = 22$ )		E ( $N = 17$ )		Kruskal Wallis tests		Post-hoc tests Mann-Whitney				
	MR		MR		MR		df	H	U	z	r	p	
Contact Seeking	44.56		16.68		27.74		2	28.445***	1,500	-5.288	.85	<.001	
									57,000	-3.043	.52	.002	
									112,500	-2.140	.34	.032	
Avoidance	17.59		43.52		19.97		2	31.328***	13,500	-4.937	.71	<.001	
									30,000	-4.467	.78	<.001	
									132,500	-.422	.07	.673	
Resistance	19.12		21.32		47.18		2	35.038***	.500	-5.063	.87	<.001	
									13,500	-5.027	.80	<.001	
									171,500	-.502	.08	.616	

Notes: F = secure; Ds = dismissing; E = preoccupied; MR = mean ranks; H = Kruskal-Wallis H statistic; U = Mann-Whitney U statistic; r = effect sizes of the Mann-Whitney pairwise comparisons. \*\*\*Significant for  $p < .001$  two tailed; \*\*Significant for  $p < .01$  two tailed; \*Significant for  $p < .05$  two tailed.

*Disclosure* subscale. Maddy strongly criticizes the way her father treats her, conveying her dissatisfaction within the relationship and implicitly asking for support. The significance of her emotional distress and need for help is then made evident by her crying, an overt attachment behavior. Finally, she conveys that her needs in the relationship are unmet, leaving it open for the therapist to connect and make an intervention.

The following excerpt is from a session with a dismissing patient, Alex, a 25-year-old male in therapy for mild depression and insecurities about his relationship with his girlfriend.

T: How did you feel about it, to talk to her about it?

P: I don't know, well I think I have to tamp it down, not my tone, but what I think, I mean – she has her opinions, and she's not ready to get involved with me like that so – but – anyway – sometimes she's great, like – she sends me nice texts throughout the day – I dunno – Sometimes I think it's just that I'm just a loser with her – Y'know – I think it's because when I was in high-school, the guys used to pick on me and that made me insecure.

In this passage, Alex seems to be trying to maintain a safe distance from the therapist (thereby limiting the possibility of rejection) by minimizing any implied distress. First, he does not disclose a feeling upon the therapist's open-ended request, avoiding the therapist's attempt to increase emotional proximity (a marker of the *Direct Avoidance* subscale). He then makes a brief reference to a negative experience, but precludes any response from the therapist by shifting to a more positive perspective (a marker of the *Downplaying* subscale). Finally, Alex provides a closed, causal explanation for his negative experience as an attempt to reinforce an appearance of self-sufficiency, preempting any proximity-increasing response from the therapist (a marker of *Releasing*).

The final excerpt is of a session with David, a 42-year-old preoccupied patient in treatment for his anxiety and occupational problems.

P: I keep having this problem at work – I need help with it, there's no question. Like my colleague – she is really an extremely crazy person – she just – just reeks of immaturity. She acts like a baby. And she – one day she said to me “you're not fucking normal” and my reaction was “I'm not normal?” If she's normal then I don't wanna be. I mean most talented musicians aren't normal people, people whose music really grabs me at a gut level they all had y'know either messed up childhoods or substance abuse problems or lousy relationships – they're not normal.

In a show of ambivalence that is characteristic of preoccupied patients, David first tries to increase closeness by making a request for help (a marker of the *Help* subscale), but then safeguards himself against any challenge to his experience by involving the therapist in joining his perspective. By making exaggerated and vitriolic claims that seem to build the case against his co-worker's worth as a person (a marker of the *Involving* subscale), David enlists the therapist's agreement. He then continues to back up his perspective by “preaching” his personal opinion as a general truth (another marker of *Involving*), persuading the therapist to recognize and affirm his view alone.

## Discussion

The present study is the first attempt to investigate systematically the in-session discourse of a relatively large sample of psychotherapy patients whose secure, dismissing, and preoccupied states of mind with respect to attachment had been independently assessed with the AAI. Results support all of the initial hypotheses about the expected ratings on the PACS scales for each attachment group. Although these results need to be replicated, the AAI classifications seem to

predict systematic differences in the discourse of psychotherapy patients that are consistent with the predictions of attachment theory (Bowlby, 1988). According to our observations with the PACS, secure and preoccupied patients were more likely than dismissing patients to seek emotional closeness with the therapist, dismissing patients were more likely than other patients to avoid or discourage proximity, and preoccupied patients were more likely than other patients to resist the therapist's support or connection. The finding that secure patients were significantly more likely to engage in contact-seeking discursive behavior than preoccupied patients (which stands in apparent contrast to the common depiction of patients classified as preoccupied, see, e.g., Mallinckrodt, Gantt, & Coble, 1995; Wallin, 2007) might perhaps be due to the impact of a subgroup of patients ( $N = 11$ ) within the preoccupied group who were classified E1 ("passively preoccupied") on the AAI. These patients, in contrast to the E2 subgroup ("involving preoccupied"), show low overall contact-seeking behavior, much like their counterparts within the corresponding Strange Situation category C2 (Ainsworth et al., 1978). These results suggest that, although the behavioral repertoire that mediates attachment varies, the attachment behaviors observed in the Strange Situation find new expression in the discourse of adults (a connection which was foreseen by Main with respect to the AAI; Main, 1995).

The method introduced in this study may too have some implications. While contemporary research in adult attachment has maintained an intensive and fruitful focus on the study of narrative and representation, the method of this study begins with the premise that the presentation of a narrative is always a relational occurrence. Any narrative presupposes an audience, and the way in which a narrative is formulated reflects not only how an experience is represented but also the narrator's expectations and understanding of his or her audience. Thus, a focus on discursive behavior could be a useful complement to the focus on narrative and representation when investigating the link between language and attachment patterns. It is our view that the introduction of this method could open a way toward a more comprehensive knowledge of adult attachment and could lead to, borrowing Main and colleagues' famous words (Main, Kaplan, & Cassidy, 1985), a move from "the level of representation" to the level of the relation.

The discursive markers devised for the PACS, aside from being indices of attachment behavior in psychotherapy, appear to represent a number of obstacles to a good therapeutic alliance, and bear a striking resemblance to markers that have been listed as examples of alliance ruptures (Colli & Lingiardi, 2009; Eubanks-Carter, Muran, & Safran, 2009; Safran & Muran, 2000) and defenses (Frederickson, 2013). Additionally, the modes of interaction captured by the PACS can be considered to be an expression of transference dynamics. Transference involves the displacement of affects and attitudes formerly associated with a parent onto another person, particularly to the therapist (Freud, 1912). The PACS markers appear to shed light on this very phenomenon insofar as, according to our results, they seem to be related to patients' attachment patterns, which arise at least in part out of early interactions with parents (Belsky & Pasco Fearon, 2008). Thus, although the PACS scales are far from providing a comprehensive operationalization of the construct of transference, they might represent some of its more slippery, pre-Oedipal aspects, which, as the psychoanalyst Betty Joseph proposed, often manifest in patients' acting through language itself (Joseph, 1989). Since the PACS scales were developed to analyze attachment behavior and not the therapeutic process, the serendipitous congruence between the PACS markers and the constructs of alliance and transference seems to lend credence to the crucial importance of attachment in psychotherapy.

Our findings are subject to several limitations. First, in this study we decided not to account for the Unresolved classification. Since indices leading to this classification most often occur in conjunction with the discussion of trauma (Main et al., 2002), the Unresolved classification would not likely be related to a pervasive pattern of discursive



organization. Given the high prevalence of the Unresolved classification in clinical samples (Bakermans-Kranenburg & Van IJzendoorn, 2009), however, its in-session correlates merit further investigation. Secondly, it is possible that the manifestations of the attachment patterns we observed are specific to the two types of psychotherapy included in the study; future research will have to investigate whether patients' attachment classification similarly predicts patients' interpersonal behavior and discourse in a broader range of treatment modalities. Finally, our sample of sessions included the first five sessions only, and further research is necessary in order to determine whether the differences in patients' discursive attachment behavior remain significant at later stages of treatment.

In conclusion, the large effect sizes yielded in this study, which explained 55% to 75% of the variance, and the high inter-rater reliability of the PACS scales lay the groundwork for the further development and validation of the PACS as a classification system of patients' attachment patterns based on in-session discourse. Thanks to the adoption of a joint perspective on discourse and interpersonal behavior, PACS could offer a window into the attachment dynamics taking place between patient and therapist, which until now have been studied through patients' reflections and recollections (Diamond, Stovall-McClough, Clarkin, & Levy, 2003; Mallinckrodt et al., 1995).

Attachment clearly does not account for all patients' presenting problems, and many other modes of interpersonal behavior such as cooperation and hostility can be enacted in psychotherapy. However, since the relational patterns associated with insecure attachment are frequently among the most pervasive obstacles to collaborative work in psychotherapy (Liotti, 2011), tracking in-session attachment behaviors might be especially important. For example, avoidant discursive behaviors seem to reinforce patients' self-sufficiency in order to avoid the risk of rejection but at the same time prevent emotional connection. On the other hand, resistant discursive behaviors are likely to summon the therapist's sustained attention and care, but in the process restrict the patient's expression of agency. By facilitating therapists' close attention to attachment, the PACS could offer a way to diagnose the problems of the therapeutic relationship. Additionally, the PACS might help therapists to better empathize with those patients who, by obstructing the therapist's attempts to connect, may seem "difficult to reach" (Joseph, 1989), but are actually trying to maintain a safe connection the way they have learned. Such a coding system could provide guidance to those clinicians who want to consider attachment dynamics in their work with patients, and facilitate a pragmatic and meaningful application of attachment theory to psychotherapy research.

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### Notes

1. The Proximity Seeking scale assesses the baby's direct or indirect efforts to gain contact or proximity to a person, and the Contact Maintaining scale accounts for the baby's efforts to maintain contact with the adult once he has gained it. The Avoidance scale rates the baby's avoidance of proximity and interaction, and the Resistance scale the baby's aggressive

- behaviors toward a person or resistance to being held. We disregarded the Distance Interaction scale because it is mainly used in the classification of the B1 sub-category.
2. We considered that a distinction between Proximity Seeking and Contact Maintaining was not as easy to make in language as it is in the interactions observed in the Strange Situation, and collapsed these two scales into one, which we termed *Contact Seeking*.
  3. Julia Belotserkovsky trained in 2009 by Mary Main and Erik Hesse; Daniela Brambilla trained in 2011 by Nino Dazzi and Deborah Jacobvitz; and Miriam Steele.
  4. The first author was trained in 2011 by Nino Dazzi and Deborah Jacobvitz.
  5. Daphne Chessa and Giorgia Rondanini trained in 2009 and 2008, respectively, by Nino Dazzi and Deborah Jacobvitz.
  6. The criteria for rating the PACS scales are too extensive to be provided here comprehensively; however, details concerning this procedure are available from the corresponding author upon request.

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