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ATTACHMENT THEORY AND MOTHER-CHILD RELATIONSHIPS FROM A PHENOMENOLOGICAL PERSPECTIVE

By

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ABSTRACT

ATTACHMENT THEORY AND MOTHER-CHILD RELATIONSHIPS FROM A PHENOMENOLOGICAL PERSPECTIVE

By

Victoria Ann Fitton

Attachment theory was developed by John Bowlby and first explicated in, *The Nature of the Child's Tie to His Mother* (1958). Bowlby believed that attachment behaviors must exist and be reciprocated for the infant to survive both physically and psychically, which presupposes evolutionary biological necessity. Attachment is defined as an enduring relationship between a young child and her mother (Ainsworth, Blehar, Waters, & Wall, 1978). It is an emotional and affective bond or tie that reflects the enjoyment, the attraction, that one individual has for another specific individual (Ainsworth, 1969; Bowlby, 1958; Cassidy, 1999; Sroufe, Fox, & Pancake, 1983).

This is a multiple manuscript dissertation. Chapter 1 provides a general introduction to and overview of attachment theory and a brief description of previous mother-infant/child research and outcome interpretations. Additionally, Chapter 1 explicates the connection of the successive papers to attachment theory and offers a rationale for the inclusion and links between the manuscripts.

Chapter 2 is the attachment theory literature review. Attachment definitions are delineated and then attachment as a construct is broken down into components for clarification. The early history and development of attachment theory and its theoretical grounding are examined. Attachment research areas and interests, strengths and weaknesses of previous research, and implications

for future research are discussed. Implications for policy making, program development, and clinical social work treatment are offered.

Chapter 3 is a case study of a young mother and her infant. Depression, ambivalence, attachment, and culture are examined, but the case is grounded fundamentally in the attachment disturbances experienced by the mother: with her baby, her dead husband, her parents, and her own internal working models.

Chapter 4 is a paper based on an observational study designed to determine indicators of healthy and pleasurable attachment between women caregivers and young toddlers. Six indicators of healthy and pleasurable attachment evolved from the coding process: reciprocity and mutuality, proximity, verbal communication, affect and emotion, physical affection, and play. These indicators were then linked to similar elements in the therapeutic relationship that may be utilized in attachment reparation.

Chapter 5 is a paper based on semi-structured, phenomenological interviews with women as mothers of young children. The study was designed to explore the attachment relationship between mothers and their infants/toddlers to gain an understanding of the meanings women attribute to being a mother and participant in an attachment relationship with their infant/toddler.

Chapter 6 provides an overall conclusion to the multiple manuscript dissertation. The case study, observational study, and interviews are linked to the literature review. The strengths and weaknesses of the research designs are discussed. And the results of the two studies, along with the literature review, are linked to implications for practice, treatment, and education.

DEDICATION

This dissertation is dedicated to all of the women in my life. To my grandmothers who showed me that grandmother love lasts a lifetime. To my mother, and all the mothers I've known over the years, for what they've taught me about mother-infant attachment. To my daughter who taught me by example that attachment relationships can be healed. To my sister who was a second mother to my children and showed me that attachment has many faces. To all of my friends and the sisterhood of women, those who have had and those who have not had children of their own, who love children deeply and showed me that maternal love transcends mere biology. And to my granddaughters who showed me unconditional love and taught me that children love intensely and forever.

ACKNOWLEDGMENTS

I wish to acknowledge and thank Dr. Rena Harold, Dr. John Mooradian, Jo Ann McFall, and Dr. Joyce Ladenson for their service on my guidance and dissertation committees and for their invaluable advice, support, and encouragement during the doctoral program. I am grateful to Jo Ann McFall for her teaching and mentoring which led to the writing of the clinical case study (Chapter 3). I am indebted to Dr. John Mooradian for his advice and guidance in the design of the observational study (Chapter 4). I am appreciative of Dr. Joyce Ladenson for her expertise in women's studies that set the stage for the feminist perspective in my work. And I am profoundly thankful to Dr. Rena Harold for her guidance in the design of the phenomenological interviews (Chapter 5) and for her invaluable role as Dissertation Chair. An exceptional committee provides the framework and impetus for a doctoral student to perform at maximum potential. This exceptional committee made it possible for me to write this dissertation and complete the doctorate in a spirit of professionalism and friendship mixed with pleasure.

I also wish to acknowledge and thank the women who participated in the phenomenological interviews that informed Chapter 5. This project was a genuinely pleasurable experience. A debt of gratitude is owed these mothers for the admittance they offered into their personal lives and a glimpse of the world they share with their child/ren, a world that fills their days and their hearts.

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CHAPTER 1

Introduction and Overview

> We're getting close, and his hands are going up. He's starting to reach when he wants to be held.... I feel like I'm still getting to know who he is. And it's still all that excitement. You know, in the morning when they wake up and see you and they're grinning from ear to ear and they're just delighted that you're back.... He calls us... he has a definite little sing-song call when he's upset and he's wanting us to come in to get him.... He'll call out to us and we'll come in, so the conversation has started and it just feels good. It just feels good that he's responsive (Amy).

Attachment behaviors serve different functions. Signaling behaviors such as smiling, waving, vocalizing, calling, and laughing alert the caregiver that the infant desires interaction and woos the mother to the child. Aversive behaviors like crying, kicking, and screaming trigger a quick maternal response to terminate the infant or child's problem or provide protection and safety. And active behaviors like approaching, holding, touching, and following take the child to closer proximity with the mother and secure base (Ainsworth, 1967; Ainsworth & Bell, 1970; Ainsworth, Blehar, Waters, & Wall, 1978; Bowlby, 1958, 1982; Seifer & Schiller, 1995). The mother, quoted above, is describing signaling behavior by her infant.

Women are primary caregivers, though not the only caregivers of children, and women as mothers with their infant/child are typically the objects of attachment research, therefore women as mothers form the cornerstone of this

dissertation. (Feminine pronouns are utilized throughout this work in deference to the preponderance of childcare provided by women, even though some men are very or exclusively involved in caring for their children.) The case study is written about a mother and her infant and their struggle toward attachment. The observational study focuses on women caregivers and toddlers, although the vast majority of the subjects were mothers as opposed to nannies or grandmothers. The phenomenological interviews were conducted exclusively with mothers of infants and children to offer mothers an opportunity to attribute particular meaning to their personal stories and experiences. This purposive sampling highlights the positive interactions between mothers and their children and the stories of these women as mothers. It is meant to create an optimistic and affirmative counterbalance to the 50 years of research about women from a somewhat pejorative perspective.

A Brief Overview of Attachment Theory

John Bowlby (1958, 1982, 1988) developed attachment theory over 50 years ago as a perspective on the secure base functions of close relationships that operate to promote child development, personality development, and affect regulation. Attachment is a physiological, emotional, cognitive, and social phenomenon that manifests in the holding environment of the mother-infant attachment relationship. "Whoever is caring for a child must know that child and must work on the basis of a personal living relationship with that child" (Winnicott, 1993, p. 99). Attachment is the deep and enduring connection established

between a child and caregiver in the first several years of life that sets the stage for all future human relationships (Bowlby, 1958). Attachment is created in an ongoing reciprocal relationship between children and their caregivers.

Attachment to a protective and loving caregiver who provides guidance, support, and a secure base is a basic human need. There is an instinct to attach, a biological necessity, what Bowlby (1982) referred to as evolutionary adaptedness. Attachment behaviors must exist and be reciprocated for the infant to survive both physically and psychically (Bowlby, 1958). Babies instinctively reach out for the safety and security of the secure base with caregivers. The instinctive attachment behaviors in the baby are activated by cues or signals from the caregiver, for example, smiling, feeding, reaching for, and gazing at the infant. Parents instinctively protect and nurture their children. The instinctual attachment behaviors in the parents are activated by cues or signals from the infant, for example, smiling, following, calling, and crying. The attachment process is defined as a *mutual regulatory system* where the baby and the caregiver influence one another over time (Tronick, 1989).

Attachment is defined as an enduring relationship between a young child and her mother (Ainsworth, Blehar, Waters, & Wall, 1978). Attachment relationships vary widely across mother-infant/child pairs (Ainsworth & Bell, 1970) but are always permanent and irreplaceable (Barnett & Vondra, 1999). Attachment relationships teach individuals how to be in relationship with significant others and influences all subsequent relationships through to adulthood. Attachment, first and foremost, occurs in the holding environment of

the mother-infant attachment relationship. All other definitions or systems of understanding must stand upon that principle.

Brief Description of Previous Mother-Infant/Child Research

For more than 50 years, attachment research has been predominantly focused on two figures (mother and infant or child), from one hierarchical perspective (researcher toward subject), viewed in one setting (the laboratory observation room) and subject to scientific empiricism and rigorous experimental design (Ainsworth & Bell, 1970; Ainsworth, Blehar, Waters, & Wall, 1978; Barnett & Vondra, 1999; Cassidy & Berlin, 1994; Forbes, Bento, & DeOliveira, 2003; Matas, Arend, & Sroufe, 1978; Seifer & Schiller, 1995; Sroufe, 1985; Steier & Lehman, 2000). The research methods defined women by their role as mothers, attributing definition to role rather than to the broad, deep, full, and rich lives of unique individuals. These studies also defined caregiver as mother, placing the responsibility for infant/child care and rearing on women.

The researcher-subject relationship was hierarchical rather than collaborative in nature, tending to place women in an objectified position. The behaviors of mothers and infants/children in laboratory settings were observed and tediously and copiously documented. Certainly implications were extrapolated from the data, replicated, and validated over time, but personal insight and reflection from the point of view of women, as mothers were never considered. Laboratory settings, which might increase replication and external

validity, can never replace the natural environment of the lived experience of women and their children.

The majority of reported studies claimed to be firmly established in scientific, positivist, experimental, normative, and empirically based methodology (Ainsworth & Bell, 1970; Blehar, Lieberman, & Ainsworth, 1977; Cassidy, 2000; Main, Kaplan, & Cassidy, 1985; Sroufe, 1985; Waters & Cummings, 2000). Data were coded, measured, and analyzed. Meaning was extrapolated. Classification lists were meticulously assembled. Children were assigned to categories. Mothers' behaviors were distilled into dichotomized variables. This kept the research focused on empiricism and left out natural environmental settings. Even when research was conducted in family homes (Blehar, Lieberman, & Ainsworth, 1977), it was done from a *scientific* point of view. Time was broken into segments. Behaviors were counted. Observers were silent. Mothers (and fathers) were ignored. No personal stories were gathered; rather, the stories were interpreted from the acquired data. The lived experience of each dyad was ignored; worse, the stories of their experiences were lost.

The relatively new interest in atypical attachment is at least refreshing. An interest in difference or uniqueness is always valuable especially in conjunction with culture. But the studies continue to categorize and label infants, children, mothers, and caregivers (Forbes, Bento, & DeOliveira, 2003). In light of basic social work principles, it seems important to challenge the historical pattern of assigning labels to individuals and families. A strengths perspective is sadly lacking (Lum, 2004; Rogers, 1961; Saleebey, 1996).

These methodological factors (narrow subject focus, hierarchical perspective, the classic laboratory observation room, and an emphasis on empiricism) maneuvered research toward the *atypical* and *at-risk* and fostered the creation of pejorative infant and child attachment classification systems and tended to blame the woman for maternal insensitivity and insecure attachment. Additionally, Caucasian, middle-upper middle class and well-educated families were investigated (Lay, Waters, Posada, & Ridgeway 1995; Matas, Arend, & Sroufe, 1978; Sroufe, Fox, & Pancake, 1983; Steier & Lehman, 2000) skewing study results, hampering external validity, and colluding with previous multicultural schisms in feminism.

Attachment research has faded from its early roots when Bowlby (1958) and Winnicott (1957) utilized the term *enjoyment* in definitions of attachment and Ainsworth (1967) focused on the *pleasurable* mother-infant relationship, and emphasis was placed on the *secure base* (Bowlby, 1988). This dissertation aims to return to the basic principles of attachment theory through observation and the lens of postmodern, qualitative and feminist methodologies and, specifically, interpretive phenomenology that emphasizes the personal meaning attributed to the lived experiences of women as mothers and their children. It is simply vital to give voice and body to the experiences of women and their children, to honor the sacred power of their words and stories.

Overview and Rationale of the Links Between the Manuscripts

This dissertation as a whole focuses on attachment theory, therefore the first paper (Chapter 2) is a literature review of attachment theory covering the five decades since its inception by John Bowlby and explicated in, *The Nature of the Child's Tie to His Mother* (1958). The paper concentrates on the origins, history, and development of attachment theory, past and current research topics as well as new and developing research agendas, and on implications for the fields of policy and practice as they relate to women and children. This paper forms the foundation for the dissertation and sets the stage for the successive three chapters.

The second paper (Chapter 3) is a case study derived from a case experience in a maternal-infant program based in a local community mental health agency. An 18-year-old woman and her infant, in an attachment relationship, are the subjects of the case study. The study addresses the mother's depression, ambivalence, attachment, and culture and how those components played out in the therapeutic alliance. Although other factors are addressed in the paper, attachment is the focal point of the case: the mother's inadequate attachment to her child, the mother's faulty attachment to her own parents, the mother's tentative attachment to the therapist, and the mother's growing attachment and connection to her *self* as object. The paper stands as a bridge between the attachment literature and the observational study (Chapter 4). It is cases like this, and many others like it, that drive the research questions behind the following two papers (Chapters 4 and 5).

The third paper (Chapter 4) is the culmination of an observational study completed in London, Great Britain. The ethnographic study was conducted to return attachment research to its positive and pleasurable roots and to observe indicators of healthy attachment that exist in the context of relationship, especially the relationship between women caregivers and toddlers as they occur in natural environments. Obviously women are not the only caregivers of children, but women as mothers (in tandem with their infant/child) are typically the objects of attachment research studies and are, therefore, the subjects of the observational study. The study focused on mothers and toddlers outside of the laboratory room and entered into places of safety, play, and relationship instead. This perspective helped to eliminate the pejorative child attachment classification system and set aside the tendency to blame the mother for insensitivity and insecurity and looked at the mother-child dyad from a fresh and dynamic vantage point.

The fourth paper (Chapter 5) focused on in-depth, semi-structured phenomenological interviews in a collaborative process between a woman researcher and women interviewees to minimize the hierarchy inherent in empirically based research designs. The phenomenological interviews that formed the basis of the paper focus on what works for each mother-child relationship dyad and offered each woman in the study an opportunity to speak her truth about that attachment relationship. The interview method was purposefully chosen as a straightforward application of feminist values and beliefs (Waller, 2005) that ground research in the experiences of women. A

feminist methodology values women and points of view from women's perspectives since their voices have not typically been heard (Waller, 2005).

Attachment research efforts to date have been conducted about women as mothers but not in collaboration with women to reveal their stories as mothers. It is of paramount importance to introduce narrative and storytelling methods in conjunction with social and cultural deconstruction from a feminist perspective to the experiences of women as mothers. This is not intended to negate the sacrificial care given to children by those who are not women but stems from a specific interest on the stories of women as mothers. Western cultures and societies attribute the child caregiving role to women; therefore it is particularly important to deconstruct that attribution by giving women an opportunity to relate the meaning behind their personal construction of being a woman and a mother simultaneously.

Conclusion

It is important to apply what can be gleaned from healthy attachment relationships to policy-making, program development, social work education, and therapeutic environments where new treatment protocols could be introduced to enhance attachment relationships and repair disrupted attachments that naturally develop as a result of trauma. A renewed and optimistic attachment research agenda has significant implications for child trauma prevention across disciplines: social work, nursing and medicine, education, child welfare, health and human services, and juvenile justice.

Policies, programs, and treatment techniques that are introduced to mediate child welfare issues are typically aimed at women as mothers from a pejorative stance (Berlin, Ziv, Amaya-Jackson, & Greenberg, 2005). This must be altered. Childcare is not the sole purview of women. Others must share in the responsibility. Motherhood is not synonymous with womanhood. A broadened perspective is needed. The objective is to strive to hear the narrative experiences of women as mothers in all of their complex identities and discover how they *name* themselves and *tell* their stories.

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CHAPTER 2

Attachment Theory Revisited:

Its Roots and Research with Implications for Policy and Practice

Abstract

Attachment theory, developed by John Bowlby and first explicated in, *The Nature of the Child's Tie to His Mother* (J. Bowlby, 1958), is the subject of this literature review. Research definitions are offered and the attachment concept operationalized by: physical security, behavioral, psychic, affective, and kinesthetic/tactile components. These components are examined in light of the holding environment of the mother-infant/child attachment relationship. Attachment theory and its history, development, and epistemological legacy are addressed. Research areas and interests are explored and critiqued and future research agenda issues and topics offered. A renewed and optimistic attachment research agenda has significant implications for child trauma prevention across disciplines. Therefore, it is important to apply attachment research to policy-making, program development, and therapeutic environments. Attachment theory has stood the test of time because the premises are based in an enduring pattern of relatedness that exists, not only for survival, but also for connection.

Key Words: *Attachment; Attachment Theory; Mother-Infant Attachment*

Attachment, as a theoretical construct, is more than 50 years old. It evolved from Bowlby's early work experiences in London and then with the World Health Organization (S. R. Bowlby, 2004). Attachment theory is a perspective on the way close relationships can provide a secure base (Ainsworth, 1967, 1969; J. Bowlby, 1988). It assumes that maternal sensitivity, responsiveness, and attunement are major factors in the quality of a child's attachment to her mother or attachment figure (Ainsworth, 1969; Ainsworth, Blehar, Waters, & Wall, 1978). The other, nearly equal component is the caregiver's own mental representation of attachment, her own internal working models experienced and developed in her infancy and childhood (Harris, 2003). (Feminine pronouns are utilized in this work in deference to the preponderance of childcare provided by women, even though some men are very or exclusively involved in caring for their children.) Attachment and secure base functions operate to promote child and personality development and affect regulation. Attachment theory also presupposes evolutionary biological necessity. Attachment behaviors must exist and be reciprocated for the infant to survive both physically and psychically (J. Bowlby, 1958).

Attachment theory was developed, in part, as an alternative to psychoanalytic theory to explain why separation caused anxiety in young children, to explain the similarities between childhood and adult loss and mourning, to explain the process of defenses in the human psyche, and to explain the mechanisms of social behavior from infancy that affect and influence the development of the personality along a continuum from healthy to debilitating

(Barnett & Vondra, 1999; Bretherton, 1985; Cristóbal, 2003; Waters, Crowell, Elliott, Corcoran, & Treboux, 2002). Attachment theory was a move away from the dominance of drive and dependency theory related to satisfaction of physiological needs. Attachment theory invoked primary instinctual responses that function to promote social interaction, comparatively independent of physiological needs, and tie the infant to the mother (J. Bowlby, 1958).

Attachment Definitions

Attachment theorists define attachment independently but the similarities are striking, including the concepts of proximity, specificity, and necessity. Additionally, Ainsworth (1967), Bowlby (1958), and Winnicott (1964, 1987, 1993) include the terms *enjoyment* and *pleasure* when describing the mother-infant attachment dyad. Bowlby's work formulated attachment theory therefore; one must begin with his words.

> Unless there are powerful in-built responses which ensure that the infant evokes maternal care and remains in close proximity to his mother throughout the years of childhood he will die. The instinctual responses... serve the function of binding the child to mother and contribute to the reciprocal dynamic of binding mother to child (J. Bowlby, 1958, p. 369).

Bowlby's words refer to biological, physical, affective, and behavioral responses that an infant exhibits in order to initiate maternal biological, physical, affective, and behavioral responses in turn. This pattern exists to create the

attachment bond between mother and infant. The bond serves to protect the infant/child from fear and harm and sets the stage for the formation of the caregiver as the secure base thereby offering the developing child a safe place from which to explore the world. The behavioral aspect of attachment serves infant survival instincts (J. Bowlby, 1958). But attachment is more complex than behavior stimulus and response mechanisms.

Attachment is also an emotional and affective bond or tie that reflects the enjoyment, the attraction, that one individual has for another specific individual (Ainsworth, 1969; J. Bowlby, 1958; Cassidy, 1999; Sroufe, Fox, & Pancake, 1983). "From an emotional perspective, attachment is the creation of a mutual bond in which the mother shapes infant development through her interactions and relationship with her child" (Porter, 2003, p. 2). One can observe and quantify attachment behaviors. One must infer and interpret attachment in its affective and emotive forms. Smiles and touches can be counted, measured, and plotted. Delight and enjoyment, however, must be lived.

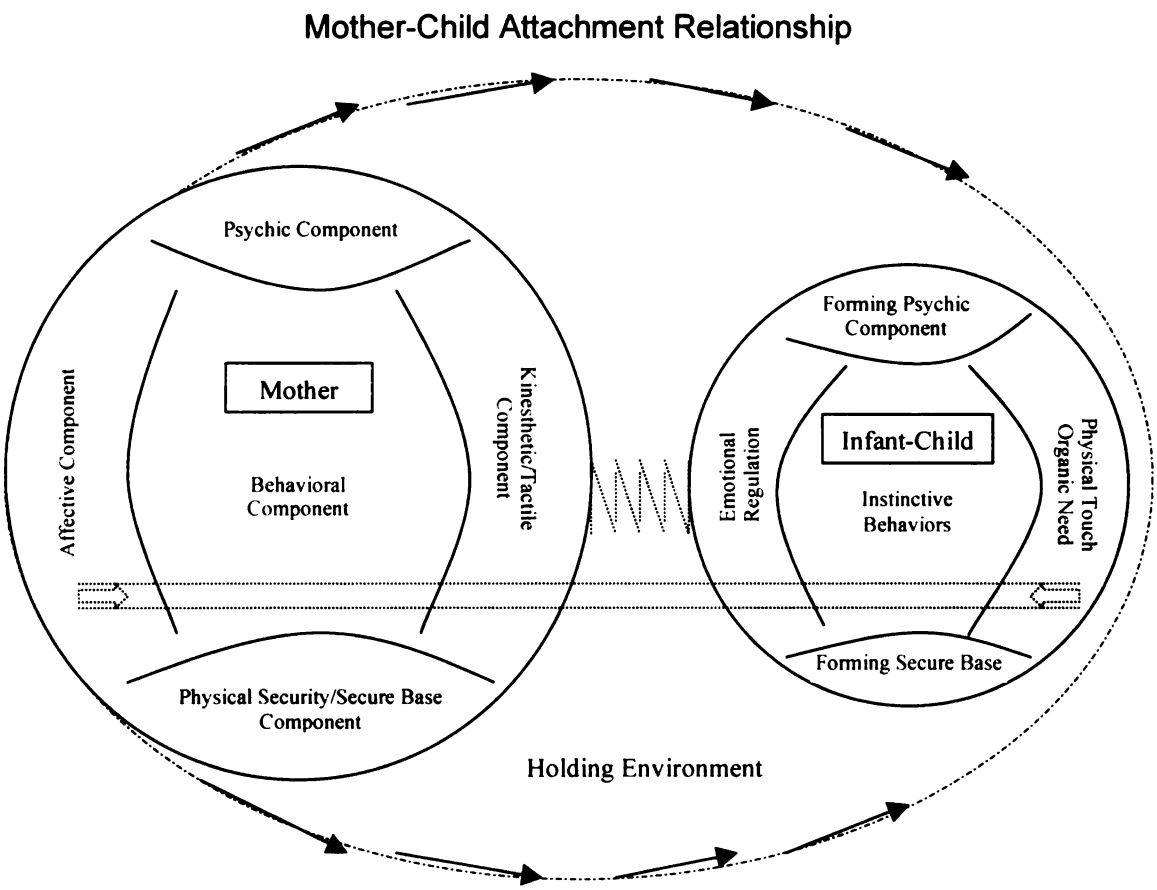
Attachment Components

Attachment is a broad and complicated concept with multiple layers of meanings and interpretations. No single definition or set of constructs can contain all of the significant elements of attachment as a concept. However, one vitally important foundational observation must be stated. Attachment, regardless of the definition, occurs in the holding environment of the mother-infant/child attachment relationship that begins in the earliest moments of an infant's life.

This holding environment is both physical and psychic. Caregivers must be able to create a good enough facilitating environment at the earliest stages of development to provide for the optimal emotional and mental growth of the child (Winnicott, 1971).

The existing definitions were synthesized and a systematic attempt made to operationalize the term *attachment*. Therefore, for the purposes of this paper, with an emphasis on implications for clinical practice, the author developed a conceptual map (Figure 2-1) of the holding environment of the mother-infant/child attachment relationship that includes: physical security (secure base function), behavioral, psychic, affective, and kinesthetic/tactile components.

Figure 2-1. *Holding Environment of Mother-Infant/Child Attachment Relationship*



Physical Security Component

Attachment has a physical security component – "a tie that binds together in space and endures over time" (Ainsworth & Bell, 1970, p. 50). This secure base is defined as the *attachment figure*. The attachment figure must be consistently physically present and psychically available to the infant/child to create the security of the secure base for the infant/child where growth and development occur. The caregiver, typically the mother, provides a physically secure environment of her presence for the infant. This happens, not only through physical handling and holding, but also, through consistent sensitivity to the needs of the infant and her availability and capacity to meet those needs in a timely manner. A particular and substantial someone, to whom the child can attach, must exist and have a specific location, therefore, attachment has a solid human context within time, space, and situations (Posada, Gao, Wu, et al., 1995; Waters & Cummings, 2000). "Without adequate environmental reliability the personal growth of a child can't take place" (Winnicott, 1993, p. 99).

Behavioral Component

Attachment has a behavioral component. Attachment behavior on the part of the infant/child operates to increase proximity and contact with the maternal caregiver (Ainsworth, 1967, 1969; Ainsworth & Bell, 1970; Ainsworth, Blehar, Waters, & Wall, 1978; J. Bowlby, 1958, 1982a; Porter, 2003; Seifer & Schiller, 1995). These instinctive attachment behaviors serve different functions. Signaling behaviors alert the caregiver that the infant desires interaction. Aversive

behaviors trigger a quick maternal response to provide problem solving or protection and safety. Active and contact-seeking behaviors promote proximity to the mother and secure base (Ainsworth, 1967; Ainsworth & Bell, 1970; Ainsworth, Blehar, Waters, & Wall, 1978; J. Bowlby, 1958, 1982a; Seifer & Schiller, 1995). Exploratory behavior decreases proximity with the maternal caregiver and promotes interaction with the environment and individuation (Ainsworth, 1967, 1969; J. Bowlby, 1958, 1982a; Field, Gewirtz, Cohen, Garcia, Greenberg, & Collins, 1984; Mahler, Pine, & Bergman, 1975; Porter, 2003; Seifer & Schiller, 1995). Attachment behavior, especially when strongly activated by stress or distress, is incompatible with exploratory behavior.

Attachment behavior on the part of the mother operates to meet the physical, emotional, psychic, and tactile needs of the infant/child. Paradoxically, these behaviors, which are unreciprocated by infants in the early weeks, work to build the attachment bond and relationship. Bowlby (1958) suggested that, "It is fortunate for their survival that babies are so designed by nature that they beguile and enslave mothers" (p. 368). As babies' signaling behaviors have different meanings, mothers' behaviors meet different needs. Feeding and diapering are physical necessities. Holding, snuggling, and rocking meet emotional needs of connection and safety. Touching, caressing, and stroking meet tactile and kinesthetic needs. And anticipatory actions and behaviors by the mother to meet her infant's unexpressed needs and wishes, serve two psychic functions. They establish the psychic availability of the mother and maintain the necessary illusion of omnipotence for the baby. These behaviors do not operate

independently but function as an organic whole to provide optimal support to the infant.

Psychic Component

Attachment has a psychic component. Attachment is "the psychological availability of a caregiver as a source of safety and comfort in times of child distress" (Barnett & Vondra, 1999, p. 5). Attachment is "the inferred internal bonds that form between infants and their caregivers" (Seifer & Schiller, 1995, p. 147). Another aspect is the caregiver's own mental representation of attachment, her own internal working models experienced and developed in infancy and childhood. Those early mental representations influence later development and relationships (Freud, 1935, 1966). The psychic component, the knowing and trusting of the other, grows developmentally from the physical security of the secure base. The mother must also be psychically available to her child and mentally carry a positive internal representation of her own attachment figures and relationships. These functions create a secure base for the infant/child.

Affective Component

Attachment has an affective component. Attachment bonds are the demonstrable and observable affectionate gestures between infants and their caregivers (Ainsworth, 1967, 1969; J. Bowlby, 1958; Porter, 2003; Winnicott, 2002). Ainsworth (1969) used the term *affectional tie* to describe the bond that forms between two specific individuals. Bowlby (1958) spoke of the attachment

relationship as a reflection of *pleasure* and *enjoyment* demonstrated in smiling, laughing, happiness, and love. Stress occurs from sudden or prolonged separation from the attachment figure and permanent loss causes grief and mourning (Barnett & Vondra, 1999). The security of the attachment relationship also provides a space for affective reactions to stress and fear indicated by crying, clinging, anger, and frustration. Emotions and "the foundation of emotional regulation [are] also established within the context of the attachment relationship" (Sroufe, 2003, p. 205).

Kinesthetic/Tactile Component

Attachment has a kinesthetic/tactile component (J. Bowlby, 1958). Attachment develops through body contact between caregiver and infant/child demonstrated in caresses and touches (Cristóbal, 2003). "You [mother] just adapt the pressure of your arms to the babies' needs, and you move slightly, and you perhaps make sounds. The baby feels you breathing. There is warmth that comes from your breath and your skin, and the baby finds your holding to be good" (Winnicott, 2002, p. 21). Gazing, touching, holding, rocking, stroking, and nuzzling are examples of kinesthetic and tactile body contact.

Holding Environment

Attachment exists in the reciprocal holding environment of the mutual mother-infant/child attachment relationship. "Whoever is caring for a child must know that child and must work on the basis of a personal living relationship with

that child" (Winnicott, 1993, p. 99). Attachment is defined as an enduring relationship between a young child and her mother (Ainsworth, Blehar, Waters, & Wall, 1978). Attachment relationships vary widely across mother-infant/child pairs (Ainsworth & Bell, 1970) but are always permanent and irreplaceable (Barnett & Vondra, 1999). Attachment relationships teach individuals how to be in relationship with significant others and influences all subsequent relationships through to adulthood. Attachment, first and foremost, exists, and is held together, in the holding environment of the mother-infant/child attachment relationship. All other definitions or systems of understanding must stand upon that principle.

History, Development, and Epistemological Legacy

In the 1950s, attachment theory emerged as a valuable working model in child development and mental health through the joint yet independent efforts of John Bowlby and Mary Ainsworth (Ainsworth, 1967, 1969; J. Bowlby, 1951, 1958, 1973, 1982a; Bretherton, 1992; Porter, 2003; S. R. Bowlby, 2004). Bowlby outlined the conditions needed for the healthy development of children in *Maternal Care and Mental Health* (1951) from his work with the World Health Organization. (It is significant to note that this early work was multicultural and multinational in nature.) He then revolutionized the view of the mother-infant bond and relationship and its disruption through deprivation, separation, and loss when he wrote, *The Nature of the Child's Tie to His Mother* (1958), and outlined attachment theory.

Bowlby believed the mother must achieve attunement with her baby to create healthy attachment. It was the attunement of the mother to her child in stressful and distressing situations that established self-regulation for infants, a biological necessity since babies do not inherently possess self-regulatory systems. The mother-induced regulation worked to keep the baby in balance and emotionally regulated. Infants relied on the relationship with their mother to keep dysregulation at bay (Porter, 2003). Thus, healthy attachment was the development of that attuned relationship.

Freud (1935, 1966) set the stage for attachment theory when he established the importance of the early maternal-infant relationship and recognized the significance and similarities between the mother-infant relationship and adult-adult relationships. He emphasized the life long impact of early relationships and experiences and how the mental representations of early life mediate later development. He established the role defenses play in affect regulation and that mourning a significant loss serves an adaptive purpose (Lay, Waters, Posada, & Ridgeway, 1995).

Yet, psychoanalytic theory and the early stages of evolutionary theory imposed dramatic parameters on the study and evaluation of attachment and attachment behaviors, especially under the constructs of determinism and instinctive behavior. These constructs were also subsumed under a hierarchical and authoritarian umbrella as a worldview, residue of which still permeates the scientific community and culture today. Bowlby (1958) however, challenged and replaced Freud's drive reduction model of relationship motivation with one that

emphasized the role relationships play in support of exploration and competence (Bretherton, 1985; Waters, et al., 2002). Bowlby managed to maintain key features of Freudian early work modified to withstand the new wave of scientific empiricism (Cristóbal, 2003).

The Strange Situation was developed by Ainsworth following her work in Uganda, for the longitudinal Baltimore study (Ainsworth, 1978; Ainsworth, Blehar, Waters, & Wall, 1978). She introduced a stressful event and situation that activated the infant's attachment system while, at the same time, provided for the caregiver to act as a secure base. This was inspired by Bowlby's (1982a) conception of the protective function of attachment figures and Ainsworth's (1967, 1969) emphasis on the caregiver as a secure base for the infant's exploration, learning, and development of the skills necessary for self-protection and intimacy (Bretherton, 1992; Forbes, Bento, & DeOliveira, 2003; Porter, 2003).

Separation and reunion research was extensively conducted and has been somewhat adapted over the years to include a wider range of ages and unfamiliar situations in an attempt to simulate stressful or distressing environmental situations for the infant or child while in close proximity to her or his mother or caregiver (Ainsworth & Bell, 1970; Ainsworth, Blehar, Waters, & Wall, 1978; Field et al., 1984). For example, researchers introduced an electronic spider into the Strange Situation to heighten the alarm for slightly older toddlers (Forbes, Bento, & DeOliveira, 2003). The Strange Situation, as originally

designed, was considered insufficient to activate attachment behavior for toddlers.

Edward Tronick (Gusella, Muir, & Tronick, 1988) created the well-known experimental situation of the Still-Face where a mother engaged in play with her baby in a face-to-face encounter and then was asked to stop the play interaction for a very brief period of time. The Still-Face episode created upset for all babies but was repaired when the mother began the interaction again. Researchers were interested in uncovering how the mother-infant interaction was repaired, the most important indicator of attachment security in their relationship (Bergman & Harpaz-Rotem, 2004).

Margaret Mahler, with a team of psychoanalysts, began a naturalistic study in 1959, designed to investigate early mother-child interaction during the separation-individuation process (Mahler, Pine, & Bergman, 1975). Mahler's interest was on the internal forces that drove a toddler toward the realization of the separate self, even in circumstances of less than optimal availability of the mother. While her interest was less about attachment and the optimal circumstances for development of the self, the research strongly supported the attachment framework of affect regulation, mutuality, proximity, and relatedness (Bergman & Harpaz-Rotem, 2002).

Anna Freud (1979), in her psychoanalytic work with children, held that the establishment of rapport and the therapeutic relationship, what she referred to as the affectionate attachment of the transference, was the basis for all work. She

provided toys and play material for the child to create an environment in her or own way to play out internal, unexpressed fantasies.

Melanie Klein (1982) equated the child's play activities with the free associations of the adult. She stressed that action or play was more natural for the little child than speech. Each child had a drawer of toys chosen especially for her, which became an individual experience for that child, symbolic of the private and intimate relationship that existed between the child and the therapist. The child became aware of her own uniqueness and that no one else had access to her toys (self).

Infant mental health and child development enjoyed rapid growth for a period of time following the work of Bowlby, Ainsworth, and others. The body of work, formed from the efforts of multiple disciplines, created explanatory variables in attachment formation, maintenance, and renewal (Bronfenbrenner, 1979; Lay, Waters, Posada, & Ridgeway, 1995; Osofsky, 1979; Piaget, 1951; Wright, 1986, 1997). These cross-disciplinary efforts impacted the models developed for play therapy. The cornerstone of play therapy intervention is attachment theory, creating a foundation for the formulation, maintenance, and renewal of attachment that also includes reparation of disrupted attachment through the play therapy treatment process (Axline, 1969, 1982; Bettelheim, 1976; Carroll, 1998; Cattanach, 1992; Gil, 1994; Ginott, 1979, 1982a, 1982b; Greenspan, 1981; Klein, 1982; Krall, 1989; Landreth, 1982, 2002; Lebo, 1982; Moustakas, 1953, 1959, 1982; Singer, 1993; Webb, 1991, 2003).

Bowlby (1958) challenged the secondary drive theory held by Sigmund Freud (1935, 1966), Anna Freud, and Melanie Klein (1986) that focused on physiological dependence and satisfaction. Freud's conception of the infant in relation to her mother was a source of drive reduction. Infant behaviors were seen as needy, clingy, and dependent. The secondary drive theory explained the mother-infant bond through the process of feeding. As the child was fed, nourished, and orally satisfied, pleasure was experienced. Satisfaction was then associated in a positive way with the mother's presence. Bowlby, on the other hand, believed the mother-infant attachment was primary and exclusive. He portrayed infants as competent, curious, and fully engaged with their caregivers and the environment (Waters, et al., 2002). Attachment theory is based in the secure holding environment of the mother-infant attachment relationship and not in physiological dependence and satisfaction.

Bowlby (1958, 1973, 1982a, 1982b) offered a coherent, formulated theoretical alternative to Freud's secondary drive theory based on the dynamic forces of evolutionary biology and ethology. He came to believe that the mechanisms that underlie the infant's attachment tie to the maternal figure originally emerged as the result of evolutionary pressure, a biologically based need for proximity that equated with survival and natural selection (Cassidy, 1999). Two key constructs evolved from Bowlby's formulation: attachment is a biological necessity and the mother-infant/child bond is the primary and essential force in infant and child development (J. Bowlby, 1958, 1975, 1982a).

Theoretical Grounding

The theoretical grounding and models that exist behind attachment theory have a broad base. They have been loosely sorted into six descriptive categories. The theories identified create a backdrop and context for the formation and research behind attachment theory. The purpose of this exercise is to illuminate context not to make direct connections across theories and frameworks.

Category 1 – Behavior

The first category includes behaviorism, behavior systems theory, and behavior systems in evolutionary adaptedness, evolutionary theory, and ethology (Ainsworth, 1969; Ainsworth & Bell, 1970; J. Bowlby, 1982a; Cassidy, 2000; Grossmann & Grossmann, 2006; Hazan & Shaver, 1994; Main, Kaplan, & Cassidy, 1985; Simpson & Rholes, 2000; Waters & Cummings, 2000). This is based in the fundamental construct that attachment exists in a behavioral system. The biological function of that system has a predictable outcome that creates a survival advantage in the "environment of evolutionary adaptedness" (a term coined by Bowlby, 1982a). Evolutionary theory is based on the trial-and-error process of variation and natural selection of systems at all levels of complexity. Ethology is the perception of behavior in an evolutionary context. The motivation behind attachment is evolutionary survival. However, it must be remembered, from the conceptual map (Figure 2-1), that attachment is a broad concept and impacted by more than behavior.

Category 2 – Positivism

The second category includes empirical methods, classic scientific methods, and experimental methods (Ainsworth & Bell, 1970; Blehar, Lieberman, & Ainsworth, 1977; S. R. Bowlby, 2004; Cassidy, 2000; Main, Kaplan, & Cassidy, 1985; Sroufe, 1985; Waters & Cummings, 2000). These methods were used nearly exclusively to research attachment theory, neglecting qualitative studies and narratives. Naturalistic studies to observe behavior in the environment were time consuming and costly. The Strange Situation was developed to simulate the activation of attachment behavior in a controlled setting that was reflective of a child's normative environment (Ainsworth, 1978; Ainsworth, Blehar, Waters, & Wall, 1978). Current meta-analyses utilize the hundreds of empirically based studies completed over the last decades. And still the literature makes demands for more rigorous theoretical and empirical analysis (Waters & Cummings, 2000). These methods must be balanced with postmodern and feminist methodologies that challenge the hierarchical and patriarchic manifestations of the positivist worldview.

Category 3 – Systems

The third category includes general systems theory, control systems theory, and dynamic systems perspective (Ainsworth, 1969; J. Bowlby, 1982a; Hsu & Fogel, 2003; Porter, 2003; Waters & Cummings, 2000). Bertalanffy's general systems theory, designed to identify and describe the principles that guide system functioning and interaction with other systems, impacted the

development of attachment theory. Bowlby also "introduced concepts from control systems theory to highlight and account for the complex monitoring of internal states, relationship experience, and context that shapes proximity seeking, communication across a distance, and exploration away from attachment figures" (Waters, et al., 2002, p. 230). These broad system theories augment biological and behavioral systems to explicate attachment behavior and theory. But again, a mother-infant attachment relationship is more than a system and the narrative of that relationship greater than the explanation of how that system operates and self-regulates.

Category 4 – Instinct

The fourth category includes instinctive behavior, ontogenetic theories, and psychobiology (Ainsworth, 1969; Ainsworth, Blehar, Waters, & Wall, 1978; J. Bowlby, 1982a; Cardoso & Sabbatini, 2001; Cassidy, 2000; Grossmann & Grossmann, 2006; Harlow, 1958; Harlow, Dodsworth, & Harlow, 1965; Main, Kaplan, & Cassidy, 1985). Instinctive behavior is considered to be genetically based and typically species-specific, behavior that is innate, complex, adaptive, and unlearned. Ontogenetic theory is based in biology and genetics. It studies the course of development of an individual organism. Psychobiology interprets personality, behavior, and mental illness in terms of responses to interrelated biological, social, cultural, and environmental factors. These interrelated factors are foundational to early attachment theory that can now be moderated by postmodern interpretation.

Category 5 – Life Models

The fifth category includes life-span models and life history theory (Bronfenbrenner, 1979; Cassidy, 2000; Erikson, 1964; Piaget, 1951; Rothbard & Shaver, 1994; Simpson & Rholes, 2000; Waters & Cummings, 2000). Life-span models typically describe the course of an individual's life by sequential tasks to be completed and/or stages, like hurdles, to be mastered. Life history theory is based in biology from a systems perspective and attempts to explain the physiological traits and behaviors of individuals in terms of key maturational and reproductive characteristics that define the life course. Attachment theory was for decades much more clearly articulated for infancy and childhood than for adulthood. This has changed significantly in the past twenty years especially with the introduction of the Adult Attachment Interview (Hesse, 1999; Main & Goldwyn, 1998). Attachment beyond infancy, and the development and maintenance of close relationships across the life span, are growing areas of research in attachment theory.

Category 6 – Learning

The sixth category includes learning theories (Ainsworth, 1969; Bandura, 1977; Sroufe, Fox, & Pancake, 1983). Social learning theory attempts to explain human behavior from the integrated perspective of cognitive, behavioral, and environmental influences. These influences are seen as being continuously reciprocated through modeling. Bandura's (1977) work emphasized the importance of observing and modeling the behaviors, attitudes, and emotional

reactions of others from the assumption that most human behavior is learned observationally through modeling. Social learning theory encompasses attention, memory, and motivation, but misses the biological and instinctual survival components that are foundational to attachment theory. Social learning theory relies heavily on *nurture* and favors post-natal environmental learning. Attachment theory relies on a balance of *nature* or instinctive behavior and *nurture* or environmental learning to explain the forging of the affectional bonds utilized as survival and protective functions and for affect regulation and social development.

New Research Areas and Interests

Attachment theory has a strong empirically based research history beginning with and evolving from Freud's (1963a, 1963b) clinical observations and case studies. Bowlby (1973, 1982a, 1982b) focused on animal studies through the lens of evolutionary biology while Ainsworth (1967), in her early work, concentrated on naturalistic field observation of maternal-infant dyads, and then moved to a laboratory setting with the development of the Strange Situation (1978). The field has burgeoned since and the areas of interest have grown dramatically.

Freud (1935, 1966) linked the mother-infant relationship to adult-adult relationships. Attachment theory research has upheld that connection demonstrating that attachment behavior plays an active role across the life span (J. Bowlby, 1979; Hesse, 1999; Main, Kaplan, & Cassidy, 1985). Current adult

dating patterns include speed dating and Internet dating relationships. These factors, when viewed together, may explain the strong thread of research being developed on adult love relationships (Berman & Sperling, 1994; Bleichmar, 2003; Porter, 2003; Shane, Shane, & Shane, 2003; Steele, & Steele, 2003; van IJzendoorn, 1995).

Infant and child attachment continues to be studied, particularly in light of the positive correlations between secure attachment and self-esteem and self-confidence (Field et al., 1984). More recent work has focused on atypical patterns of attachment that has been used to identify infants and children who might be at risk for delays or distortions in attachment (Forbes, Bento, & DeOliveira, 2003). This research history has been used to identify diagnostic criteria for attachment disorders (Greenberg, 2005). This research area is particularly under-developed as can be seen from the paucity of diagnostic categories for attachment difficulties across the life span in the *Diagnostic and Statistical Manual of Mental Disorders* (APA, 2000).

Attachment has also been shown to correlate with maternal sensitivity and maternal adaptation to infants and children (Ainsworth & Bell, 1970; Cassidy, Woodhouse, Cooper, Hoffman, Powell, & Rodenberg, 2005; De Wolff & van IJzendoorn, 1997; Field, 1991; Field, et al., 1984; Seifer & Schiller, 1995; Sroufe, 1985; van IJzendoorn, Bakermans-Kranenburg & Juffer, 2005). However, maternal sensitivity has typically been plotted as a dichotomous variable – sensitive or insensitive (De Wolff, & van IJzendoorn, 1997). Recent research on maternal sensitivity questions the dichotomous assignment as rigid and

restricting. The results of newer studies detect only a slight correlation for sensitive mothers with securely attached infants and insensitive mothers with insecurely attached infants (Cassidy, et al., 2005).

A pattern that emerged in the First Year Project (Cassidy, et al., 2005) indicated that infants could meet insensitivity from their mothers yet remain securely attached. In one case, an infant had an insensitive and rejecting mother who initially and persistently resisted her infant's pleas to be comforted. However, the mother eventually relented and held her baby. The baby was considered securely attached though she worked hard to gain access to her mother. It is believed that babies can tolerate a certain amount of insensitivity when some other positive feature exists in the relationship, for example, the mother's fundamental willingness to act as the infant's secure base (Cassidy, et al., 2005).

Currently in research studies of infant-mother attachment, the mother is classified as sensitive or insensitive. The baby is observed for attachment behavior and utilization of the secure base, presumably offered by the mother. The baby is then attributed an attachment classification that, in some mysterious way, predicts her future school achievement, relationship patterns, self-esteem, and self-confidence.

Researchers of the *First Year Project* (Cassidy, et al., 2005) believe that a shift should be made in the research design to focus on maternal secure base provision rather than on dichotomous classification of maternal sensitivity. They hypothesize that mothers would demonstrate elements of maternal sensitivity

across a continuum. The nuances of the behaviors could then be observed and coded. They suggest that the baby be classified as securely or insecurely attached and the mother observed for nuance, attunement, acceptance, affect regulation, etcetera, and whether or not the mother helped create a secure base (or offered herself as a secure base) to her infant (Cassidy, et al., 2005).

Mother-infant/child attachment classification systems (Forbes, Bento, & DeOliveira, 2003) and atypical patterns of early attachment continue to be studied (Barnett & Vondra, 1999). Pre-school leave-taking and reunion experiences with caregivers (Field, et al., 1984), early separation from parents and peers (Field, 1991), and complex caregiving systems (Cassidy, 2000) are foci of research studies especially in light of secure base functioning and close relationships (Waters & Cummings, 2000). Childhood dependency behaviors (Sroufe, Fox, & Pancake, 1983), competency and adaptive behaviors (Matas, Arend, & Sroufe, 1978), mood induction (Lay, et al., 1995), and transitional objects (Steier & Lehman, 2000) have all been examined in studies. Other areas of interest include infant temperament (Seifer & Schiller, 1995) and enhancing early attachment (Berlin, 2005). And more recently, adult love relationships and adult sexuality have become areas of interest and research in the attachment literature (Berman & Sperling, 1994; Bleichmar, 2003; Cassidy, et al., 2005; Porter, 2003; Shane, Shane, & Shane, 2003; Steele, & Steele, 2003; van IJzendoorn, 1995).

Also, on a more positive and hopeful note, research interests have begun to highlight the importance of nonmaternal caregivers in children's lives and the

affectional bonds that are created between nonmaternal caregivers and infants and children. Some of those relationships being studied include, for example, nannies and daycare providers, preschool and Head Start teachers, foster care workers and especially partners or fathers and other close family members and friends (Porter, 2003).

Present day research is integrated and interdisciplinary, adding to the historic compilation of attachment theory from the fields of neurology, psychiatry, biology, genetics, and psychology. This evolving research offers compelling, cross-discipline evidence that attachment is the cornerstone of infant and child development. Some of this new research is also focused on how caregivers can create the kind of healthy atmosphere and secure environment that has the power to guide infants and children into a full revelation of their potential selves. As disciplines and methods are blended, attachment theory is more fully explicated and validated.

Strengths and Weaknesses In Past Research

Attachment theory evolved out of the mid-twentieth century white culture that esteemed stay-at-home mothers as primary caregivers and leveled the responsibility for infant attachment, development, and health at mothers. But secure attachment does not occur in a vacuum, nor is it the privilege of the middle class white community. Relational attunement and developmental assistance are key features of attachment relationships. Therefore, it is not only the role of mother, but also the role of every other primary figure that plays a part

in the life of the infant and child's development, to aid in the attunement and developmental processes. Thus, complex caregiving systems, relationships across generations, and parental relationships in foster care settings are growing concerns in attachment research (Cassidy, 2000; Cassidy & Berlin, 1994; Cassidy & Shaver, 1999; Cassidy, et al., 2005; Haight, Kagle & Black, 2003; Kretchmar & Jacobvitz, 2002).

Sixty years ago, Winnicott gave weekly radio talks to British mothers (parents) of infants to give insight, increase enjoyment, and help normalize the mother-infant relationship. Some of those broadcasts have been collected into small books: *Babies and their Mothers* (1987), *Talking to Parents* (1993) and *The Child in the Family* (2002). Recently research on mothers and infants has begun to include the impact of positive emotional and play states in the mother-child relationship (Porter, 2003), very reminiscent of Winnicott in the 40s and 50s. This research indicates that when a mother-infant dyad has the ability to create joy, elation, interest, and excitement together, they establish early healthy child development and set the stage for a lifetime of physical and mental health for the child (Porter, 2003). This research demonstrates a much-needed movement away from the negative and pejorative aspects of neglect, avoidance, stress, hostility, rejection, deprivation, and insensitivity and emphasizes instead the enjoyment of the mother-infant/child attachment and all the positive benefits that ensue.

Attachment research is thriving but experiments continue in the laboratory with predominantly white middle and upper-income families (Barnett & Vondra,

1999; Lay, et al., 1995). Recruitment is often through newspapers, parenting magazines, postings on daycare and preschool bulletin boards, and through pediatric offices (Steier & Lehman, 2000; Waters, Hamilton, & Weinfield, 2000), which are weighted to the Western white culture. Meta-analyses are evident in the literature, which increases the reliability and validity of the findings but when those studies cull information from the predominant white culture in a multicultural world, those findings must be viewed as limited.

Researchers do not yet understand how individual temperament or the personalities of the mother and infant, or the finances and economic structure of families, or the ethnic and cultural characteristics of families influence what is observed in attachment studies (Cassidy, et al., 2005). Dichotomous maternal sensitivity classifications and pejorative infant attachment classifications are still widely utilized in research along with Ainsworth's Strange Situation (Ainsworth, 1978; Ainsworth, Blehar, Waters, & Wall, 1978) and Edward Tronick's Still-Face (Gusella, Muir, & Tronick, 1988). However, attachment theory is not to be equated with the Strange Situation or the Still-Face (or the Adult Attachment Interview [Hesse, 1999; Main & Goldwyn, 1998] for that matter). The theory stands on its own regardless of the introduction of these experiments and assessments.

Race, culture, and gender may or may not validate the assumptions of the Strange Situation. However, Caucasian, middle-upper middle class and well-educated families (presumably a married husband and wife), but most distinctly women (mothers) and their children, have nearly exclusively been the subject of

investigation in attachment research (Lay, et al., 1995; Matas, Arend, & Sroufe, 1978; Sroufe, Fox, & Pancake, 1983; Steier & Lehman, 2000) skewing study results, hampering external validity, and colluding with cultural schisms and gender bias. In light of globalization and Bowlby's (1951) early work with the World Health Organization, it is necessary to expand attachment research across diverse populations regardless of how the term diversity is defined (Corey, 2005; Corey, Corey, & Callanan, 2007; Laird, 1998).

It is also important to return to the basic principles of attachment theory through the lens of postmodern, qualitative and feminist methodologies and specifically interpretive phenomenology (Reid, Flowers, & Larkin, 2005) that emphasizes the personal meaning attributed to the lived experiences of women as mothers and their children. It is important to give voice to the experiences of women and their children through narrative and storytelling.

Implications for Future Research

Race, culture, and gender are not the only missing pieces in attachment research. Attachment theory could inform work with orphaned, institutionalized, and foster children around the world and have an impact on therapeutic work with issues of bereavement, suicide prevention, substance use and abuse, child abuse and neglect, terrorism, parenting, and adult love relationships (Dozier, Lindhiem, & Ackerman, 2005; Haight, Kagle & Black, 2003; Hindy & Schwarz, 1994; Juri & Marrone, 2003; McDonough, 1992; Wohl & Kaufman, 1985). Individuals may form multiple attachments across the lifespan, each of which is a

distinct relationship. Those, typically long lasting relationships, can mediate the effects of social issues in the lives of children, adolescents and adults. The nature of the attachment relationship is to provide a sense of security because of the secure base function, and promote confidence and competence in interaction with the social environment.

Harlow (1958) first studied the neurobiological and behavioral consequences of disrupted attachment in his research with primates. Over the following decades, controlled animal studies of disrupted attachment in conjunction with clinical studies of maltreated children demonstrated that early adverse experiences, such as child abuse and neglect and other attachment disrupting traumas, had lifelong effects on subsequent responses to stressors (Putnam, 2005). This research must continue. Healthy parenting and child abuse prevention programs must also be evaluated to most effectively impact cases of child maltreatment and trauma (Applegate & Shapiro, 2005; Lieberman & Amaya-Jackson, 2005; Miller, 2005; Putnam, 2005; Siegel, 1999). But it must also be remembered that Ainsworth (1967) and Bowlby (1979) believed and demonstrated that attachment develops despite repeated punishment and abuse from primary attachment figures. This has also been supported by more current research (Cassidy, et al., 2005) and must be taken into consideration in cases of child maltreatment and trauma.

Researchers and clinicians must begin to look carefully at how mothers and infants/toddlers can repair the disruptions that occur in their relationship and particularly how disruption and reparation can enrich rather than disturb a

mother-infant or mother-toddler way of being together (Bergman & Harpaz-Rotem, 2004). And attachment principles as potential reparative features through therapeutic venues in adolescent and adult disrupted attachment need to be added to research agendas to bring healing and hope to disrupted lives.

Research is needed that uses the mother-child attachment relationship to enlighten therapeutic intervention across the life span to help assess, and then repair, attachment trauma and increase the social functioning of hurting individuals regardless of age or life circumstances. Attachment research on attachment therapy across the life span and across culture is sadly lacking and desperately needed in a third millennium world characterized by extended life and globalization.

The majority of reported studies claimed to be firmly established in positivist, scientific, experimental, normative, and empirically based methodology. But any research focused on the internal affective and cognitive structures of infants and young children and the relationships and connections to the adults who care for them, face difficulties in design and methodology. Laboratory settings increase replication and external validity but laboratory settings cannot replace the natural environment.

Implications for Policy Making and Program Development

Many services do exist to enhance the lives of infants and children, to offer safety and protection, and to create treatment opportunities for those children suffering from the effects of attachment deprivation. Currently more than

400 Healthy Families and 700 Head Start/Early Head Start programs are in existence in the United States, all heavily dependent on attachment theory (Berlin, Ziv, Amaya-Jackson, & Greenberg, 2005).

A wide variety of attachment-based techniques and intervention programs are being designed and implemented aimed at promoting and enhancing positive attachment relationships between infants and children and their caregivers. It is necessary that these intervention techniques and programs be evaluated for efficacy, effectiveness, and efficiency (Berlin, 2005; Greenberg, 2005; Nagle & Wightkin, 2005; Osofsky, 1979; van IJzendoorn, Bakermans-Kranenburg & Juffer, 2005; Ziv, 2005). Intervention protocols indicate that enhancing early attachment has implications for current policy development (Nagle & Wightkin, 2005; O'Connor & Nilsen, 2005).

Evidence based treatment interventions and protocols have already been developed that work to reestablish attachment relationships and reduce attachment disturbances in children (Berlin, 2005; Brisch, 1999; Cassidy & Shaver, 1999; Fraiberg, Adelson, & Shapiro, 1975; Fraiberg, Shapiro, & Spitz-Cherniss, 1994). In that case, it is imperative that similar protocols be created for efforts with adolescents, adults, and seniors (Antonucci, 1994). This would lead to research, treatment, and policy in the areas of child abuse and neglect, parenting, substance use and abuse, suicide prevention, bereavement, adult love relationships, elder care, and death and dying. Obviously infants and young children are especially at risk for attachment disruptions.

Currently most of the programs and pilot studies in place to intervene in infant/child attachment, operate at the adult level. These interventions target the caregivers (even prior to the birth of the infant) to protect the infant and child, strengthen sensitivity, attunement, and listening behaviors, build support systems, and add services as needed (Cassidy, et al., 2005; Cooper, Hoffman, Powell, & Marvin, 2005; Olds, 2005). The treatment protocols demonstrate an increase in maternal-infant/child secure attachment and those are solid and good results. However, sometimes the attachment trauma is severe and sustained, creating life-long relationship and behavior problems for many people. Intervention in these circumstances must be more intense and sustained.

Prevention, intervention, and policy needs are great. Yet policy makers, while they do not hesitate to create policies to protect children, do hesitate to provide adequate financial support for those policies. Time and effort must be expended to educate policy makers on the specific attachment needs of infants and children and the prevention benefits of ensuring secure attachment relationships.

Implications for Clinical Social Work Treatment

"It is believed that observation of how a very young child behaves towards his mother, both in her presence and especially in her absence, can contribute greatly to our understanding of personality development" (J. Bowlby, 1982a). An understanding of personality development connected to attachment behavior in the context of the holding environment of the mother-infant attachment

relationship can be of tremendous importance in the therapeutic environment (Diamond, Clarkin, Stovall-McClough, Levy, Foelsch, Levine & Yeomans, 2003; Fairbairn, 1952; Lott, 2000; West & Keller, 1994; Zanardi, 1990).

It is the accessibility, sensitivity, and responsiveness of the mother or primary caregiver (the principal attachment figure) that typically determines whether a child exists in a state of security, anxiety, or distress (S. R. Bowlby, 2004). And these affective states can endure across the life span. However, healthy maternal-child relationships demonstrate life-affirming and beneficial attachment behaviors that can be extrapolated to the therapeutic environment for healing and repair of disrupted attachment (Cristóbal, 2003; Slade, 1999; Weiner, 2003).

An understanding of the mother-child attachment relationship can be utilized for attachment reparation in treatment settings. The therapist is not the mother a mother substitute. Rather, the therapist utilizes herself as a temporary therapeutic attachment figure for the client (J. Bowlby, 1975) and with great sensitivity and care, balances being both the internal representation of the maternal caregiver and the external therapist/stranger. The therapist uses mother-child attachment principles to educate and guide the client to self-observation and reflection, understanding of the nature of attachment relationships, and reparation of disrupted attachment. Therefore, in treatment, the clinician in concert with the client must be able to develop and maintain a therapeutic attachment relationship similar to the therapeutic alliance but informed by attachment principles, utilizing the characteristics of accessibility,

sensitivity, attunement, and responsiveness to further the exploration of significant attachment relationships. This helps the client forge a link between the historic attachment figures (mothers and other caregivers) and present adult attachment figures (therapist, lover, relatives, and friends).

Several key principles of attachment theory are at stake in this scenario. The attachment system is active across an individual's entire lifespan (J. Bowlby, 1958; Weiner, 2003). Attachment behaviors may decrease, diminish, or even disappear over the course of an extended absence (even over the course of a lifetime) from the maternal object of attachment but the attachment itself is not necessarily *diminished* (Ainsworth & Bell, 1970). The principle holds true even in cases of adverse care. "Indeed, an attachment can develop despite repeated punishment from the attachment figure" (J. Bowlby, 1979, p. 203).

It is the primary force of the mother-child bond that the therapist helps the client cull from the chaotic fragmentation of the past. It is the affectional tie, even a hoped-for affectional tie, which clients utilize to recreate attachment and secure base functions in their lives. In therapy, the clinician teaches the client, through psychoeducation and modeling, to utilize the bounded attachment relationship and secure base with the therapist to forge new patterns of attachment behavior in current life relationships (Cortina & Marrone, 2003; Diamond, et al., 2003).

Clinicians are responsible for creating a safe and bounded holding environment (Winnicott, 1971) that prevents harm to or loss of the client and a flexible therapeutic attachment relationship with the client to foster attachment reparation. Clinicians can act as the secure base for clients as they struggle to

differentiate and integrate the self through the proximity and elasticity of the therapeutic relationship (Diamond, et al., 2003). And the security of the therapeutic attachment relationship can help the client learn social and relationship skills, build or enhance internal regulatory systems, and experience success and mastery in their adult environments (Diamond, et al., 2003; Harris, 2003).

Clinicians can be trained to enhance, therapeutically repair, and solidify a client's affectional bond with the historic, initial maternal attachment figure thereby creating a safe and more effective internal secure base for the adult client to promote health and healing for the client. And clinicians can be trained to utilize the person of the therapist to promote and enhance attachment reparation and establish and reinforce the internal working models of attachment relationships and secure base functions (Cortina & Marrone, 2003; Diamond, et al., 2003; Harris, 2003).

Conclusion

Attachment theory has stood the test of time because the premises are based in an enduring pattern of relatedness that exists, not only for survival but also, for connection. Attachment is not static or deterministic. Attachment is dynamic, complex, and ever evolving. It has both an internal, psychic organization and an external, observable manifestation. That may explain why it is so difficult to define and study, but it also explains why the theoretical

principles are elastic and adaptable to current culture and trends. Attachment theory has a place in social work for the twenty-first century.

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CHAPTER 3

A Case Study: A Discussion of Depression, Ambivalence, Attachment and Culture Portrayed in the Therapeutic Environment

Abstract

This paper uses Object Relations Theory to conceptualize and manage the complexities of a home-based case, followed for a period of six months. It discusses maternal depression in relation to the caregiver role, self-harm, and self-determination. The client's ambivalence issues are addressed, with particular emphasis on transference and countertransference issues in the relationship and the use of transitional space and objects. Also discussed is the effect of maternal depression and ambivalence on mother-infant attachment, with the introduction of Interaction-Guidance as a treatment modality. There is a discussion of cultural differences and the concomitant ethical implications that arose in the treatment process. And finally, therapeutic implications and reflexivity are addressed.

Key Words: *Depression; Ambivalence; Attachment; Culture*

> Now when Job's three friends heard of all these troubles that had come upon him they met together to go and console and comfort him. When they saw him from a distance, they did not recognize him, and they raised their voices and wept aloud; they tore their robes and threw dust in the air upon their heads. They sat with him on the ground seven days and seven nights, and no one spoke a word to him, for they saw that his suffering was very great (Job 2:11-13).

When I first saw her, I don't think I *saw* her at all. Rather, I reacted to her, to her pain. I experienced her body as being wrapped tightly in a dark cloak of grief, loss, desperation, and anguish. Her eyes were wounded slits. As she sat, small and hunched, I was flooded by feelings of loneliness, heartache, hopelessness, and despair. And like Job's friends, I could only sit with her in silence to acknowledge, on some level, her desperate suffering. I did not speak. I did not touch. I held her in the space that was created between us.

On the surface, the referral appeared to be uncomplicated. The presenting problems were maternal depression, and mother-infant attachment deficiencies. The primary figures were few: one young mother, an infant, and a set of maternal grandparents. The referral notice was typed neatly and information given concisely, briefly, and orderly. But lives are not lived in neat, straightforward and orderly lines. Life is often messy, full of crashes and afflictions.

This young woman suffered from multiple collisions. She ran away from home with a young man when she was fifteen. She was married, but not legally. She conceived a child, but her husband died before the birth of their baby. Her parents stepped into the picture to provide support and a place to live, but she found herself thousands of miles away from the home and friends she had created with her husband. She was enfolded into family and a culture, but one she had rejected. She was isolated, lonely, grief-stricken, and tormented. She had no education, no driver's license, no income, no friends, no husband, and no home. She'd lost her created life and independence and gained an infant who was utterly dependent. She was trapped. Those were the unwritten words that, if typed on the referral note, might have smudged the paper and torn the edges in a dim reflection of the brokenness they represented.

Background

Susan is eighteen years old, Caucasian, and the mother of a six-month-old male, Caucasian infant. She lives with her parents in a middle-class home in a medium-sized, Midwestern community. I met her six months ago and have seen her on a weekly basis.

My orientation to this case, particularly in reference to mother-infant attachment, has been predominantly from Object Relations Theory influenced by Bowlby, Fairbairn, Klein, Mahler, Sandler, and Winnicott (Buckley, 1986), bearing in mind Erikson's (1964, 1968) developmental stage theory and ego psychology. Object Relations Theory shapes the way I conceptualize the case within the

therapeutic endeavor. I hold those formulations simultaneously with an attitude grounded in humanistic psychology, particularly as shaped by Carl Rogers (1961) and what has come to be called Person-Centered Therapy (Corey, 2005). If I am able to bring to the therapeutic relationship personal congruence, unconditional positive regard and an accurate empathic understanding, I believe that I will be able to provide a space in which the client is free to become herself (Corey, 2005; Rogers, 1961).

Depression

Susan's depression had a profound impact on me, from the first moment of our meeting. I was forced to listen at a deeper level, dependent on nonverbal cues and transference and countertransference to hear the story she was so afraid to tell. In our early sessions, she communicated through demonstration and dramatization of her despair. She sat in a corner of the couch holding the baby loosely across her arms and barely moved. Her motions were excruciatingly deliberate and contained. If she spoke at all, it was slowly and with great effort, as though it was difficult to form the words and push them past her lips: words of grief wrapped in sadness. She never looked at me. She rarely moved. The baby was still, nearly lifeless. Her vacant eyes couldn't see him as she held a dead-like baby in her arms, a dead baby shrouded in the same dark despairing gloom that covered her, and made me shudder.

Sometimes mother and baby were so still I wondered if they were breathing. And, I wondered if they were so connected in this dance of death that

their breathing was in tandem. If baby died, would mother die? If mother died, would baby die? Could they pass through a life together sharing this deadness? If she came back to life, was she afraid the baby would join his father in death and leave her more alone? And, did the baby have enough living, breathing life around him to keep him vital and help him thrive?

Susan wished she had died with her husband, but the power of that wish dwindled with the birth of her baby. Even in the midst of the terrible grief, much of her unconscious wished to live, and most of her conscious mind wished to stay alive for the sake of the baby. The life and death ambivalence was a function of boundary confusion among her, her husband, and their child. Who was dead? Who was alive?

Susan was resistant to antidepressants. When she discovered that she was pregnant, she quit drugging and drinking. She still smoked a pack of cigarettes daily, but desired to live cleanly for the sake of the baby. She perceived that taking antidepressants was defeating. I believe she also derived unconscious pleasure from the pain and suffering she experienced and was unwilling to give it up. Suffering was an indication to her of being alive. Suffering represented a defense against death. In the mourning process, a time finally came when that suffering became productive (Klein, 1986).

I found a seductive pleasure in the depression melodrama. She cast me in the role of observer-participant. My own abandonment fears created a mutual desire to play out the scenario. It took tremendous effort on my part not to succumb to the invitation to play dead and to drown in the darkness with mother

and baby. Someone needed to project hope into the fragile space between us. Susan wanted desperately to keep that space blank, filled with nothingness, but that space, as I believe Winnicott (1982) envisioned, was intended to be a playing field for life, not death. I had to choose life. I had to be the mother container, the bearer and supporter of life, in order to create a space that was safe enough and strong enough to hold the grief while we practiced living, one breath at a time. Eventually, Susan began to test the space.

Susan's depression afforded opportunities for me to explore some of the more subtle ramifications of the therapeutic self in the process. How safe was Susan from self-harm? My intuitive self believed that she would not suicide. Why did I trust that? What was it about my experiences that resonated with Susan to accept her word? Did I hear her voice clearly, or did I superimpose myself, and what I wished to hear, over her words? Did I believe too strongly in my own strength and hope or was that strength and that hope *good enough* (Winnicott, 1982) to support Susan?

I remembered the advice of a clinician I heard speak many years ago in a family therapy context. It is important to understand the character and strength of the adolescent, believe them to be true, and act toward the adolescent out of that truth (J. Young, personal communication, 1988). I believed that Susan spoke the truth and clearly wished to stay alive for her child. I accepted that truth, validated her wish and strength, and portrayed that I believed her. This undergirded her resolution and multiplied the hope and trust within the therapeutic space. I believe it was imperative that I rely on my intuition and believe in Susan's

strength, which allowed her to move forward toward the light and out of the darkness. It also became clear to me that Susan knew her way out, would struggle to climb out of the depths in her own way and time, and that I needed to listen and follow, but not impose or direct.

Ambivalence

Ambivalence is another salient feature in my work with Susan. She tests my tenacity and the working alliance at every session. In some ways, I was prepared for that challenge. I realized that a depressed adolescent who has birthed a child and who has just lost her life's soul mate would be struggling with ambivalence and abandonment, with no place to safely play those out. She never outright canceled a session, but at the first assessment session I arrived at her home to find her in bed sleeping. I had time in my schedule so I left her a card and returned later the same day. She was up and ready to receive me then. However, as I described earlier, depression and ambivalence were tightly connected during the assessment phase.

Once as I arrived, Susan was on her way out the door, but she asked her mom to tell me about her childhood development. Mom thought it strange that Susan waited until I arrived before leaving the house, but it didn't seem quite so strange when I remembered Susan had revealed a great deal about herself in the previous session. She now felt the need to back away and give herself some space. I thought it noteworthy she actually waited for my arrival before leaving, as if to notify me, and to reassure herself that she didn't need me.

During another session, she walked out of the room to nurse the baby and never returned. I waited the length of the session, left her a note and an appointment card setting up a session for the same time the following week. I never invaded her space unless invited. It was important to our work. She perceived her life as out of control. I thought it consistent and valid from a strengths perspective for Susan to have control over inviting and rejecting. I was never sure why she felt the need to leave the session at that precise moment. It might have been the topic of her conversation, or the feeling attached to it, or the dependence and attachment she was beginning to feel for me.

Eventually the pattern softened; the ambivalence began to give way. At another scheduled session, she kept me waiting fifteen minutes before she came up from her room. A short time into the session she walked out with baby for several minutes, but managed to return. When she prepared to leave the room again to smoke on the deck, she finally invited me to go with her. That felt like a major breakthrough.

This new pattern continued. First she invited me to go with her when she smoked, then it was while she changed the baby's diaper, or to show me her room, or to sit someplace quieter so we could talk. Finally, after five months, she asked me if I would like to hold the baby. Instinctively I felt she was asking if I would like to hold her. I remarked to the baby as I gathered him in my arms, that since he was so closely connected to his mother, it was like hugging both of them at the same time. She smiled and leaned her head ever so slightly closer to me.

It might have been an overly imaginative state of wishful thinking on my part, but I think not.

I made sure to be on time. In the early sessions I brought her something concrete, such as an article, a magazine, or notes about infants, development, or depression. I tried to communicate that I was prepared to accept the relationship on her terms, and not abandon her. I believed my calmness, promptness, patient waiting, and physical continuity through the use of concrete reminders of my presence created a space between us that was secure and trustworthy. I founded this practice on Winnicott's (1982) conception of transitional space: the intermediate area of experiencing that lies between the subjective inner reality and external life, which is objectively perceived. These attributes finally began to have a powerful affect on Susan. She used the alliance, the transitional space, in small doses until she began to trust the permanent quality and texture of the space. She eventually used the sessions to tell her story.

Susan began to play out and work through some of her ambivalence to a therapeutic alliance. She resolved part of her defensive stance against connectedness. Through playing "come here/come here - get away/get away," she tested the edges and boundaries of my symbolic promise not to abandon her, a reenactment of the practicing subphase of differentiation in which the exploring child uses mother as a stable home base for refueling, confirmation, and comfort through physical contact (Corey, 2005; Mahler, Pine, & Bergman, 1975). But the underlying issue of separation-individuation has yet to be addressed. "An old, partially unresolved sense of self-identity and of body

boundaries, or old conflicts over separation and separateness, can be reactivated (or can remain peripherally or even centrally active) at any and all stages of life" (Mahler, Pine, & Bergman, 1975, p. 4). Clearly, Susan has strong ambivalence issues attached to being a daughter/mother, a child/woman, and alive/dead. It is also true she may not be able to tolerate termination and will prematurely abandon the process as a preemptive strike. I am afraid she will run away to prevent feeling abandoned. I need to be cautious, and cannot let the expectation that she may flee determine a course and pace of treatment that is not in Susan's best interests.

We have only five sessions remaining. Susan is planning an extensive trip to visit friends and relatives that will effectively end our time together. She has been resistant to discussing her feelings attached to our permanent physical separation. I ask how she will take care of herself in my absence. We discuss options and alternatives, two words that are new to her vocabulary, along with flexibility and creativity. I remind her of the time limits at each session and reinforce her insights, attachment behaviors, and changes in thought patterns. Susan has incorporated parts of me. This has created a shift in her reality testing and ego function (Fairbairn, 1952).

Her ambivalence has generally failed to provoke a strong reaction in me. Perhaps because the alliance is inherently unequal, I have been able to maintain a tolerant stance with her. She cast me in the role of rejecting mother, but I refused to take it up. Basic trust was at stake. Vital elements of the therapeutic alliance needed to be established. Hope must be secured, love reciprocated, and

fidelity proven reliable (Erikson, 1964). When she left, I remained. When she approached, I drew near. When she pushed away, I came back. Sometimes I felt like the proverbial rubber ball secured to a paddle by an elastic string. Susan held the paddle. How far could she push, or how hard could she bounce me before the string broke or she broke? It was my job to make sure the string did not break. That is a clear re-enactment of a toddler learning to separate from mother, a going away and coming back for reassurance. I have attempted to establish a corrective relationship in the separation-individuation phase, acting as a bridge between child-Susan and her mother, in order to facilitate an increase in awareness of both the separateness and differentiation of her *self* from the *other*, and of a reality in the outside world (Mahler, Pine, & Bergman, 1975).

Susan came to appreciate the fact that there are no easy or perfect solutions to the paradoxes life offers. She is a child with a child of her own. The question is how to meet her own dependency needs, and at the same time, meet the dependency needs of her infant? Her trapped feeling comes when she is unable to hold both positions simultaneously: both a child, with unmet needs, and a mother with the responsibility to meet needs.

> Unpleasant experiences and the lack of enjoyable ones, in the young child, especially lack of happy and close contact with loved people, increase ambivalence, diminish trust and hope and confirm anxieties about inner annihilation and external persecution; moreover they slow down and perhaps permanently check the

> beneficial processes through which in the long run inner security is achieved (Klein, 1986, p. 150).

The lack in Susan's early life prevents her from achieving inner security. Susan's fear of annihilation impedes her ability to care for her infant son.

In a similar manner, she is afraid to both love and hate her dead husband. She concentrates on and idealizes the good about her husband, Sam, while she denies the anger and hate boiling inside her because he abandoned her and the baby by using the drugs that were so dangerous to his health and life. She displaces her anger onto his parents for abandoning Sam when he chose another lifestyle. Unfortunately for her, that line of thought has brought her up against another paradox. She hates his parents for denying Sam their love and leaving him so alone when he was often deeply in need of support, but she is beguiled by the love these same parents have for their grandchild. She desperately needs to tell them how angry she is, how she despises their past behavior, but at the same time, doesn't want to add to the guilt and remorse they feel over the death of their son and the grief they caused him.

Over and over she collides with her ambivalence crashing into love and hate, black and white, yes and no. However, the tolerance she has experienced in the push-pull relationship of the therapeutic alliance has given her insight and drawn her to reach the intellectual conclusion that it is necessary to reject the polarity of either/or and accept the inclusive nature of the paradox. She needs to regain trust in external objects, realizing that they are not perfect. She needs to

regain and strengthen her confidence and trust in the love she has for her husband and the love he had for her (Klein, 1986).

Attachment

John Bowlby (1958, 1969) formulated Attachment Theory 50 years ago. He defined *attachment* as an emotional and affective bond that reflected the enjoyment, the attraction, that one individual had for another individual (Bowlby, 1958; Cassidy, 1999). Bowlby (1958) and Winnicott (1968, 1987, 1993) included the term *enjoyment* when describing the mother-infant attachment dyad. Bowlby described the pleasurable mother-infant connection as a process of attachment that he considered nearly identical to the idea of love. He believed proximity to mother (or a mother figure) was essential to survival, that the mechanisms that underlie the infant's attachment tie to the maternal figure originally emerged as the result of evolutionary pressure, a biologically based need for proximity that equated with survival and natural selection (Cassidy, 1999). Therefore proximity seeking and maintaining and renewing behaviors led to a secure base and feelings of love, self-assurance and joy. However, disruption in the process produced anxiety, grief and depression (Karen, 1994).

A grave concern from the initial assessment was Susan's minimal involvement and attachment to her infant. She had an intellectual capacity for nurturing, but failed to respond physically or emotionally to her baby's needs. She did not cuddle the baby, rather held him openly and loosely in her arms, almost exclusively turned away from her. The baby did not follow her, rather

turned or arched away, and was more interactive with either of his grandparents. Babies need physical stimulation, sensitivity, eye contact, affective responses, and adjustment to their own level of sensitivity. These maternal characteristics are necessary for optimal mother-infant interactions but maternal depression interferes with the likelihood that these qualities will be present (Rukstele, 1997).

Susan struggled with boundary confusion. She projected characteristics of her dead husband onto the baby that distorted her perceptions of the infant, her self, and the attachment and affection between them (Wright, 1997). On a conscious level she desired to meet the needs of a live, functioning baby. However, on an unconscious level, Susan held a dead baby/husband in her arms. This unconscious fantasy kept her from connecting with her baby, a belief that the baby was as dead as his father. "Under favorable circumstances... the baby makes his own imperative claim upon parental love and, in strict analogy with the fairy tales, the bonds of love protect the child and his parents against the intruders, the malevolent ghosts" (Fraiberg, Adelson, & Shapiro, 1975, p. 387). Unfortunately, in this case, the infant was unable to make that imperative claim upon his mother's love.

During case consultation, a colleague suggested the Interaction-Guidance Technique (McDonough, 1992) to boost the attachment process and promote boundary definition between Susan and her baby. I videotaped Susan and the baby as they interacted at the next session. We than watched the tape together. We used her responses and insights to seeing herself interact as a mother as a basis for further communication and education.

The intervention itself had a powerful impact on Susan. She is a very bright young woman and quickly realized the videotaping was more than an opportunity to take pictures of the baby. Placing herself in front of the camera gave Susan an opportunity to critically evaluate her vision of and responses to the baby. Over a three-month period I videotaped Susan and her baby three times for a total of 90 minutes of tape. "If there were tenderness and deep love for the baby, the presence of the baby evoked the most poignant expressions of love. If there were conflicting emotions toward the baby, the conflict seemed to surface with his physical presence" (Fraiberg, Shapiro, & Spitz-Cherniss, 1994, p. 50).

Susan had an intellectual grasp of what it was to be a mother, but her behaviors as a mother in response to her infant were discrepant and incongruent. She quickly perceived the deficits and made alterations and adaptations. Susan holds, feeds, diapers, plays, and interacts with her baby kindly, generously, and non-sadistically in front of the camera and in my presence. In response, the baby clings, smiles, giggles, gazes, and plays appropriately for his age.

We used the Interaction-Guidance Technique over the course of treatment to have an outcome measure at termination. The video is a powerful and compelling portrayal of mother-infant movement toward attachment. The videotape will also serve as a concrete transitional object between Susan and me following termination. All of the transitional objects utilized over the course of treatment can be handled in moments of stress and separation to alleviate anxiety and fear of separation (Winnicott, 1957).

I continue to have grave concerns for Susan and her baby. As Susan climbs out of the depression and begins to feel her feelings, she may again become overwhelmed. She no longer has the luxury of mastering childhood and moving on to the complications and problems of adulthood. These two worlds have collided in the person of her baby. The myriad issues surrounding the birth of the baby and his presence in her life, on multiple levels, bring a vast array of treatment problems to the discussion. I resonate with Winnicott's work. This extraction from one of his papers helps me a great deal in comprehending and holding Susan's unconscious hate for her baby.

> Let me give some of the reasons why a mother hates her baby: The baby is not her own (mental) conception. The baby is not the one of childhood play. The baby is not magically produced. The baby is a danger to her body in pregnancy and at birth. The baby is an interference with her private life, a challenge to preoccupation. He is ruthless, treats her as scum, an unpaid servant, a slave. After an awful morning with him she goes out, and he smiles at a stranger, who says, "Isn't he sweet?" If she fails him at the start she knows he will pay her out for ever.... A mother has to be able to tolerate hating her baby without doing anything about it. She cannot express it to him.... The most remarkable thing about a mother is her ability to be hurt so much by her baby and to hate so much without paying the child out, and her ability to wait for rewards that may or may not come at a later date (Winnicott, 1958, p. 201-202).

I do not think Susan has developed the capacity "to tolerate hating her baby without doing anything about it." I wonder if her sadistic tendencies are too close to the surface. Two sessions previously Susan came up from her room in a rage. She cursed and swore, threw cups and pans around the kitchen, knocked over several chairs, and eventually stomped back downstairs. Her parting comment from the lower level was, "Tell her to get the f___ out and never come back." She may have consciously intended the remark for me, but, intuitively, I felt it was directed toward the baby. "I love him. I hate him." It formed a singsong echo in my head.

I instinctively felt that she harbored an unconscious desire to kill the baby, simply because she was so terrified that he would die (Bowlby, 1958; Karen, 1994). Closely aligned with the love/hate dilemma toward the baby is the same dilemma toward her own sense of self. "I love her. I hate her." Unfortunately, this has created a great deal of confusion and chaos for Susan. She insists she loves Sam, she loves the baby, and she hates herself. The opposite of that statement, "I hate Sam, I hate the baby, I love myself," is inconceivable to her. And holding the paradox simultaneously is also impossible for her at this point in time. It makes her incredibly vulnerable to her own hate and rage, because she denies they exist. For that reason, I carry concern for the baby.

Susan has many suppressed feelings and representations about this infant, as well as herself as an infant. This has created a transference-countertransference dance within our relationship, especially given the maternal role she created for me. It helps me stay more accurately attuned to Susan in the

therapeutic moment believing that the countertransference is an immediate reflection of her internal sensitivities and unconscious communication (Wright, 1986, 1997). I listen to Susan more carefully with my mind and heart. But the dance has also created havoc with what I hold near and dear about the care and comfort of an infant.

Susan's ambivalent attachment to her baby triggers maternal anxiety within me and prompts a destructive urge to fix the problem, and find a perfect, quick solution. I desire Susan to find her way out of the darkness, face her demons, establish effective coping skills, and learn to be a perfect parent. In other words, "Susan, would you please grow up and learn to take care of yourself and the baby. And could you speed that up, because you're leaving at the end of April." These thoughts, and others like them, scare me. I very much believe in the strengths perspective. Susan demonstrates time and again tremendous internal strength, resources, and determination. I need to step out of the way and act as her mirror. I trust her. I have hope in her. I need to act on what I know to be true about her.

Susan has tremendous personal strength, environmental support, and an alliance with a therapist (Saleebey, 1996). My expectation is that her innate will to heal, mixed with hope, will prove to be a strong catalyst for forward movement, but that movement must be self-directed. I must be able to keep my personal values, desires, and wishes where they belong - in my head.

Culture

I mentioned in the introduction that I did not really *see* Susan when I first met her. It wasn't until I viewed the first videotaped session with colleagues that the vast cultural gulf that existed between Susan and me began to take shape and form before my eyes. In the first sessions, listening for her underlying communication was important. As sessions progressed, listening to her narrative was imperative. But, my listening to her in an invisible and blind state was a handicap for both of us, as well as a disservice to her person.

What the videotape revealed was not a new Susan. I was conscious of how she looked; I wrote a description of her appearance for a mental status exam. But for unconscious reasons of my own, I missed the impact of Susan's appearance and, therefore, participated in the silent conspiracy of invisibility that was part of the family pattern. Susan was assigned the role of the lost, invisible, and secret child in the family.

Susan exhibits little visual conformity to the middle-class, white culture in which she now finds herself. She wears extremely tattered black Goth clothes that usually bear a graphically violent slogan or logo. She wears a variety of metal jewelry, but is partial to one particular black leather and metal, spiked choker that is several inches wide with inch long spikes. She has dark, navy-blue facial tattoos that she says are tribal markings she designed herself, but look very much like a navy-blue goatee. Under her lip at the crease of her chin, in the middle of the goatee, she has a large silver metal piercing. She has an extra-large, heavy, metal nose ring shaped like an upside down U, emphasized by

heavy metal balls at the ends. Horizontal bones, one inch in diameter, run through her stretched and pierced ear lobes. She easily puts her index finger into the holes to stretch her ear lobes. She has many other body tattoos and piercings and frequently designs new ways to burn and cut herself.

She enjoys talking about the steps to burn, color, cut, scab, and heal a tattoo or piercing. Her natural hair color is nearly black and, until recently, she wore her hair in a fairly traditional manner, even though she often chopped at it with scissors to blunt the ends. Two weeks ago she made a radical change to her appearance. She shaved parts of her head, bleached or vividly colored parts of her hair, and created dread locks in other parts. Her baby showed no reaction to this visual change in his mother. Her parents continued the invisibility theme by failing to notice the dramatic difference. Fortunately I *noticed* right away which brought a sigh of relief from her.

In contrast, the room she shares with the baby is neat, orderly, and spotless. The baby has a new crib piled high with toys and decorated with a colorful mobile. She has a new stereo to play an amazing stack of records that all sport covers depicting graphic physical and sexual violence. Next to the records is a camera. She takes many pictures of the baby dressed in his designer fashions. At our last session she showed me a picture album of her friends: smoking, drinking, vomiting, running, bleeding, beaten, and jailed. She brought out an album of herself as a baby and little girl. It was crammed with pictures of a beautiful child on her birthdays, at Christmas, playing, smiling, and riding bikes and ponies, alone and with her sister, playing sports, and taking dance lessons.

The photos were charming and beguiling. She ended the session by sharing an album of her photographs of her own baby that she had started. I wondered how long she could pay the emotional price of this compartmentalization.

When Susan was fifteen years old, she met Sam who was eight years older than she. Susan dropped out of school, and she and Sam left town together, identifying themselves as *travelers*. They lived on the fringe of society, train hopping and hitchhiking, eating in city missions, sleeping in rail yards, and were in constant trouble with the law. They identified solely with the hobo and drug cultures. Susan was a chronic, daily user of alcohol and street drugs. Sam was in worse shape, suffering from chronic liver disease, and living in a constant state of chemical dependence. When they needed a little money for more dope or food, Susan took part time jobs, usually in a tattoo and piercing salon. Sam died from a drug overdose two months before the birth of his son.

Culture and ethnicity shape the self and the human story in powerful ways. It is vitally important to seek individual cultural stories, to know enough to ask good questions, and to notice culture in the appearance of clients (Laird, 1998). Susan narrates stories that give me insight into her character and her lifestyle, her philosophy of life and her goals and dreams. Sometimes we talk about her writing a book. She is a wonderful storyteller, imaginative and creative. I often feel as though I am running beside her as she flees from the police, or sitting beside her as she eats in an inner city mission, or sleeping beside her in the open country, drunk or high, and covered in leaves or vomit depending what the

last waking moments held. I am often spellbound, and I wonder what it is that attracts me, mesmerizes me.

A primitive element of freedom flows through her stories. She is unencumbered with belongings; she stuffs only what she can carry into a tattered backpack. She has no money to waste on necessities, much less frivolous accouterments. An unnecessary purchase can be a wasted expense if she decides it is too much weight to bear and has to dispose of the object. What is and is not essential in belongings is distilled into necessities.

The same can be said of friendship, of relationship. She carries a connection to only one person, Sam, and that because she is the one in control. She is the caregiver, the supporter, the lookout, and the anchor. All other friendships are transitory, based in mutuality or usefulness, which ebb and flow by train schedules and jail sentences. Who is and is not essential in relationships is distilled into nothingness.

What attracts and fascinates me is merely illusion. Deprivation is not freedom. Freedom manifests itself in choice. Over time deprivation creates a tight fist of grinding misery from which there is often no escape. What begins as a perception of choice, reveals itself, ultimately, as a desperate trap. She has nothing because she is attached to nothing. She loves no one because she is terrified of intimacy. She carries nothing and desperately seeks freedom in flight, but is tragically unaware she carries her personal and private baggage with her wherever she goes like weighted locks and chains.

I listen, I sigh, I wonder, and I wait. I have been brought deeply into another culture and gained insight. I have gleaned more information than Susan intended to reveal. I hold that knowledge carefully. I do not want her to feel invaded and violated. I am aware that I find her stories provocative to my intellect and my emotions. I must not pry for selfish and voyeuristic fulfillment. A fragile and brittle young woman sits with me in trust and in hope, session after session, and desperately seeks to understand herself, and reframe her narrative, and fight for the ability to breathe again with utter unselfconsciousness. I must nurture that work by understanding the meaning she ascribes to her life and culture, and not contaminate her experience by imposing my own interpretation or expectation.

While I am intrigued by Susan's experiences, I am simultaneously appalled and repelled. She has been drunk or high more days than not, been arrested and jailed, been brutally beaten and left for dead, suffered from broken bones and internal injuries that were never treated, had friends murdered and slept with murderers, experienced malnutrition and near starvation, been spat upon, shunned, reviled, and suffered through the death of her husband. As Susan reveals these facts through the stories she tells, they were delivered with an air of suppressed excitement. She enjoyed these experiences. She defines herself by mutilation, torture, and death.

In the face of this excruciating pain, I ask myself what I can do to help her: how I can fix her myriad problems: where I can find the resources to meet her needs? The answer: I can do nothing, fix nothing, and find nothing. What I can

offer is myself, fully present with her, and a *good enough* holding environment (Winnicott, 1987) for Susan to do, fix, and find as she determines.

> If I can create a relationship characterized on my part: by a genuineness and transparency, in which I am my real feelings; by a warm acceptance of and prizing of the other person as a separate individual... then the other individual in the relationship: will experience and understand aspects of h[er]self... become better integrated... more similar to the person [s]he would like to be... more self-directing and self-confident... more of a person, more unique and more self-expressive... able to cope with the problems of life more adequately and more comfortably (Rogers, 1961, p. 37-38).

Conclusion

I have culled from my experiences with Susan those moments that were particularly significant or poignant. Most of what I have communicated about Susan is my interpretation of her insight. Her narrative is in stories, stories she tells as though standing outside herself, detached and disconnected. Yet, buried beneath, is a part of Susan she keeps hidden from her self; the young woman I find so charming and irresistible. Susan has communicated to me those dimensions of her personality and her ego which she has denied: the split off and lost parts of her that have created her ambivalence. My hope is that I held, carefully and lovingly enough, and mirrored that brokenness accurately enough,

so Susan can begin the process of integration. My hope is that she will successfully mourn her loss, find a secure internal home base, attach to her infant, and use the termination process as a reparative function in which she is free from the fear of abandonment and annihilation.

Susan has taught me much. I love deeply and connect strongly. Therefore, I am susceptible to hurt. My capacity for holding suffering is immense, but not bottomless. My senses are acute and my intuition trustworthy, but not infallible. I learned again that this work is not for the fainthearted. I learned again that all I have to offer is my self, in the very basic and primitive sense of the word. But above all, I learned that I must be scrupulous about examining my self, my pain, my biases, my weaknesses, and my strengths at all times. I alone am responsible for the state of my self as I am called to sit in the presence of another's suffering.

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CHAPTER 4

Attachment: Indicators from Caregivers and Toddlers – Implications for Adult Treatment

Abstract

An ethnographic study was conducted to observe indicators of healthy and pleasurable attachment between women caregivers and toddlers in natural environments. Nineteen dyads were observed for an average of 20.3 minutes. Data were collected in three ways: field notes, sketches, and reflexive writing. Six indicators of healthy and pleasurable attachment evolved from the coding process that can provide categories for clinicians to consider in adult treatment settings: reciprocity and mutuality, proximity, verbal exchange, affective features, physical affection, and physical activity and play. One other fundamental component that emerged from the study concerned caregiver use of environmental space for toddler safety and exploration that supports the secure base functions of the maternal-infant/child attachment relationship.

Key Words: *Attachment; Attachment Relationship; Environmental Space*

> The story of a human being does not start at five years or two, or at six months, but starts at birth – and before birth if you like; and each baby is from the start a person, and needs to be known by someone (Winnicott, 1964, p. 86).

Attachment issues form a foundation for what underlies the difficulties many adults struggle to overcome. In private practice, clinicians observe the effects of disrupted attachment in the lives of clients and bear witness to the difficult and lengthy healing process necessary for them to establish mature, adult relational patterns. These clients did not experience an *affectional tie* (Ainsworth, 1969) with a significant someone in their childhood world or an *affective bond* (J. Bowlby, 1958) between self and other, nor were they securely held against mother's skin to feel her heart beat and to hear her breathe (Winnicott, 2002). Their experiences were of crying in frustration, clinging to nothing, following and smiling but receiving no response in return, and suckling from nothingness. Their overwhelming sense of hopelessness and despair stems from these unmet attachment needs because a child's tie to the mother/caregiver is disrupted through experiences of separation, deprivation, and bereavement (J. Bowlby, 1958; Bretherton, 1985).

The antecedents to the formation of a secure or insecure attachment base with an attachment figure and how attachment behaviors (or lack thereof) are triggered in an individual is unique to each person. However, it does seem consistent from a therapeutic point of view, that clients who report having serious

relationship difficulties also report a distant, cold, rejecting, and/or neglectful mother/caregiver, a mother/caregiver without sensitivity and attunement (Harris, 2003; Winnicott, 1993). They also report that no other significant individual in their immediate childhood environment met protective and nurturance needs either. Certainly the lack of maternal sensitivity toward these clients when they were children plays a part in the relationship problems that plague their adult lives (Ainsworth, 1967, 1969; Ainsworth & Bell, 1970; Ainsworth, Blehar, Waters, & Wall, 1978; Anna Freud Centre, n.d.; Sroufe, Fox, & Pancake, 1983; Winnicott, 1993). Other factors can impact adult relationship issues but attachment is the focus and concentration of this study.

These clinical and educational experiences and hypotheses formed the basis of the research objectives. Other significant influences came from the early roots of attachment theory and research. Bowlby (1958) and Winnicott (1957) utilized the term *enjoyment* in definitions of attachment. Bowlby portrayed infants as competent, curious, and fully engaged with their caregivers and the environment (Waters, Crowell, Elliott, Corcoran, & Treboux, 2002). Ainsworth (1967) focused on the *pleasurable* mother-infant relationship followed by development of the concept of the *secure base* in the attachment relationship. In addition, the earliest research activities were field observation techniques (Ainsworth, 1967; Bretherton, 1985). Therefore, this study aimed to return to the basic principles of attachment theory, to enjoyment and pleasure in the attachment relationship, to the secure base function of behavior, and to field observation.

Research Questions

The first question then is: What are the observable indicators of a positive, healthy attachment relationship between women caregivers and toddlers? It is assumed that attachment behavior and attachment theory are stable over time and that present indicators are similar to the earliest field observations (Ainsworth, 1967). The second question is: What happens in the space between a woman caregiver and a young child? Winnicott (1971) postulated that the transitional space between mother and infant/child is where the relationship occurs. He conceived of that transitional space as psychic space. The space that exists between people is also visible, measurable, and usable space that can serve the function of dynamic and purposeful interaction. And finally, the third question is: What are the implications of the indicators of a positive, healthy attachment relationship in treatment settings? Understanding elements of what creates positive, healthy attachment relationships can offer valuable information in clinical settings to aid in emotional, developmental, and attachment reparation. If those indicators, extrapolated from caregiver/mother-infant/child attachment relationships, can be utilized for benefit in therapeutic treatment, then the principles can be taught in a social work clinical curriculum.

Study Purpose

This observational study was designed to focus on indicators of healthy and pleasurable attachment and attachment behaviors between women caregivers and young toddlers in natural environments. It was carried out in

London, Great Britain, public parks and spaces. It was hypothesized that observable elements of healthy attachment could be documented and coded in public settings just as early researchers observed and coded attachment signaling behaviors, for example, clinging, smiling, crying, and following in field research and laboratory settings (Ainsworth, 1967; Ainsworth & Bell, 1970; Ainsworth, Blehar, Waters, & Wall 1978; J. Bowlby, 1958, 1982; Seifer & Schiller, 1995). However, in order to categorize elements of positive, healthy attachment relationships to extrapolate meaning into the therapeutic venue, subject selection was purposely biased toward playful, interactive, and positively engaged women caregivers and toddlers.

A second purpose of the study was to test and modify an *Observation Check List* (OCL) created by the researcher for use in the field as a shorthand aide to note taking and data sorting. This method evolved from work as a play therapist, where a similar tool was created as a session observation and process-reporting tool. From that idea, and with a similar purpose in mind, the OCL was created as a tool for field observation. It is a shorthand method developed to maximize the observation data and make the process more efficient because taking notes can be tedious when done for long minutes over many observations. It was hypothesized that the shorthand tool would minimize interruption of visual contact with the caregiver-toddler during observation and maximize data gathering.

Figure 4-1. *Observation Check List*

OBSERVATION CHECK LIST

Monday Tuesday Wednesday Thursday Friday Saturday Sunday

8am----------12----------4----------8pm

observe X_____ park_____ book store_____ McDonalds_____

cool----------warm rain----------shine

woman –teen----------60 ***child***-toddler----------2----------3

short----------tall thin----------heavy short----------tall thin----------chubby

blond---------red---------brown---------black blond---------red---------brown---------black

strt------crly shrt-----long braids__ pony__ strt------crly shrt-----long braids__ pony__

clothes –dirty----------clean *clothes* –dirty----------clean

clothes – casual----------formal *clothes* – casual----------formal

dress suit slacks jeans t-top shirt dress suit slacks jeans t-top shirt

sweater jacket phone purse jewelry hat sweater jacket hat shoes sneakers

high shoes low shoes sandals sneaker sandals hair accessories

glasses hearing chair braces crutches glasses hearing chair braces crutches

cane other_____ cane other_____

touch –nose eye ear mouth cheek chin *touch* –nose eye ear mouth cheek chin

neck hair_____ neck hair_____

blanket pacifier toy_____

woman affect ***child affect***

flat smile laugh frown cry tears mobile flat smile laugh frown cry tears mobile

woman actions ***child actions***

whisper speak yell command discipline toddle walk run skip jump hop

redirect scold hit slap remove stop swing legs swing arms

kiss hug snuggle carry hold run to.... run from.... _____

diagram space of caregiver/child interaction

The OCL (see Figure 4-1) has place markers to circle the day of the week, kind of weather, time of day, gender, general appearance of woman and child, affects like smile, laugh, frown, scold, and actions like hug, hold hands, and snuggle. The OCL includes a rectangle drawing box so that sketches of the space where the interactions occur can be diagrammed and recorded. This drawing box was designed to help answer the study question of what happens in the space between a woman caregiver and toddler. (Sample sketches can be seen in Figures 4-2 and 4-3.) And finally, lined pages are included for writing field notes or for jotting thoughts, feelings and interpretations during reflexive writing following the observation.

Figure 4-2. *Caregiver-Toddler Interaction in Natural Environment*

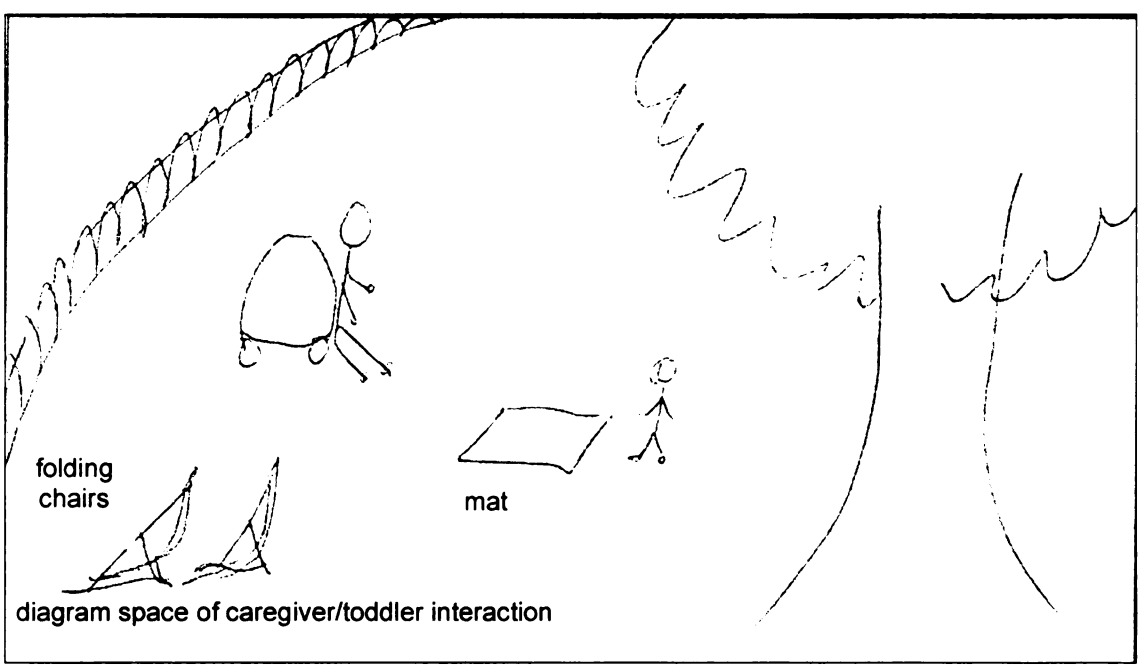
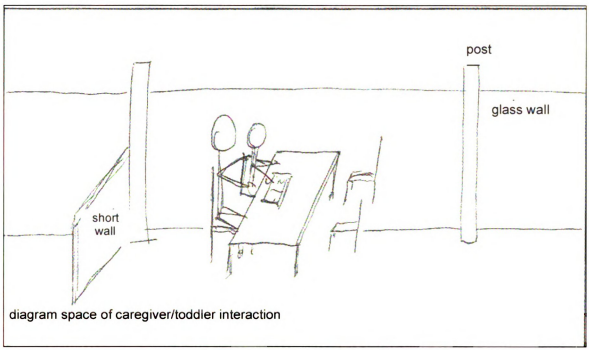


Figure 4-3. *Caregiver-Toddler Interaction in Built Environment*



Literature Review and Theoretical Framework

Attachment theory was developed by John Bowlby (1958, 1982, 1988) 50 years ago, in part, as an alternative to psychoanalytic theory to explain why separation caused anxiety in young children, to explain the similarities between childhood and adult loss and mourning, to explain the process of defenses in the human psyche, and to explain the mechanisms of social behavior from infancy that affect and influence the development of the personality along a continuum from healthy to debilitating (Barnett & Vondra, 1999; Bretherton, 1985; Cristóbal, 2003; Waters, Crowell, Elliott, Corcoran, & Treboux, 2002). Bowlby did not intend that the attachment concept substitute for social bonds or be attributed to all aspects of the parent-child relationship. He intended that the roles of attachment figure and playmate be conceptually distinct. When a child feels stress, distress,

or fear, she seeks an attachment figure for safety, protection, and regulation. However, when a child is happy, content, and playful, she seeks a playmate. (Feminine pronouns are utilized in this work in deference to the preponderance of childcare provided by women, even though some men are very or exclusively involved in caring for their children.)

Attachment theory is a perspective on the secure base functions of close relationships that operate to promote child development, personality development, and affect regulation. The theory assumes that maternal sensitivity, responsiveness, and attunement are major factors in the quality of a child's attachment to her mother or attachment figure (Ainsworth, 1967, 1969; Ainsworth, Blehar, Waters, & Wall, 1978). Attachment theory also presupposes evolutionary biological necessity. The needs of infants and small children are not variable; they are inherent and unalterable (Winnicott, 1964). Attachment behaviors must exist and be reciprocated for the infant to survive both physically and psychically.

> Unless there are powerful in-built responses which ensure that the infant evokes maternal care and remains in close proximity to his mother throughout the years of childhood he will die. The instinctual responses... serve the function of binding the child to mother and contribute to the reciprocal dynamic of binding mother to child (J. Bowlby, 1958, p. 369).

Attachment theorists define the term attachment independently but the similarities are striking, including the concepts of proximity, specificity, and

necessity. "'Attachment' refers to an affectional tie that one person (or animal) forms to another specific individual" (Ainsworth, 1969, p. 971). [A]ttachment refers to the *relationship*... the affective bond between infant and caregiver" (Sroufe, Fox, & Pancake, 1983, p. 1616).

Several distinctions of attachment theory are mentioned here. Dependence and attachment are separate and different constructs (J. Bowlby, 1958). Attachment relationships are permanent and irreplaceable (Barnett & Vondra, 1999). Attachment behavior is heightened in situations perceived as threatening but attachment itself is not necessarily strengthened (Ainsworth, 1969). Attachment behavior, especially when strongly activated by stress or distress, is incompatible with exploratory behavior. A distressed child seeks comfort, not stimulation and exploration. Following a prolonged absence from the maternal or primary attachment figure, attachment behavior may diminish or even disappear, but the attachment itself is not necessarily diminished (Ainsworth & Bell, 1970). This is a particularly relevant concept in therapeutic relationships. Attachment relationships vary widely across mother-infant/child pairs (Ainsworth & Bell, 1970). Stress occurs from sudden or prolonged separation from the attachment figure and permanent loss causes grief and mourning (Barnett & Vondra, 1999).

Attachment is a broad and complicated concept with multiple layers of meanings and interpretations. No single definition or set of constructs can contain all of the significant elements of attachment as a concept. However, one vitally important foundational observation must be stated. Attachment, regardless

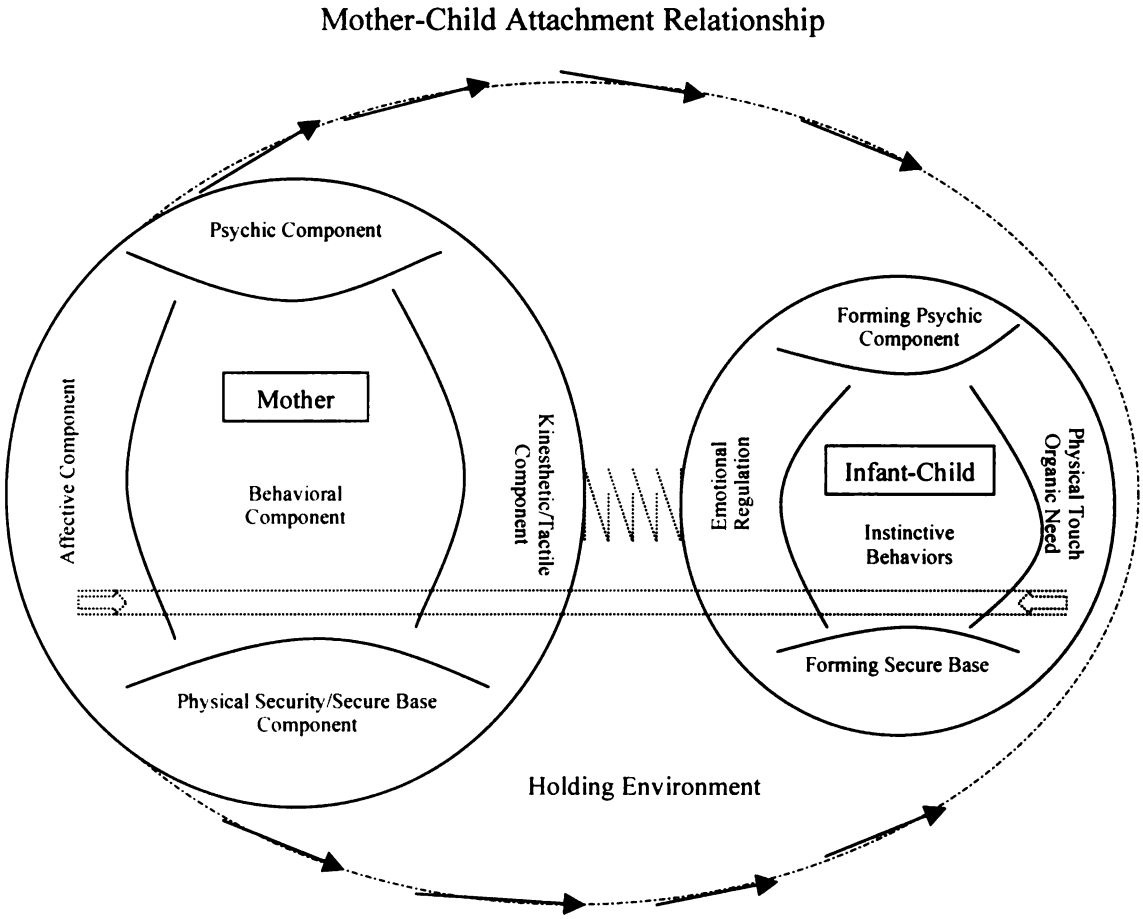
of the definition, occurs in the flexible holding environment of the mother-infant/child attachment relationship that begins in the earliest moments of an infant's life. This holding environment is both physical and psychic. Caregivers must be able to create a good enough facilitating environment at the earliest stages of development to provide for the optimal emotional and mental growth of the child (Winnicott, 1971).

The caregiver, typically the mother, provides a physically secure environment of her presence for the infant. This happens, not only through physical handling and holding, but also, through consistent sensitivity of the needs of the infant and her availability to meet those needs. The mother must also be psychically available to her child and mentally carry a positive internal representation of her own attachment figures and relationships. These functions create a secure base for the infant/child.

The existing definitions were synthesized and a systematic attempt made to operationalize the term *attachment*. Therefore, for the purposes of this paper, with an emphasis on implications for clinical practice, the author developed a conceptual map (Figure 4-4) of the holding environment of the mother-infant/child attachment relationship that includes: physical security (secure base function), behavioral, psychic, affective, and kinesthetic/tactile components.

Attachment has a *physical security component*. The secure base is defined as the *attachment figure*. This attachment figure must be present and available to the infant/child. A particular and substantial someone, to whom the child can attach, must exist in a specific location, therefore attachment has a

Figure 4-4. *Holding Environment of Mother-Infant/Child Attachment Relationship*



solid human context within time, space, and situations (Posada, Gao, Wu, et al.,1995; Waters & Cummings, 2000). "Without adequate environmental reliability the personal growth of a child can't take place" (Winnicott, 1993, p. 99).

Attachment has a *behavioral component.* The instinctive attachment behaviors "serve to create the attachment bond, protect the child from fear and harm, and assist in the safe exploration of the world" (Porter, 2003, p. 2). Attachment behaviors serve different functions. Signaling behaviors alert the caregiver that the infant desires interaction. Aversive behaviors trigger a quick maternal response to provide problem solving or protection and safety. And

active behaviors promote proximity to the mother and secure base (Ainsworth, 1967; Ainsworth & Bell, 1970; Ainsworth, Blehar, Waters, & Wall, 1978; J. Bowlby, 1958, 1982; Seifer & Schiller, 1995).

Attachment has a *psychic component*. Attachment is "the psychological availability of a caregiver as a source of safety and comfort in times of child distress" (Barnett & Vondra, 1999, p. 5), "the inferred internal bonds that form between infants and their caregivers" (Seifer & Schiller, 1995, p. 147). Another aspect is the caregiver's own mental representation of attachment, her own internal working models experienced and developed in infancy and childhood (Harris, 2003). The psychic component, the knowing and trusting of the *other*, grows developmentally from the physical security of the secure base.

Attachment has an *affective component*. Ainsworth (1969) used the term *affectional tie* to describe the bond that forms between two specific individuals, a mother and her infant. Bowlby (1958) spoke of the attachment relationship as a reflection of pleasure and enjoyment: smiling, laughing, clapping, happiness, and love. The security of the attachment relationship also provides a space for affective reactions to stress and fear: crying, clinging, anger, and frustration. A full range of emotional affect and "the foundation of emotional regulation is also established within the context of the attachment relationship" (Sroufe, 2003, p. 205).

Attachment has a *kinesthetic/tactile component* (J. Bowlby, 1958). Attachment develops through body contact between caregiver and infant/child demonstrated in caresses and touches (Cristóbal, 2003). "You [mother] just

adapt the pressure of your arms to the babies' needs, and you move slightly, and you perhaps make sounds. The baby feels you breathing. There is warmth that comes from your breath and your skin, and the baby finds your holding to be good" (Winnicott, 2002, p. 21). Gazing, touching, holding, rocking, stroking, and nuzzling are examples of kinesthetic and tactile body contact.

Attachment occurs in the holding environment of the mother-infant/child attachment relationship. "Whoever is caring for a child must know that child and must work on the basis of a personal living relationship with that child" (Winnicott, 1993, p. 99). Attachment is defined as an enduring relationship between a young child and her mother (Ainsworth, Blehar, Waters, & Wall, 1978). Attachment relationships teach individuals how to be in relationship with significant others and influences all subsequent relationships through to adulthood. Attachment, first and foremost, exists, and is held together, in the flexible holding environment of the mother-infant/child attachment relationship. All other definitions or systems of understanding must stand upon that principle.

Method

The research method utilized in the study was naturalistic-ethnographic observation. The OCL was used to help guide the field note process in the observation, diagram the environmental space created by the woman, and to sketch the dyadic interaction.

The constant comparison method was used to guide the coding process and emergent themes (Echevarria-Doan, & Tubbs, 2005; Richards, 2005;

Wolcott, 1990). Each new case was compared to previously analyzed cases. The study was strengthened by triangulation: observations, sketches and diagrams, reflection, external coders, and peer debriefing. It is believed that the drawings and diagrams can be used to illustrate not only the natural and built environmental features of the interaction, but the manifest and latent expressions of the relationship.

Naturalistic qualitative research methods stand upon interpretive techniques utilized to understand the meanings behind phenomena that naturally occur in the social world (Riessman, 1994). This method was prescribed by the research questions. Naturalistic observation allows the observer/researcher to view what occurs naturally in the environmental and relational context and focus on particular phenomena of interest, in this case, indicators of positive, healthy attachment relationships. The distinction between *observer* and *participant* can be subtle and influential in field observation even when the study has been designed as observational research. As an observer of dyads in parks, the researcher participates in the activities and enjoyment of the park and is, therefore, subject to the same conditions of the environment and may overlook potentially valuable sources of data (Richards, 2005).

Taking notes, interpreting and analyzing notes, and constantly comparing against previous data are time-consuming processes (Agar, 1996; Echevarria-Doan, & Tubbs, 2005; Richards, 2005). However, there are many benefits of direct observation. Direct observation precludes participation in the observed context, assumes a detached perspective, can be more focused, and is typically

less time-consuming than participant observation. These factors mean that the direct observation is much less obtrusive and therefore less likely to impact the interactional behavior of the dyad and change or alter the phenomena being observed.

Subject Selection

Women are primary caregivers, though not the only caregivers of children, and women as mothers (in tandem with their infant/child) are typically the objects of attachment research studies and are, therefore, the identified subjects in the study. Women caregiver-toddler dyads, though randomly observed in public places, were specifically chosen for observation when elements of pleasure and play were evident in the dyadic relationship. This was based upon Bowlby's (1958, 1982) early theoretical formulation that the attachment relationship was an emotional and affective bond that reflected the enjoyment and the attraction that one individual had for another individual. Subject selection was purposely biased toward playful, interactive, and positively engaged women caregivers and toddlers.

The observations, lasting anywhere from 10-45 minutes, were completed in public parks and spaces in London, Great Britain. London was chosen for its convenience (the researcher was living in London for the summer), diverse population, and sheer numbers of people and places for women caregivers with toddlers to be observed. Four locations were selected intentionally: Regent's Park, St. James' Park, Hyde Park, and Leicester Square. The three parks have

open green spaces, sports areas, hedged gardens, and bodies of water, walking paths, eateries, and both fixed and movable seating. Leicester Square is much smaller and enclosed but a notable gathering place. Observations were conducted in each setting on different days of the week at different times of the day. The observations were done randomly based on chance encounters with women-toddler dyads in public spaces.

Data Collection

The original sample estimate was for 25 observations. However, when 19 observations were completed, the observer believed a level of saturation useful to the original intent of the study had been reached. No new or unusual physical features, affective components, or play behaviors were demonstrated. Each dyad was unique and a pleasure to observe, but no new data were being collected.

Data were collected in three ways. First, a sketch was made of the caregiver-toddler dyad in the natural and/or human-made environment where the observation occurred. This was done first so that the sketch and diagram were as objective as possible, to minimize observational bias. Second, field notes were written as quickly and as thoroughly as possible during the observation and for the full 10-45 minutes. Sketches and notes were drawn and written on the OCL. And third, reflexive thoughts and comments were written in a personal journal at the end of each day's field observations.

Data Analysis

Data analysis was done in a three-part, inductive process established in the constant comparative method (Echevarria-Doan, & Tubbs, 2005; Richards, 2005; Wolcott, 1990). The decision was made to begin with case analysis rather than cross-case analysis. First, each observation was evaluated independently for themes. A line-by-line and word-by-word analysis was performed. In this process, primary patterns in the data were identified and coded. Each successive case was compared to previously analyzed cases. This process generated codes of spatial, behavioral, and affective data.

Second, from the identified codes, major categories or themes emerged. As themes emerged, the observations were examined a second and third time for examples of those themes and any additional emergent characteristics or themes. Category generation from qualitative data has a subjective basis. In this case, category generation may have been influenced by the researcher's inferences from the data, initial research questions, theoretical perspective, interpretation, and previous experience and knowledge.

Third, two colleagues were recruited to code three representative observations to establish coding reliability. Each colleague took the same three observations and independently coded those observations, line-by-line and word-by-word, and created independent lists of emergent themes. The two colleagues created category lists very similar to each other, which were in turn similar to the original categories culled by the researcher. With the added information and a three-way collegial debriefing conversation, the categories were finalized at the

end of the third level of coding. Table 1 highlights the six categories and provides a sample of the completed coding.

Discussion

Nineteen woman-toddler dyads were observed for an average of 20.3 minutes. The observations included 11 boys and 8 girls with an estimated age range of 12-24 months (5 children around 12 months; 6 children around 18 months; and 8 children around 24 months). Six indicators of healthy and pleasurable attachment and attachment behaviors between women caregivers and young toddlers evolved from the coding process: reciprocity and mutuality, proximity, verbal communication, affect and emotion, physical affection, and play. These indicators demonstrate key principles of attachment theory. All of the dyadic observations included elements in every coded category indicating that the relationship demonstrated a full range of positive, healthy attachment behavior.

Reciprocity

Reciprocity is a hallmark feature of relationship presuming two participants where one initiates and the other receives. In the observations this typical behavior was demonstrated by the caregiver reading as the toddler listened, the toddler hiding and the woman finding, or one of the dyad performing an action (kicking a ball toward the other) and the other imitating (kicking the ball back). In these observational instances reciprocity foreshadows the give and take, the

reciprocity, of a mature relationship. The caregiver models culturally appropriate social and relational skills. In this scenario, as a child offers to the caregiver and the caregiver responds adequately, the child begins to learn self-confidence and self-efficacy because her *offerings* are acceptable to the recipient, her caregiver and attachment figure (Moustakas, 1992).

Table 4-1. *Categories of Attachment Indicators in Attachment Relationships*

Reciprocity and Mutuality	Proximity	Verbal Communication	Affect and Emotion	Physical Affection	Play
reading - listening	sit knee to knee	happy screech	smiling	arm round child	climbing
pull on w - lifts c	walk side by side	oohhh and aahhh	wistfulness	pull mom's leg	wandering
give food -accepts	sitting together	protesting request	concentrate	plays w/ c feet	swinging arms
action - imitation	run away - back	jabbering to w	waving	smooth lotion	chasing squirrel
speak - respond	directly behind c	w calls child back	indulgent	kissing	playing w/ ball
leave - following	lean toward c	ma, ma, ma	laughing	snuggling	drop, kick ball
hiding - finding	swivel to face c	name - repeat	crying	hugging	turning in circles
looking - finding	hand in hand	uh oh	clapping	holding	clapping hands
washes child	face each other	saying bye - wave	following	fall in w's lap	splashing water
child washes self	laying together	teach - model	giggling	patting child	play w/ objects
c counts - w claps	wander - return	tandem chatter	scared	touching	climbing in/out
laughing together	running ahead	giggling	relaxation	crawl over w	crawling
run toward other	dragging behind	gibberish	freedom	holding hands	bouncing
w calls - c turns	hiding in bushes	jabbering	frustration	twirling child	master balance
chatter together	hover over child	laughing	rejection	w hold c on lap	chasing pigeons
move in tandem	touching distance	mimicking	patience	tousle c's hair	running
playing together	run after child	whispering	delight	hold and rock	falling
jabber in tandem	stoop to child	cheering	playful	take pictures	rolling
offering -accepting	c limits distance	counting	watchful	carry in arms	picking flowers
eating together	walk - hold hands	reprimanding	protection	run hand-hand	rocking
holding - taking	c stands over w	woman said no	competence	swinging child	swinging
offering - reaching	child sits on lap	groaning	engagement	cuddling	swaying
mutual touching	c looks for w	come, come	encourage	tuck in stroller	exploring
tandem feed bird	c in mom's arms	calling name	kindness	stroking back	playing airplane
both cheering	moves c to safety	giving directions	adventurous	stroking arm	playing w/ dolls
	follow child		calmness	swaying into w	
w = woman				holding tight	
c = child					

Mutuality

Mutuality manifests in the shared experience or expression of the relationship. In the observations this was expressed by eating together, moving in tandem, laughing and jabbering together, and mutual touching. Mutuality is not a separate category from reciprocity but an extension of the feature. Mutuality is the fulfillment of reciprocity as teaching leads to togetherness. The caregiver both feeds herself (modeling behavior) and feeds the child (both sustenance and nurturance). The child accepts the food (building trust), begins to feed the caregiver (mimicking), and eventually participates in the mutuality of eating together. The toddler learns to trust that her needs will be met. The ability to trust in the presence of the other leads to a mitigation of existential isolation (Buber, 1965) and solidifies the development of the secure base function of the attachment relationship (J. Bowlby, 1988).

Reciprocity and mutuality include physical, verbal, and affective features so some aspects of this construct cross categories. The physical feature includes walking, eating, and playing together and the offering and receiving of food and gifts that can be initiated by either the caregiver or the toddler. The verbal feature includes jabbering in tandem or a pattern of speaking and responding. Naming objects and repeating the name is a mimic game initiated by the caregiver and crosses between categories of verbal communication and play. Affect and emotion, which crossed all categories, were added to reciprocity and mutuality when caregiver and toddler expressed pleasure together in laughing, giggling, or cheering. Otherwise, when the child or caregiver smiled, laughed, or giggled

independently it was coded in the affect and emotion category, for example, when a caregiver smiled while watching the toddler from a distance or the toddler giggled while chasing a squirrel.

Proximity

The category of proximity was demonstrated in the observations through the dynamic tension of the physical connectedness and distance exhibited by a woman caregiver-toddler dyad. For example, all of the dyads maintained close physical contact during part of the observation. They sat knee-to-knee, walked side-by-side or hand-in-hand, lay on the grass together, or the child climbed on the caregiver, sat on her lap, or was held in her arms. As the physical contact was broken, the caregiver typically exhibited hovering, standing over, leaning in, stooping down, and watching behaviors. When the toddler ran away, hid from, or wandered off it triggered a different set of behaviors in the caregiver, for example, following, running after, and finding. Caregiver behavior flowed effortlessly between contact, alertness, and active containment. The toddlers, by contrast, exhibited behaviors of connection (hugging caregiver) and exploration (wandering away).

The proximity feature of the observation related to the practicing subphase of separation-individuation (Mahler, Pine, & Bergman, 1975) and to the secure base function of the attachment relationship (Ainsworth, 1969; J. Bowlby, 1988). The toddler used the caregiver as a home base resembling a game of "tag." She touched, sat upon, or lay on the caregiver before wandering or running away

from the woman only to return again in a short period of time. Some toddlers ran ahead or alternatively dragged behind but always within a prescribed distance that was specific to the caregiver-toddler dyad. Sometimes the caregiver established the perimeter with physical boundaries and/or verbal calling or command. Sometimes the toddler self-limited the distance she wandered from the home base. Often the distance was negotiated between the pair.

Verbal Communication

Negotiating distance led directly to verbal communication. The caregiver called the child's name or said "no" or "stop" and the child responded, sometimes with words although most often with groaning, gibberish, or screeching because the majority of children observed were very young toddlers with limited language. Sometimes there was a call from the caregiver for the child to return, or to notice a potential danger. Another form of verbal communication between the pair was a spontaneous outburst of laughing or giggling in response to engagement in physical activity and play. Reciprocity occurred when a caregiver named objects (tree, pond, duck, or book) and the child mimicked the words.

Nonverbal communication was also present in the caregiver-toddler interactions. This was evident, for example, in large motor activity like a toddler intentionally running away from a caregiver when called to return. The researcher maintained significant physical distance from the dyad to prevent intrusion into the space of the relationship. This made it difficult to distinguish fine motor or facial nonverbal cues between the woman and toddler. Therefore, specific to this

sample, nonverbal expressions of communication were excluded from the categories. The term *communication* could easily be substituted for *verbal communication* in the categorical list for future research providing observation was proximate enough to register nonverbal communication accurately.

Affect and Emotion

The anticipated attachment indicators of enjoyment and pleasure (Ainsworth, 1967; J. Bowlby, 1958, 1988; Winnicott, 1957) were demonstrated in the affects and emotions smiling, laughing, giggling, waving, clapping, watching, and following. Some of the subtle affective and emotional features displayed by the caregiver were indulgence, patience, encouragement, kindness, calmness, and responsiveness. The subtle features exhibited by the child were concentration, freedom, frustration, delight, competence, and adventurousness. The shared affective features included relaxation, playfulness, happiness, and delight. These affective and emotional labels were subject to interpretation of the nuance in the attachment relationship between the woman caregiver and the toddler but studies demonstrate reliability of visual indicators of affective states (Martin & Clore, 2001).

Physical Affection

Physical affection was another anticipated sign of attachment organization indicative of enjoyment and pleasure. Physical affection was demonstrated in the dyad by hugging, kissing, snuggling, cuddling, rocking, holding hands, touching,

and carrying. When a toddler tugged on her caregiver's leg and was lifted into her arms to be snuggled or carried, this was an example of a toddler's way of signaling a desire for closer contact with the caregiver. The child initiated this action, but the caregiver's positive response indicated a heightened level of attunement and sensitivity to the child's needs in the moment (Ainsworth, 1967, 1969; Hsu & Fogel, 2003).

Play

Play was the last category included but stands out as integral to positive, healthy attachment relationships between women caregivers and toddlers. A child must be in a reciprocal, mutual, proximate relationship in an affective environment of safety and freedom to engage in play. Without those aspects of the attachment relationship, a child's engagement with the environment is restricted (Axline, 1969).

In all of these observations, toddler play was free and spontaneous. The caregiver provided minimal props or toys for the child. In two cases, a ball was introduced, in one case a doll was found in a stroller, and in one case a wading pool was brought to the park. In all other cases the toddler improvised with the environment: climbing in and out of folding chairs, chasing pigeons, squirrels, or other children, and finding, collecting, dropping, and throwing stones or sticks. Other evidence of sheer physical delight in self included swinging arms and legs, swaying or rocking back and forth, twirling round and round, rolling in the grass, bouncing up and down, and running to and from. "[R]esearch shows that the

capacity to create joy, elation, interest, and excitement together with [the] baby is a key to early healthy development and lifelong physical and mental health. Thus, the focus.... recognizes the central importance of happiness and joy" (Porter, 2003, p. 7).

Environmental Space

Another fundamental component that emerged from the observational study concerned the caregiver use of environmental space. Caregivers naturally created bounded spaces, even in huge wide-open parks, that contained their child as they played and set the stage for a relaxed interaction that optimized the child's exploration of the world and the relationship with the caregiver. Women were incredibly resourceful with both natural and human-made boundaries in the environment to contain their child. For example, fencing, hedges, benches, gates, a border of trees, tables, chairs, strollers and their own body placement relative to the external markers to contain the child. The similarity of those created spaces across women was remarkably consistent (Winnicott, 1964). They typically maintained the original contrived containment setting to maximize child safety and caregiver relaxation while, at the same time, providing a flexible area for the child to explore. The distance a toddler wandered from a caregiver was not very different by child whether the space was restricted or wide open. In parks or open spaces, the child maintained contact within roughly a 20-yard radius.

The use of environmental space related directly to the attachment feature of proximity. Women arranged the space to curtail the youngster and prevent personal harm to or loss of the child. Women used their bodies as the secure base, setting themselves as the center (though not necessarily the geographic center) of the space, creating a womb-like environmental chamber for the child in which they were safe to explore but within easy reach or sight of their secure base. This holding environment (Winnicott, 1971, 1986) supported the proximity and elasticity of the relationship, which offered the child an opportunity to go and come back, leave and return as they practiced separation and individuation (Mahler, Pine, & Bergman, 1975). These securely attached toddlers were able to use the attachment figure as a secure base for exploration of the environment and as a safe haven to which to return for reassurance (Bretherton, 1985).

> If the attachment figure has acknowledged the infant's needs for comfort and protection while simultaneously respecting the infant's need for independent exploration of the environment, the child is likely to develop an internal working model of self as valued and reliable. Conversely, if the parent has frequently rejected the infant's bids for comfort or for exploration, the child is likely to construct an internal working model of self as unworthy or incompetent (p. 782).

Aspects of positive, healthy woman caregiver-young child interactions reflected features known to promote healthy child development (Berk, 2007; J. Bowlby, 1982; Bretherton, 1985). Mutual and reciprocal relationship building

happened in the space. A gentle but steady introduction of the world to the child occurred (Winnicott, 1964, 1986). The supportive stance of the caregiver offered a secure base for the child. The teaching and modeling of the caregiver offered the toddler an opportunity to practice, master, and succeed at competency skills within the frame of the attachment relationship. This kind of caregiver-child interaction, in developmental terms, would help to instill autonomy in the child and build self-confidence and self-esteem. In the process of these interactional exchanges the child would learn social skills, build internal regulatory systems for behavior and affect, and increase competency skills (Bandura, 1977; Matas, Arend, & Sroufe, 1978; Waters, Hamilton, & Weinfield, 2000).

Specific attachment behaviors were observed in the woman-toddler holding environment that relates to early attachment theory that had its beginning in biological behavior predicated on evolutionary survival and adaptedness (J. Bowlby, 1958, 1975, 1982). These evolutionary and biological behaviors as instincts caused the child to seek the attachment figure in times of distress or danger and also served as protective and survival mechanisms (Ainsworth, 1967, 1969). Attachment behavior was determined to be predictable and worked to increase the proximity of the infant with the mother or attachment figure (Cassidy, 1999). These attachment behaviors served different functions.

Signaling Behaviors

Signaling behaviors such as smiling, waving, vocalizing, calling, and laughing alerted the caregiver that the infant desired interaction and wooed the

mother to the child. This was demonstrated in the observations by the reciprocal, verbal, and physical affection categories.

> *Child toddles to caregiver; looks/gazes at caregiver; lifts own shirt and giggles; points to own belly; giggles again; caregiver sits on her feet; child stands in front of caregiver; face each other; toddler pulls own shirt back down; caregiver and child giggle together (Observation #13).*

Aversive Behaviors

Aversive behaviors like crying, kicking, and screaming triggered a quick maternal response to terminate the infant or child's problem or provided protection and safety. Caregivers demonstrated alertness to potential dangers the environment could present to the child. They anticipated harm as well as reacted quickly in dangerous circumstances to provide protection.

> *Child indicates desire to throw bread in water fountain; pigeons in fountain; caregiver lifts child; stands child on edge of fountain lip; caregiver stretches far to hold child in place; caregiver never lets go of child; other pigeons fly to fountain; abruptly child shows fear by pulling back; caregiver reacts immediately; swinging child down onto the grass a safe distance from fountain; caregiver holds child's hand (Observation #15).*

Active Behaviors

Active behaviors like approaching, holding, touching, and following took the child to closer proximity with the mother and secure base. The behaviors demonstrated the relationship and interconnectedness, the system of attachment, between the infant/child and the mother/attachment figure with the ultimate goal of protection.

> *Caregiver turns to easily watch toddler; child runs to caregiver, turns in circles, and falls in her lap; caregiver holds child up; caregiver sits child down and pats his head; toddler lays his head in caregiver's lap; child climbs onto caregiver; caregiver snuggles child (Observation #2).*

These examples highlight the caregiver's construction of the holding environment, the physical and psychic space where the child is held in security and safety. In this space, the toddler is free to express a full range of intuitive behavioral responses to her own internal environmental pressures as well as to stimuli from the external environment.

Applicability of Study Findings to Practice Settings

One premise of the study is that it is possible to gain an understanding of the nature and dynamics of attachment relationships to inform clinical thinking and intervention (Cristóbal, 2003; Slade, 1999). The six indicators of healthy and pleasurable attachment and attachment behaviors between women caregivers and toddlers and the caregiver use of environmental space can be used to

validate, enhance, and inform attachment work clinicians engage in with clients. Attachment behavior indicators in conjunction with Winnicott's (1971, 1986) construction of the holding environment and transitional space relate directly to adult treatment and specifically to the therapist-client alliance and attachment relationship (Diamond, Clarkin, Stovall-McClough, et al., 2003).

The positively engaged caregiver-toddler dyads observed in this study demonstrated positive attachment behaviors, highlighted attachment relationships, and reinforced the concept of the secure base, therefore the purpose of the enclosed space created by the caregiver was to protect the *child* not the *relationship*. The boundaries of the natural and built environment strengthened and utilized by the caregiver were designed to enhance the patterns of the attachment relationship and the child's exploration of the external environment and offer a safe arena for the child to practice separation and individuation (Mahler, Pine, & Bergman, 1975) with the inviolate security of the visible secure base of the caregiver. Everything about the pattern and place of the observations powerfully portrayed positively engaged, nurtured, and attuned attachment relationships between caregivers and toddlers.

In a similar manner, a therapist is responsible for the physical and psychic space in which treatment occurs, but for an opposite reason. In attachment work, the therapist must create a safe holding environment (Winnicott, 1971, 1986) and secure base (J. Bowlby, 1958, 1982) for the client that prevents harm or loss *because* an attachment relationship does not yet exist either in the client's past or within the present therapeutic environment. And just as dyads remain in the

same created place, treatment occurs in the continuous, steady, created space to maximize safety, familiarity, and consistency. This creates a flexible area for the client to explore their internal historical landscape similar to a toddler exploring the environmental landscape.

In both the caregiver-toddler scenario and the clinician-client scenario, the holding environment is where the relationship occurs and develops. The contained space allows the clinician to relax and be fully present with the client in the therapeutic alliance and attachment relationship (Diamond, et al., 2003) in a similar way that the caregiver is able to relax and be fully present with the toddler in the attachment relationship. This maximizes availability, sensitivity, and empathic attunement (Ainsworth, 1967, 1969; Ainsworth & Bell, 1970). The relaxed interaction in conjunction with an optimal attachment relationship allows the therapist to provide a space or secure base for the client to examine and repair historic attachment figures and relationships and to forge a new attachment relationship with the therapist that fosters new patterns of positive and healthy reciprocal, mutual, and proximate relationships with others (J. Bowlby, 1977; Cortina & Marrone, 2003; Harris, 2003).

A related feature to the holding environment and transitional space is the dynamic tension between connectedness and distance. Proximity in the therapeutic relationship means creating optimal closeness without triggering symbiosis or dependence. Connectedness, boundaries, and distance are typically of particular difficulty for clients who have experienced attachment disruptions that often lead to trust issues and fear of abandonment. The therapist

prescribes the space and distance until the client is able to self-regulate optimal distance and connection in healthy mutual relationships.

It is the accessibility, sensitivity, and responsiveness of the mother or primary caregiver (the principal attachment figure) that typically determines whether a child, or adult, exists in a state of security, anxiety or distress (S. R. Bowlby, 2004). Therefore, in treatment, the clinician, in concert with the client, must be able to develop and maintain an attachment relationship, utilizing the characteristics of accessibility, sensitivity, attunement, and responsiveness to further the exploration of other significant attachment relationships in the life of the client (Diamond, et al., 2003). This helps the client forge a link between the historic attachment figures (mothers and other caregivers) and present adult attachment figures (therapist, lover, relatives, and friends). In adult reparative work, the therapist must, with great sensitivity and care, balance being both the internal representation of the maternal caregiver and the external therapist/stranger. The therapist utilizes herself as a temporary attachment figure for the client (J. Bowlby, 1975; Diamond, et al., 2003).

When behavioral indicators of positive, healthy attachment relationships can be firmly established and then modified appropriately for therapeutic environments, social workers can be educated and trained in attachment reparation protocols. This would mean that a client in a bounded attachment relationship with a trusted clinician could moderate retroactively disrupted childhood attachment and actually find, understand, and utilize the attachment benefits underlying the original attachments. If those original attachments were

weak, it would be possible, in the present therapeutic relationship, to strengthen the original maternal connection/bond in the internal representations or object relations. This could offer access to the positive affectional tie for the client (Harris, 2003).

Trustworthiness

Trustworthiness was addressed in several ways within the study. An audit trail was created and maintained throughout the study process that included: literature review, hypotheses building, method selection, Institutional Review Board process, data gathering procedures, reflexive writing, coding procedures, and data analysis. The study was designed for maximum data gathering ability with minimal bias that utilized extensive field notes, sketches and diagrams, and reflexive writing. And data analysis was strengthened with external coders and peer debriefing.

Study Limitations

Field observation has obvious strengths. First and foremost, the goal is to observe rather than interpret behavior. This serves to limit interpretation and bias related to theoretical framework and personal experience. On the other hand, field observation has limitations. The nature of the study, the observation process, precludes meaning attribution by the subjects involved because subjects are not included directly. The features of attachment delineated here are subject to cultural expectations of the researcher, even though the study was

placed in a multicultural setting. Peer debriefing, after the fact, acts as a control against theme bias, but the field notes, already collected, came from one perspective and that perspective may have been clouded by theoretical orientation, clinical practice experience, and teaching clinical practice in social work education. And it may be that the sketches of the environmental space and position of the dyad within that space were subject to researcher bias because the theoretical framework might precipitate expectable behavior of caregiver-toddler dyads.

The study focused on a relatively small sample and that sample was selectively biased toward women as caregivers and then dyads who demonstrated pleasure and enjoyment in their relationship. Those criteria met the goals of the study and corroborated early field research on attachment behavior but the criteria do not reflect the diverse population of individuals currently associated with child caregiving. The focus on women as caregivers obviously eliminated men from the study. The study findings are a tentative beginning to understanding the therapist-client attachment relationship separate from the alliance, and attachment reparation protocols in therapeutic treatment. But it may be presumed that men and women react differently and uniquely both to attachment disruptions and therapeutic treatment.

Conclusion

The observable indicators of a positive, healthy attachment relationship between women caregivers and toddlers were identified as: reciprocity and mutuality, proximity, verbal communication, affect and emotion, physical affection, and play. These indicators are consistent with the basic principles of attachment theory. The sketches and diagrams demonstrate that caregivers use environmental space to support the secure base functions of the maternal-infant/child attachment relationship. These two outcomes (attachment indicators and use of environmental space) have implications in clinical practice, not only with children, but also with adults who did not have healthy, positive attachment relationships early in their lives. The six indicators of positive, healthy attachment relationships provide categories for clinicians to consider in treatment settings. And clinician use of environmental/transitional space and secure base functions of the attachment relationship continue to have critical meaning in adult treatment of attachment disruptions.

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CHAPTER 5

Women as Mothers of Children in the Attachment Relationship

Abstract

Attachment and attachment relationships that mothers have with their children are examined through semi-structured, in-depth phenomenological interviews. The study method and data analysis were driven by interpretive phenomenological analysis (IPA) and feminist theory and method. Attachment theory and attachment constructs provide a background for the study questions, literature review, and interview instrument development. Mothers were the identified subjects and selection was purposely biased toward playful, interactive, and positively engaged mothers and children. Each case was specifically analyzed for data related to the research questions and the attachment categories delineated in a previous observational study: reciprocity and mutuality, proximity, verbal communication, affect and emotion, physical affection, and play. In addition, themes with rich supportive data across cases were identified as: education; responsibility; childcare; and time management. These mothers spoke lovingly and authentically about the attachment relationship with their children. Every woman addressed the multiple roles that are a reflection of being a mother with a breadth and depth of emotive language that not infrequently brought her to tears. The mothers were articulate and vulnerable, fully engaged in the collaborative process of the interviews with the researcher. The narratives are rich and flow with language of love, tenderness, pleasure, and attachment.

Key Words: *Attachment; Mother-Child Relationship; Childcare; Secure Base*

> I feel it very strongly now; there's no going back and that's okay.... Attachment is forever. Attachment that you just can't anticipate and I can't deny either. I can't walk away from her. I think that's surprising too, the strength of that [attachment] (Beth).

John Bowlby outlined attachment theory and revolutionized the view of the mother-infant bond and relationship when he wrote, *The Nature of the Child's Tie to His Mother* (Bowlby, 1958). Bowlby (1958, 1973, 1982a, 1982b) believed that attachment was primary and exclusive. He held that the mother must achieve attunement with her baby to create healthy attachment. It was the attunement of the mother to her child in stressful and distressing situations that established self-regulation for infants, a biological necessity since babies do not inherently possess self-regulatory systems. The mother-induced regulation worked to keep the baby in balance and emotionally regulated. He outlined the conditions needed for the healthy development of children in *Maternal Care and Mental Health* (Bowlby, 1951).

> [W]hat is believed to be essential for mental health is that the infant and young child should experience a warm, intimate and continuous relationship with his mother, or permanent mother substitute, in which both find satisfaction and enjoyment (p. 368).

Two key constructs evolved from Bowlby's early research. First, attachment is a biological necessity. Bowlby came to believe that the mechanisms that underlie the infant's attachment tie to the maternal figure

originally emerged as the result of evolutionary pressure, a biologically based need for proximity that equated with survival and natural selection (Cassidy, 1999). And second, the mother-infant/child bond is the primary and essential force in infant and child development (Porter, 2003). It is the accessibility and the sensitivity and responsiveness of the mother, or primary caregiver, that typically determines whether a child exists in a state of security, anxiety or distress. Attachment theory premises are based in an enduring pattern of relatedness that exists, not only for survival but also for connection between mothers and their children. These premises form the backdrop and impetus for this study.

The study was designed from an interest in the attachment relationship between mothers and their infants/children to gain a detailed understanding of the personal definition of attachment and the meanings women attribute to being a mother and participant in an attachment relationship with their child/ren. The major research question is, what meanings do women as mothers ascribe to their attachment relationships with their infants/toddlers? The ancillary follow-up questions include: How will mothers describe interactions with their child? Will those descriptions relate to the basic constructs of attachment theory? Will those descriptions relate to the indicators of healthy attachment coded from a previous observational study (Fitton, 2008): reciprocity and mutuality, proximity, verbal communication, affect and emotion, physical affection, and play?

Previous attachment research defined women by their role as mothers, attributing definition to role rather than to the lived experience of unique individuals (Ainsworth, 1969a; Ainsworth & Bell, 1970; Ainsworth, Blehar,

Waters, & Wall, 1978; Lay, Waters, Posada, & Ridgeway, 1995; Matas, Arend, & Sroufe, 1978). These studies also defined caregiver as mother placing the responsibility for infant/child care and rearing completely on women. The research concentrated on negative and pejorative aspects of neglect, avoidance, stress, hostility, rejection, deprivation, and insensitivity on the part of the mother. This study was designed to focus on the perceptions, interpretations, and expressions of meaning women give to their own experiences of being a mother (Riessman, 1994). And, since attachment research had a tendency to blame the mother for insensitivity, this study emphasized the enjoyment of the mother-infant/child attachment and all the positive benefits that ensued from a positive, healthy attachment relationship.

This study is a logical follow-up to a previous observational study (Fitton, 2008) because it enhances the data already gathered by looking at attachment phenomena from a different perspective, field observation to phenomenological interviews. Rather than attempting to establish objective descriptions, interpretive phenomenological analysis (IPA: Smith, 1996) is used in conjunction with feminist methods to take a subjective approach and focus on the uniqueness of a woman's thoughts and perceptions, the phenomenology of her experience in relationship with her children.

Understanding the phenomenological experiences of women with their children in attachment relationships can be utilized for benefit in therapeutic treatment. The stories can be used to impact understanding in the fields of women's studies, child development, and clinical practice across the life span. It

is also important to return to the basic principles of attachment theory through the lens of postmodern, qualitative and feminist methodologies and specifically interpretive phenomenology (Reid, Flowers, & Larkin, 2005; Smith, 1996). These methods emphasize the personal meaning of the lived experiences of women as mothers with their children and honor the sacred power of their words and stories (Marshall & Rossman, 1999).

Literature Review

Attachment theory was developed by the psychiatrist, John Bowlby (1958, 1973, 1982a, 1982b, 1988), 50 years ago, in part, as an alternative to psychoanalytic theory to explain why separation caused anxiety in young children, to explain the similarities between childhood and adult loss and mourning, to explain the process of defenses in the human psyche, and to explain the mechanisms of social behavior from infancy that affect and influence the development of the personality along a continuum from healthy to debilitating (Barnett & Vondra, 1999; Bretherton, 1985; Cristóbal, 2003; Waters, Crowell, Elliott, Corcoran, & Treboux, 2002). Bowlby did not intend that the attachment concept substitute for social bonds or be attributed to all aspects of the parent-child relationship. He intended that the roles of attachment figure and playmate be conceptually distinct. When a child feels stress, distress, or fear, she seeks an attachment figure for safety, protection, and regulation. However, when a child is happy, content, and playful, she seeks a playmate. (Feminine pronouns are utilized throughout this work in deference to the preponderance of childcare

provided by women, even though some men are very or exclusively involved in caring for their children.)

Attachment theory is a perspective on the secure base functions of close relationships that operate to promote child development, personality development, and affect regulation (Bowlby, 1977). The theory assumes that maternal sensitivity, responsiveness, and attunement are major factors in the quality of a child's attachment to her mother or attachment figure (Ainsworth, 1967, 1969b; Ainsworth, Blehar, Waters, & Wall, 1978). Attachment theory also presupposes evolutionary biological necessity. The needs of infants and small children are not variable; they are inherent and unalterable (Winnicott, 1964). Attachment behaviors must exist and be reciprocated for the infant to survive both physically and psychically.

> Unless there are powerful in-built responses which ensure that the infant evokes maternal care and remains in close proximity to his mother throughout the years of childhood he will die. The instinctual responses... serve the function of binding the child to mother and contribute to the reciprocal dynamic of binding mother to child (Bowlby, 1958, p. 369).

Attachment theorists define the term attachment independently but the similarities are striking, including the concepts of proximity, specificity, and necessity. "'Attachment' refers to an affectional tie that one person (or animal) forms to another specific individual" (Ainsworth, 1969b, p. 971). "[A]ttachment

refers to the *relationship*... the affective bond between infant and caregiver" (Sroufe, Fox, & Pancake, 1983, p. 1616).

Several distinctions of attachment theory are mentioned here. Dependence and attachment are separate and different constructs (Bowlby, 1958). Attachment relationships are permanent and irreplaceable (Barnett & Vondra, 1999). Attachment behavior is heightened in situations perceived as threatening but attachment itself is not necessarily strengthened (Ainsworth, 1969b). Attachment behavior, especially when strongly activated by stress or distress, is incompatible with exploratory behavior (Bowlby, 1982a). A distressed child seeks comfort, not stimulation and exploration. Following a prolonged absence from the maternal or primary attachment figure, attachment behavior may diminish or even disappear, but the attachment itself is not necessarily diminished (Ainsworth & Bell, 1970). This is a particularly relevant concept in therapeutic relationships. Attachment relationships vary widely across mother-infant/child pairs (Ainsworth & Bell, 1970). Stress occurs from sudden or prolonged separation from the attachment figure and permanent loss causes grief and mourning (Barnett & Vondra, 1999).

As these statements indicate, attachment is a broad and complicated concept with multiple layers of meanings and interpretations. No single definition or set of constructs can contain all of the significant elements of attachment as a concept. However, one vitally important foundational observation must be stated. Attachment, regardless of the definition, occurs in the holding environment of the mother-infant attachment relationship that begins in the earliest moments of an

infant's life. This holding environment is both physical and psychic. Caregivers must be able to create a good enough facilitating environment at the earliest stages of development to provide for the optimal emotional and mental growth of the child (Winnicott, 1971).

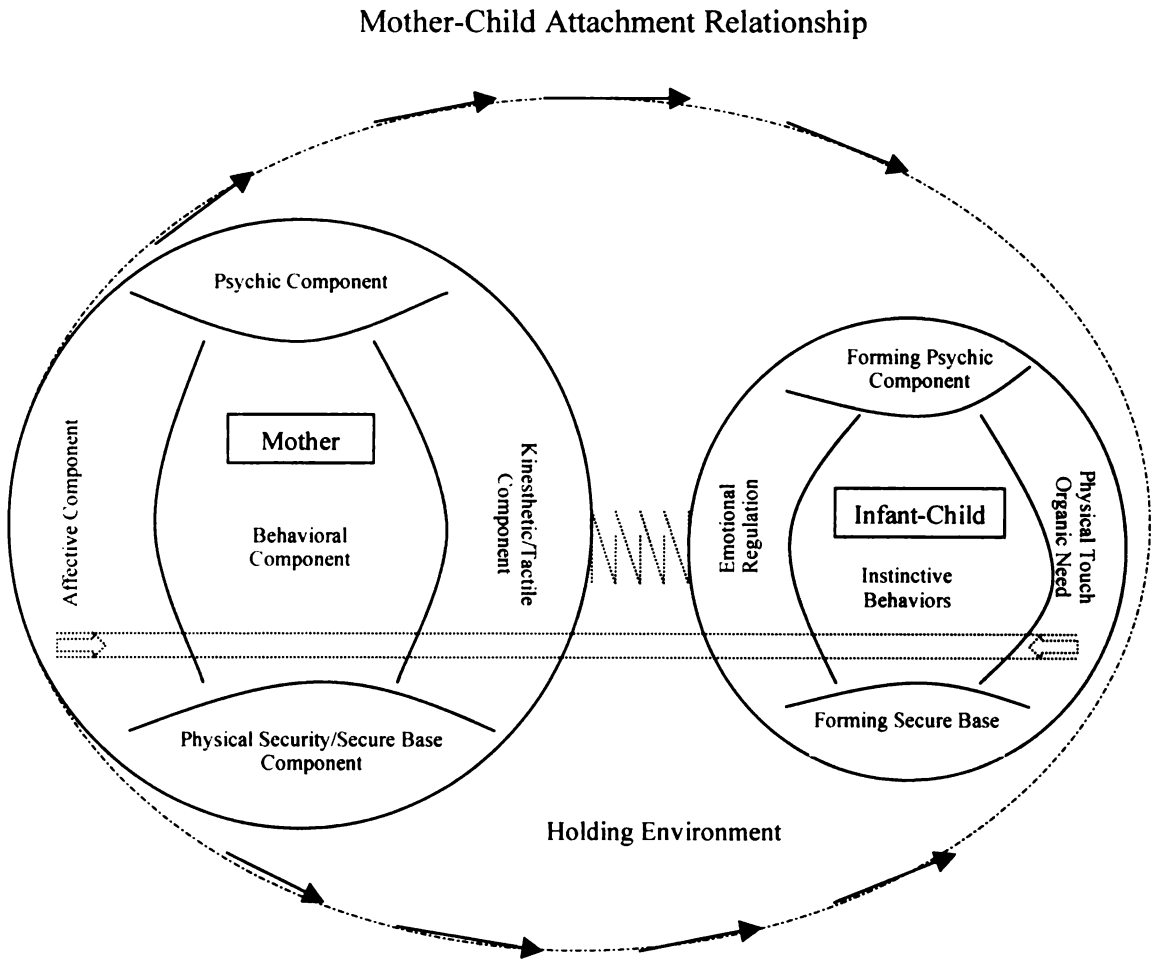
The existing definitions were synthesized and a systematic attempt made to operationalize the term *attachment*. Therefore, for the purposes of this paper, with an emphasis on implications for clinical practice, the author developed a conceptual map (Figure 5-1: Fitton, 2008) of the holding environment of the mother-infant/child attachment relationship that includes: physical security (secure base function), behavioral, psychic, affective, and kinesthetic/tactile components.

Physical Security Component

Attachment has a physical security component – "a tie that binds together in space and endures over time" (Ainsworth & Bell, 1970, p. 50). This secure base is defined as the *attachment figure*. The attachment figure must be consistently physically present and psychically available to the infant/child to create the security of the secure base for the infant/child where growth and development occur. The caregiver, typically the mother, provides a physically secure environment of her presence for the infant. This happens, not only through physical handling and holding, but also, through consistent sensitivity to the needs of the infant and her availability and capacity to meet those needs in a timely manner. A particular and substantial someone, to whom the child can

attach, must exist and have a specific location, therefore, attachment has a solid human context within time, space, and situations (Posada, Gao, Wu, et al., 1995; Waters & Cummings, 2000). "Without adequate environmental reliability the personal growth of a child can't take place" (Winnicott, 1993, p. 99).

Figure 5-1. *Holding Environment of Mother-Infant/Child Attachment Relationship*



Behavioral Component

Attachment has a behavioral component. Attachment behavior on the part of the infant/child operates to increase proximity and contact with the maternal caregiver (Ainsworth, 1967, 1969b; Ainsworth & Bell, 1970; Ainsworth, Blehar, Waters, & Wall, 1978; J. Bowlby, 1958, 1982a; Porter, 2003; Seifer & Schiller, 1995). These instinctive attachment behaviors serve different functions. Signaling behaviors alert the caregiver that the infant desires interaction. Aversive behaviors trigger a quick maternal response to provide problem solving or protection and safety. Active and contact-seeking behaviors promote proximity to the mother and secure base (Ainsworth, 1967; Ainsworth & Bell, 1970; Ainsworth, Blehar, Waters, & Wall, 1978; J. Bowlby, 1958, 1982a; Seifer & Schiller, 1995). Exploratory behavior decreases proximity with the maternal caregiver and promotes interaction with the environment and individuation (Ainsworth, 1967, 1969b; J. Bowlby, 1958, 1982a; Field, Gewirtz, Cohen, Garcia, Greenberg, & Collins, 1984; Mahler, Pine, & Bergman, 1975; Porter, 2003; Seifer & Schiller, 1995). Attachment behavior, especially when strongly activated by stress or distress, is incompatible with exploratory behavior.

Attachment behavior on the part of the mother operates to meet the physical, emotional, psychic, and tactile needs of the infant/child. Paradoxically, these behaviors, which are unreciprocated by infants in the early weeks, work to build the attachment bond and relationship. Bowlby (1958) suggested that, "It is fortunate for their survival that babies are so designed by nature that they beguile and enslave mothers" (p. 368). As babies' signaling behaviors have different

meanings, mothers' behaviors meet different needs. Feeding and diapering are physical necessities. Holding, snuggling, and rocking meet emotional needs of connection and safety. Touching, caressing, and stroking meet tactile and kinesthetic needs. And anticipatory actions and behaviors by the mother to meet her infant's unexpressed needs and wishes, serve two psychic functions. They establish the psychic availability of the mother and maintain the necessary illusion of omnipotence for the baby. These behaviors do not operate independently but function as an organic whole to provide optimal support to the infant.

Psychic Component

Attachment has a psychic component. Attachment is "the psychological availability of a caregiver as a source of safety and comfort in times of child distress" (Barnett & Vondra, 1999, p. 5). Attachment is "the inferred internal bonds that form between infants and their caregivers" (Seifer & Schiller, 1995, p. 147). Another aspect is the caregiver's own mental representation of attachment, her own internal working models experienced and developed in infancy and childhood. Those early mental representations influence later development and relationships (Freud, 1935, 1966). The psychic component, the knowing and trusting of the other, grows developmentally from the physical security of the secure base. The mother must also be psychically available to her child and mentally carry a positive internal representation of her own attachment figures and relationships. These functions create a secure base for the infant/child.

Affective Component

Attachment has an affective component. Attachment bonds are the demonstrable and observable affectionate gestures between infants and their caregivers (Ainsworth, 1967, 1969b; J. Bowlby, 1958; Porter, 2003; Winnicott, 2002). Ainsworth (1969b) used the term *affectional tie* to describe the bond that forms between two specific individuals. Bowlby (1958) spoke of the attachment relationship as a reflection of *pleasure* and *enjoyment* demonstrated in smiling, laughing, happiness, and love. Stress occurs from sudden or prolonged separation from the attachment figure and permanent loss causes grief and mourning (Barnett & Vondra, 1999). The security of the attachment relationship also provides a space for affective reactions to stress and fear indicated by crying, clinging, anger, and frustration. Emotions and "the foundation of emotional regulation [are] also established within the context of the attachment relationship" (Sroufe, 2003, p. 205).

Kinesthetic/Tactile Component

Attachment has a kinesthetic/tactile component (J. Bowlby, 1958). Attachment develops through body contact between caregiver and infant/child demonstrated in caresses and touches (Cristóbal, 2003). "You [mother] just adapt the pressure of your arms to the babies' needs, and you move slightly, and you perhaps make sounds. The baby feels you breathing. There is warmth that comes from your breath and your skin, and the baby finds your holding to be

good" (Winnicott, 2002, p. 21). Gazing, touching, holding, rocking, stroking, and nuzzling are examples of kinesthetic and tactile body contact.

Holding Environment

Attachment exists in the reciprocal holding environment of the mutual mother-infant/child attachment relationship. "Whoever is caring for a child must know that child and must work on the basis of a personal living relationship with that child" (Winnicott, 1993, p. 99). Attachment is defined as an enduring relationship between a young child and her mother (Ainsworth, Blehar, Waters, & Wall, 1978). Attachment relationships vary widely across mother-infant/child pairs (Ainsworth & Bell, 1970) but are always permanent and irreplaceable (Barnett & Vondra, 1999). Attachment relationships teach individuals how to be in relationship with significant others and influences all subsequent relationships through to adulthood. Attachment, first and foremost, exists, and is held together, in the holding environment of the mother-infant/child attachment relationship. All other definitions or systems of understanding must stand upon that principle.

Method

The qualitative research method utilized in the study was a semi-structured, in-depth, phenomenological interview. Eight to ten interviews were planned with an interview time of one to one and a half hours in duration. Institutional Review Board (IRB) approval was granted, informed consent procedures followed, and both confidentiality and privacy maintained.

The semi-structured in-depth, phenomenological interview was used to expand the understanding of what women hold to be true about their thoughts, feelings, and behaviors as demonstrated toward their child (Echevarria-Doan, & Tubbs, 2005; Marshall, & Rossman, 1999; Smith & Osborn, 2003). The semi-structured, interview has a pre-set format of questions to guide the interview but allows for freedom to occasionally ask spontaneous questions as indicated by the direction of the collaborative interview which can be described more as a dialogue between researcher and participant. The semi-structured interview was chosen as an appropriate methodology to address the research questions.

The semi-structured interview helps to guide the collaborative conversation. The structure places boundaries on the topic and offers form to the narrative content. The structure implies a destination (a narrative of the attachment relationship) and a purpose (giving voice to women as mothers). And yet the semi-structured interview offers enough flexibility to adapt to the individual characteristics and temperaments of women in conversation. The respondent, in a semi-structured interview, shares in the direction of the interview (Smith & Osborn, 2003).

Interpretative phenomenological analysis (Reid, Flowers, & Larkin, 2005; Smith, 1996; Smith & Osborn, 2003) was used to help understand how women perceive their attachment relationship with their child in their personal world. It is believed that, in dynamic collaboration, women as mothers can be heard, seen, and validated. IPA is also interpretive. The researcher utilizes personal skills and abilities of interpretation to make sense of the women's experiences in a way that

addresses the research questions (Smith & Osborn, 2003). IPA is an inductive method similar in approach to grounded theory or data-driven theoretical formulation (Reid, Flowers, & Larkin, 2005). The researcher is not expected to begin data collection with hypotheses already established (although this is a difficult task given all the preconceived ideas from a review of attachment literature and the attachment indicators that emerged from the observational study). The data are intended to define how the research questions are answered. IPA is used to answer questions about what it is like for women to be mothers of infants and toddlers and how they attribute meaning to being mothers in an attachment relationship with their child.

Feminist methodology was also used to ground the research in the experiences of women. Feminist methodology can lead to the empowerment of women and is designed to work explicitly toward meaningful social change (DeVault, 1999). Traditionally men have been the focus of research. A feminist methodology values women and points of view from women's perspectives since their voices have not typically been heard (Waller, 2005). This methodology moves researcher and interviewees into a mutual and collaborative relationship. Feminist methodology embraces narrative, in the forms of personal life experiences, life histories, and stories, as critical to understanding social interaction and therefore rejects the mandate that research is objective. Feminists understand that research questions, methods, measurement, and the language used in written reports all reflect subjective and political choices. So interview methods are purposefully chosen as a straightforward application of

feminist values and beliefs (Waller, 2005).

The semi-structured, in-depth interviewing technique is a fundamental data gathering method encouraged in IPA and feminist methodology. The open-ended dialogue fosters a collaborative relational experience between the researcher and the participant that can lead to new ideas and perspectives on the research questions (Smith & Osborn, 2003). IPA is remarkable for its demand of the detailed and nuanced responses and reflections of participants that are not possible to collect from written notes, therefore, all interviews were digitally recorded. The written analysis includes substantial verbatim excerpts from the data. And the use of IPA highlights the personal and cultural meanings of each woman's constructed existence.

Subject Selection

Mothers are primary caregivers and, along with their children, are typically the objects of attachment research studies. Women as mothers are, therefore, the identified subjects in this study. Initially mothers were specifically recruited as participants when elements of pleasure, enjoyment, and play were evident in the relationship with their children. This was based upon Bowlby's (1958, 1982a) early theoretical formulation that the attachment relationship was an emotional and affective bond that reflected the enjoyment and the attraction that one individual had for another individual.

Participants of the study were chosen by convenience and availability. Two colleague acquaintances and one neighbor acquaintance were approached

with information regarding the study, as prescribed by the institutional review board process, and each agreed to be a study participant. Contacts for successive interviews were gleaned from each previous participant to give access to a larger number of mothers. Subsequent women participants met the preferred selection bias of playful, interactive, and positively engaged mothers. This biased sample may have occurred because women participants referred sisters, friends, and colleagues whom they assumed would *enjoy* participation in the study. It seems reasonable to assume that a woman participant who enjoyed participating in an interview/narrative about their relationship with their child/ren, would be playfully, interactively, and positively engaged in that attachment relationship.

The interviews, lasting anywhere from one to two hours, were completed in quiet, private places, either at a School of Social Work office or the participant's home. The location was designated by the participant and confirmed by the researcher to maximize confidentiality and privacy. The researcher conducted all seven interviews, transcribed each interview, hand-coded the data, and was the only one with access to all information and records.

Data Collection

An original eight to ten interviews were planned but access to mothers and time constraints limited the number of interviews to seven. Interviews ranged from 52 – 112 minutes with an average time of 76 minutes. The mothers ranged in age from 28 – 38 with an average age of 31 years. Four of the mothers

interviewed, Beth, Carol, Donna, and Grace, have one child each: 7 months, 7 months, 17 months, and 25 months. One mother, Amy, has two children: 48 months and 8 months. And two mothers, Eva and Fran, have three children each: Fran's children are 7 years, 33 months, and 17 months and Eva's are 6 years, 30 months, and 4 weeks. All of the children are birth children. (All of these names are fictitious to protect the identity of the mother participants.)

All mothers are Caucasian and in long-term, committed relationships with a significant other. Amy, Beth, Eva, Fran, and Grace all have male partners, identify as heterosexual, and are married. Four of those men are Caucasian. Eva's husband is Cuban. Carol and Donna self-identify as lesbian and have female partners who are Caucasian. These couples are prevented from having a *legal* marriage. All of the families represented live together and partners described as involved in the childcare process. Amy and Eva, who have multiple children, have one child (their first child) from a previous heterosexual relationship. Both mothers have full custody of their children.

Amy, Beth, Donna, and Eva have graduate degrees, Carol and Grace are in graduate school, and Fran is completing a baccalaureate degree. Beth, Carol, and Fran work part-time. Amy, Donna, Eva, and Grace work full-time. These demographics highlight small aspects of the context to these mother-child relationships and yet hint at their diversity. The mothers are similar in that they all desired to have children and love their children.

Caucasian, middle-upper middle class and well-educated families have nearly exclusively been the subject of investigation in attachment research (Lay,

et al., 1995; Matas, Arend, & Sroufe, 1978; Sroufe, Fox, & Pancake, 1983; Steier & Lehman, 2000), therefore, in this study, all of the women and their children are Caucasian, middle-upper middle class and well-educated. Current subject selection was intended to reflect previous subject demographics for two reasons. Attachment research has historically been empirically and quantitatively based. This qualitative approach adds another reflective dimension to previous attachment research and logic dictated the use of similar subjects. Second, a multicultural approach to attachment research is sadly lacking therefore a model for evaluating attachment within culture is unavailable. Race and culture were intentionally excluded as variables in the study.

Data were collected from the transcribed phenomenological interviews. The interview was developed with the study questions in mind, to maximize the mothers' reflections and perceptions related to their attachment relationship with their child/ren and phenomenological experiences as women and mothers. The semi-structured interview consisted of 10 major questions with multiple prompts designed to elicit information across a wide range of thoughts, feelings, and reflections (Table 5-1). Once the interview outline was established, it was not altered. The process of the interview provided flexibility to follow the women through the pattern of their narrative. The collaborative nature of the semi-structured interview increased the connection between researcher and participant and presumably increased full involvement by the mothers with the interview process (Smith & Osborn, 2003). Mothers with more than one child (Amy, Eva, and Fran) were encouraged to respond to the interview questions

Table 5-1. *Interview Questions*

Question	Probes
1. What are the first things that come to mind about your relationship with your child?	1a. Can you remember your first moments with your child? 1b. How would your family and friends describe your interactions? 1c. What would you like me to know about your relationship?
2. How would you describe attachment?	2a. What does it look like? 2b. What kinds of activities does it include? 2c. What does attachment feel like?
3. What are your favorite things to do with your child?	3a. How do you play together? 3b. What do you play with? 3c. What are your favorite things to do together? 3d. Where do you go together?
4. How do you and your child show affection to each other?	4a. Do you show affection in the same ways? 4b. Are your affectionate gestures more physical or more verbal, e.g., pet names?
5. How do you and your child communicate with each other?	5a. What kinds of language to you use? 5b. What non-verbal cues exist between you?
6. What else would you like people to know about your experience with your child?	
7. How has your life changed since you had your child?	7a. Has anything surprised you about yourself? 7b. Has anything surprised you about your child? 7c. What are some of the hard things? 7d. What are some of the positive things?
8. What helped you manage and/or cope with having an infant/child?	8a. What supports you? 8b. Who supports you? 8c. What keeps you going?
9. How do you manage to be both a woman and a mother?	9a. How do you define yourself as a woman? 9b. How do you define yourself as a mother? 9c. How have your roles changed since becoming a mother? 9d. How have you been successful as a mother? 9e. How have you been successful as a woman?
10. What else would you like people to know about your experience as both a woman and a mother?	

with their infant and/or toddler-aged child in mind. These mothers spontaneously answered some of the questions about all of their children, thinking back to the toddler age of their older children. Narrative was not interrupted. Prompts were used when participants hesitated or in the case of more reticent subjects to encourage engagement with the process.

Interviews were digitally recorded. The researcher took copious notes on both content and process as each participant responded. To maximize narrative accuracy, the researcher transcribed each interview. Therefore, the researcher enjoyed a four-fold engagement with the data: listening to the initial interview responses, taking process notes during the interviews, detailed listening for transcription, and reading completed transcripts for analysis. Reflexive thoughts and comments were written in a personal journal at the completion of each interview and revisited during coding. Information logs and an audit trail were maintained throughout the interviews, transcription, and coding processes.

Data Analysis

Data analysis was completed using interpretive phenomenological analysis (Smith & Osborn, 2003). Initial coding began with an idiographic approach that analyzed each interview as a single case. Each transcribed interview was searched in detail and independently for significant themes. A line-by-line and word-by-word analysis was performed using a color-coding technique with keywords written in the right hand margin. Each transcript in its entirety was treated as data and no passages were selected or omitted for specific

interpretation (Smith & Osborn, 2003). In this process, emergent themes were identified and coded and then connections sought between them, creating clusters. The researcher relied on personal interpretive technique while balancing the sense of that interpretation with the actual words of the participant, what Smith and Osborn (2003) call evidence of convergence. The clustered themes were then examined for evidence of convergence across the transcripts to identify overarching concepts relevant to all participants. A list of themes was generated and clusters grouped and given an identifier. Over time, themes were dropped from the list when supportive data were minimal in a single transcript and/or had no supportive data from subsequent transcripts.

Themes from the first case oriented the subsequent analysis (Smith & Osborn, 2003). Special care was taken to both acknowledge repeating patterns and identify new themes. Each transcript was analyzed using the interpretive process and compared across cases. When themes and clusters were identified, the transcripts were examined a second and third time for examples of those themes and any additional emergent characteristics or themes. Additionally, each transcribed interview was examined a minimum of three times for specific examples of material related to the study questions and the attachment indicators and then a table of categories developed.

The categories selected for discussion in this paper (Table 5-2) were chosen for the richness of the data in transcription passages as well as how those data work to illuminate the broader narrative. These passages were well represented within the transcripts and reflected the understood meanings that

thread the participants' accounts rather than the researcher's expectations. Each case was specifically analyzed for data related to the research questions and the attachment categories delineated a previous observational study (Fitton, 2008): reciprocity and mutuality, proximity, verbal communication, affect and emotion, physical affection, and play. Those themes with rich supportive data across cases were identified as: education; responsibility; childcare; and time management.

Table 5-2. *Categories and Themes*

Attachment Indicators	Emergent Themes
Reciprocity and Mutuality Proximity Verbal (& Non-Verbal) Communication Affective Features Physical Affection Physical Activity and Play	Education Responsibility Childcare Time Management

And finally, the interpretations and conclusions derived by the researcher were discussed with study participants. To maintain confidentiality, dialogue was limited to conversations with each woman individually. However, one wonders what might be the effect of a group interaction and conversation among these intelligent, thoughtful, and engaging women.

Interpretations

This section of the paper is devoted to the words and images mothers used to describe their experiences, thoughts, and feelings about the attachment relationship with their child/ren. It begins with descriptive language of their relationships and then moves to their personal definitions of attachment and the

secure base. The six attachment indicators flowed through all interviews. Representative data are matched to those indicators. And finally, four emergent themes are identified and interview quotations offered to support those themes.

Relationship

Attachment, which occurs in the holding environment of the mother-infant relationship, is the foundation of all relationships and influences all subsequent relationships through to adulthood. Bowlby believed the mother-infant attachment was primary and exclusive and portrayed infants as competent, curious, and fully engaged with their caregivers and the environment (Waters, Crowell, Elliott, Corcoran, & Treboux, 2002). In this study, mothers' responses regarding their relationship with their child/ren were warm and tender, full of attachment language, unconditional love, protectiveness, and personal vulnerability.

> He's my little snuggler, my little snuggle guy.... It [is] wonderful.... He's just squeezable. He's so soft and sweet.... I love just holding that little body. Ah, it feels so good. They're so warm. They're just like little furnaces. I love it (Amy).

> In the beginning I held her all the time.... I don't know what I would do without her.... Or I will get up early in the morning just so I can be the one to feed him or I'll just hold him.... I love my children. I love them to death. I hope every mother does (Eva).

> She's made my life so much more rich.... You can't explain to someone else your connection to your child very well, at least I can't, and have them understand the sheer joy that it brings.... I feel a lot more protective than I used to and nervous at the same time (Donna).

> Obviously there were some really positive feelings around [the first moments], but also a certain sense of fear. You know, fear of opening that door of being vulnerable to loving someone else, and that could be painful at times (Beth).

> I didn't understand how dynamic and beautiful our relationship could be, which is silly because I have a beautiful relationship with my mother, but it's actually incredible.... The profundity of what the relationship between a mother and a daughter is, just hits me sometimes. I get bashed by it (Grace).

Attachment

Attachment is described in the literature as a deep and enduring connection between a child and maternal figure. "From an emotional perspective, attachment is the creation of a mutual bond in which the mother shapes infant development through her interactions and relationship with her child" (Porter, 2003, p. 2). Mothers described this bond as life long, connected, intertwined, supportive, physically and emotionally close, and as unconditional love.

> The way I understand attachment is the idea of being a base for my child's emotional needs and self-esteem and almost like this island where she can come back to and find what she needs but then be able to kind of reach out from that and explore and see new things and do new things, but to come back to something that's familiar and something that's safe (Beth).

> [P]eople who are attached to each other enjoy spending time with each other.... If you're attached to someone you care about their well being. You care about whether or not or how they're experiencing the world and that they feel loved and supported, free to express whatever emotion that happens to be.... I don't feel like her attitude necessarily affects the level of attachment that I have (Carol).

> It's just that bear part of me, that bear part, that I just have to hold my young and I'll kill anyone who tries to hurt my baby, kind of thing.... It looks like holding a baby. Just holding them. Keeping them close.... It's just the feelings and the love, and whatever other emotions, are beyond everything else (Amy).

> Attachment to me is life long. It feels like you're connected, you're interconnected and intertwined. I want her to also feel attached to me. I'm sure I'll always feel attached to her.... It feels like she's

> holding my heart. That's what it feels like to be attached. She could do anything and it just makes me melt.... As soon as she came out of the womb though I was attached to her. I knew I would be attached to her until I died, unconditional love. That's how I feel (Donna).
>
> Attachment is like your heart breaking into a hundred million little pieces and then exploding in joy and bewilderment.... Like a simultaneous explode and implode of your whole being. She's absolutely everything, and absolutely everything is at risk (Grace).

Secure Base

Babies instinctively reach out for the safety and security of the *secure base* with caregivers. The secure base is defined as the attachment figure, a particular and substantial someone in a specific location, to whom the child can attach, therefore attachment has a solid human context within time, space, and situations (Posada, Gao, Wu, et al., 1995; Waters & Cummings, 2000). The holding environment (Winnicott, 1971) supports the proximity and elasticity of the mother-child relationship and offers the child an opportunity to go and come back, leave and return as they practice separation and individuation (Mahler, Pine, & Bergman, 1975). These securely attached children were able to use their mother, the attachment figure, as a secure base for exploration of the environment and as a safe haven to which to return for reassurance.

> Attributes of the secure base would be if, while she's exploring, and something doesn't go right or if she's hurt or if she feels like she doesn't do something right or failure or whatever, that there's still acceptance, that there's this unconditional love and acceptance that she can have which gives her the confidence to do those things in the first place (Beth).

> She just can entertain herself for a good while. If you put a few toys within her reach, she may occasionally look up to see if you're around... but she's pretty secure (Carol).
>
> I really feel like she trusts me a lot. I feel like she knows that I'm available to help her. And it's been really, really fun to watch her start to assert that independence of toddlerhood. She says things like, "No mommy. [I] will do it. I can do it. I can take care of it." And I know that I kind of helped facilitate that. It's definitely not some kind of rejection. It's a taking over of some responsibility that's definitely appropriate (Grace).

Attachment Indicators

Elsewhere, six indicators of healthy and pleasurable attachment and attachment behaviors between women caregivers and young toddlers were delineated: reciprocity and mutuality, proximity, verbal communication, affect and emotion, physical affection, and play (Fitton, 2008). These indicators demonstrate key principles of attachment theory. All of the interviews included elements of every coded category indicating that the relationship demonstrated a full range of positive, healthy attachment behavior.

Reciprocity and Mutuality

Reciprocity is a hallmark feature of relationship presuming two participants where one initiates and the other receives. Reciprocity is demonstrated through behaviors such as giving and receiving, reading and listening, hiding and finding, or imitation. Mutuality manifests in the shared experience or expression of the relationship through such activities as eating together, moving in tandem, laughing and jabbering together, and mutual touching. Reciprocal and mutual

behaviors were evident through all the interviews.

> She'll watch you and what you're doing. If I have a toy, and I'm showing it to her, she'll watch me. If we're eating, she'll watch us as we're eating. She really watches us all the time (Carol).

> She runs off and goes here or there. I can leave her for a minute but when she leaves my sight, I have to stop and go and look for her (Beth).

> At this point it's more like a teaching relationship. She knows who I am. I know who she is. I'd like to think our relationship is very tight and some day it will be. But right now we're just getting to know each other, seeing what she likes and what she doesn't like. I'm sure she's checking me out too, seeing how I react to certain situations. We have just a great relationship (Donna).

> We love to go to the park. And we went to a play park. She's so fun. It was Friday afternoon and we were both out of school and just kind of unwinding. She said she wanted to sit in the red swing. It's kind of a big infant swing contraption thing. So I put her in there. She's just so sweet. She pointed to the swing next to it and said, "Mama sit in blue one." "Alright, you'd like mama to swing too?" "Mama swing too" (Grace).

Proximity

Proximity is demonstrated through the dynamic tension of the physical connectedness and distance exhibited by a mother and her child. Close physical contact is the feature characteristic of proximity, for example, sitting close together, holding hands, climbing on or clinging to mother, or being held in her arms. As the physical contact is broken, mothers typically exhibit hovering, standing over, leaning in, stooping down, and watching behaviors. Proximity relates to separation-individuation (Mahler, Pine, & Bergman, 1975) and to the secure base function of the attachment relationship (Ainsworth, 1969b; Bowlby, 1988). The child uses the mother as a home base.

> And I think, probably on the more literal level, it's just that I want them close to me. I don't want them far from me (Amy).
>
> I like to hold him. We have this little wrap thing. It's called a mobi-wrap and you can put him in there so it frees up your hands. I love to wear that when we're going for a walk or going to the mall or somewhere that we're going to be out for a while as opposed to having him sitting in the car seat, in the stroller or something (Eva).
>
> I think of proximity, of being able to wander further away. You know, the whole idea of her looking back and seeing myself or my partner and feeling confidence to try something new or to play with another child that she maybe doesn't know very well (Beth).
>
> In the very beginning she wanted to be right on our chests and that was great (Carol).
>
> She wants to be right in the middle of everything so we take her everywhere.... It's the best job in the world and it's fun and I never want them to move away (Eva).
>
> They grab onto my leg and not let go.... I usually let them stick with me. They'd stick like glue.... The easiest thing for me was to bring him along from room to room, upstairs, downstairs.... I want my babies with me (Fran).
>
> She initiates the sweetest interactions. Like the other day, my partner was out of town and I was giving her a bath and she was splashing around. And she points to me, "Mama shirt off." "What are you thinking?" "Mama pants off." "What's your plan?" She goes, "Plan having mama in tubby too." So pants off, shirt off, sure enough. So we played in the tubby. And she wanted to help me get my hair washed. We were having a blast in there. It was really fun. Being able to be flexible and receptive to the things she wants too is really important because they are often the most beautiful moments (Grace).

Verbal Communication

Communication occurs when mothers call their child's name and the child responds, sometimes with words although most often with groaning, gibberish, or screeching because many of these children have limited language. Verbal

communication also occurs in a spontaneous outburst of laughing or giggling in response to engagement in physical activity and play. Some of the mothers interviewed had young infants so verbal communication is translated to basic communication and the *knowing* that exists between a mother-infant dyad.

> I was getting all frustrated because I was telling my partner, "I don't know if he's getting enough food," because we were nursing. "Do we give him a bottle? Is he getting enough? Is he tired?" It was like ahhh! And my partner would say, "No, you guys are communicating." "What are you talking about?" To me it wasn't showing, but to my partner it was showing that I would be talking to baby and [baby] would be sort of talking back with me (Amy).
>
> Just last night, my mom was here, and [baby] would squeal, my mom would squeal. It went back and forth for five minutes at least. We try to encourage her to have a conversation with us. We give her time to respond. And if she doesn't respond then we do it again and if not then we give her a couple of times to see if she's interested and if not then give her some space to have quiet time if she wants it (Carol).
>
> I tell her that I love her and she tells me that she loves me (Eva).
>
> He'll call out to us and we'll come in, so the conversation has started and it just feels good. It just feels good that he's responsive (Amy).
>
> She does communicate a lot. If she doesn't want to go somewhere she will run away from you. And if she's upset about something, she'll stamp her feet. She's a little bit of a drama queen at times. It's clear but it's short-lived, too.... She gets over it pretty quickly but she'll let you know if she's not happy about it (Beth).
>
> I think we communicate mostly through touch and through facial expressions. She could *not* be smiling and you make an excited face and she'll just light up. She knows it's time to be happy. We're going to do something exciting (Donna).
>
> We started signing with her when she was 9 months old. She was 13 months old when she really exploded into it, but then she was picking up four and five signs a day and that changed our relationship. That was the point at which the relationship really started to blossom. She's so intense that as soon as she could

> communicate her needs, even if I wasn't able to meet them, understanding that someone was thinking about her and understanding what she wants was very important to her (Grace).

Affect and Emotion

Attachment behavior also manifests in affect and emotion. The affectionate bond of the relationship reflects pleasure and enjoyment and is demonstrated in smiling, laughing, giggling, waving, clapping, watching, and following. But subtle affective features can be displayed, such as those indicated below with italics, by mothers and demonstrated in children of all ages.

> I enjoy snuggling, giggling, playing and making her laugh (Eva).

> There's nothing better than her laugh. There's nothing better in this world. I love to make her giggle and belly laugh (Donna).

> He watches me when I come in to care.... He likes to watch. He wants to watch what you're doing (Amy).

> If you're playing with her, she'll laugh and giggle and she'll watch you and what you're doing.... She just loves it. She giggles and laughs (Carol).

> She's 18 months old and she desires to be more independent and is able to be more independent so it's *exciting* and *frightening* at the same time. It's like that's the goal and yet it's *frustrating* at times too.... Everything feels new to some degree and trying to make decisions without having past experience, that feels *challenging* to some degree (Beth).

> It's still all that *excitement*. You know in the morning when they wake up and see you and they're grinning from ear to ear and they're just *delighted* that you're back (Amy).

> She's very *relaxed* and she kind of does her own thing whenever she wants to. We've been able to *accommodate* that for the most part (Carol).

> I was *jealous* about having to leave the home [and baby].... If something would have happened to her, I'm sure I would have been *devastated* (Donna).
>
> I don't really have the words for it but they are stronger feelings than I've ever had in any other part of my life.... It's just the *feelings* and the *love* and every other *emotion* are beyond everything else (Amy).

Physical Affection

Attachment has a strong tactile component (Bowlby, 1958) and develops through body contact between mother and infant/child demonstrated in caresses and touches (Cristóbal, 2003). Physical affection is indicative of enjoyment and pleasure and is demonstrated by hugging, kissing, snuggling, cuddling, rocking, holding hands, touching, and carrying. Children often signal a desire for closer contact by tugging on their mother's leg or clothes. The mother's positive response, by lifting the child into her arms, indicates a heightened level of attunement and sensitivity to the child's needs in the moment (Ainsworth, 1967, 1969b; Hsu & Fogel, 2003).

> I love to snuggle with them at night. We'll put pillows and blankets on the floor and they'll all cuddle me and we'll watch cartoons. I love it when they all snuggle me. That's my favorite.... We give hugs all the time. Lots of kisses. It's so wonderful because they are so affectionate to each other too so it melts my heart. [The baby] goes to bed, I take her up to her crib first, and she gives me a kiss, and then she gives [her sister] a kiss and gives [her brother] a kiss. I mean we cannot go to bed unless we give everybody a kiss. We're really affectionate. I love it (Fran).
>
> Lots of hugs. We do lots of squeezes. Lots of kisses. She's very physically cuddly so she likes to sit on our laps and we read to her (Beth).

> He's into his feet because he grabs his feet and so if he's grabbing his feet you watch him and agree that you like his feet. He likes that. He's doing the talking to the hands thing. And it's just that we're sort of joining in with him and letting him know that his little hands are so fabulous. He just loves them, loves those hands. Loves those feet. Maybe, he's on the change table, we have that sort of time that's full of affection like, "Oh yeah, you are fabulous." Skin to skin. That's part of the bath I love, just holding that little body. Ah, it feels so good. I love it (Amy).

> We do a lot of normal physical stuff. I can't keep my hands off her. She's going to make me stop really soon. I just can't stop. I can't let her go. Hugging her all the time and playing with her hair and touching her feet. She's getting to the point she's like, "Mama stop it." "I can't, I'm sorry." I hug that baby every second. I just love her to pieces (Grace).

> Kissing and hugging. She's extremely loving. Telling her all the time that I love her (Eva).

> Hugs, believe it or not. She'll sit on my lap and she'll make eye contact. And she'll lean in and I'll give her a big hug and she'll sit back up and she'll do it again. Or lots of kisses. Or if I'm feeding her and she reaches up and touches my face or lips. When she falls asleep on me. I like to tickle her feet. I like to kiss her cheeks, take hold of her hand, give her baths, and play (Donna).

Play

Attachment behavior includes play. A child must be in a reciprocal, mutual, proximate relationship in an affective environment of safety and freedom to engage in play. Without those aspects of the attachment relationship, a child's engagement with the environment is restricted (Axline, 1969). In all of these interviews, mothers described their child's play, and their interactive play, as free and spontaneous.

> Love to play. That's my favorite thing to do. It's my favorite thing to do.... I want to play with her up until she's grown, and after. And I want her to come and say, "Let's just play. I just want to play with

you, mom." I think it's a great learning experience. The best way they can learn is through play.... All she needs right now is play.... I think more people should learn to play. I think as people grow up they forget that (Donna).

I had both the kids and they needed baths so we all got naked. We filled up the tub, my daughter, mom and baby.... Baby is this mellow kid, but he gets loud. He started splashing. And you know splashing around makes a noise. He started howling, this sort of laugh howling thing. And he's just flapping, a four-point flap, all arms and legs going.... The baby was laughing, splash, splash, splash. And so that was fun playing. That was fun playing. He loved the water. He loved the splashing (Amy).

Sometimes we play really aggressive. Not rough, but I think that kids need physical play sometimes, that hard physical play, especially with [my son].... So I kind of started with that and continued along. We'll play tug-a-rope, push/pull activities and things like that.... I love to play (Fran).

I like playing tea party with her because it's very funny who she invites to the tea party. I love the animals that are invited.... I love going to the beach with her, too. She's very playful and pretty daring in the water so far (Beth).

She can draw me into her world and we can play together.... Play has everything to do with attachment because her existence fostering a sense of play in me has been so fulfilling.... I love being silly with her (Grace).

Education

One of the themes that emerged in the data analysis process was a construct related to education and new experiences, for example, learning, teaching, and modeling. Every one of these mothers mentioned, with great fascination, a remarkable pleasure in the experiential learning that happened with their children. "We show her things and sort of watch what she is looking at. It's fun to watch her improve and react to new

experiences" (Carol). Mothers spoke to the influence they have over children. "There's something really cool about that. You get to have that influence over this little person" (Beth). Mothers mentioned the responsibility to model positive and appropriate behaviors for children. "Even walking around the block would help our energy level as parents and help be a positive model to our kids" (Amy). Mothers also spoke to the role teacher plays in the attachment relationship and the responsibility they feel to have a variety of tangible and intangible objects and experiences to offer to their children. "I try to initiate a lot of interesting things. And I try not to be too dorky and not too didactic but it's pretty bad. I'm really a teacher" (Grace). And, not only did mothers accept the role as teacher of their children but they often mentioned the process of learning from their children in the reciprocal nature of the relationship. "I think of a lot of learning. As I say that a lot of learning on my child's part but also a lot of learning on my part" (Beth). "Nobody told you how to be a mom but I tell my daughter she was a very good teacher because we definitely learned a lot" (Eva).

> I find it fascinating to see her little mind be a little sponge where she is just taking things in. You get to show them certain things for the first time. They see a little butterfly outside for the first time or whatever and they're really excited because they never saw it before. Or when she saw a plane and she's like, "Oh, what's that." There's something very rewarding about providing her those new experiences.... Just seeing her really seeing new things, always seeing new things, experiencing new things, and kind of seeing her take it all in (Beth).
>
> We're learning as we go and we're teaching each other (Donna).

> [S]he's so inquisitive and she's at an age where she's learning so much. You can see her pick up an object and turn it around and look at it and try to figure it out. So to watch her with all of these new experiences and think about what her brain is maybe thinking about and what she's learning is really fun (Carol).
>
> Absolutely every night we would review the day and I would tell her the things that I remembered and enjoyed about the day and how we spent time together. And every night I would tell her what I was proud of that she accomplished that day (Grace).
>
> [I want to] be patient and set good examples (Eva).
>
> I tell her the things that I see that she does that I feel are positive. Like she is often very affectionate with her baby [doll]. She will pat it and pat baby's back while baby's sleeping and I tell her how sweet she is and that's so nice to be helpful and to be caring (Beth).

Responsibility

Another theme that emerged out of the analysis was the responsibility mothers feel for the health and welfare of their children. Mothers mentioned being more aware of safety issues when driving a car occupied by a child or the vulnerability and risk involved in air travel. "Now I'm terrified of flying because... if the plane went down my kids wouldn't have a mother" (Fran). Some mothers talked about the risky behaviors to which some children are drawn. "She's already fallen... stuck a bead up her nose... cut open her ear... and smashed her finger. She's just not cautious at all.... I'm afraid what's going to happen when she goes to school and playing on the playground, what she's going to do out there" (Eva). And most mothers spoke to their awareness of potential dangers and harms that could befall their child and the helplessness they felt in the face of those fears. "You watch the news and hear so many bad things, so I

make sure the door is locked one more time" (Donna).

> I remember feeling just very emotional and feeling.... both my husband and I had this overwhelming sense of, "Oh my gosh here is this child that we're both responsible for now." It was really bizarre because we were both feeling it at the same time. When we were in the hospital we were kind of like... It was this actually weird thing that there was almost this sense of fear. "Oh my goodness my child could be hurt." All of a sudden life became more complicated (Beth).
>
> I called my partner. Didn't get through so I called right over to the baby center and the kids hadn't been picked up yet. And it was, part of me wanted to start crying. "Oh my God, where's the baby and where's my partner? And if he's not there, I should be there." It was so physical.... I'm talking about it because I'm so upset even though in my brain I knew that the children were safe. They were with caretakers who love them. Someone was coming. None of that was going on. I think the fear of them feeling left or alone. I'm sure was some kind of projection or something. But he's just an infant, an infant alone. It was just like, panic (Amy).
>
> My focus is so external now.... It's so important to get her needs met before mine. But then I do understand that you have to make sure that you respect your own self so that you can make sure you're available for that kind of attachment. If you're so caught up in your own martyrdom, or whatever it is, then you can't be available for forging really solid relationships (Grace).
>
> She's just not cautious at all, so he said, "Be ready. This is going to happen and you can't freak out every time and panic. You need to be stronger for her." And he's right. I'm trying. She scares me but we just need to teach her the right thing to do.... I don't want her to suffer or have any kind of pain, but I don't think that she'll be careful until she experiences that pain and then goes out to do it again (Eva).
>
> That first experience was amazing.... I was overjoyed but at the same time I knew I had a big responsibility from that point on.... I feel a lot more protective than I used to and nervous at the same time (Donna).
>
> I was just really young and immature. I was a really good person, I was just really confused about what I wanted to do with my life and then along came my daughter and everything changed. I, not grew up, but I really matured when I had her. I wanted to be a better

> person. I wanted to go back to school. I saw things differently. I got real paranoid. That's the one thing my husband doesn't care for. All of my actions, I don't think of how it's going to affect me, I think about how it's going to affect my children. It changed completely, everything, every aspect (Fran).

Childcare

Women had particularly strong feelings around the issue of childcare. The initial experience of leaving a child was fraught with emotion. "When I was leaving her and she was upset, I felt guilty" (Beth). Differences existed among the women about expectations related to childcare dependent on their personal childhood experiences with external childcare. "She's been in daycare since she was four months old. I didn't have any concerns about that in the beginning. My partner did just because she did not grow up in daycare whereas I did" (Carol). Yet, overwhelmingly, women agreed that, if their child was comfortable, content, and happy in the childcare setting, it relieved maternal anxiety about working. "Knowing that they're in good hands is the first and best thing" (Fran).

> I feel like it takes so much to carve out... the space that it's okay to be at work, that it's okay for your child to be cared for somewhere else.... It's very much a process to have that be an okay thing. And my mom helped me with it. I mean my mom saying, "Working *is* taking care of your child." With baby... the women who are taking care of him in childcare are wonderful. I call them day mamas. And one of them.... baby loves her, loves her.... Baby sees her and he lights up from ear to ear and does his little penguin [flap]. And that's all I needed. It's like, "You know what? This little baby is delighted with you." I can go to work now. It's okay and so that's huge (Amy).

> I'm thinking about my own feelings around having somebody else be influential in my child's life and how that feels and actually the experience when I initially brought her to daycare and her reaction to me leaving, and now her reaction to me leaving is just very different.... I think when I was leaving her and she was upset, I felt

> guilty. I questioned, Should I be going? Should I be leaving her? Is this really okay for her? I kind of went through my own feelings around working and whether or not that was okay.... Knowing that she's okay with [daycare], I don't feel threatened by that. I don't feel like, "Oh no, she doesn't need me anymore." Which is nice because I do feel like she still needs me. It's very evident that she needs me, that she needs me in different ways (Beth).
>
> We both wanted me to be able to stay home with her the first few months if at all possible and prolong her age when she started daycare.... That first week at daycare was hard.... But I think now we both really see it as an extremely valuable experience for her because she's in a place where the daycare providers are really attentive to her and they really try to keep a small ratio of infants to teachers (Carol).
>
> Definitely going back to work was good because it put me in a place where I was feeling competent and in control for most of the day. Although I really wrestled with the guilt that I should be home with her but that was hard even though I didn't want to be and then I felt double guilty for not wanting to be with her as I should (Grace).
>
> Their nanny is just fantastic and she loves them like they're her own children. That makes it easy. If it wasn't for that I don't think it would be as easy for me, but I know that as soon as I walk out the door.... Like this morning, baby cries, but as soon as I'm in the car I know she's fine and everything is great (Fran).
>
> A piece of that attachment is when I see his connection to the people taking care of him. I can get in the car and drive to work. If that wasn't there, I swear I don't know what I would be doing. That would be a nightmare (Amy).

Time Management

The last theme to emerge from the coding process revolved around the issue of time and time management. Some women expressed the feeling that time slowed down. "I do feel like it's forced me to slow down in a lot of ways" (Beth). Other women felt that time sped up. "It seems like there's more to do. My semester, this semester is very busy. And I still have a million things to take care

of when we get home" (Carol). While one woman expressed a sense of being trapped in time. "I felt like this is how it's going to be. I got myself into this. I guess I'm going to spend 15-hour days walking circles around the dining room table. That's how it's going to be" (Grace). All of the women interviewed felt that managing their work time for maximum impact was crucial to maintain enough quality time to be a mother. "I always wanted to be a mom and now I am and it's perfect. I just wish I could spend more time with her. You gotta. You just gotta. If she's going to go to daycare, you just gotta" (Donna).

> It gives you a different perspective on things. It seems like there's more to do.... And I still have a million things to take care of when we get home... but it's emphasized the factor of time management and needing to get things done. I feel like there's less room for me *not* to get things done because I know it's going to mean less time with my partner and with the baby when I get home. So I try really hard to make my work hours productive. It doesn't always happen but I feel like I put more pressure on myself to try to do that because I want to try to have work at work and then be able to enjoy the stuff at home too (Carol).

> [H]aving a child makes me think a lot about my own way of doing things, my own agenda and how my agenda and her agenda don't always match and how I manage it well or don't always manage it well, and then how that may come across to her.... My agenda versus her agenda and being willing to not necessarily get done all the things that I want to get done or that I planned to get done in my own head because I think it requires me to be a lot more flexible.... I do feel like it's forced me to slow down in a lot of ways. It's weird though, it's forced me to slow down but then also it feels very busy. It's a different sort of pace (Beth).

> Everyone kept saying, "Oh, baby changes your life." Baby number one doesn't feel like anything compared to baby number two. It's pace and timing and how to keep the attention with my daughter and keep up with her and her needs. But because my time with baby is... it's very physical. It's very literal. It's very right there.... All the roles need to be done more carefully. Like at work, the job description hasn't changed, but I just need to be more vigilant because I don't have the stopgaps that I used to have (Amy).

Giving voice to women's stories was a fundamental goal of this paper, based on the fact that attachment research methods have defined women by the role of mother, attributing definition to role rather than to the broad, deep, full, and rich lives of unique individuals. It was a pleasure and an honor as a researcher to be given access to these wonderful stories, memories, experiences, and feelings. The mothers interviewed felt similarly. Amy addressed this clearly.

> This was a treat. I can't believe how selfish I feel that I got to sit around and talk about being a mom to my babies. And this is just like a present. There isn't a lot of space to sit here and talk about kids. That would bore the hell out of people. The experience itself is just everything.

The meanings mothers ascribe to their attachment relationships with their children are eloquently stated in the above passages. What is not so easily communicated on paper were the non-verbal gestures, the tears, and body language of the participants as they spoke about their children. Amy, as she said, "I want them close to me. I don't want them far from me" put her hands up on her chest over her heart. When mothers talked about hugging, snuggling and cuddling with their child, they often wrapped their own arms around their body in that hugging motion. Carol, as she said, "She was reaching for my hair and touching my hair" put her hand to her head and gently touched her own hair, reminiscent of her child. And Grace, in her response to the first things that came to mind about her relationship with her child, said, "I'm overwhelmed with how dynamic it is and how fluid it is and how easy it is for it to change as she changes

in ways that I think are awesome and beautiful." Her eyes filled with tears and she said, "I'm going to cry in the first sentence."

Mothers described interactions with their child with powerfully emotive language that held positive connotations for Western Caucasian culture: unconditional love, joy, adore, excitement, delighted, wonderful, successful, comforting, fabulous, fantastic, pleasure, overwhelmed, attached, vulnerable, acceptance, warmth, encouraged, flexible, happy, awesome, fortunate, enjoying, amazing, surprised, supported, relaxed, secure, connection, and engaged. They also used powerful emotive language that has connotations of stress: anxious, scared, tense, afraid, nervous, frightening, worried, fear, painful, conflicted, guilty, upset, frustrating, stressful, struggle, exhausting, jealous, devastated, and uneasy. Maternal descriptions of attachment relationships with their children related directly to the basic constructs of attachment theory as evidenced by the connection to the literature review. And, as detailed above, the mother participants in this study provided beautiful descriptions of their attachment relationships directly related to the indicators of healthy attachment coded from the previous research: reciprocity and mutuality, proximity, verbal communication, affect and emotion, physical affection, and play.

Trustworthiness

Trustworthiness was addressed in several ways in the study. An audit trail was created and maintained throughout the study process that included: literature review, hypotheses building, method selection, IRB process, data

gathering procedures, reflexive writing, coding procedures, and data analysis. A semi-structured phenomenological interview was designed for maximum data gathering through a researcher-participant collaborative discourse that was digitally recorded to capture exact words and nuance.

The reduction of bias in a qualitative study is a difficult process. Cooperative inquiry was established as part of the collaborative interviewing relationship to offer each woman the opportunity to concur with or challenge the interpretations following completion of data analysis. Multiple researchers for data collection and comparison of analyses were not practical but peer debriefing was incorporated into the process to reduce bias and address researcher triangulation. Interpretive phenomenological analysis (Smith, 1996) was the primary method utilized in this study but it was mixed with feminist methodology (DeVault, 1999; Waller, 2005) and therefore method triangulation was addressed to some extent. Analysis triangulation was addressed by incorporating features of the constant comparative method (Echevarria-Doan & Tubbs, 2005) in conjunction with IPA.

Limitations

Category generation from qualitative data, particularly from a feminist perspective, has a subjective basis. This is intentional. In this case, category generation was influenced by the researcher's inferences from the data, initial research questions, theoretical perspective, interpretation, previous experience and knowledge, and the dynamic interaction with the study participants. Another

possible limitation is quoting out of context to support interpretation and generalization (Riessman, 1994) though every effort was made to be cautious in this regard.

Conclusion

This study has implications for research, policy, and treatment. The earliest attachment research focused on theory development, explaining attachment and its primary function of bonding and security for biological survival (Ainsworth, 1967; Bowlby, 1958). In the decades following, attachment research focused on mother-child behavior and the creation of attachment classification systems utilizing quantitative methods (Ainsworth & Bell, 1970; Ainsworth, Blehar, Waters, & Wall, 1978; Barnett & Vondra, 1999; Cassidy & Berlin, 1994; Forbes, Bento, & DeOliveira, 2003; Gusella, Muir, & Tronick, 1988).

There is a need, in future research, to work toward understanding and enhancing the development of healthy attachment between infants and children and their caregivers. This study demonstrates that mothers feel a bond form with their infants either before or following birth. They articulate a clear understanding of the need for an attachment relationship with their children. And these mothers know how to use that relationship for the growth and development of their child. This rich and detailed information is a missing piece of previous attachment research indicating the addition of qualitative methods to future attachment research.

The current policy environment has fostered programs and pilot studies to intervene in maternal-infant/child attachment, however, these programs operate almost exclusively at the adult level. The interventions target caregivers who are typically considered at-risk young mothers (even prior to the birth of the infant) to protect the infant and child, strengthen maternal sensitivity, attunement, and listening behaviors, build caregiver support systems, and add services for the family as needed (Cassidy, Woodhouse, Cooper, Hoffman, Powell, & Rodenberg, 2005; Cooper, Hoffman, Powell, & Marvin, 2005; Olds, 2005). The intervention protocols and models have demonstrated an increase in maternal-infant/child secure attachment. But as this study demonstrates, attachment is reciprocal, mutual, and proximate and occurs in the holding environment of the mother-infant/child attachment relationship. Any protocol or model that focuses solely on one half of an attachment relationship denies the vital offering of the other half of the relationship and the dynamic interchange that happens in the transitional space (Winnicott, 1971) of the mother-infant dyad. Infants and children, who live in relationship with their mothers and/or caregivers, need to be added to the treatment protocols.

This study also has implications for treatment.

> A feature of attachment behaviour of the greatest importance clinically, and present irrespective of the age of the individual concerned, is the intensity of the emotion that accompanies it, the kind of emotion aroused depending on how the relationship between the individual attached and the attachment figure is fairing.

> If it goes well, there is joy and a sense of security. If it is threatened, there is jealousy, anxiety, and anger. If broken, there is grief and depression (Bowlby, 1988, p. 4).

Healthy maternal-child relationships demonstrate life-affirming and beneficial attachment behaviors that can be extrapolated to therapeutic environments (Cristóbal, 2003; Slade, 1999; Weiner, 2003) to help repair what may have been threatened or broken in the relationship. Clinicians, educators, and students who have a strong understanding of secure, healthy attachment relationships can use that knowledge to mediate the symptoms of disrupted attachment (Bowlby, 1977).

The mother participants in this study have much to offer the field of attachment research through the words and narratives of their dynamic and interactive relationships with their children.

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CHAPTER 6

Conclusion

> Making the decision to have a child is momentous. It is to decide forever to have your heart go walking around outside your body (Elizabeth C. Stone, Professor, Department of Anthropology, Stony Brook University).

Current research indicates that when a mother-infant dyad has the ability to create joy, elation, interest, and excitement together, they establish early healthy child development and set the stage for a lifetime of physical and mental health for the child (Porter, 2003). This research demonstrates a much-needed movement away from the negative and pejorative nature of earlier attachment research and emphasizes instead the enjoyment of the mother-infant/child attachment relationship and all the positive benefits that ensue. It also reflects more clearly the picture Bowlby painted as the author of attachment theory when he defined attachment as an emotional and affective bond that reflects the enjoyment, the attraction, that one individual has for another specific individual (Bowlby, 1958, 1977).

"In the case of human personality the integrating function of the unique mother-figure is one the importance of which I believe can hardly be exaggerated; in this I am at one with Winnicott" (Bowlby, 1958, p. 369). Winnicott (2002), a pediatrician and child psychoanalyst for 40 years speaks gently, thoughtfully, and positively about mothers, children, and families and never labels or uses pejorative or derogatory language. During radio talks to British parents of infants his words were typically uplifting and beautiful. "You just adapt the

pressure of your arms to the babies' needs, and you move slightly, and you perhaps make sounds. The baby feels you breathing. There is warmth that comes from your breath and your skin, and the baby finds your holding to be good" (p. 21). This is a powerful reflection of the lived experience of a mother and her infant. From another broadcast, he adds,

> Whoever is caring for a child must know that child and must work on the basis of a personal living relationship with that child, not on the basis of something learnt and applied mechanically. Being reliably present and consistent to ourselves we provide the stability which is not rigid but which is alive and human, and this makes the infant feel secure (Winnicott, 1993, p. 89).

This dissertation as a whole was meant to reflect Bowlby's (1958) and Winnicott's (1993, 2002) formulations of the maternal-child attachment relationship and the inherent enjoyment and pleasure reflected in those relationships. The literature review, the case study, and the two qualitative research studies illuminate the early roots of attachment theory.

Attachment theory evolved out of the early to mid-twentieth century Western, white culture that esteemed stay-at-home mothers as primary caregivers and leveled the responsibility for infant attachment, development, and health at mothers. Women continued to be defined as the *angel in the house*, a Victorian era construction that emerged and solidified from Coventry Patmore's (1854) popular poem, *The Angel in the House*, of the ideal wife and woman.

Women were expected to live in a separate sphere from men and the outside world.

This binary spilled over into attachment research. Mothers and infants were observed in homes and laboratories, their behaviors scrutinized and categorized, but personal stories and narratives never gleaned. Therefore, this dissertation focused on women as mothers in the attachment relationship from the perspectives of phenomenology and feminist theory. The case study was added because it told the story of two women from a phenomenological perspective, the young mother and the therapist. Field research was selected for the observational study as a reflection of Ainsworth's (1967) early attachment work in Uganda. And the in-depth, semi-structured interviews were designed and analyzed using both interpretive phenomenological analysis (Reid, Flowers, & Larkin, 2005; Smith, 1996; Smith & Osborn, 2003) and feminist theory (DeVault, 1999; Waller, 2005).

Mother-Child Attachment Relationships Across Papers

The case study and the two qualitative studies demonstrate the powerful connection between mothers and their children. Bowlby (1958) suggested that, "It is fortunate for their survival that babies are so designed by nature that they beguile and enslave mothers" (p. 368). Unfortunately, as can be seen in the case study, life events, whether perceived as positive or negative, have the power to disturb the maternal-child bond. In this case, suffering and loss hampered the development of the young mother's attachment to her child. Indeed, the baby

was so attuned to his mother that he *played dead* for her in representation of the father/husband.

In contrast, the visual depiction of mother-toddler attachment in the observational study revealed not only positive and healthy attachment indicators but also optimal settings for that attached connection to foster personal growth of the toddlers. The field study provided an opportunity to observe mothers and their children from an objective perspective. And the purposive sampling of positively engaged dyads offered an opportunity to investigate aspects of emotionally healthy mother-child behaviors for optimal transfer to treatment settings in cases of attachment reparation.

Mother-child attachment relationships were the focus of the second qualitative study but sought from the perspective of the mother's voice. In the phenomenological study, mothers described their lived experience as participants in an attachment relationship with their children. These narratives were full of attachment language and emotion that reflected positive, healthy indicators of attachment between mothers and their children. These rich data highlight once again early attachment research that focused on those behaviors that drew mother to child and child to mother in a relational dance that was biologically necessitated but ensured through pleasure and joy. This has deep and specific meaning in the treatment of attachment disruption in therapeutic venues.

Papers Connected to the Literature Review

> Briefly put, attachment behaviour is conceived as any form of behaviour that results in a person attaining or retaining proximity to some other differentiated and preferred individual, who is usually conceived as stronger and/or wise. While especially evident during early childhood, attachment behaviour is held to characterize human beings from the cradle to the grave (Bowlby, 1977, p. 203).

The case study (Chapter 3: Fitton, 2008b) is a good example of attachment across the life span. The case is founded in attachment principles and relationships. The young mother struggled to create an attachment bond with her child. The therapy was directed most pointedly to this issue, utilizing the interactive guidance technique (McDonough, 1992) to boost the mother's insight regarding the faulty attachment with her child, and to promote sensitivity toward her child and his needs. The young mother's own faulty childhood attachment was an understood element of the treatment, especially as it related to her inability to bond with her child. The sudden and permanent loss of the attachment relationship she had with her husband caused tremendous grief and mourning (Barnett & Vondra, 1999) which also negatively affected the bond between mother and child. The therapist also wrestled with attachment during the course of treatment. The collaborative attachment and therapeutic relationship between client and therapist was tenuous but served as the foundation for client change in the process of treatment.

The field study (Chapter 4: Fitton, 2008a) was conducted to observe indicators of healthy and pleasurable mother-toddler attachment. Six attachment indicators were confirmed from the analysis: reciprocity and mutuality, proximity, verbal communication, affect and emotion, physical affection, and play. These were also observed to exist in the context of a secure relationship with a secure base for child exploration and maternal adaptation of the external environment. The six attachment indicators with the secure base functions and environmental adaptedness demonstrate key principles of attachment theory (Bowlby, 1958, 1973, 1977, 1982a, 1982b, 1988). The study features align closely to the attachment constructs outlined in the literature review: physical security including the secure base; behavioral, psychic, affective, and kinesthetic/tactile components; and all within the holding environment of the mother-infant/child attachment relationship (Fitton, 2008a).

The phenomenological interviews (Chapter 5) were designed to elicit narratives from mothers concerning their attachment relationships with their infants and children. This was intended to return attachment research to the basic principles of attachment theory through the lens of postmodern, qualitative and feminist methodologies and specifically interpretive phenomenology (Reid, Flowers, & Larkin, 2005; Smith, 1996; Smith & Osborn, 2003). These methodologies emphasize the personal meaning individuals attribute to their lived experience. The words and stories represented in Chapter 5 help to illustrate the breadth and depth of attachment theory. These data reflect not only the principles of attachment theory as first outlined by Bowlby (1958) but the

growth of attachment theory and its constructs as it has been expanded over the past 50 years.

Mothers spoke poignantly of the attachment relationship with their children. They expounded the basics of attachment theory as they related stories of interactions with their children. These women were so engaged in the process of storytelling that voice inflection, emotional reaction, and body language heightened the narrative. They spoke their stories with words, gestures, tears, and feelings, and offered their stories with wide-open abandon and vulnerability.

Implications for Practice and Education

Attachment behavior indicators in conjunction with Winnicott's (1971) construction of the holding environment and transitional space relate directly to adult treatment and specifically to the therapist-client alliance and attachment relationship (Diamond, Clarkin, Stovall-McClough, Levy, Foelsch, Levine, & Yeomans, 2003). The six indicators of a secure attachment relationship must occur in the holding environment of the mother-infant/child attachment relationship that also includes secure base functions and use of environmental space (Fitton, 2008a).

Reciprocity presumes two participants where one initiates and the other receives. This relates directly to collaboration and participation in treatment. Mutuality manifests in the shared experience or expression of the relationship. In this case, both the client and the clinician invest in the experience of the therapeutic relationship and alliance creating pleasure and enjoyment in the act

of being together in a shared space and connection. A word of caution: the therapeutic holding environment must have physical and psychic boundaries in order to create a place for the client to explore, experience, and express in safety.

A dynamic tension exists in all relationships between connectedness and distance in the process of forging interdependence and maintaining independence. Proximity in the therapeutic relationship means that the clinician is responsible for creating optimal closeness without triggering symbiosis or dependence in the client. The therapist helps prescribe the space and distance through boundary definition until the client is able to self-regulate optimal distance and connection in healthy mutual relationships.

Verbal communication can be minimal in an attachment relationship where mutual understanding creates a process whereby each individual feels known, heard, and understood by the other. Words in verbal exchange between mothers and their children are typically used for protection, education, and spontaneous outbursts of joy. In treatment, similar exchanges exist. It is the responsibility of the therapist to create safety and protection, to provide psychoeducation, and to teach and participate in a genuine and spontaneous relationship with the client. It is important to understand that communication is key, not specific words or conversations.

Attachment disruption often manifests in restricted or incongruent affect for clients. Therefore treatment in these cases focuses on helping the client create and maintain congruency, increase the ability to experience and label a

full range of emotions, and moderate negative affect that can lead to self-harm and/or damaged interpersonal relationships. The therapist teaches these constructs to the client through psychoeducation, modeling, role-play, and supportive relationship building.

Touch is paramount in attachment relationships. Physical affection is the demonstrable outcome of relationship and must exist to balance other features. Physical touch is both tactilely and psychically necessary for all individuals across the entire life span. And physical affection is typically the single greatest loss and the most profound missing element in attachment disorder. Clinicians must understand the need for and use of touch in attachment treatment and judiciously introduce physical touch for clients to learn to appreciate their own tactile needs within prescribed boundary limitations. Touch is a critical element of attachment reparation; yet, touch is taboo in current therapeutic environments.

Play is a behavioral feature of attachment relationships. This construct represents the freedom and spontaneous exploration that are hallmarks of secure attachment for children. Attachment disruption leads to restriction, flatness, and the vegetative symptoms of depression. Traditional talk therapy often ignores the element of play.

> Psychotherapy takes place in the overlap of two areas of playing, that of the patient and that of the therapist. Psychotherapy has to do with two people playing together. The corollary of this is that where playing is not possible then the work done by the therapist is directed towards bringing the patient from a state of not being able

to play into a state of being able to play (Winnicott, 1968).

Therefore, physical activity and playfulness must be encouraged as treatment goals.

Children depend on the secure base function of the maternal attachment relationship to explore their world and individuate as persons. The purpose of the enclosed space created by the caregivers in the observational study was to protect the *child*, not the *relationship*. In attachment work, the therapist must create a safe holding environment (Winnicott, 1971) and secure base (Bowlby, 1988) for the client that prevents harm or loss *because* an attachment relationship does not yet exist either in the client's past or within the present therapeutic environment. The secure holding environment is characterized by continuous, steady and secure holding to maximize safety, trust, familiarity, and consistency that eventually helps the client forge new patterns of behavior and create positive and healthy adult attachment relationships.

It is also important to educate future clinical social workers in the foundations of human experience. That includes attachment theory because, as Bowlby (1977) states, "[A]ttachment theory is a way of... explaining the many forms of emotional distress and personality disturbance, including anxiety, anger, depression and emotional detachment, to which unwilling separation and loss give rise" (p. 201). These are fundamental treatment issues in clinical social work practice for which students must be prepared.

Attachment theory also complements developmental theories, theories of personality development, and family systems theory typically taught in the human

behavior in the social environment curricula. The durable "internal working models" of relationships (Bowlby, 1982a) develop through the experience of the mother-infant/child attachment relationship, affecting the child's security, trust, and functioning in all other relationships throughout life. This has life-long implications for the individual. It has life span implications for the social worker. The six indicators of positive, healthy attachment relationships provide categories for social work educators to consider in clinical education and training and for clinicians to consider in treatment settings.

Attachment indicators, secure base functions, and use of environmental space have implications in clinical practice, not only with children, but also with adults who have not had healthy, positive attachment relationships early in their lives. And since early attachment relationships set the stage for all future relationships, the implications of attachment research across the life span and across social systems are remarkable. These are foundational elements of social work education, the life span and transitions of individuals and families in the social environment.

Strengths and Weaknesses of the Research Designs

The papers presented in this dissertation are exploratory in nature. The single case study highlights the difficulties attachment disruption creates in the formation a of maternal-child bond. The case also illustrates how a faulty childhood attachment relationship impacts the self through the life span. And, while this is illustrative of damaged attachment and the difficult work that goes

into reparation, the case study does not lead to new information on attachment theory or therapy. The case exemplifies how attachment research was drawn into classifying insecure attachment styles. Researchers, educators, clinicians, and mothers know what secure attachment looks like, and understand the behavioral dimensions of faulty or broken attachment. What is not so clearly understood, is how to utilize the knowledge of secure attachment to remediate disrupted attachment, but the case study sheds no particular light on that subject. The case study does, however, indicate the necessity for attachment reparation protocols.

Attachment indicators emerged from the observational study and, unlike the case study, offer attachment features to consider in attachment reparation therapy. The study returns to, and reinforces, early attachment theory research and what it was designed to accomplish, but also, in the present environment of evidence based treatment, lacks the experimental rigor suggested in such a stance. This may call into question the efficacy of evidence based treatment in all circumstances or at least what *evidence* means for treatment purposes. The indicators from the field study (Fitton, 2008a) align closely to attachment theory and research. From a strengths perspective, it makes sense to seriously consider attachment indicators from healthy attachment for attachment reparation therapy.

The phenomenological interviews serve as a foil to the quantitative research methods historically used in attachment research and stands on its own merits. Phenomenology, from a feminist perspective, is the key to weakness in quantitative methods. Its very strength is giving voice to the lived experience of those subjects whose behavior was so exquisitely detailed through quantitative

methodology. Qualitative methods breathe life into those dry and brittle data. And feminist methods specifically highlight the thoughts and experiences of women who have been so neglected in male dominated research. Feminist methodology also highlights "women's experience in terms of their own imagery of relationships... and also provides a nonhierarchical vision of human connection" (Gilligan, 1993, p. 62).

One of the strengths of these two studies is the fresh view of attachment behavior and relationship from a positive, healthy, and life-affirming perspective. Other strengths are the stories and the vivid descriptions of what it feels like from mothers' perspectives to be attached to their children and to live day by day in those attachment relationships. Weaknesses in the study designs include: cultural homogeneity, small sample sizes, and restricted caregiver sampling. The field study might have been enhanced by adding photographs to the design for a pictorial view of the caregiver-toddler interactions that could further validate the attachment indicators that emerged from the study. And finally, videotaping the interviews with mothers would have added non-verbal body language and an extra level of narrative communication as women told the story of their lives with their children. A poignant element of each interview was missed through the one-dimensional audiotape.

Further Areas of Study

Attachment theory has a strong empirically based research history but experiments continue in the laboratory with predominantly white middle and upper-income women and children (Barnett & Vondra, 1999; Lay, Waters, Posada, & Ridgeway (1995). As policy decisions are affected by attachment research and programs developed to prevent attachment disruption, especially for young children, demographics are changing to at-risk categories that stereotypically focus on women of color from low socioeconomic status (Cassidy, Woodhouse, Cooper, Hoffman, Powell, & Rodenberg, 2005; Cooper, Hoffman, Powell, & Marvin, 2005; Olds, 2005). Attachment research clearly needs to be expanded to include qualitative methods to enrich data gathering techniques, and to include diversity by adding gender, sexual orientation, race, culture, socioeconomic, and age factors to study designs (Corey, 2005; Corey, Corey, & Callanan, 2007; Laird, 1998).

Researchers and clinicians must look carefully at how mothers and children can repair the disruptions that occur in their relationship and particularly how disruption and reparation can enrich rather than disturb a mother-infant or mother-toddler way of being together (Bergman & Harpaz-Rotem, 2004). Research is needed to help understand how individual temperament or the personalities of the mother and infant influence what is observed in attachment studies (Cassidy, et al., 2005). Research is needed to understand ethnic and cultural characteristics of families in attachment relationships. Research is needed that enlightens therapeutic intervention across the life span to help

assess, and then repair, attachment trauma and increase the social functioning of hurting individuals regardless of age or life circumstances. And longitudinal studies are needed to gain an understanding of how positive and healthy attachment relationships affect the biopsychosocial development of children over time and across settings and environments.

The interviews (Chapter 5) generated enough data to write a second paper on women's perceived roles as mothers. While these data focus on the role of mother and represents a shift away from childhood attachment per se, the material is still steeped in relationship and those relationship factors continue to shed light on attachment across the life span. For example, women spoke of the physical and emotional support they received from their adult relationships in meeting the demands of being a woman with an added role of mother: their own mother/parents, significant other, sisters, women friends, and work associates. Attachment research and intervention protocols indicate that enhancing early attachment has positive life long implications for children and adults (Nagle & Wightkin, 2005; O'Connor & Nilsen, 2005) and sets the stage for all future relationships (Bowlby, 1977; Hesse, 1999; Main & Goldwyn, 1998; Main, Kaplan, & Cassidy, 1985; Freud, 1935, 1966), therefore, it is important to understand the connection between positive and healthy childhood attachment and subsequent relationships across the life span.

Conclusion

Attachment theory has stood the test of time. Fifty years after Bowlby, attachment across constructs (e.g., secure base functions; affective, behavioral, psychic, and kinesthetic/tactile components; and attachment styles) and the life span continues to be the focus of research and operates to inform clinical education, practice, and policy decision-making and program development. Social work is in a unique position to strengthen the effects of attachment theory on research, policy, education, and practice by adding two of its basic principles, empowerment and the strengths perspective (NASW, 1999), to attachment theory research. This dissertation was an attempt in that direction. The clinical case was formulated from a strengths perspective, designed to empower a young mother to work toward healthy self-identity in order to offer a secure base to her child and create a healthy attachment bond. Both qualitative studies focused on positive, healthy attachment indicators and relationships. And the interviews were designed to give voice to and empower women as mothers.

This dissertation represents a move away from negative and pejorative attachment classification systems. It reflects instead positive and healthy attachment relationships and those indicators that may be used to help form early attachment bonds between mothers and infants or used to help repair disrupted attachment across the life span. This hopefully, echoes the attachment theory legacy of Bowlby, the optimistic object relations perspective of Winnicott, and the empowerment and strengths perspective inherent in today's social work environment. In sum, current research indicates that when a mother-infant dyad

has the ability to create joy, elation, interest, and excitement together, they establish early healthy child development and set the stage for a lifetime of physical and mental health for the child (Porter, 2003). Thus, it is imperative to focus attachment research on those life-affirming elements and maximize developmental health of all children and their subsequent life relationships. The work in this dissertation offers testimony for this approach.

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