Intersubjective Embodied Experience: Aesthetics of attachment in the psychotherapeutic field

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CONTENTS

1. INTRODUCTION 4

1.1 Attachment in adulthood 6
  1.1.1 Adult attachment styles and the model of self/others (personality organization) 7

1.2 From intersubjectivity to the aesthetics of the psychotherapeutic field 11

1.3 Conceptualization 13
  1.3.1 Intersubjectivity 13
  1.3.2 Embodiment 13
  1.3.3 Aesthetic 13
  1.3.4 Attachment 13
  1.3.5 Field 14

1.4 Current study 15
  1.4.1 Research questions 15

2. METHODS 16

2.1 Participants and procedure 16

2.2 Instruments 18
  2.2.1 Patient Health Questionnaire - 9 (PHQ-9) 18
  2.2.2 A brief measure for assessing Generalized Anxiety Disorder (GAD-7) 18
  2.2.3 State of Adult Attachment Measure (SAAM) 18
  2.2.4 Experiences in Close Relationships Scale-12 (ECR-12) 19
  2.2.5 Experiences in Close Relationships - Relationship Structures (ECR-RS) 19

2.3 Analysis 20

3. RESULTS 21

3.1 Descriptive results 21
  3.1.1 RQ1: “Is any attachment style highly prevalent among the international clients?” 22
  3.1.2 RQ2: “Is there any change in client’s attachment style after brief Gestalt therapy?” 24

3.2 Case study 29
  3.2.1 Kim – anxious-preoccupied attachment 29
  3.2.2 Eva – fearful-avoidant attachment 31
  3.2.3 RQ3: “How attachment theory can be used in therapy from the perspective of field?” 33

4. DISCUSSION 35

APPENDICES

- APPENDIX A. – CONSENT FORM
- APPENDIX B. – PHQ-9
- APPENDIX C. – GAD-7
- APPENDIX D. – SAAM
- APPENDIX E. – ECR-12
- APPENDIX F. – ECR-RS

REFERENCES
1. INTRODUCTION

What does the baby see when he or she looks at mother’s face?

The baby sees himself or herself.

The mother is looking at the baby and what she looks like depends on what she sees there.

Winnicott 1971, p. 112

The human contact, as Winnicott describes above, develops and transforms in the co-created relatedness. What is in-between the beings, the interacting field (Perls, Hefferline, Goodman, 1994, p. 4) is also what psychotherapy consists of, between the client and the therapist. It is the origin and the destination, the journey mutually created and experienced.

Attachment theory’s emphasis on relationality as a basis of human development can be seen harmonized in contemporary Gestalt therapy, highlighting the dialogical and relational approach. Recently, Gestalt community has focused more and more on the concept of field, which has gained an increasing foothold in literature and research (e.g., Spagnuolo Lobb, 2017a; 2017b; Roubal, Francesetti, & Gecele, 2017; Francesetti, 2015; 2012). To my surprise, however, the concept of attachment has been widely bypassed: for example, the British Gestalt Journal (BGJ), has published only one article (Harris, 1996) and two book reviews (Wakelin, 2014; Harris, 2002) on the topic during its history.

Attachment, being an extensively studied and researched topic in psychology and psychotherapy today (see e.g., Cassady & Shaver, 2016; Brown & Elliott, 2016; Mikulincer & Shaver, 2016; Daniel, 2015; Muller, 2010), it could also be argued to be one of the driving forces behind the alignment of various psychotherapy approaches towards the concept relationality. For example, the psychoanalytic and psychodynamic community has slowly moved (and assimilated) its practice from the ‘intrapsychic’ human experience to
‘intersubjective’. This relational movement is largely based on the work of (intersubjective) developmental analysts such as Daniel Stern (1985; 1995) or more recently Peter Fonagy (e.g., Fonagy et al., 2004) and Jeremy Holmes (e.g., Holmes, 2014).

The debate between the intrapsychic and intersubjective experience of others owes a lot to Martin Buber (1947) and his notion of “I–Thou” relationship, which is “marked by mutuality, dialogue, and the ability to experience others in their own terms” (Wallin, 2007, p. 55), while “intrapsychic relating confines us to an “I–It” relationship in which mutuality is absent, imposition supersedes negotiation, and preexisting categories dominate our experience of other people” (ibid.).

How attachment theory and intersubjectivity then are related, and what is their role in Gestalt therapy? How contemporary Gestalt field theory can be implemented to all of this?
1.1 Attachment in adulthood

Love and loneliness are emotional processes that serve biological functions
Hazan & Shaver, 1987, p. 523

Originating from the pioneering work of John Bowlby and Mary Ainsworth in the 1960’s and 1970’s, then followed by the important additions by Mary Main and Judith Solomon in the 1980’s, the attachment theory focused first on children-caregiver dynamics. As their findings suggested, caregivers’ behavior and the way of being in relation to their child functions as a basis for the development of the infant’s self through the structure of internal representations or ‘working models’. While being “organized and regulated by social input, specifically by primary caregiver responsiveness to distress signals” (Hazan & Shaver, 1994, p. 5), these working models are created based on these repeated interactions, where child learns what to expect while adjusting her/his behavior accordingly. This is how child’s beliefs and feelings about her/himself are construed, especially in relation to others.

In the end of 1980’s, the theory of attachment was expanded to adult relationships. The studies of Cindy Hazan and Phillip Shaver (1987; 1990; 1994) and Kim Bartholomew (1990; Bartholomew & Horowitz, 1991; Griffin & Bartholomew, 1994) discovered how adult romantic relationships had fundamental similarities with child-caregiver relationships: adults (as well as children) felt comfortable when being together with their partner and anxious when their partner was absent. As in child-caregiver relationship, the adult romantic relationship functions as a secure base in the times of setbacks, challenges and loss. Figure 1 shows the attachment behavioral system (Hazan & Shaver, 1994), which represents child’s attachment model, while it can also be applied to adult romantic relationships by replacing the ‘attachment figure’ with a dating partner.
Figure 1. The attachment behavioral system (Hazan & Shaver, 1994)

Figure 1 represents Hazan and Shaver’s behavioral system where attachment is divided into three main dimensions: (1) security, (2) anxiety (‘fear’), and (3) avoidance (‘defensiveness’). This tripartite classification of attachment is still used today in attachment research (see e.g. Mikulincer & Shaver, 2016; Gillath et al., 2009). The main question or ‘task’ in an attachment relationship is related to the fulfilment of ‘secure base’ by the attachment figure: “Is the attachment figure sufficiently near, attentive, responsive, approving, etc.?”. If the secure base is formed and maintained in the relationship, it forms ‘felt security, love and confidence’ and behaviors such as being ‘playful, less inhibited, smiling, exploration-oriented, sociable’. If this demand is not met, it either creates anxiety or avoidance. This is the basis of insecure attachment.

1.1.1 Adult attachment styles and the model of self/others (personality organization)

Continuing the work of Hazan and Shaver (1987), Bartholomew (1990) integrated the Bowlby’s original thought of child’s internal working models and the model of self/others (personality organization) to the different attachment styles in adults. As a modification to the
three attachment styles already found in adults (‘secure’, ‘preoccupied’ and ‘avoidant’),
Bartholomew divided the avoidant attachment style in two, specifying ‘dismissive–avoidant’
and ‘fearful–avoidant’ categories based on their different models of self (positive & negative).

In addition to the categorization based on the model of self/others, a distinction between
organized (secure, avoidant, anxious) and disorganized (or ‘unresolved’) attachment styles has
been recently made (e.g., Lyons-Ruth & Jacobvitz, 2016; Daniel, 2015). This is based on the
findings that while avoidant and anxious styles deviate from the secure style, they do it in a
specific, organized way by either deactivating (avoidant) or hyperactivating (anxious) the
attachment system, whereas fearful-avoidant style is complex and disorganized. Adult
attachment styles and the models of self/others are represented in figure 2.

![Figure 2. Attachment styles in two-dimensional space (based on Bartholomew, 1990)]
According to Bartholomew (1990, p. 147), the 'fearful' category is characterized by a conscious desire for social contact inhibited by fears of its consequences, while 'dismissive' by a defensive denial of the need or desire for greater social contact. As mentioned, these two categories differ in the model of self: "people who fearfully avoid intimacy view themselves as undeserving of the love and support of others, and people who dismiss intimacy possess a positive model of self that minimizes the subjective awareness of distress or social needs.” (ibid.).

According to Wallin (2007, p. 242), individuals with predominantly dismissive-avoidant style are uncomfortable being close to others, relying on others, have difficulties being in touch with their feelings, while anxious-preoccupied (or 'ambivalent') attachment style functions more like an opposite of this, being "lively and vivid—but also overwhelmed by their feelings" and "filled with self-doubt and fearful of being too independent" (p. 224). Fearful-avoidant (or 'unresolved'/'disorganized') individual has often childhood history with traumatic disorganized attachment (also apparent with borderline, dissociative and post-traumatic stress disorders). This relationship, while being overwhelmingly painful for a child without the sense of safety for coping, tends to generate incoherent models of the self, the other, and the relationship between them (ibid., p. 244). These dispiriting models are significantly apparent in therapy with lack of resolution of trauma/loss. In contrast to insecure attachment styles, secure attachment is represented with a capacity to respond (to think, sense, feel, and act) with openness and flexibility, while giving a possibility to modify old representations with new ones in the light of experience (ibid., p. 65).

One of the psychotherapy’s aim can be seen as supporting client’s secure and integrated construction and development of the self. This can be facilitated by attachment-oriented treatment. There are several ‘methods’ a therapist might attempt to adopt in relation to their clients, as ‘caregivers in relation to their children’. According to Wallin (2007) these are "contingent, affectively attuned communication (Siegel, 1999; Stern, 1985); an approach that conveys empathy, an ability to cope, and an appreciation of the child’s “intentionality” (Fonagy
et al., 1995); a framework of response that embodies inclusiveness in relation to the breadth of the child’s subjective experience, scaffolding of the child’s emerging capacities, a readiness to initiate repair when there is disruption, and a willingness to struggle with the child when necessary (Lyons-Ruth, 1999)." (pp. 107-108).
1.2 From intersubjectivity to the aesthetics of the psychotherapeutic field

Resonance is co-influenced movement.
Francesetti 2012, p. 7

The paradigm shift from ‘personal psychopathology’ (the diagnosis and treatment of individual’s symptoms) to more holistic understanding of human experience, has recently seen a subtle movement in psychology and psychiatry. This new paradigm integrating the mind and the body, the environment and the organism, is reflected in the field of psychotherapy by the concepts of relationality and intersubjectivity. These concepts align themselves to the notion of field.

Originating on Kurt Lewin’s (1951) idea of “various forces, vectors, and ‘influences’ act together to produce a specific, unique outcome in a particular situation at a particular time” (Parlett, 2005, p. 46), Gestalt therapy, being interested in the whole ‘therapeutic field’, puts focus on what happens in the contact-boundary between the client and the therapist. That is, as Spagnuolo Lobb (2013) mentions, "the place of the therapy", where "patient tends to be more spontaneous with the therapist than s/he has been able to be in preceding significant relationships.". The treatment is based on “the relational recognition of that intentionality of contact that had been blocked” (ibid.).

Field, therefore, has a fundamental role in the practice of contemporary Gestalt therapy. Parlett (2005, pp. 47-52) describes four distinct features and implications of field:

1. The therapist, or "observer", is not detached, objective, separated from the field but rather a part of it.
2. The field is organized, and therapy involves the mutual investigation of how it is organized.

3. Gestalt therapists work in the "here and now" and explore the immediate, present field.

4. The therapist attends to exploring different parts of the field.

Parlett’s four features of field can be implemented to attachment theory in relation to Gestalt therapy: (1) the therapist is not detached from the client’s attachment pattern and (2) therapy involves mutual investigation of attachment’s organization (3) in the immediate presence, by (4) attending to different parts of the embodied attachment. Therefore, with the perspective of field theory, therapist must consider and be aware of her/his own attachment styles and patterns, as it resonates in the unique contact with client’s attachment style.
1.3 Conceptualization

1.3.1 Intersubjectivity

Intersubjectivity has a history in psychoanalytic literature and clinical research (Atwood & Stolorow, 1984/2014). Here the notion approaches the Gestalt concept of field, by a definition of Natterson and Friedman (1995): “Intersubjectivity is the over-arching term that refers to the reciprocal influence of the conscious and unconscious subjectivities of two people in a relationship” (p. 1).

1.3.2 Embodiment

Spagnuolo Lobb (2013) refers to embodiment as “a knowledge which is embodied, intensioned-to-contact and aesthetic, rooted in the unitary nature of organism/environment”, while “the therapeutic task consists in helping the person to recognize the creative experience of her/his adjustment, re-appropriating it in an embodied manner, without anxiety, in other words with spontaneity”. Therefore, embodiment in this study is seen as an expression of spontaneity intensioned-to-contact.

1.3.1 Aesthetic

Aesthetic is defined as “(1) it is perceived by senses..., (2) that follows the rules of the figure forming..., and (3) that can be felt as a feeling of something beautiful emerging during the session.” (Roubal, Francesetti, & Gecele, 2017, pp. 1-2).

1.3.2 Attachment

The concept of attachment is used in the context of psychotherapy, between client and therapist. While the main focus is on the attachment of a client (as s/he is the one being in therapy), from the field perspective and attachment literature, individual’s attachment style does not exist in a vacuum: it is shaped relationally (Levine & Heller, 2012; Mikulincer &
Shaver, 2016. Therefore, here, attachment is defined as the ongoing bond based on attachment behavioral systems of client and therapist.

1.3.3 Field

The therapeutic field is defined here as a mutually created process of interaction between client and therapist (Spagnuolo Lobb, 2017a; Parlett, 2005). This includes verbal and nonverbal interaction, the sensory experience and perception of it.
1.4 Current study

The study is based on mixed methods design. This means that I am using both quantitative and qualitative methods with descriptive and case study research.

First, I quantitative data from all the clients was gathered with a set of self-report questionnaires (PHQ-9, GAD-7, SAAM, and ECR-12) that was given to them to be filled at home. These instruments created a ‘base line’ of quantitative data of all participants. Second, based on my therapeutic work, three clients with whom I have had at least 12 sessions were chosen for a re-test for PHQ-9, GAD-7, and SAAM self-report questionnaires, in addition to their ECR-RS scores. Third, two of these three clients were chosen for a case study, for a more detailed qualitative analysis.

1.4.1 Research questions

The study has three research questions.

First, as all my clients are adults with an international background, coming from various countries and cultures (also called as ‘expatriates’ or ‘expats’; Bushong, 2013), I am interested in investigating their current attachment styles:

RQ1: “Is any attachment style highly prevalent among the international clients?”

Second, I am also interested to see if brief Gestalt therapy (here meaning gestalt therapy lasting 3-4 months, one to two sessions per week, approximately 12-20 hours in total) can affect client’s attachment style or state over time:

RQ2: “Are there any change in client’s attachment style after brief Gestalt therapy?”

Third, by a qualitative case study, I will explore the main research question of the study:

RQ3: “How attachment theory can be used in therapy from the perspective of field?”
2. METHODS

2.1 Participants and procedure

Participants were gathered from my private practice in Paris, France. The time frame to participate to the study was from the beginning of December 2017 to the beginning of March 2018. During this time, 10 participants took part in the first phase of the study. Figure 3 shows the procedure and the assignment of participants in the study.

In the first phase, participants (n=10) filled a set of self-report questionnaires (PHQ-9, GAD-7, SAAM, ECR-12) at home after the initial therapy session. The BDI-II (Beck’s Depression Inventory II) was also included in this set of questionnaires, but it is not presented here for
the sake clarity (PHQ-9 measures similar symptoms) and because of the copyright permissions.

When participants brought back the filled questionnaires (generally for the second therapy session), a written consent form to participate to the study (Appendix A.) was signed. This was done after having the answers of the questionnaires to eliminate any bias for the responses (Hawthorne effect). At the second therapy session, an additional questionnaire, the ECR-RS, was given to all participants. This questionnaire was given afterwards, so that there would not be too many attachment questionnaires to be filled at once, and since its information was used more for therapeutic use than research purposes.

Three participants of the initial 10 who met the required 12 sessions of therapy were chosen for the second phase of the study. In this phase they filled another set of self-report questionnaires (PHQ-9, GAD-7, SAAM) during the week 18 in 2018, to measure any possible change in depressive (PHQ-9) and anxiety (GAD-7) symptoms and state of attachment (SAAM). Here, their ECR-RS scores were also calculated for a more detailed attachment picture.

Two participants were chosen for to the final third phase for qualitative case study. Inclusion criteria here was the coherence with the attachment theory in relation to their cases. Here my personal notes from the therapy sessions were acquired and analyzed.

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1 According to attachment research in relation to clinical practice and psychotherapy (e.g., Wallin, 2007), therapist is favored to enable attachment patterns to rise naturally in the therapeutic process between client and therapist. This process naturally takes time occur and develop, which is why no less than 12 sessions were including in the second and third phase of research.
2.2 Instruments

2.2.1 Patient Health Questionnaire - 9 (PHQ-9)

The PHQ-9 (Kroenke, Spitzer, & Williams, 2001; Appendix B.) is a brief 9-item questionnaire widely used in clinical practice globally to measure depressive symptoms. It is extensively studied and validated for depression outcome measurement (Löwe, Kroenke, Herzog, Gräfe, 2004; McMillan, Gilbody, Richards, 2010; Manea, Gilbody, McMillan, 2012), while being translated to many languages. The PHQ-9 uses 4-point scale, starting from 0 ('Not at all') to 3 ('Nearly every day'). The scoring of PHQ-9 goes as following: 0-4 'minimal/none', 5-9 'mild', 10-14 'moderate', 15-19 'moderately severe', 20-27 'severe'.

2.2.2 A brief measure for assessing Generalized Anxiety Disorder (GAD-7)

The GAD-7 (Spitzer et al., 2006; Appendix C.) is a short 7-item self-report questionnaire for measuring generalized anxiety disorder (GAD). Used widely in clinical practice, it is a valid and efficient tool for screening and assessing GAD. It exists in several languages. In GAD-7, the scale is the same as in PHQ-9: from 0 ('Not at all') to 3 ('Nearly every day'). The scoring of GAD-7 goes as following: 5-9 'mild', 10-14 'moderate', 15- 'severe'.

2.2.3 State of Adult Attachment Measure (SAAM)

Developed by Gillath and colleagues (2009; Appendix D.), SAAM is a 21-item self-report questionnaire measuring short-term changes in attachment states. Unlike other attachment instruments, respondents are asked how they feel in a given moment (e.g. ‘I really need to feel loved right now’ or ‘If something went wrong right now I feel like I could depend on someone’). SAAM uses 7-point Likert scale from 1 to 7, 1 signifying ‘Disagree strongly’ and 7 being ‘Agree strongly’. SAAM measures three-dimensional profile of attachment (as originally proposed by Hazan & Shaver, 1987): avoidance, anxiety and security. In this study, SAAM is used to measure the baseline and the change over time of participants’ attachment state/style.
2.2.4 Experiences in Close Relationships Scale-12 (ECR-12)

The ECR-12 (Lafontaine et al., 2016; Appendix E.) is the most recent addition to the adult attachment measurement. It is a shortened version of the original ECR, including only 12 items, of the original ECR (Brennan, Clark, & Shaver, 1998) which included 36 items. Therefore, it is easier and faster to use in research and clinical work. According to robust validation, it has the same internal consistency as the original ECR. The ECR-12 can be used for measuring attachment in romantic partners and/or in close relationships in general with a 7-point Likert scale (1 indicates ‘disagree strongly’ and 7 ‘agree strongly’). The scores are divided into attachment avoidance and attachment anxiety.

2.2.5 Experiences in Close Relationships - Relationship Structures (ECR-RS)

The ECR-RS (Fraley et al., 2011, Appendix F.) measures attachment in relation to specific attachment figures (mother or mother-like figure, father or father-like figure, dating partner, and best friend) with 9 items. Therefore, it gives a more holistic picture of an individual’s attachment style. The ECR-RS, as SAAM and ECR-12, uses 7-point Likert scale from 1 (‘disagree strongly’) to 7 (‘agree strongly’) and the two-dimensional avoidance–anxiety paradigm for measuring attachment. The ECR-RS can be seen as a useful tool in therapy to map client’s attachment styles across significant others. Here ECR-RS is used mainly as a therapeutic tool and intervention, in addition to SAAM and ECR-12, to gather more information of the participants of the second phase in the study.
2.3 Analysis

In the first phase of the study data was collected from the questionnaires and put into Excel. The names of the respondents were coded anonymous and the total scores of each respondent were calculated. Based on these total scores, descriptive results were made. Representative figures were made on based on these values.

Three participants continued to the second phase of the study. Their ECR-RS scores were calculated, as well as the new PHQ-9, GAD-7 and SAAM scores. Comparative results were analyzed and representative figures were made based on these values.

Two participants were included to the third phase based on their cases’ coherence to attachment theory. Personal notes of their therapy sessions were analyzed for final case study analysis.
3. RESULTS

3.1 Descriptive results

Descriptive results from the first data collection are presented in table 1.

Table 1.  
*The baseline: descriptive results (n=10) after initial therapy session*

<table>
<thead>
<tr>
<th>Participant</th>
<th>PHQ-9</th>
<th>GAD-7</th>
<th>SAAM (AvA; AAx; ASe)</th>
<th>ECR-12 (P) (AvA; AAx)</th>
<th>ECR-12 (C) (AvA; AAx)</th>
</tr>
</thead>
<tbody>
<tr>
<td>C1</td>
<td>14</td>
<td>8</td>
<td>6; 5; 4,4</td>
<td>3,2; 5,5</td>
<td>4; 4,5</td>
</tr>
<tr>
<td>C2</td>
<td>8</td>
<td>11</td>
<td>3,4; 5,3; 2,9</td>
<td>2,7; 5,7</td>
<td>6; 3,5</td>
</tr>
<tr>
<td>C3</td>
<td>19</td>
<td>17</td>
<td>5,1; 5,9; 2,6</td>
<td>5,7; 6,8</td>
<td>2,5; 4,8</td>
</tr>
<tr>
<td>C4</td>
<td>11</td>
<td>11</td>
<td>4,1; 4; 6</td>
<td>3,8; 4,5</td>
<td>3; 3,3</td>
</tr>
<tr>
<td>C5</td>
<td>19</td>
<td>11</td>
<td>2,1; 5; 3,3</td>
<td>2,4; 4,9</td>
<td>3,3; 5,3</td>
</tr>
<tr>
<td>C6</td>
<td>4</td>
<td>6</td>
<td>2,3; 4,4; 5</td>
<td>2; 4</td>
<td>3,5; 4,2</td>
</tr>
<tr>
<td>C7</td>
<td>13</td>
<td>10</td>
<td>1,4; 6; 6,4</td>
<td>1,7; 3,8</td>
<td>5,4; 3,2</td>
</tr>
<tr>
<td>C8</td>
<td>15</td>
<td>12</td>
<td>1,5; 5,4; 6,7</td>
<td>2,7; 4</td>
<td>3,8; 3,3</td>
</tr>
<tr>
<td>C9</td>
<td>2</td>
<td>1</td>
<td>2,6; 2,3; 6,1</td>
<td>1,5; 1,7</td>
<td>2; 1</td>
</tr>
<tr>
<td>C10</td>
<td>4</td>
<td>8</td>
<td>3; 6,3; 5,7</td>
<td>1,3; 5,8</td>
<td>2,5; 5</td>
</tr>
</tbody>
</table>

Note. SAAM: AvA = avoidant attachment; AAx = attachment anxiety, ASe = attachment security. ECR-12: AvA = avoidant attachment; AAx = attachment anxiety. ECR-12 (P) = dating partner, ECR-12 (C) = close relationships. SAAM/ECR-12 scores in bold = scores on attachment scales equal or over 5 (out of 7). PHQ-9 in bold = ‘moderately severe depression’. GAD-7 in bold = ‘severe anxiety’. PHQ-9 in italics = ‘moderate depression’. GAD-7 in italics = ‘moderate anxiety’.
Table 1 shows the baseline scores for PHQ-9, GAD-7, SAAM, and ECR-12 for all participants (n=10). Three participants (C3, C5, C8) had ‘moderately severe’ scores (15-19 points) on PHQ-9. One participant (C3) had ‘severe’ (15 or above points) on GAD-7.

Regarding attachment scores, several participants (C1, C2, C3, C10) scored high (5 or above) in both SAAM and ECR-12 (P) on avoidance and/or anxiety. Participant C3 had high scores both on avoidance and anxiety in both measures, while also having high scores on PHQ-9 and GAD-7. The ECR-12 (C) ‘dating’ scores seems to differ from ECR-12 (P) ‘close relationships’ scores. Individuals with high attachment anxiety (e.g., C1, C2, C3) do not seem to see themselves acting similarly towards their close relationships in general.

3.1.1 RQ1: “Is any attachment style highly prevalent among the international clients?”

To answer to the first research question in a more figurative way, the data presented in table 1 can be placed in Bartholomew’s (1990) two-dimensional space. There the horizontal and vertical axes (x-axis; y-axis) represent anxiety (x) and avoidance (y). The ECR-12 attachment scores from table 1 can be seen in this format in figure 4.

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**Figure 4.** Attachment scores of ECR-12 in two-dimensional space (n=10)
Figure 4 shows the results of attachment questionnaires for ECR-12 (n=10). For dating relationships, the ‘anxious–pre-occupied’ attachment style in the bottom right segment seems to be the most prevalent among participants. The ECR-12 close relationship scores differ from these largely: participants tend to be higher in avoidance and lower in anxiety than with dating partners.

![SAAM Diagram]

*Figure 5. Attachment scores of SAAM (without security dimension) in two-dimensional space (n=10)*

The SAAM scores for attachment avoidance and anxiety are shown in Figure 5. They show largely same results as ECR-12 for dating, except for participant C1. This person seems to have much higher avoidance score on SAAM than on ECR-12. SAAM also included attachment security dimension. The results suggest that six participants in total (C4, C6, C7, C8, C9, C10) had a score of 5 or higher (out of 7) on attachment security.
3.1.2 RQ2: "Is there any change in client’s attachment style after brief Gestalt therapy?"

Three participants who were included in the second phase of the study repeated PHQ-9, GAD-7 and SAAM questionnaires during the week 12 in 2018. These results are shown in table 2.

Table 2.
Re-test on PHQ-9, GAD-7 and SAAM after at least 12 therapy sessions (n=3)

<table>
<thead>
<tr>
<th>Participant</th>
<th>PHQ-9</th>
<th>GAD-7</th>
<th>(AvA; AAx; ASe)</th>
</tr>
</thead>
<tbody>
<tr>
<td>C1</td>
<td>10 (14)</td>
<td>10 (8)</td>
<td>5 (6); 4,7 (5); 3,7 (4,4)</td>
</tr>
<tr>
<td>C2</td>
<td>5 (8)</td>
<td>7 (11)</td>
<td>3,1 (3,4); 5,3 (5,3); 3,4 (2,9)</td>
</tr>
<tr>
<td>C3</td>
<td>13 (19)</td>
<td>18 (17)</td>
<td>4,9 (5,1); 4,3 (5,9); 2,6 (2,6)</td>
</tr>
</tbody>
</table>

Note. In brackets = the values from first set SAAM: AvA = avoidant attachment; AAx = attachment anxiety, ASe = attachment security. ECR-12: AvA = avoidant attachment; AAx = attachment anxiety. ECR-12 (P) = dating partner, ECR-12 (C) = close relationships. In bold in SAAM/ECR-12 = scores on attachment scales equal or over 5 (out of 7). PHQ-9 in bold = ‘moderately severe depression’. GAD-7 in bold = 'severe anxiety'. PHQ-9 in italics = ‘moderate depression’. GAD-7 in italics = ‘moderate anxiety’.

According to these findings, PHQ-9 scores decreased significantly with all three individuals from baseline to re-test (C1: 4 points; C2: 3 points; C3: 6 points). GAD-7 scores, however, increased slightly with two participants (C1: 2 points; C3: 1 point) and with one decreased considerably (C2: 4 points). These changes over time are represented in figures 5 and 6.
Figure 5. Changes from baseline to re-test for PHQ-9 (n=3)

Figure 6. Changes from baseline to re-test for GAD-7 (n=3)
Table 2 represents the SAAM scores at the baseline (after initial therapy session) and at the re-test (after at least 12 sessions of therapy) for three participants: avoidant attachment (AvA) decreased with all three individuals (C1: 1 point; C2: 0,3 points; C3: 0,2 points), while attachment anxiety decreased with two (C1: 0,3 points; C3: 1,6 points) and with C2 stayed the same. Attachment security decreased with C1 (0,7 points), increased with C2 (0,5 points), and stayed the same with C3. These results are presented in figure 7.

Figure 7. Changes from baseline to re-test for attachment avoidance (AvA), anxiety (AAx) and security (ASe) on SAAM (n=3)

The second research question was: “Is there any change in client’s attachment style after brief Gestalt therapy?” According to the current findings, there seems to be subtle changes in client’s self-reported attachment states after 12 sessions of Gestalt therapy. However, to see if the attachment styles change over time, the SAAM scores need to be put into the two-dimensional space. This is presented in the figure 8.
Figure 8. Changes from baseline to re-test for attachment scores of SAAM (without security dimension) in two-dimensional space (n=3)

When the SAAM scores are put into two-dimensional space, we can see that the actual attachment styles seem to stay in their original segments: C1 and C3 being in the fearful-avoidant segment (upper right) and C2 in anxious-preoccupied (bottom right). However, the participant C3 seems to be moving towards dismissive-avoidant segment (upper left) and C1 towards anxious-preoccupied. These results will be discussed in more detail in the discussion section.

To have a fuller picture of the attachment styles of the participants in the second phase of the study, the ECR-RS scores were calculated for the participants C1, C2, and C3. These can be found in table 3.
Table 3.

**Descriptive results for ECR-RS (n=3)**

<table>
<thead>
<tr>
<th>Participant</th>
<th>Mother (AvA; AAx)</th>
<th>Father (AvA; AAx)</th>
<th>Dating (AvA; AAx)</th>
<th>Best friend (AvA; AAx)</th>
</tr>
</thead>
<tbody>
<tr>
<td>C1</td>
<td>3,7; 3</td>
<td>4,2; 4</td>
<td>3; <strong>5,3</strong></td>
<td>1,8; 4</td>
</tr>
<tr>
<td>C2</td>
<td>4,8; 2,7</td>
<td><strong>5,2;</strong> 1,3</td>
<td>2,8; <strong>5,3</strong></td>
<td>3,2; 4</td>
</tr>
<tr>
<td>C3</td>
<td><strong>6,3;</strong> 4,3</td>
<td>–</td>
<td>4,8; <strong>6,7</strong></td>
<td>2; <strong>5,7</strong></td>
</tr>
</tbody>
</table>

*Note. AvA = avoidant attachment; AAx = attachment anxiety. In bold = score on attachment scale is equal or over 5 (out of 7).*

The ECR-RS shows scores on attachment avoidance (AvA) and anxiety (AAx) in relation to one’s significant others, such as parents. This information can be used in therapy for different therapeutic interventions. Table 3 shows how C1 scored high on anxiety scale for dating partner, but not for others. C2, however, scored high on avoidance for father (5,2; and 4,8 for mother), and also high on anxiety for dating partner (5,3). C3, on the other hand, had high avoidance for mother (6,3) and high anxiety for dating partner (6,7) and best friend (5,7). C3 did not have attachment scores for father as he had passed away when C3 was young.
3.2 Case study

Two participants (C2 and C3) of the second phase were chosen for the final case study analysis. These participants were chosen based on their cases’ coherence with the attachment theory. In this part the participants are given names to be referred to: C2 is called ‘Kim’ and C3 is called ‘Eva’.

This case study analysis is based on the quantitative data gathered (the questionnaires represented in the earlier sections) and on my personal notes of the therapy sessions with these participants. The aim of this case study is to answer to the final third research question: “How attachment theory can be used in therapy from the perspective of field?”.

3.2.1 Kim – anxious-preoccupied attachment

Kim’s example represents a case of anxious-preoccupied attachment style. Looking back at Kim’s self-report scores, it seems that her high attachment anxiety is visible on all attachment questionnaires: ECR-12 dating (5,7), SAAM over time (5,3 and 5,3) and ECR-RS dating (5,3). Her PHQ-9 and GAD-7 scores were mild/moderate after the initial therapy session and after 12 sessions both scores were mild. Regarding ECR-RS scores for parents, Kim had fairly high avoidance scores for her mother (4,8) and father (5,2).

*Kim is in her late 20’s, recovering from a dating relationship where she 'became clingy, needy, and obsessive’ – in her own words. Recently Kim met a new guy – Mark – and while they have met only once, Kim already starts to have excessive fears of ‘screwing things up by not being capable of controlling her emotions’. She becomes overwhelmed by anxiety and sadness. She needs to take a day off from work as she cannot function properly. She is thinking about Mark all the time: how painfully long it takes for him to reply to her messages, the uncertainty it creates and makes her crazy, and how she is afraid to tell him what she really wants: a proper relationship. Kim is sure her 'clingy-neediness’ is going to destroy this relationship as well – as*
it has before. She is deeply ashamed of her situation, she feels helpless and cries heavily every session.

As mentioned earlier, an individual with a predominantly anxious-preoccupied attachment style tend to present themselves in therapy as overwhelmed by their feelings while filled with self-doubt (Wallin, 2007, p. 224). They seek intimacy and desire to merge with others. They are disposed to intensify negative feelings as they do not find others reliable and while not being capable of 'taking care of themselves', they are filled with insecurity, low self-esteem and self-confidence (Daniel, 2015, pp. 80-81). What is also typical for anxious-preoccupied attachment style is the pattern of basing one’s self-worth on the feedback from others, which can affect one’s shaky self-esteem in the moments of rejection or criticism (ibid., p. 82). This is related to the unclear boundaries between self and others that entail a degree of emotional overinvolvement, being easily 'infected' with others' feelings (ibid., p. 84).

During our session with Kim, I start to sense my constant need to solve Kim’s overwhelming helplessness.

Her endless words of misery regarding her situation are filling the room as her self-confidence is drowning through the floor. Her cheeks are filled with endless tears. She is looking at me with her praying eyes and her quivering voice.

Kim’s clinginess makes me somehow uneasy. I notice this as my posture starts learning forward and my speech growing faster and louder, as I try to balance the ambiance with strength and determination, some kind of solution.

I share this – that I feel that in this very moment I have this huge urge to ‘save’ her. And that in some way I feel her ‘clinginess’ in between us, right now, which makes me feel unease.

She reacts to my comment with a tender surprise and smile.

“I know exactly what you mean”, she replies, and corrects her posture more upwards, standing now straight. She looks at me with clear eyes: “I really need to act regarding Mark. I can’t stay in this hazy obscurity anymore.”
As shown in the short example above with Kim, anxious-preoccupied attachment can create a dominating field of helplessness that is perceivable in the therapeutic interaction. Kim’s ‘clinginess’ and helplessness was validated and shared: how it affected me, how it dominated the field in between us. Verbalizing what was obvious in the field in my perspective made Kim to realize her position with a sense of agency: enhancing self-support in the present moment. She did not want to retroflect anymore, she wanted to use her aggression to confront Mark and make her wants and needs (boundaries) clear.

3.2.2 Eva - fearful-avoidant attachment

Eva’s example represents a case of fearful-avoidant (or ‘unresolved’) attachment style. Looking back at Eva’s self-report scores, it seems that she had high scores for both attachment avoidance and anxiety: ECR-12 dating (AvA: 5,7; AAx: 6,8), SAAM baseline (AvA: 5,1; AAx: 5,9) and for ECR-RS dating (AvA: 4,8; AAx: 6,7). She had high (severe) scores on PHQ-9 (19) and GAD-7 (17) at the baseline. After 12 sessions of therapy, however, her SAAM scores dropped (AvA: 4,9; AAx: 4,3), as well as PHQ-9 dropped to moderate (13) while GAD-7 stayed severe (18). Regarding ECR-RS scores, Eva had high avoidance for her mother (6,3) and high anxiety for her best friend (5,7).

Since her childhood Eva has suffered from her abusive authoritarian mother and sister. She has experienced constant neglect and physical abuse, and her family was overwhelmed by conflicts and fighting. Eva’s father died when she was young. After this, Eva’s role in the family changed: her task was to be supportive, joyful and helpful. She was the one to take care of mother’s depression and her sister’s aggressions. According to Eva, her mother ‘owned’ her, mentally and physically. She feels that nothing was enough, as she was constantly left alone with the feeling that her attempts to help others (especially her mother and sister) were not enough, or that she was not trying hard enough. Nowadays she feels that she doesn’t deserve
to have a relationship with anyone and that she is not worth of anything. She feels that she doesn’t own her own body. She would want to get rid of it.

Fearful-avoidant (or ‘unresolved’/’disorganized’) attachment is often rooted in traumatic childhood history, being overwhelmingly painful without the sense of safety for coping with this pain (Wallin 2007, p. 244). Individuals with this attachment are characterized by a conscious desire for social contact which is inhibited by fears of its consequences and they tend to view themselves as undeserving of the love and support of others (Bartholomew, 1990, p. 147). They tend to experience greatest difficulties in developing open and trusting relationships with other people of all the four attachment styles: the conflicting impulses of seeking proximity while simultaneously being avoidant means that they might appear incomprehensible by others and their way of handling conflicts often inadequate (Daniel, 2015, p. 94). The way of being in treatment might shift unpredictably as the main attachment strategy of deactivation or hyperactivation might change in the relationship, giving mixed signals with wants and needs opposing each other (ibid., pp. 94-95). Dissociation (‘splitting up’ one’s consciousness or attention) is a typical behavioral pattern related to fearful-avoidant attachment.

Over the course of therapy, Eva starts to ‘freeze’: her movement halts, her body stiffens, eyes wander in the room’s ceiling and the walls. Her hands continue to do a circulating movement. "What are your hands saying?”, I ask Eva with a curiosity, while initiating contact with her. Eva continues to ‘zone out’, until after a moment she awakens and replies: "Ah, I don’t know, they’re just here”, while looking at her hands. "And you are…?”, I continue with curiosity. "I’m in ‘nothingness’, it’s a dead space where nothing is and everything is white.” Eva’s body stiffens even more while she looks at me with cold distant eyes. “Alright...Now take a deep breath with me and try to sit steadily with your both feet on the ground”, I guide her to breathing and grounding exercise. "What happens in your body right now?”, I ask. "There’s pain now”, she replies.
“Where exactly?” I silently ask and lean a bit forward.

“In my back”, Eva says, “In my spine and back.”

“Ok. If you want, you can try to focus on that pain and stay with me for a moment. I’m here.”

Eva stays rigid, breaths deeply and looks at me while I look at her.

After a moment she turns her shoulders and looks away, as a kind of movement of purification.

“Now it’s gone”, she says.

To work with the dissociative states, as Wallin (2007) puts it, integration can be seen as the very heart of the therapy, but “while with most patients the relationship with the therapist is a significant part of therapy, for patients who are unresolved the therapeutic relationship is the therapy” (pp. 243-244).

In the case of Eva and the dominant field of dissociation, our intensive work (twice a week) consists of breathing exercises, focusing on the body, and investigating the dissociative experiences with curiosity and psychoeducation, integration being the main goal. As our work can sometimes be quite challenging, my experience has been that by sharing my own sense of helplessness (when occurring), for example, makes also her pain somehow lighter in that moment. While Eva’s goals for the treatment (or of her ‘progress’) might sometimes seem hopeless to her, in those very moments my determination and trust for our process keeps it in motion.

3.2.3 RQ3: “How attachment theory can be used in therapy from the perspective of field?”

As shown in the two case studies above, attachment theory can be used for understanding the (under)currents of the therapeutic field, what is between the client and the therapist. It helps to understand in relational patterns and conflicts of the client also outside therapy: this is what is going on between the client and her/his partner. In the other hand, therapist, being aware of her/his own attachment style, and how certain styles makes her/him ‘feel’, s/he can use
that information in the work with countertransference. As current literature stresses the importance of acknowledging how certain attachment styles (such as anxious-preoccupied and dismissive-avoidant) collide and create troubled pairs (Levine & Heller, 2012), we might end up having that type of dyadic pairing in therapy.

To sense the attachment *currents* in therapy, the concept of field is really useful. It helps to understand and experience, pay attention to the aesthetics of this embodied experience with the client: an expression of spontaneity intentioned-to-contact.
4. DISCUSSION

In this section I will go through the research questions of the study and present the conclusions.

The first research question of the study was: “Is any attachment style highly prevalent among the international clients?”. According to the quantitative data gathered (n=10), ‘anxious–preoccupied’ attachment style was the most prevalent attachment style among the international participants with the current sample. Measured in the baseline, according to ECR-12 (C) ‘dating’ scale five participants and six according to SAAM were determined as anxious-preoccupied (scores on anxiety higher than 4 and scores on avoidance lower than 4). Notably, the ECR-12 dating scores differed from ECR-12 (P) ‘close relationships’ scores: participants with high attachment anxiety (e.g., C1, C2, C3) did not seem to see themselves acting similarly towards their close relationships in general. From the baseline data one participant (C3, or Eva) had high scores in most of the questionnaires, which was indicating – and later verified as fearful-avoidant attachment style. This disorganized type of attachment is fairly rare among the general population and may in some occasions require specialized care (e.g., when occurring with severe borderline personality disorder).

The second research question was “Is there any change in client’s attachment style after brief Gestalt therapy?”. When looking at the changes in the SAAM scores, subtle changes were found after 12 sessions of therapy, however, the attachment styles did not change among the participants (n=3) while there was clear movement towards different styles. This progression remains to be seen in the future of the treatment. I will most probably re-test the clients again with a similar set of questionnaires around the 25th session of therapy. This measurement method, in my experience, can be really useful for therapeutic work. It gives information about the progress of therapy while also creates clarity for treatment goals for the client. Certain statements on SAAM, such as “I feel alone and yet don’t feel like getting close to others.”
(measuring avoidant attachment) or “I want to share my feelings with someone.” (attachment anxiety) can be valuable for measuring therapeutic alliance/relationship. How is our mutual relationship progressing? How am I present with my client and how am I approachable? Looking from this point of view, the subtle changes in this study from baseline to after 12 sessions of therapy can be seen as promising/hopeful: avoidant attachment (AvA) decreased with all three individuals, while attachment anxiety decreased with two and with one stayed the same. PHQ-9 scores decreased significantly with all three individuals from baseline to re-test, while GAD-7 scores increased slightly with two participants and with one decreased considerably. These results could be interpreted so that as the therapeutic relationship developed and strengthened over time (changes in SAAM), also depressive symptoms (PHQ-9) decreased. Anxiety levels (GAD-7), in turn, slightly increased because of the ‘opening of the wounds’ during the therapeutic work. Clients become more aware of their maladaptive patterns and internal working models. Knowledge increases responsibility, which again increases anxiety.

The third research question was “How attachment theory can be used in Gestalt therapy from the perspective of field?”. As the earlier quantitative results and the short case study examples represent, clients’ attachment styles or states tend to come to surface in therapy. This happens especially during painful experiences. Kim exemplified how predominantly anxious-preoccupied client might create a field of clingingness or helplessness that is sensible by a therapist. Eva’s case, in turn, represents how predominantly fearful-avoidant (or ‘unresolved’/‘disorganized’) client might sink into frightening ‘nothingness’ during a session. This dissociative experience of unresolved trauma/loss was sensible by the field’s ‘emptiness’. It directed me to focus on breathing and grounding, integration and investigation of this mutual experience.

All in all, attachment theory helps the therapist to move towards the contact boundary in the continuous development of the psychotherapeutic field. It is an intersubjective embodied experience. Aesthetic resonance.
APPENDIX A.

“Attachment in the Psychotherapeutic Field”
Mikko Karhulahti
Gestalt Institute of Scandinavia

CONSENT FORM

I am willing to take part in the research project Attachment in the Psychotherapeutic Field by giving the permission to the researcher Mikko Karhulahti to use the scores of the questionnaires I have filled for his research anonymously. I also give permission to the researcher Karhulahti to use his personal notes of our sessions in his research anonymously. The researcher ensures that all research material in the study will be presented in a manner that secures participants anonymity. There are two copies of this consent form, one for the participant and one for the researcher.

I understand that

• all information is handled with confidentiality
• all information gathered and analyzed is made anonymous
• no one will have access to the research material other than the researcher
• taking part in the research is voluntary and I may withdraw at any time

Date:

Name of the participant:

Signature:

Date:

Name of the researcher: Mikko Karhulahti

Signature:
APPENDIX B.

**PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)**

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use "✓" to indicate your answer)

<table>
<thead>
<tr>
<th>Problem</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Feeling down, depressed, or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Trouble falling or staying asleep, or sleeping too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Feeling tired or having little energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Poor appetite or overeating</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Feeling bad about yourself — or that you are a failure or have let yourself or your family down</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Thoughts that you would be better off dead or of hurting yourself in some way</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

**For office coding**

0 + □ + □ + □ + □

=Total Score: □

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

<table>
<thead>
<tr>
<th>Not difficult at all</th>
<th>Somewhat difficult</th>
<th>Very difficult</th>
<th>Extremely difficult</th>
</tr>
</thead>
<tbody>
<tr>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

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APPENDIX C.

GAD-7

<table>
<thead>
<tr>
<th>Over the last 2 weeks, how often have you been bothered by the following problems?</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Feeling nervous, anxious or on edge</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Not being able to stop or control worrying</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Worrying too much about different things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Trouble relaxing</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Being so restless that it is hard to sit still</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Becoming easily annoyed or irritable</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Feeling afraid as if something awful might happen</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

(For office coding: Total Score T = ___ + ____ + ____)

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APPENDIX D.

State Adult Attachment Measure (SAAM)

The following statements concern how you feel right now. Please respond to each statement by indicating how much you agree or disagree with it as it reflects your current feelings. Please circle the number on the 1-to-7 scale that best indicates how you feel at the moment:

<p>| | | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>Disagree strongly</td>
<td>Neutral/ mixed</td>
<td>Agree strongly</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Right now . . .

1. I wish someone would tell me they really love me.  
2. I would be uncomfortable having a good friend or a relationship partner close to me.  
3. I feel alone and yet don’t feel like getting close to others.  
4. I feel loved.  
5. I wish someone close could see me now.  
6. If something went wrong right now I feel like I could depend on someone.  
7. I feel like others care about me.  
8. I feel a strong need to be unconditionally loved right now.  
9. I’m afraid someone will want to get too close to me.  
10. If someone tried to get close to me, I would try to keep my distance.  
11. I feel relaxed knowing that close others are there for me right now.  
12. I really need to feel loved right now.  
13. I feel like I have someone to rely on.  
14. I want to share my feelings with someone.  
15. I feel like I am loved by others but I really don’t care.  
16. The idea of being emotionally close to someone makes me nervous.  
17. I want to talk with someone who cares for me about things that are worrying me.  
18. I feel secure and close to other people.  
19. I really need someone’s emotional support.  
20. I feel I can trust the people who are close to me.  
21. I have mixed feelings about being close to other people.

Note. The SAAM includes the following three total scores:
1. The Avoidant Attachment score is computed by averaging items 2, 3, 9, 10, 15, 16, and 21.
2. The Attachment Anxiety score is computed by averaging items 1, 5, 8, 12, 14, 17, and 19.
3. The Attachment Security score is computed by averaging items 4, 6, 7, 11, 13, 18, and 20.

When referencing the SAAM, please cite the following article:
APPENDIX E.

ECR-12: A Brief Version of the Experiences in Close Relationships Scale (ECR)

[including alternative instructions and wordings for romantic/couple relationships or for close relationships in general]

A. [Instructions for romantic relationships in particular.] The following statements concern how you generally feel in close couple relationships (i.e., with romantic/marital partners). Respond to each statement by indicating how much you agree or disagree with it. Write the number in the space provided, using the following rating scale:

B. [Instructions for close relationships in general.] The following statements concern how you generally feel in close relationships (e.g., with romantic partners, close friends, or family members). Respond to each statement by indicating how much you agree or disagree with it. Write the number in the space provided, using the following rating scale:

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Disagree</td>
<td>Disagree</td>
<td>Disagree</td>
<td>Neutral/mixed</td>
<td>Agree</td>
<td>Agree</td>
<td>Agree</td>
</tr>
<tr>
<td></td>
<td>strongly</td>
<td>slightly</td>
<td>mixed</td>
<td>slightly</td>
<td></td>
<td>strongly</td>
<td></td>
</tr>
</tbody>
</table>

1. I feel comfortable depending on romantic partners. [I feel comfortable depending on others.]
2. I worry that romantic partners won’t care about me as much as I care about them.
3. I usually discuss my problems and concerns with my partner.
4. I worry a fair amount about losing my partner.
5. I tell my partner just about everything. [I tell my close relationship partners just about everything.]
6. I worry about being abandoned. [I worry a lot about my relationships.]
7. I don’t mind asking romantic partners for comfort, advice, or help. [I don’t mind asking close others for comfort, advice, or help.]
8. I worry about being alone. [I worry about being alone.]
9. I don’t feel comfortable opening up to romantic partners. [I don’t feel comfortable opening up to others.]
10. I need a lot of reassurance that I am loved by my partner. [I need a lot of reassurance that close relationship partners really care about me]
11. I feel comfortable sharing my private thoughts and feelings with my partner. [I feel comfortable sharing my private thoughts and feelings with others.]
12. If I can’t get my partner to show interest in me, I get upset or angry. [If I can’t get a relationship partner to show interest in me, I get upset or angry.]

Note. Items 1, 3, 5, 7, and 11 must be reverse-keyed prior to computing the following scores:

1. The Avoidant Attachment score is computed by averaging the six odd-numbered (1, 3, 5, 7, 9, 11) items. Higher scores reflect greater avoidance.
2. The Attachment Anxiety score is computed by averaging the six even-numbered items (2, 4, 6, 8, 10, 12). Higher scores reflect greater anxiety.

When referencing the ECR-12, please cite the following article:
APPENDIX F.

Experiences in Close Relationships—Relationship Structures Measure (ECR-RS)

Instructions used for each relationship domain.
A. Please answer the following questions about your mother or a mother-like figure.
B. Please answer the following questions about your father or a father-like figure.
C. Please answer the following questions about your dating or marital partner. Note: If you are not currently in a dating or marital relationship with someone, answer these questions with respect to a former partner or a relationship that you would like to have with someone.
D. Please answer the following questions about your best friend.

Respond to each statement by indicating how much you agree or disagree with it. Write the number in the space provided, using the following rating scale:

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disagree</td>
<td>Disagree</td>
<td>Disagree</td>
<td>Neutral/mixed</td>
<td>Agree</td>
<td>Agree</td>
<td>Agree</td>
<td></td>
</tr>
<tr>
<td>Strongly</td>
<td>slightly</td>
<td>mixed</td>
<td>slightly</td>
<td>strongly</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Questionnaire items (the nine items are repeated for each of the specific relationship partners)

1. It helps to turn to this person in times of need.
   A.  
   B.  
   C.  
   D.  

2. I usually discuss my problems and concerns with this person.
   A.  
   B.  
   C.  
   D.  

3. I talk things over with this person.
   A.  
   B.  
   C.  
   D.  

4. I find it easy to depend on this person.
   A.  
   B.  
   C.  
   D.  

5. I don’t feel comfortable opening up to this person.
   A.  
   B.  
   C.  
   D.  

6. I prefer not to show this person how I feel deep down.
   A.  
   B.  
   C.  
   D.  

7. I often worry that this person doesn’t really care for me.
   A.  
   B.  
   C.  
   D.  

8. I’m afraid that this person may abandon me.
   A.  
   B.  
   C.  
   D.  

9. I worry that this person won’t care about me as much as I care about him or her
   A.  
   B.  
   C.  
   D.  

Note. Items 1, 2, 3, and 4 must be reverse-keyed prior to computing the following scores:

1. The Avoidant Attachment score is computed by averaging items 1–6. Higher scores reflect greater avoidance.
2. The Attachment Anxiety score is computed by averaging items 7–9. Higher scores reflect greater anxiety.

These two scores should be computed separately for each relationship target.

When referencing the ECR-RS, please cite the following article:
REFERENCES


