A Sense of Entitlement to Self in Relationships: An Elaboration of Attachment and Feminist Object Relations Theories

Suzanne Elaine Wolfe

Western Michigan University

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A SENSE OF ENTITLEMENT TO SELF IN RELATIONSHIPS:
AN ELABORATION OF ATTACHMENT AND FEMINIST
OBJECT RELATIONS THEORIES

by

Suzanne Elaine Wolfe

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A SENSE OF ENTITLEMENT TO SELF IN RELATIONSHIPS:  
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OBJECT RELATIONS THEORIES

Suzanne Elaine Wolfe, Ed.D.  
Western Michigan University, 1998

Many women who present for psychotherapy with symptoms of depression and/or anxiety describe a common pattern of involvement in current and past nonmutual relationships. This phenomenon is described and explored in light of a new conception of entitlement. It is proposed that one's sense of entitlement is a relative relational position along a continuum from overentitlement through healthy entitlement to underentitlement, and that these women are often underentitled in their adult relationships. Their relationships are often with overentitled others, and they may hold internal convictions that their place in relationships is to be underentitled. A particular pattern contributing to underentitlement in adult women may be a history of mother-daughter role reversal, in which the caregiving function was inverted.

Selected research from attachment theory is presented that applies to the hypothesis that one's sense of entitlement as an adult is related to relational expectations learned very early in life and internalized in working models of relationships, originating especially from the relationship with mother. Evidence is offered to demonstrate that these working models carry forward, affecting later social and cognitive development, and also mothering styles in adulthood. The feminist
object relations perspectives of Chodorow (1989) and Eichenbaum and Orbach (1983) that suggest mother-daughter role reversals and underdeveloped identity in the daughter, which may occur as a result of their shared gender, is discussed.

Therapeutic provisions that address underentitlement and alter these women's internal expectation of underentitlement are suggested. Because one's working model regarding entitlement, like all working models, is learned and confirmed in relationships, changing the sense of entitlement hinges upon a different, disconfirming relational experience. Some relational experiences not provided (or insufficiently provided) in early attachment relationships will need to occur in treatment, in order for the person to more fully grow into selfhood and healthy, mutual relationships with others.

The importance of therapists' healthy sense of entitlement is discussed. The implications of therapists' entitlement-related training experiences are considered. Finally, areas for future research related to entitlement are identified.
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CHAPTER I

INTRODUCTION

Statement of the Problem

Women who present for therapy with symptoms of depression and/or anxiety often describe current and past nonmutual relationships. They describe similar conditions: feelings of emptiness ("I don't know who I am"); sole responsibility for household maintenance chores; self-perceived obligation to satisfy families' emotional needs; husbands and children who determine leisure activities and enjoy hobbies and activities outside the home; and fear of expressing anger or disappointment. While they try to calm or prevent the frustrations of others, they are often without such comforting.

Purpose of the Study

The frequency of these characteristics among women clients displaying symptoms of depression and anxiety suggests the value of exploring their causation, which in turn may suggest useful therapeutic approaches:

Questions to Be Answered

In the author's clinical experience, clients in these situations are observed to
have similar dysfunctional self-concepts and a particular pattern of childhood relational experiences. The research task, then, is to examine the potential relevance of one's self-concept and such childhood experiences to the appearance of nonmutual relationships in adult women presenting clinical depression and anxiety.

Statement of the Hypotheses

A novel feature of this study is an expansive redefinition of the concept of entitlement. Previously used as descriptive of narcissism, the author proposes that entitlement is a continuum ranging from underentitlement through healthy entitlement to narcissistic overentitlement.

The hypotheses of this dissertation are:

1. Women in problematic nonmutual adult relationships often have a dysfunctional sense of self in relationships; they perceive themselves as less entitled.

2. One's sense of entitlement as an adult is often related to relational expectations learned very early in life and internalized in working models of self in relationships, originating especially from the relationship with mother. A particular pattern contributing to underentitlement in adult women may be mother-daughter role reversal. Some causes of underentitlement, therefore, can be sought in client histories.

An implication of this is that because one's internal sense of underentitlement may predispose her to nonmutual relationships and depression and/or anxiety, treatment that addresses her internal sense of underentitlement will ameliorate her symptoms and promote her involvement in mutual relationships.
Methods

The hypotheses will be tested and elaborated by: (a) a review of relevant literature on attachment theory and research and feminist object relations theory, and (b) the writer's clinical observations.

Key Concepts

The concept of entitlement is central to this dissertation, and is defined in a new way. Therefore, this concept is described in depth below.

This study will draw primarily from two theoretical perspectives that emerged from object relations theory: feminist object relations theory and attachment theory. These theoretical perspectives will support the proposed conception regarding entitlement. Explanations of important concepts from these perspectives are presented in Chapter III.

Entitlement Terms

Broadly sketched, entitlement may be viewed as the expectation of care and regard from others. More specifically, entitlement here is intended to refer to an individual's sense of deserving various objects (such as money, clothes, food, etc.) and emotional, physical, and intellectual experiences, including attention, affection, services by others, education, obedience of others, power and efficacy, sexual intimacy, and time. When a person feels entitled, the receipt of such experiences or
objects seems natural; the question of deserving does not arise. There is no guilt in being the recipient of others' care, deference, services, or goods.

**Entitlement Continuum**

In this study, entitlement is conceptualized as a relative position along a continuum from overentitlement to underentitlement. The writer believes that the overall amount of entitlement—too little or too much—can contribute to many different pathologies, both Axis I and Axis II. Here, the differences in amount of entitlement are indicated by the terms "overentitlement," "healthy entitlement," and "underentitlement."

**Overentitlement.** A sense of entitlement is identified as one of the diagnostic criteria for Narcissistic Personality Disorder in the Diagnostic and Statistical Manual of Mental Disorders-IV ([DSM-IV] American Psychiatric Association, 1994). In the description of Narcissistic Personality Disorder, the DSM-IV describes some characteristics that this writer associates with overentitlement: (a) "a pervasive pattern of grandiosity, need for admiration, and lack of empathy"; (b) the assumption "that others attribute the same value to their efforts"; (c) "inflated judgments of their own accomplishments" and an implicit "underestimation (devaluation) of the contributions of others"; (d) the belief that they are "superior, special, or unique" and the expectation that others recognize this; (e) "a sense of entitlement is evident in these individuals' unreasonable expectation of especially favorable treatment"; (f)
"they expect to be catered to and are puzzled or furious when this does not happen," assuming that "their priorities are so important that others should defer to them"; "they expect to be given whatever they want or feel they need, no matter what it might mean to others"; (g) the "sense of entitlement and lack of sensitivity to the wants and needs of others may result in conscious or unwitting exploitation of others"; and (h) "a lack of reciprocal interest" in others with whom they relate (pp. 658-659).

**Healthy Entitlement.** In the midrange of the continuum is a healthy sense of entitlement. Some sense of entitlement is necessary in optimal adjustment. This writer proposes that a healthy entitlement is characterized by: (a) a regard for and interest in self and others; (b) an ability to be aware of and consider one's own needs and feelings along with those of others (empathy); (c) flexibility in giving and receiving (versus rule-bound); an ability to choose to defer to another's need or preference at times, but also be able to stand for one's own need or preference at times; (d) a healthy self-appreciation and the expectation of decent treatment and nonexploitation from others and also nonexploitation of others; (e) appropriate objection to the lack of consideration from others for one's own priorities or to abusive treatment from others; (f) a reasonable sense of one's own value, abilities, competence, and accomplishments; (g) a sense of personal efficacy and power that permits recognition and appreciation of others' value and abilities; (h) the ability to assess and recognize one's own and others' responsibility for mistakes or problems; (i) and the expectation
of and hope for quality-of-life needs and experiences, such as money, clothes, food, and fulfilling emotional, physical, and intellectual experiences, including attention, affection, the consideration of others, education, personal power and efficacy, and sexual intimacy. A healthy sense of entitlement takes into account both the world of self and the world of others.

**Underentitlement.** At the other end of the continuum is underentitlement, which refers to a relational stance in which one believes that he or she does not deserve care and regard from others. Such underentitled people believe that seeking or receiving valued objects and experiences is selfish and "bad," and therefore elicits feelings of guilt. Others' feelings and needs must be tended, but not one's own. Unkind or hurtful treatment from others is to be expected, understood, and borne. One's own abilities, strengths, and gifts are minimized or unrecognized.

**Nonmutual Relationship**

This term is used here to describe a relationship in which reciprocity or mutuality is largely absent. In such a relationship, one person tends to be the "giver" and the other the "receiver" in an ongoing pattern. What is given and received includes goods and services. A nonmutual relationship, as presented in this study, is often related to the entitlement dynamic: the relationship is nonmutual because one person, the "giver," is underentitled, and the other, the "receiver," is overentitled.
Role Reversal and Parentification

Parentification is a term first introduced in family systems theory (Boszormenyi-Nagy & Spark, 1973). It refers to a role reversal in which the child provides the caregiving for parents and/or siblings, rather than the parents doing so for the child. It involves a child assuming responsibilities beyond those appropriate to development and age. Attachment theory suggests that the child becomes the attachment figure to the parent in such inverted relationships. When the child must meet the needs of the parent, his or her own attachment needs remain unmet.

Limitations, Scope, and Values

This study is limited to the relevance of entitlement and child development to nonmutual relationships of adult women seeking therapy for depression and anxiety. The writer's clinical experience has been primarily with lower middle class to middle class white clients in southwestern Michigan, of whom the largest proportion have been adult women. The writer also has a relatively large experience base in working with preschool-aged children, and some experience working with Native American women and children, which may contribute insight but not validation. Although interpretations and ideas presented here may be relevant to other populations, the writer cannot make claims of validity beyond her clinical reach.

Attachment literature has its own shortcomings, which will necessarily affect the conclusions drawn from that research. There are almost no data regarding
attachment differences among siblings. The few studies that have examined childhood attachment status by pairing children have assigned the pairing so that the natural groupings are distorted or controlled against. These studies have paired children in same-sex dyads so cross-sex relational behaviors in childhood are not yet understood. Many studies on infant attachment have not assessed the infant's relationship with the father, and many early but significant studies did not include the more recently identified disoriented/disorganized attachment classification. Longitudinal studies that track attachment from infancy to adulthood have not been competed yet, although some samples have been followed into adolescence. The limited number of cross-cultural attachment studies support the relevance of attachment theory to other cultures, but most of the research has been based on North Americans, albeit from an array of socioeconomic groups.

These limitations should be considered in light of the overall utility of attachment theory and research. In support of using this theoretical approach are the hundreds of studies supporting the theory that have shared the same or similar methodologies. The research is unique in its assessment of the internal aspects of relationships. The writer believes that this research base provides ample evidence for the utility and validity of attachment theory.

Finally, this study will offer a new perspective to well-established conceptions of development. The ideas that will be proposed do not claim to be fully validated. However, the "entitlement dynamic" will be offered as a concept that may have value in a therapist's clinical practice. Empirical research supporting this particular view
remains for future exploration. It is hoped that this study will encourage such endeavors.

The writer wishes to clarify from the outset her recognition of social and cultural pressures on the development and circumstances of women and children. However, the clinical setting should not be confused with the political arena and clients must be accepted as they are, not how they might be in a better world. The interpretations and ideas that will be presented in this study should be understood in this perspective. The writer generally believes that adults are responsible for their actions; this is a statement of regard and confidence in people's ability to find kindness and change within themselves, given sufficient support. It is also a statement of hope for future generations. We cannot change where we came from, but we can change where we are going.

Outline of the Study

In this chapter, the nature of the research problem has been described and the hypotheses have been presented. Chapter II describes the methodology and source material used to explore the hypotheses with published literature and with clinical observations. In Chapter III, the hypotheses will be examined using relevant literature from several perspectives on the development of a sense of self in relationship with others, including attachment studies that suggest role reversals and studies that suggest gender differences in child-mother attachment relationships. The feminist object relations perspectives regarding gender identity development in relation to the
mother, as conceptualized by Chodorow (1989), and Eichenbaum and Orbach (1983), will be introduced. Chapter IV consists of the application of clinical observations to the hypotheses and elaboration of the hypotheses. This will incorporate the writer's own ideas based on clinical observation and the literature review of Chapter III. The final chapter will present possible avenues for treatment of entitlement imbalances and implications for therapists. Implications for future research are presented.

In this dissertation the writer addresses gender neutral language by using the pronouns he and she and her and his interchangeably where possible. In some instances the writer refers to a specific gender because this study considers possible gender-related entitlement issues. It should be noted, however, that both males and females may be underentitled or overentitled.
CHAPTER II

METHOD

Approaches Used

Clinical observation suggested the hypotheses of this dissertation. Relevant literature from two perspectives, attachment theory and feminist object relations, was consulted because of their emphasis on relationships and the role of early relationships in the development of self. The relevant elements of the hypotheses will be tested against the published material.

Then the hypotheses will be elaborated by a consideration of observations. These are synthesized from the writer's clinical practice between 1990 and 1998. The clinical population consisted of white married middle and lower class women in southwestern Michigan.

Ideas from attachment theory and research, selected object relations concepts and perspectives, and the writer's clinical observations will then be synthesized and integrated. This will provide the basis for a proposed model for clinical intervention that addresses the nonmutual pattern of relationships and the concurrent distress.

Rationale

Wolcott (1992) distinguishes two broad approaches to research: "theory-first"
and "theory-after" (p. 12). The proponents of theory-first proceed deductively; theory poses the problems that will be researched and allows control over the inquiry. Implicit in this is a certain amount of control over the results of the inquiry. "Theory-after" proponents enlist theory "to help understand what already has been observed rather than to dictate what one should be looking for" (p. 12). This research employs the latter approach. The formulation that is developed in this dissertation originated in the writer's observations of human relationships.

The writer will use empirically-derived evidence from attachment research and observations from her clinical experience to advance the development of a limited sense of entitlement as a possible cause that contributes to depression and/or anxiety and nonmutual adult relationships for women. The clinical vignettes presented in this study are intended to illustrate the writer's conception of entitlement. In order to ensure their relevance to the topic, these vignettes are rooted in clinical observations drawn from eight years of clinical practice. No vignette describes a particular client with whom the researcher has worked. Names, demographics, and other details of clients have been significantly changed so that in no way can they be connected to specific persons. Although the details have been changed, the meaning, interpretation, and understanding of each vignette is true. Informed consent was not deemed necessary from the Human Subjects Institutional Review Board (HSIRB) and was not obtained by the writer. Appendix A presents HSIRB approval for this dissertation under the "exempt" status.
CHAPTER III

LITERATURE RELEVANT TO THE HYPOTHESES

Introduction

This chapter will present selected literature from attachment theory and research, object relations theory, and feminist object relations theory that applies to the following hypotheses: (a) one's sense of entitlement as an adult is often related to relational expectations learned very early in life and internalized in working models of self in relationships, originating especially from the relationship with mother; and (b) a particular pattern contributing to underentitlement in adult women may be mother-daughter role reversal. The hypotheses are explored to provide an explanation for the frequent incidence of nonmutual relationships described by adult women who present for therapy with depression and/or anxiety.

There are alternative views that attempt to explain the phenomenon of nonmutual relationships. Notably, some scholars emphasize the impact of the "patriarchal" social context on women in relationships (Miller & Stiver, 1997). This writer holds the position that, although the larger social context significantly influences development and experience, social change begins with individual change. Moreover, like Chodorow (1989), this writer considers internal psychological processes, such as meaning-making (Kegan, 1982), at least as crucial to development
and experience as social context. Something deeper occurs than the learning of social role behaviors: the culture and features of social structure are "internalized through the family and the child's early social object relationships"—a largely unconscious process (Chodorow, 1989, p. 54). "The nature and quality of the social relationships the child experiences are appropriated, internalized, and organized by her or him and come to constitute her or his personality". (Chodorow, 1989, p. 47). Early relationships are the bedrock; the learning of social roles, including gender roles, is a more conscious, overt process, or surface structure.

Attachment theory, emerging out of object relations theory, focuses on the earliest relationships, especially the mother-child relationship. How the early relationship with the caregiver shapes development of self and influences one's later relational experience has been examined and empirically tested in attachment research. For these reasons, attachment theory and research are used to support the hypotheses advanced in this study.

A review of selected literature on attachment theory and research follows. The theory is introduced and its central concepts described. Then, the branches of attachment research are summarized, and the approach of this study is discussed. Attachment research methodology for assessing the mother-infant relationship is described, and early attachment styles identified. Research findings on the impact of the child's early relationship with mother over time and across a number of dimensions are presented. These are followed by research on internal working models and evidence that mothers' early childhood attachment experiences impact their
mothering. Then, attachment research that suggests mother-child role inversions is presented. Finally, mother-daughter role inversions are discussed in light of selected feminist object relations perspectives.

Throughout this study, the child's early caregiver is referred to as the mother, because this is most often the case. However, the caregiver may be the father, another relative, or some designated person like a foster parent, who has ongoing responsibility for the child.

Attachment Research Pertaining to the Impact of the Early Relationship With Mother on Child Development

Attachment Theory: Introduction

Research related to attachment theory has its first roots in Bowlby's search for the origins of psychopathology in children and adults (Berman & Sperling, 1994, citing Bowlby, 1960). Bowlby was influenced by object relations theorists, notably Melanie Klein, Michael Balint and Alice Balint, D. W. Winnicott, and Ronald Fairbairn. Object relations theory views "object relations as primary rather than secondary and acquired" gradually over time (Ainsworth, 1969, p. 972).

Melanie Klein, for example, recognized that physiological sustenance may not be the only basis for the child's bond with mother. Although Klein emphasized the critical role of mother in personality development, her view, with its focus on the internal, instinctual life of infants, was not sufficiently "relational" to others who followed. The impact of social interaction between mothers and babies remained for
others to amplify (Eichenbaum & Orbach, 1983).

In contrast to Klein's view, other object relations theorists emphasized that the first object relation reflected an innate need for contact and other non-oral connections with mother. Balint and Balint, Therese Benedek, Margaret Ribble, and others emphasized a social and emotional bond (Bowlby, 1958). Bowlby felt that Klein placed too much emphasis on the "oral component" (Bowlby, 1958, p. 354). Fairbairn proposed that people are motivated by the need for contact with people; humans are "person-seeking" (Karen, 1994) not pleasure-seeking. Winnicott saw the mother's provision of food from the breast as less important than her provision of beingness and love (Winnicott, 1948, cited in Bowlby, 1958).

Fairbairn (1946/1952) addressed this squarely, postulating a theory that dismissed instincts as the primary determinant in personality development, sharply diverging from the Freudian conception. Human beings are motivated, he said, not by sexual or aggressive drives, but by the primary "need to seek objects and attach meaningfully to other people" (Hamilton, 1988, p. 300). Fairbairn saw early life as characterized by utter dependence on the primary caretaker. The original, unified state of primary identification of the ego at birth is broken by trauma into three ego states, each identifying with a particular aspect of the object (Fairbairn, 1946/1952; Grotstein, 1981; Hamilton, 1988). Unmet needs generate anxiety; the anxiety is addressed by denying the need, and drawing that split-off part of the self into a hidden inner world (Eichenbaum & Orbach, 1983). Healthy development results in the unification of these splits.
D. W. Winnicott (1953, 1958, 1964, 1965, 1969) set forth unequivocally the fundamental importance of maternal care to the development of the infants. He introduced the notion of the "good enough mother" (Winnicott, 1953) who is able to guide the child through dependence and attachment to a strong, autonomous sense of self. Most mothers have, he believed, a natural ability to empathize and provide appropriate care, which comes out of a maternal identification with their babies. This identification gradually lessens as infants grow. Failure to provide adequate nurturing may leave the child unable to reconcile the good-bad object splits, resulting in an inner, isolated "true self," and an outer, disembodied "false self" (Grotstein, 1981).

More recently, Margaret Mahler (1968; Mahler, Pine, & Bergman, 1975) formulated a developmental progression of stages to describe the psychological tasks of infants' life. Infants begin life in an "autistic" phase, unable to relate. At about two months, they begin the stage of "symbiosis" with mother, in which mother is not perceived as separate from self; that is, the sense of self has not yet developed. "Separation-individuation" from mother begins at about six months of age, and this process continues as an active developmental task with several subphases until about two years of age, when the child develops "object constancy," the "ability to hold a steady image of the object, especially the mother, whether she is present or absent, gratifying or depriving" (Hamilton, 1988, p. 53). Splitting and projection help the child to accomplish object constancy. Awareness of gender develops late in the separation-individuation phase.
Like Fairbairn and Guntrip, Bowlby abandoned the notion of drive-based behavior (Greenberg & Mitchell, 1983) in favor of "an array of innate behavior patterns . . . that are enriched and developed by the responses they receive from the environment" (Karen, 1994, citing Bowlby, 1958). Bowlby noted studies in which both human and nonhuman infant primates attached to others who were not necessarily involved in their feeding. These and other studies convinced Bowlby that attachment was instinctive and at least as critical to survival as eating.

**Attachment Theory: Key Concepts**

Ainsworth (1982), who has devoted her professional life to the study of attachment, concisely delineates the central concepts of attachment theory:

An attachment is an affectional tie that one person forms to another specific person, binding them together in space and enduring over time. Attachment is discriminating and specific. One may be attached to more than one person, but one cannot be attached to many people. Attachment implies affects. Although the affects may be complex and may vary from time to time, positive affects predominate, and we usually think of attachment as implying affection or love.

Animals of many species are capable of forming attachments, and these perform significant functions that promote the survival of the individual or the species. Under ordinary circumstances, the infant, whether human or animal, forms his first attachment to his mother. He is not born with a ready-made attachment to her; his attachment must develop over time. (p. 135)

The following section will elaborate on these concepts. This will clarify meanings for the ensuing literature review of attachment research. The central concepts presented below are the attachment relationship, attachment behavior, the attachment system, the secure base and felt security, working models, and attachment
Attachment Relationship

The attachment relationship is conceptualized as a distinct but critical subset of social relationships. It is not the same as a social bond (Bretherton, 1985). Differences can be understood by considering how a playmate, for instance, differs from an attachment figure. The two kinds of relationships have different functions, although the two functions may be fulfilled by the same person at different times. Thus, Bretherton notes that "a child is said to seek the attachment figure when under stress but to seek a playmate when in good spirits" (p. 4).

Bowlby differentiated between attachment and dependency. A child who is temporarily away from his or her attachment figure will remain attached, even though dependent on someone else for care (Bowlby, 1958). The two concepts have tended to become blurred in the literature, in part because both can apply to early child behaviors in relation to the mother, such as crying, clinging, and proximity-seeking. Sroufe, Fox, and Pancake (1983) point out that just because the concepts are not synonymous does not mean that they are unrelated. Dependency implies a relationship but it is a separate concept that refers to a personality trait. Ainsworth (1969) poses the difference between attachment and dependency as follows:

If one asks: "Does a phobic wife who clings to her husband and constantly seeks his proximity love him more than a woman who is less neurotic and more competent loves her husband?" The answer is clearly, "No, not necessarily." Indeed, a clinician might infer that the phobic wife loves less than the healthier wife. A comparable question is: "Is the child who especially
clings to his mother more attached to her than a child who clings less—or is he merely more insecure?” Nevertheless, the clingy child and the clingy wife are clearly more dependent, even though they do not necessarily love more, and even though they are not more strongly attached. We must conclude that dependency and attachment are by no means identical, even though there is a great overlap in infancy between dependency behaviors and attachment behaviors.” (p. 1,015)

Attachment refers, then, to a relationship or more specifically to "an aspect of a relationship with someone perceived as stronger/wiser" that is "persistent over time and situations" (Hinde, 1982, p. 61). Note that because "stronger/wiser" is a matter of perception, adult-adult attachment relationships are also possible.

There has been some confusion in the research regarding what is being measured, for example, in the Strange Situation protocol: the attached person, the attachment figure, or the attachment relationship? Hinde (1982) clarifies this confusion:

Because in the strange situation test parental behavior is controlled while the infant's behavior is free to vary and forms the basis for later categorizing, it would be easy to suppose that characteristics of the infant are being measured. But given the dialectic between personality and relationship, it seems more accurate to regard the test as intruding on the relationship at a particular point in time and assessing an aspect of that relationship from the infant's point of view. Indeed such a view is necessary to accommodate the finding that an infant may be categorized in one way with his mother but in another quite different way with his father. (p. 66)

Thus, attachment studies can examine the effects of the child on relationships and vice versa.

Attachment Behavior

The term "attachment behavior" is somewhat ambiguous, since it refers to
both an internal psychological system and to a set of behaviors observable by others
(Ainsworth, 1969). To add to the confusion, attachment behavior has affective and
cognitive aspects. The cognitive dimension guides the behavior in the form of
working models of attachment figures (Hinde, 1982). Attachment behavior refers to
certain kinds of interactions that occur in the context of the specific attachment
relationship. The internal psychological organization (Sroufe & Waters, 1977) may be
inferred from attachment behaviors.

Ainsworth, Blehar, Waters, and Wall (1978, p. 302) identify attachment
behaviors as those "that share the usual or predictable outcome of maintaining a
desired degree of proximity to the mother figure--behavior through which the
attachment bond is first formed and then later mediated, maintained and further
developed" (cited in Hinde, 1982, p. 62). Attachment behavior also functions to help
prevent separation from the attachment figure (Ainsworth, 1982). Since the
attachment relationship persists over time and across situations due to internalized
representations, the attachment figure need not be present physically for attachment
behavior to occur.

Attachment behavior is activated by separation or distance from the mother
according to the "set-goal" of felt security. Attachment behavior is also activated by
threatening situations, helping to assure the "predictable outcome" of protection in
times of stress or threat. Other factors may also activate the system, including the
physiological state of the infant (Ainsworth, 1969).
Attachment behaviors therefore promote proximity or contact. In infancy, these behaviors include signaling behavior, such as crying, smiling, and vocalizing; orienting behavior; locomotive behavior relative to another person, such as following or approaching; and active physical contact behavior (Ainsworth, 1982). They begin in rudimentary form at birth, becoming increasingly complex as development unfolds.

Bowlby (1969) grounded his theory in Darwin's evolutionary principals. He understood attachment behavior as serving a biological function: it provides a survival advantage to an individual and to the species by assuring parental protection and care during the vulnerable period of immaturity. Bowlby believed that there was no need to postulate a further motivation or drive to attachment beyond its function of perpetuation of the individual and the species (Ainsworth, 1969) by assuring that the infant "obtains parental care sufficient for his survival" (Bowlby, 1958, p. 364). Whatever internal and/or external conditions activate the behavior patterns are themselves the "causes" (Bowlby, 1958, p. 362).

Attachment behavior is instinctive. By "instinctual response," Bowlby meant an observable pattern of behavior that is biologically advantageous. The infant is born with a propensity to develop the complex attachment behavioral system from "component instincts" (Bowlby, 1958). The more specific features of the system are shaped by the environment in which it develops. The differences in specific developmental environments help to explain the individual differences in attachment styles among children and adults, through the development of internal working models.
Attachment System

Bowlby conceptualized attachment as a system of goal-corrected behavior. Viewed from the outside by an observer, the system regulates proximity to and contact with particular people who serve as attachment figures. As experienced from the inside of the attached person, its set-goal is "felt security" (Bischof, 1975, cited in Bretherton, 1985).

Bowlby identified five behavioral systems that contribute to infant attachment, each of which is relatively independent of the others at first. These become increasingly focussed on the mother, strengthening the infant's tie to the mother and vice versa. The earliest attachment behaviors are smiling, crying, sucking, following, and clinging, no one of which is "more primary than another" (Bowlby, 1958, p. 366). These develop and synthesize into elaborate and complex structures: "from relatively few and simple components rich and varied structures may be created" (p. 365). Bowlby later (1969) elaborated on the increasing sophistication and complexity of these systems as the child matures, emphasizing the control systems model.

Several assumptions are postulated regarding the attachment system (Main & Weston, 1982). First, it is assumed that infants will develop preferences for particular others based on their interactions. Second, when object permanence is achieved, children will make clear their preferences for particular others. Third, children will react to threats of separation negatively. And finally, it is understood that threats of separation will lead to proximity-seeking with the attachment figure, regardless of the...
nature of their attachment relationship. Therefore, "threats of separation from the mother, acts of physical rejection by her, and alarming conditions in the environment are presumed to activate the system at particularly high intensities" (p. 33). The mother's rejecting or alarming behavior may also trigger the child's proximity-seeking to the mother, who is herself the source of threat. This double-bind situation leads to a particular pattern of attachment behavior, which will be discussed in a later section.

The development and integration process of attachment in early childhood includes at least four phases (Ainsworth, 1982). The first phase, "undiscriminating social responsiveness," occurs from birth to two or three months, in which the infant is capable of orienting to salient features of the environment, sucking and grasping, and signalling, bringing the mother into proximity and/or contact. Phase two emerges gradually, as the infant moves into "discriminating social responsiveness." He or she now shows preference and differential behavior for familiar people. Phase three, "active initiative in seeking proximity and contact," is attained at about seven months of age, and is characterized by locomotion in pursuit of proximity, greeting responses, and "goal-corrected" behavior sequences. That is, the infant alters its behavior in response to the attachment figure. This phase coincides with the emergence of object relations and the beginning of a sense of object permanence, reflecting significant cognitive development. It is during this phase that infants develop marked differential responses to others, exhibiting a fear of strangers and preference for the mother (Bowlby, 1958). The fourth phase in early childhood is that of the "goal-corrected partnership," or formation of a "reciprocal relationship" (Ainsworth, 1969). Perhaps
emerging at about age three, the child is able to gradually develop reciprocity as he or she begins to grasp the perspective of the other, and to make plans based on that growing understanding.

The attachment system is a higher-order construct that refers to the set of attachment behaviors serving the internal function of regulating felt security and the external function of regulating proximity. The integrated attachment behavior system exists in equilibrium alongside other broad behavior systems, such as exploration and play (Ainsworth, 1982). Because the system interacts with other behavioral systems within the individual, some of the behaviors from diverse systems may overlap:

behavioral systems interact with each other and . . . each involves a number of different types of behavior which may be related to each other, directly or indirectly, in a variety of ways. Some patterns may be appetitive to others, some alternative to others; some might share positive causal factors, others might share negative (consummatory) factors; some might be mutually facilitatory, others mutually inhibitory. (Hinde, 1982, p. 64)

Notably, the attachment system interacts with the exploratory and other "information-and stimulation-seeking behaviors" (Bretherton, 1985, p. 7). Attachment serves a function of protection, but just as important is its function in support of exploration. With the sense of security and safety provided by proximity, the child may explore the environment. Thus, attachment also promotes exploration, and, hence, by implication, further cognitive and sensorimotor development from the "secure base" (Ainsworth, 1967).

The infant's attachment system also interacts with behavioral systems of others in the child's environment. As Ainsworth (1969) stresses, Bowlby's model is, above all, interactional:
The infant's initial equipment, genetically programmed as it is, develops through his interaction with his environment. The person is always viewed in a social context with his attachment behaviors interlocking with reciprocal behaviors of others; those of the infant are in inevitable interaction with the reciprocal behaviors of the mother figure. In the larger view, the infant-mother pair, coupled though they are [sic] by reciprocally interacting behavioral systems, are perceived in a wider environmental context with behaviors drawing them apart held in dynamic balance with behaviors drawing them together. (p. 1,009)

As will be discussed below, the attachment system in the infant also interacts with the mother's caregiving behavior, and her other adult behaviors that lead her away from caretaking (Ainsworth, 1982). Bowlby viewed various infant behaviors such as smiling to be signals that initiate maternal caregiving responses. "It is fortunate for their survival that babies are so designed by Nature that they beguile and enslave their mothers" (Bowlby, 1958, p. 367).

Bowlby's avowed belief in "monotropy" is evident in this statement. He agreed with Winnicott that the mother-figure has a unique importance in the infant's development; she is essentially irreplaceable, or replaced only with great care (Bowlby, 1958).

It must be emphasized that the mother lives in her own context of relationships, and has her own internal relational history; these inevitably interact with her mothering, as will be shown in a later section of this chapter.

Secure Base and Felt Security

A cornerstone of Bowlby's formulation is the control systems model, drawn from the metaphor of a machine that self-regulates to maintain a preprogrammed set-
goal. Regulation is achieved by feedback from the environment via receptors, which indicate the adjustments needed to achieve the set-goal (Ainsworth, 1969).

The internal set-goal in the attachment system is "felt security." This points to the role of affect and emotion in attachment behavior. Bowlby conceptualized feelings as important appraising processes that serve to compare environmental input to internal set-points or standards (Ainsworth, 1969). Thus, they help to monitor and regulate the attachment system. Not all appraising processes, however, are "felt," or conscious.

In infancy, the mother serves as the secure base (Ainsworth, 1967), which mediates "the dynamic balance between exploration of the environment and seeking physical proximity and/or contact with the attachment figure(s)" (Cicchetti, Cummings, Greenberg, & Marvin, 1990, p. 18). With increasing development, children can use internal talk to reassure themselves when away from the mother.

Bowlby proposed that the attachment system was activated by perception of threat, and deactivated by perception of safety. Bretherton (1985) suggests that the attachment system is continuously active, making limits on how far or how long the child will leave the mother's proximity for exploration. If too far or too long away, the system's set-goal will "pull" the child to the attachment figure.

The set-goal itself may also change in response to the intensity of perceived threat or according to the physical state of the individual. For example, children tend to seek physical contact with their attachment figures when ill, tired, hungry, or in pain (Ainsworth, 1969). Over time, the set-goal may be altered according to the
characteristic responsiveness of the attachment figure, as internal working models develop out of real-life experience.

**Working Models**

The attachment behavior system, in order to be effective, "must incorporate sensitivity to and expectations about the other participant" (Hinde, 1982, p. 64) in the attachment relationship. The mechanism through which this occurs is the working model.

From Piaget, Bowlby borrowed the idea of internal working models. Piaget proposed that humans come equipped with schemata, "a system of extremely flexible mental and behavioral programs . . . that enable us to explore and make sense of our environment. It is upon this inborn framework that all future learning is built" (Karen, 1994, p. 208). The programs are modified by experience throughout life and their function is "mastery."

Bowlby saw the parallels to his theory and adapted it: babies are born, he said, with capacities and needs and a striving toward relatedness, building models of how relationships work as they go along. These models "reflect the child's relationship history, codifying the behaviors that belong to an intimate relationship, and defining how he will feel about himself when he is closely involved with another person" (Karen, 1994, p. 209). That is, working models of others and of relationships intertwine with working models of self. "Thus, if valued and given comfort when requested, the child comes to feel valued and special; conversely, if neglected or
rejected, the child comes to feel worthless and of little value" (Cassidy, 1988, p. 122).

Main, Kaplan, and Cassidy (1985, pp. 76-77) list a number of features of working models. Some of these include:

1. They have affective and cognitive components, and are part of a larger system that guides behavior.

2. They may exist outside of conscious awareness.

3. They are formed out of "generalized event representations," specifically, out of representations of attachment-related events, and are quite stable over time.

4. The differing ways that infants' efforts to achieve proximity are met by the caregiver will lead to different internal working models. Infants whose efforts are met with acceptance will have very different working models than those whose efforts are rejected or accepted only inconsistently. Rejecting or unpredictable responses from the caregiver will engender "reorganization, restriction, and redirection in attention, behavior, and emotional expression" (Main et al., 1985, p. 77) in these children.

5. Working models form within the first few months of life, and by one year, differences in attachment seen in the Strange Situation reflect differences in internal working models.

6. Working models may change in the absence of the caregiver, for example, in response to her absence.

7. "Internal working models of relationships provide rules and rule systems for the direction of behavior and the felt appraisal of experience" (Main et al., 1985, p. 77).
8. They also provide "rules for the direction and organization of attention and memory, rules that permit or limit the individual's access to certain forms of knowledge regarding the self, the attachment figure, and the relationship between the self and the attachment figure." Further, these rules will be apparent "in the organization of thought and language as it relates directly and indirectly to attachment. Many will be unconscious" (Main et al., 1985, p. 77).

9. Working models can change. In childhood, they can be altered only by sufficient, concrete experience. Later, they may be changed by thinking, with the ability to view thoughts from different perspectives. Working models can also change from relational experience and from therapy (Fraiberg, Adelson, & Shapiro, 1975; Lieberman, 1991; Lieberman, Weston, & Paul, 1991).

10. Working models tend to be stable, but they "are not conceived as templates. They are best conceived as structured processes serving to obtain or limit access to information" (Main et al., 1985, p. 77). The term "template" implies a static quality; working models are always in process, shaping and shaped by the environment.

West and Sheldon-Keller (1994) consider this flexible aspect of working models to be a critical difference from other theoretical conceptions of the developmental path toward "normalcy." Traditional psychoanalytic theory views development as proceeding through certain stages, with each stage building upon the prior one. Thus, if something goes awry in an earlier stage, all else that follows will be built upon this shaky foundation. Object relations theory, according to these
authors, also assumes that early wounds will impede future growth. Attachment theory, they assert, is a branching theory of development with many routes toward normalcy. "In this model, development is not blocked by particular experiences of deficits, but rather is constrained into increasingly particular pathways" (West & Sheldon-Keller, 1994, p. 49). Attachment experiences limit the choices among possible alternatives, but do not block development. Attachment-related working models develop very early in life, but are not unchangeable. Their persistence is gradually strengthened or weakened by ensuing experiences that confirm or disconfirm them.

Working models are subject to special distortions in very young children whose cognitive abilities are not yet well-developed, which may result in misinterpretations of parents' meanings. Moreover, intense emotions may distort perception of reality, and defenses may also interfere (Karen, 1994). These distortions then distort the further understanding of future interactions. Distortions may also arise from parents' own purposeful misrepresentations of real events, for example, when a parent portrays someone's suicide as an accident (Troy & Sroufe, 1987).

**Organizational Construct**

Sroufe and Waters (1977) contributed an important new direction to Bowlby's original theory: an understanding that attachment is an organizational construct. The "strength" of attachment cannot be measured by discrete behaviors; the bond is inferred from observable behavior, and its value lies in its integrative power. It is
clear from the concepts elucidated above that attachment is by no means a trait. Rather, it refers to an affective bond that operates flexibly between infant and caregiver, and between other behavioral systems, and is continually shaped by context. Research on internal working models suggests that individual differences in attachment may become "traitlike" over time, insofar as the expectations inherent in the working models tend to filter and shape future experience.

When the functions and outcomes of attachment and the underlying control systems through which behavior is organized are emphasized, then developmental transformations in specific attachment behaviors can be understood. Continuity is seen in patterns of attachment behavior, versus in discrete behaviors. This difference is critical, as can be seen from looking at proximity-seeking behaviors. In infancy, proximity may be sought by crying, or, a little later, by crawling to approach. As the child matures, the need for proximity may be served by a glance from a distance or a brief touch (Bowlby, 1980). In both cases, the goal is felt security, and it would be mistaken to assert that the baby who now no longer cries for mother has passed through and "finished" with attachment. On the contrary, as noted by Cicchetti et al. (1990):

Once an attachment develops, it continues to undergo transformations and reintegrations with subsequent accomplishments such as emerging autonomy and entrance into the peer world. Thus, children are continually renegotiating the balance between being connected to others and being independent and autonomous as they encounter each new developmental phase. In other words, we believe that attachment, as is the case with other developmental issues, is a life-span task that requires continual coordination and integration as individuals adapt to their environment. (p. 3)
This view is consistent with, though not identical to, that of Kegan (1982) and of Mahler et al. (1975).

Likewise, viewing attachment as an organizational construct makes sense of attachment behaviors that are exhibited in the absence of the attachment figure. Robertson and Robertson (1971, 1989) noted the stages of protest, anger, despair, and detachment that beset many children when they are separated from their mothers during a critical age in infancy. These transformations occur in the caregiver’s absence. The attachment, then, does not end when the parent leaves the field, but persists as an underlying organizational influence in the child’s behavior.

From this perspective, attachment researchers have explored continuity in attachment organization over many years, even into adulthood (e.g., Ainsworth et al., 1978; Bretherton, 1985; Lewis et al., 1984; Main et al., 1985; Main & Weston, 1982; Matas et al., 1978). Though the specific behaviors may change with age, the underlying organization tends to remain stable and logically related to earlier patterns.

**Conceptual Domains and Categories of Analysis in Attachment Research**

Attachment theory was launched to the public with an article published by Bowlby in 1958. It has been elaborated in a number of books and articles by him and others over many years. Mary Ainsworth (Ainsworth & Wittig, 1969) is credited with developing the research methodology, known as the "Strange Situation," that has been used in hundreds of studies by a generation of researchers to test various aspects of the theory. With data provided by these studies, Bowlby’s original theory has been
validated and further developed.

A thorough review of the many branches of attachment research is beyond the scope of this dissertation, which is concerned with how early relational experiences contribute to the development of internal working models about entitlement in relationships. However, some important trends should be mentioned.

Ainsworth’s research shifted the emphasis of research away from the etiology of psychopathology toward a focus on the early development of attachment in infancy (e.g., Ainsworth, 1973; Ainsworth et al., 1978; Lewis et al., 1984; Londerville & Main, 1981; Main & Solomon, 1986; Main & Weston, 1982; Matas et al., 1978; Waters, 1978; Waters, Wippman, & Sroufe, 1979). From that base, many researchers have studied attachment as a normal developmental process (e.g., Ainsworth & Wittig, 1969; Cicchetti et al., 1990; Erickson, Sroufe, & Egeland, 1985; Main et al., 1985), extending the empirical data to support the notion that attachment is a lifelong phenomenon (e.g., Ainsworth, 1985; Antonucci, 1994; Kobak & Hazen, 1991; Kobak & Sceery, 1988; Rothbard & Shaver, 1994).

Others have returned to Bowlby’s roots in the study of the relationship between attachment and later psychopathology (e.g., Berman, 1988; Berman & Sperling, 1991; Lewis et al., 1984; Parker, 1979; Parker, Tupling, & Brown, 1979; Sperling, 1988; Sperling & Berman, 1991; Sperling, Berman, & Fagen, 1992; West & Sheldon, 1988; West, Sheldon, & Reiffer, 1987). A relatively new approach has arisen from the analysis of the relationship between normal and pathological development: developmental psychopathology. This view conceptualizes any
psychopathology "as a distortion in the normal ontogenetic process" (Cicchetti et al., 1990, p. 29) and takes a strong interactional/relational position:

We believe that other than autism and the organic forms of mental retardation, the vast majority of the disorders of the early years of life can best be characterized as transactional "relational psychopathologies"—that is, as problems that have occurred as the result of a dysfunction in the parent-child-family environment transactional system. (p. 30)

Other researchers working with this approach include Rutter and Garmezy (1983), Sroufe and Rutter (1984), and Zigler and Glick (1986).

Marvin and Stewart (1990) argue that attachment theory and research are enhanced by incorporating a family systems framework. They view the two approaches as consistent with one another, as well as with Bowlby’s early control systems model and his later work (1973-1980) incorporating general systems theory (Marvin & Stewart, 1990). Others adopt this perspective as well.

A review of the attachment literature points to a number of ways to analyze of attachment. These include the following:

1. The study of attachment in infancy, which tends to focus on accounting for "individual differences" in attachment behavior and styles by examining the interactions between the child and the mother. Ainsworth is a notable example of a researcher emphasizing this focus. Within this domain, researchers may emphasize the mother's contribution, the infant's contribution, or the interaction between the two. Some (e.g., Egeland & Farber, 1984) regard the domain of the mother's contribution as the study of "antecedents" of attachment.

2. The analysis of stability and change in attachment patterns over a period of
time, for example, in the work of Main et al. (1985), and Egeland and Sroufe (1981). Studies such as these compare early patterns to later patterns in the same individuals over time. Longitudinal studies may focus on the period from infancy to toddlerhood or preschool; some data are accumulating for comparisons of infant attachment classifications to adolescent behavior.

3. The study of correlates of attachment status with other functional domains. These include, for example, study of preschoolers' social competence as associated with early attachment classifications, represented in the work of Lieberman (1977) and Waters et al. (1979). Under this domain may be included the risks of psychopathology associated with insecure attachment styles, as in, for example, the study of victimization in children by Troy and Sroufe (1987).

4. Retrospective studies may compare adult parenting with their recollections of childhood attachment or other traumatic childhood experiences, such as DeLozier's (1982) study of childhood abuse. These latter studies may be classified as pertaining to the intergenerational transmission of attachment. They look for the "effects of early attachment relationships on other relationships" (Emde, 1990, p. xi).

5. All of the above issues may be explored from the vantage point of internal working models. For example, Main (Main & Solomon, 1986; Main et al., 1985) conceptualizes individual differences in attachment relationships as reflecting individual differences in internal working models. This vantage point tends to emphasize the development of a sense of self and others and relationships (e.g., Ricks, 1985) and may also look at how these internal models shape or affect other
relationships, including the predictions that can be made. Especially powerful are the prospective, predictive studies of how mothers' working models of relationships affect their newborns' developing attachment to them (e.g., Fonagy, Steele, & Steele, 1991).

It is clear that the differences between the above domains are a matter of the relative emphasis on one aspect or another. There is necessarily an overlap because of the relational, interactive aspects of attachment behavior. Thus, for example, studies of children also include, implicitly or explicitly, the mothers or others with whom they have attached. Therefore, when examining the mother-child relational unit, one may emphasize what the mother brings to the relationship, what the child brings to the relationship, or the nature of the relationship itself. This dissertation is primarily concerned with what the mother brings to the relationship and how this affects the child's development as a person in relationships.

Assessing Mother-Child Relationships

Mary Ainsworth elaborated attachment theory and developed the basic research methodology, known as the Strange Situation, that has been used and validated in literally hundreds of studies over a period of decades. In this section, the Strange Situation protocol is described. The four attachment classifications that have been identified from Strange Situation research and other methods to assess attachment after infancy are also presented.
The "Strange Situation"

Ainsworth set out to test the central theses of attachment theory. She applied her conceptualization to a longitudinal, naturalistic study in Uganda in 1954, the results of which were not published until 1967. Her observations showed that secure babies use their mothers as a base from which to explore. Further, she noted that the babies respond differently to their mothers than to others, and some are soothed by being picked up, while other babies are not.

Ainsworth attempted to validate her Uganda results using in-home observations of 26 families in Baltimore. A difference emerged: the Baltimore babies showed fewer secure base activities in the home than the Uganda babies. To delve deeper into this, Ainsworth designed the Strange Situation, a method that has become the foundation for much of the subsequent research on attachment. The original purposes of the Strange Situation procedure were to observe the child's use of mother as a secure base for exploration of the environment, the child's response to separation from the mother, and the child's response to a stranger. The latter two responses were expected to be more intense in a laboratory setting than in the home, and some of the behaviors that might appear in the Strange Situation were expected to not be evident at all in the home (Ainsworth & Wittig, 1969).

Briefly, the Strange Situation procedure involves a series of "episodes." The child and mother (or other attachment figure) are brought to a laboratory setting. In most studies, the child is about one-year-old. The following sequence of episodes
(from Ainsworth & Wittig, 1969, pp. 114-118) then occurs:

1. An observer brings the mother and child to the room, remains about 30 seconds, then leaves mother and child alone together.

2. Mother and baby remain alone for three minutes, with the mother engaged in another activity unless and until the baby seeks her attention.

3. The "stranger" enters the room and remains for three minutes. For the first minute, she sits quietly; after that, she engages the mother in conversation for a minute. During the last minute, the stranger attempts to engage the baby in interaction. Throughout, the mother is instructed to talk only when spoken to by the stranger.

4. The mother exits the room, leaving her purse behind, while the stranger engages the child. This episode also lasts three minutes. After the mother has left, the stranger disengages from the child, and sits quietly but for responding to the baby's overtures. If the baby is distressed, she tries to comfort it or distract it; if these efforts fail, the episode is cut short.

5. The mother then alerts the baby that she is returning and enters the room. Her instructions are simply to make the baby comfortable on the floor with toys in preparation for the next episode; she may take as long as she wishes for this. The stranger leaves the room.

6. The mother then leaves the baby alone in the room, again leaving her purse on the chair, for a period of three minutes, unless the baby is extremely distressed. If this occurs, the episode is cut short.
7. The stranger enters the room again, remaining for either two or five minutes, depending on the baby’s response in episode 4 and also this episode: if the child had previously explored, the stranger would slowly approach and interact with the baby for two minutes. If the child had not explored, the stranger is to allow three minutes for exploration, and then approach the child for interaction lasting two minutes. A distressed child is comforted by the stranger; if this is unsuccessful, the episode is limited.

8. The mother then slowly enters the room, approaches her baby, and the stranger leaves.

The whole procedure is observed from multiple vantage points, and observations are recorded in multiple ways, including, for instance, videotaping, narrative accounting into an audio tape, and written observations. Typically, observers are trained and interrater reliability is established at a high level of agreement. Results are often painstakingly analyzed on a number of variables, sometimes by stop-frame of video recordings that may take years to complete.

Many variables can be assessed in a single study with this procedure. For instance, in the Ainsworth and Wittig (1969) study, children were assessed for exploratory locomotion, exploratory manipulation, and visual exploration; visual orientation; crying by kinds and degrees; responses to the mother’s departure from the room, including efforts to regain her, crying, and other evidence of acute distress; responses to the mother’s return, including approaching, cessation of crying, smiling, clinging, and withdrawing; responses to the stranger’s entrance; responses to being
picked up by the mother and by the stranger; and responses to being put down. All of these variables were analyzed by episode as well. The child's behavior in the home was then compared to his or her behavior in the Strange Situation. Finally, the responses of the mothers were also assessed using scales developed by Ainsworth that viewed maternal acceptance, rejection, and responsiveness to the baby's signals. These results were then compared to the child's attachment classification.

**Infant-Mother Attachment Classifications**

Using the children she had observed earlier in their homes, Ainsworth tested how insecurity would manifest. Three categories captured the differences in children's responses to their mothers' absence: resistant/ambivalent, avoidant, and secure. Her observations of the babies in their homes contrasted with what she observed in the Strange Situation (Ainsworth & Wittig, 1969). The babies who had been classified as secure in the home because they rarely cried, managed small separations without upset, and cuddled, frequently reacted to separation from their mothers in the Strange Situation with extreme distress. The babies who had appeared insecure in the home handled the separation from their mothers in the Strange Situation with relative equanimity, showing indifference upon reuniting with them in the laboratory setting. This secure-appearing behavior reminded Ainsworth of children who had been separated from their mothers for a long period of time. These avoidant babies seemed to experiencing the same sense of rejection and detachment.
She found that mothers of the securely attached infants were "significantly more responsive to their infants' signals, quicker to pick them up when they cried, inclined to hold them longer and with more apparent pleasure. They were rated much higher in sensitivity, acceptance, cooperation, and emotional accessibility" (Karen, 1994, p. 159). The mothers of infants both ambivalently and avoidantly attached were rated low on all the scales. The main difference in maternal behavior between the two insecure groups was that the mothers of ambivalently attached infants were very unpredictable; mothers of the avoidant babies were rejecting, occasionally rough, and tended to dislike physical contact (Main & Weston, 1982).

Although three main infant-mother classifications were originally identified, described, and subsequently used for many years in research projects, researchers found that some children were being placed in the secure category who clearly did not belong there. A fourth category was therefore described and validated (Main & Solomon, 1986, 1990). Referred to as "disorganized/disoriented," many of the children identified in this category had histories of abuse.

Ainsworth's methods of assessment, especially her scales to measure parental responsiveness to child's signals/needs, allowed assessment of the context in which infants' behavior occurred. Her method opened the doors for research in toddler, adolescent, and adult attachment that ensued. Further elaboration of methodology accompanied research that extended into toddlerhood and preschool years. New methods were needed when it was found that the Strange Situation procedure did not apply well to children beyond about 18 months of age. Sroufe and Water's (1977)
focus on underlying, organizational patterns of attachment furthered the studies beyond infancy, which include methods of assessing internal working models such as those described below.

The emerging research has shown correlations between the infancy and early childhood patterns (Main, et al., 1985). The descriptions of infant and preschool behavior associated with the four attachment classifications (from Main & Cassidy, 1988, p. 420) follow.

The insecure avoidant attachment organization is characterized at 12 months with the following behaviors: The infant "actively avoids and ignores parent on reunion, looking away, and remaining occupied with toys." The extremely avoidant infant may move away from the parent and ignore efforts to communicate. This category is referred to as "A" in the literature. At six-years-old, this child "minimizes and restricts opportunities for interaction with parent on reunion, looking and speaking only briefly and minimally as required and remaining occupied with toys or activities" (Main & Cassidy, 1988, p. 420). The extremely avoidant child will subtly move away from the parent, using an excuse such as retrieving a toy.

The "B" category, which refers to securely attached children, manifests at one year in active seeking of interaction, proximity, and/or physical contact with the parent on reunion. This child will often seek to maintain physical contact and is easily soothed by the parent after distress. She or he will then return to exploration or play (Main & Cassidy, 1988). Pipp, Easterbrooks, and Brown (1993) tested infants recognition of self, mother, and father, and the relationship of this awareness to
attachment classification as assessed in the Strange Situation. At 20 months of age, the securely attached children demonstrated more complex knowledge of self features than did the insecurely attached infants. At age six, this child tends to stay calm during the separation episodes, and reunites with the parent by either initiating conversation or by responding readily to the parent's overtures. This child may move into proximity or physical contact with the parent (Main & Cassidy, 1988).

The insecure ambivalent category, referred to as "C," and sometimes as "resistant," is assigned to infants whose distress at separation is not soothed by the parent at reunion. These infants often show overt or subtle anger toward the parent; though they may appear to seek proximity and contact, they may resist it once contact is achieved. By six years, this attachment organization is characterized by some avoidance and subtle hostility upon reunion. The child may seek proximity or contact, but indicates ambivalence about it. The child "appears to attempt to exaggerate intimacy with the parent as well as dependency on the parent" (Main & Cassidy, 1988).

Disorganized/disoriented infants, referred to as the "D" classification, show reunion behaviors that appear odd and suggest an inner disorganization. For example, they may approach the parent with head averted, or approach at an oblique angle (Main & Solomon, 1986, 1990). These children seem to adopt a parental role toward their parent by age six. They attempt to control their parents' behavior through one of two strategies: by punishing or shaming them, or through "overbright/caregiving behavior" (Main & Cassidy, 1988).
Lewis et al. (1984, p. 124) reviewed studies that have used the Strange Situation and concluded that the distribution of infants (at 12 months) in the three categories (A, B, C) in middle class samples in the United States is roughly as follows: 20% fall in the A/avoidant category; 70% fall in the B/secure category; and 10% fall in the C/resistant/ambivalent category (citing Ainsworth et al., 1978, Connell, 1976; Londerville & Main, 1981; Matas et al., 1978; Waters, 1978; Waters et al., 1979). Sroufe's "poverty sample" has 55% of the children placed in the B/secure category, and 21% in the C/resistant/ambivalent category (Egeland & Sroufe, 1981). Most longitudinal studies show that infant attachment classification is 60% to 80% stable over 6 months, and up to age 6 (Marvin & Stewart, 1990, p. 79).

Later Patterns of Behavior and Affect Associated With Early Attachment Classification

Longitudinal studies have accumulated a data base that extends from infancy into the toddler and preschool years and beyond. One area of the research emphasizes the long-term effects of early attachment status. These studies are concerned with the patterns of behavior and affective responses of children as they develop, and how these cluster for attachment styles as identified in the Strange Situation in infancy. They focus on the breadth of impact across life activities from early experience.

Attachment is not a developmental task that is resolved once and for all in infancy. The biological function of attachment is protection and security; this continues to be important as the child ages. Felt security may be obtained through
different channels with the development of language and the increasing strength of internal working models from longer experience with the attachment figure. As cognitive and social skills develop, children begin to monitor not only their own safety but also others' safety in effort to increase their own sense of security (Cicchetti et al., 1990). New developmental tasks face the child as he or she matures, including separation-individuation (Mahler et al., 1975). Early attachment classification, as assessed in the Strange Situation at about one year, has been shown to be related to a number of dimensions in later childhood.

Matas et al. (1978) tested the hypothesis that there would be a continuity in attachment patterns over time despite developmental growth and behavior change. They expected that the earlier developmental experience of exploration would be related to later object-mastery skills and to a "sense of effectance." Confident of emotional support, the securely attached child would demonstrate a greater investment in the world, which in turn would lead to greater competence. They selected a sample of 48 white, middle class infants and their mothers, including representatives of avoidant and resistant/ambivalent children. The children classified as securely attached at 18 months fared better than the insecurely attached toddlers on every measure but one. The interesting exception was that the secure children rated highest on oppositional behavior during toy cleanup. They involved themselves in significantly more symbolic play, and were more enthusiastic, persistent, and positive in a tool-using task. They asked for help from their mothers more readily when stuck. The secure children remained on-task more, a result supporting Main's (1973) finding
that securely attached children had longer attention spans. The mothers of the insecure children were rated lower on quality of assistance and supportive presence. The securely attached children showed no aggressive behavior and less angry behavior. They ignored their mothers less and were more compliant. The researchers predicted that the avoidantly attached infants would later show more aggression, noncompliance, affective uninvolvement, and a low frustration tolerance. Indeed, this was the case.

This same sample of children was reassessed at four-and-a-half-years by Arend, Gove, and Sroufe (1979) on measures of competence. Competence was conceptualized as "ego resiliency"; measures assessed curiosity, and the ability to respond flexibly, persistently, and resourcefully. The children who had been securely attached in infancy scored significantly higher in all areas than the insecurely attached children. Those who had been designated as securely attached in infancy were found to have a moderate range of ego control. Their scores fell in between those of the ambivalently attached children, who were impulsive, and the avoidant children, who were overcontrolled.

Quality of early attachment relationship is related to social-emotional development and competence in toddlers and preschool-aged children. For example, Erickson et al. (1985) found an association between teacher reports of behavior problems in children in preschool and their attachment classification at 18 months. Insecurely attached children, both avoidant and resistant/ambivalent, predominated in three problem areas: they engaged in the most "acting out," were more withdrawn,
and had attention problems. Children who had been classified at 18 months as insecurely attached received fewer positive responses from their peers at age 3 than those who were securely attached (Jacobson & Wille, 1986, cited in Turner, 1991). George and Main (1979) found that children who had been abused avoided friendly overtures from others significantly more often than a control group, and were more likely to assault, threaten, or burst into unpredictable aggression.

These studies suggest that attachment affects more than the relationship with the primary attachment figure. Waters et al. (1979) undertook a set of studies to assess positive affect associated with securely attached infants and later peer competence and quality of social interaction. Securely attached infants exhibited more smiling, smiling and vocalizing, and toy showing than did anxiously (insecurely) attached infants. At both 18 months and 24 months, the secure infants were rated higher than the insecurely attached infants on quality of affect in free play. When assessed at age three-and-a-half in a preschool setting, a relationship between earlier secure attachment and personal and interpersonal competence was found. There were significant differences between the secure and anxious children on all dimensions of peer competence. The secure children demonstrated more "sympathy to peers' distress," but the anxiously attached children were most "typically in the role of listener."

Dimensions of ego strength were also assessed. The securely attached children were more "self-directed" and also curious. The anxiously attached children were often found to be "unaware, turned off, spaced out" (Waters et al., 1979). The most
significant differences between securely and anxiously attached preschoolers were in the following areas: secure children were sought out by others more frequently; they were less socially withdrawn; they suggested activities more frequently; and were less hesitant to engage.

Londerville and Main (1981) found correlations between secure attachment in infancy and children's later cooperation with an adult woman while engaged in free play. As toddlers, the secure children were also significantly more compliant with their mothers' commands. Londerville and Main report that these differences were not due to differences in Developmental Quotient (DQ), although securely attached children show a slight advantage on this dimension by age two. They conclude that "compliance and cooperation with the mother and with other persons were positively related to the mother's warmer tones and gentler physical interventions" (p. 289). Also, mothers of the securely attached children physically intervened more frequently than did mothers of insecurely attached children.

With a sample of 40 three-year-olds, Lieberman (1977) showed a relationship between in-home behavior with the mother and peer competence in a laboratory setting. Lieberman assessed amount of prior peer experience the children had, in order to factor in the relative weight of that experience on peer competence. Social competence was conceptualized as a child's flexibility in dealing with situations, which would involve initiating interactions, engagement versus withdrawal, contingent responses to the initiations of others, positive affect, and behavior that would not interfere with reciprocal interactions. Security of attachment was assessed
in an age-adapted version of the Strange Situation and a home visit. Security of attachment at home was highly correlated with peer experience. Lieberman notes the influence of the mother in arranging the child's social experiences with peers: overprotective mothers may limit these activities, and secure mothers may encourage their children's further social expansion. Lieberman also found that amount of prior peer experience was correlated only with verbal measures of peer competence in the peer interaction setting, and security of attachment was correlated only with nonverbal measures of peer competence, such as sharing, giving, and crying.

In addition, Lieberman (1977) assessed mothers' attitudes toward their children. She observes that there is "no direct relation . . . between the mother's attitudes toward a specific issue and the child's behavior in that sphere" (p. 1,285). The effect of maternal attitude is more generalized, tending to show in the child as social competence or incompetence. She found a significant correlation between child peer competence and mothers' attitudes with regard to their children's expression of aggression and freedom to explore. The mother's restrictive attitude toward child exploration was positively related to child negative behavior and negatively related to child responsiveness to others.

Klaus and Karen Grossmann undertook two comprehensive, longitudinal studies in different parts of Germany, following babies from birth. The study in Northern Germany found two-thirds of the sample to be insecurely attached in the Strange Situation; half of these insecurely attached infants were classified as avoidant. The researchers attributed this high proportion to the culturally sanctioned views on
independence in that region (Karen, 1994, citing interview with Grossmann, 1991). Though a cultural norm, early independence is achieved at a price that shows up much later. The avoidant youngsters in this sample did not have the same behavior problems identified in American avoidantly attached children, until, for example, at age 10, when their failure to form close friendships appeared and they had more problems with peers, were less confident, less self-reliant, and less resilient than the secure children (Grossmann & Grossmann, 1991, cited in Karen, 1994).

Pastor (1981) paired 37 securely attached toddlers each with another same-sex, same-age partner such that every combination of secure and other classification (as assessed in the Strange Situation at 18 months) was represented in the sample. These dyads were observed in a short play session with their mothers present. He found that at 20 to 23 months, children who were insecurely attached in infancy were rated lower than securely attached toddlers on sociability, orientation to peers, and orientation to mother. The avoidant children demonstrated a more negative orientation toward both mother and peer. The resistant/ambivalent children were stressed by the situation, were the most negative toward their mothers, and tended to ignore their peer-partner. Their mothers ignored or rejected their bids for contact most frequently. The mothers of the secure children were more supportive, appropriately directive, and synchronous with their children.

The results of post hoc analyses of the mothers' behavior with dyads consisting of secure children with each classification of insecure children revealed a significant difference: when their secure children were paired with insecure children,
these mothers were more supportive and directive than when their secure children played with other secure children. Also, secure children were found to engage in more object struggles with avoidant children, and to make more object offers to children in this group. They tended to be more sociable with other secure children or other ambivalent children, and to be more mother-oriented when playing with either avoidant or ambivalent children.

In an interesting study by Troy and Sroufe (1987, cited in Turner, 1991), children were rated for the presence or absence of "victimization" relationships. Victimization was defined as a relationship characterized by exploitation and manipulation. Using 38 preschool children who had been classified in infancy by attachment status, Troy and Sroufe created a number of same-sex dyads that included every combination of attachment classifications. When avoidant children were paired with other insecurely attached children, both avoidant and resistant/ambivalent, victimization was a likely result. The avoidant children tended to be identified as the "victimizers" and the ambivalent children tended to be the "victims" in these pairings. The dyads with at least one secure child were not characterized by this kind of relating.

Children who are classified as secure in infancy, then, fare better in their social relationships throughout the toddler and preschool years. They have had relationships with their mothers in which their needs were met with sensitivity, learning that they are worthy of care and love. Secure children's greater social competence seems to reflect positive expectations of others. This positive approach
seems to be based on that early experience with their mothers, and may also be enhanced by the opportunities for developing greater self-confidence with more mastery of new experiences from the secure base. Insecurely attached children "may bring patterns of behavior to relationships with peers that reflect an expectation of insensitivity, rejection, and/or unpredictability from others" (Turner, 1991, p. 1,476).

Bretherton (1985) understands these "carryover effects" from early attachments to later relationships in terms of internal and external influences. First, family environments tend to remain relatively stable, so that children experience a persistent pressure to move along a particular developmental path that is likely to continue. Second, and from that pressure, internal working models of self and others, "once constructed, tend to have an additional stabilizing influence because they influence construal of present experience" (p. 20). And finally, the environmental and intrapersonal processes interact in such a way that the environment is "partially created by the individual" (p. 20, citing Bowlby, 1973, pp. 368-369).

Internal Working Models of Self, Others, and Relationships in Childhood

The research presented above supports the hypothesis that the child's earliest experience with the caregiver profoundly, though not irrevocably, impacts future relationships, at least up through preschool. Many attachment scholars offer interpretations to explain the behaviors associated with childhood attachment categories. Attachment styles are understood as reflecting strategies for coping with maternal caregiving styles. These styles become encoded in internal working models
of self, others, and relating, which influence future interactions, strengthening their influence over time.

Thus, another area of attachment research focuses on the continuity or "stability" of attachment styles over time. This area tends to be more theoretically-oriented, as researchers seek to uncover the orderly and predictable transformations of attachment status in development. These studies typically emphasize the internal representations of self and others and relationships, looking for "rules" that have developed and how these are reflected in interpersonal behavior and language.

Attachment scholars have devised methods for assessing the internal working models of children (e.g., Cassidy, 1988; Main et al., 1985), providing empirical support for this important notion. Mary Main's research has emphasized the study of internal working models in children. She asserts that the critical difference between anxious and secure children is located internally in their psychological structure, with behavior reflecting that inner structure. Working models also organize and direct feelings and cognitive processes, such as attention and memory. Therefore, different attachment histories would be revealed in different "patterns of language and structures of the mind" (Main et al., 1985, p. 67).

Main and her colleagues (1985) devised a means to assess how children and parents hold relationships in mind at the level of internal representations, and how children's and their parents' representations hook together. They found that an important dimension pertained to the degree of rules related to relationships. Relational rules are apparent, they say, in the language itself and reflect the internal
working models. The very secure individuals are more flexible, versus rule-bound, and they have greater access to self and others both internally and externally.

In this study, Main and her colleagues assessed a sample of 40 mothers, fathers, and their children. Representatives from the disorganized/disorganized attachment classification were deliberately included in the study. The infants were assessed with the Strange Situation protocol at one year and at 18 months. Five years later, the same sample was again tested for stability of reunion behavior over that span of time, and for a comparison of early attachment status to later attachment representations in the speech of parents and children. They surmised that children's internal representations of parents could best be glimpsed in the absence of the parent, and so used observations of children's responses to a photograph of their parents while parents were out of the room. They also interviewed the children regarding a set of pictures of other children, asking what the pictured children could do about a separation from their parents. The Adult Attachment Interview ([AAI] George, Kaplan, & Main, 1985) was administered to the parents. This instrument reveals information about adult attachment-related working models of self and others in an analysis of the language used to describe past events. Finally, they transcribed and analyzed the nature of the discourse between the child and parents.

When the children were six-years-old, the mother-child dyads that had been classified as avoidant in infancy were characterized by restricted dialogues with frequent lapses in the conversation. Topics discussed were generally impersonal. The disorganized/disoriented dyads featured a disorganized dialogue, with false starts in
conversation by both parents and child. The parents rarely initiated conversation with
the child. (The records of the ambivalently attached dyads did not permit analysis.)
The secure dyads' dialogues were fluent and covered a range of topics, both personal
and impersonal in nature.

Early attachment with the mother was significantly related to the child's
overall functioning at age six. The relationship between these variables and
attachment to the father in infancy was not significant.

Using pictures of other children separating from their parents, the children
were also assessed for their emotional openness in response to these images. Their
responses were compared to early attachment with each parent. High scores were
given to those children who were able to talk freely about how the children in the
pictures felt. Those who received high scores could imagine that the pictured children
were sad, lonely, fearful, or angry, and explain why. High scores also went to the
children who, when asked what the pictured children could do, responded with
constructive ideas for how to convince the parent to not leave. The insecurely
attached children responded in a variety of ways that suggested their inability to
manage the imagined separation of other, pictured children. The securely attached
children scored high on this measure. The responses of the secure and insecure
children were strongly related to security of attachment in infancy with the mother,
but not the father.

Children's responses to the photograph of their family differed according to
early attachment classification. The secure children showed interest in the photograph
and then set it down. Avoidantly attached children tended to avoid the photograph, refuse to accept it, or turn it away from their view. The disorganized/disoriented children responded to the photograph with depression or in a disorganized manner. Again, there was a strong relationship between early attachment with the mother and response to the photograph, but not with the father.

The parents' responses to the AAI showed that mothers of securely attached infants were able to discuss both favorable and unfavorable aspects of their early relationships with their parents and they valued attachment. They considered their attachment experiences as influential in shaping their personality. On this measure, there was a moderately significant relationship between fathers' "apparent internal working model of attachment" (Main et al., 1985, p. 91) and child attachment classification. The relationship of these variables to the mother was very significant.

Jude Cassidy (1988) attempted to access the internal representation of self in six-year-old children through an ingenious study. With a sample of 52 white, middle class children, she explored the associations between working models of self and the attachment figure, and also the patterns of self-perception associated with attachment styles. Sixteen children represented the insecure/controlling classification (the disorganized/disoriented pattern of infancy) were included. Her proposition was that "experiencing the parent as available, sensitively responsive, and affectively accepting leads the child to develop simultaneously both a secure attachment and the sense that, as one who merits such treatment, he or she must be inherently worthy" (Cassidy, 1988, p. 122).
To assess the sense of self, Cassidy used several techniques. A procedure devised by Main et al. (1985, p. 67) involving the completion of six attachment-related stories through an enactment with a doll family was utilized to capture how the child saw himself or herself in relation to the attachment figure. To assess the esteem accorded the child by "unspecified others," puppets were questioned by the examiner regarding the child. The child was to answer the puppet. Questions included, for example, "Do you like (child) the way he is, or do you want to make him better?" (Cassidy, 1988, p. 125). It was assumed that the answers would reflect the child's self-esteem. Self-esteem was also measured by an instrument designed for that purpose and by child self-report from an interview. Results are summarized as follows:

Children classified as securely attached showed a warm and intimate relationship to the mother in the reunion situation. In both the puppet and self interviews, these children described themselves in a positive light yet possessed a capacity to admit normal imperfections, a combination that reflects the confidence to explore and reveal both strong and weak points of the self... Just as these children could tolerate imperfections in themselves, so the relationships described in the [doll] stories could tolerate stress. The working models of these children and of their attachment figures appear to lead to a sense that they will be accepted despite flaws. (p. 130)

The eight children classified as avoidant admitted no faults, describing themselves as essentially perfect in the "puppet interview." This pattern was also evident in the self interview and in the doll stories. The number of ambivalently attached children in the sample was too small (n=6) to generate conclusive findings. Many of the insecure-controlling children made explicit negative statements regarding their self-worth in the interviews; there were also instances of hostility and
violence in their doll stories.

The research cited above suggests the validity of the concept of working models. Recent studies of brain development are beginning to show how and why the earliest relationships have longlasting impact. A longitudinal study by Dawson was presented at the 1996 Child Development Conference in Chicago. She measured the brain activity of 160 children of severely depressed mothers over a period from infancy to six-years-old, looking for how mother-infant interaction affects brain development. She found that in infancy these children had low activity levels in the portion of the brain that is involved in positive feelings; and that by three-and-a-half-years-old, if the mother had not received effective treatment, these children had more behavior problems, such as aggression, sleep disturbances, and sadness. In contrast, the normal brain activity returned for the children of those mothers who got immediate treatment for their depression. In infancy, the brain has a surplus of connections; as it develops, some of these connections are elaborated and strengthened while others die off from disuse. Dawson speculates that infants’ brain development is impacted by depressed mothering, in which the mothers are less responsive to infants’ signals, more withdrawn and disengaged, and more irritable with their babies. It may be that the neural pathways are “sculpted” by this early experience with mother. Perhaps this process contributes to the formation of working models.
Impact in Adulthood of Early Relationships Via Working Models

The mother brings her own biology and interpersonal history (Bowlby, 1969) to bear on her relationship with her child. Attachment research has explored the impact of mothers' histories on their children's attachment with them. Some of the characteristics that mothers bring as antecedents to their relationships with children are addressed in the following section.

Bowlby's theory (1973, 1988) suggests that early attachment relationships may be transmitted to succeeding generations via working models that shape expectations of self, others, and relationships. Although attachment styles may change, there is evidence that attachment patterns do tend to persist (Bretherton, 1985; Cassidy, 1988) and affect the next generation of children (Crowell & Feldman, 1988; Main & Goldwyn, 1984; Main et al., 1985). Studies have demonstrated an association between mothers' memories of their childhood relationships with attachment figures and the quality of their relationships with their children as assessed in the Strange Situation at one year (Belsky & Isabella, 1988; Grossmann, Fremmer-Bombik, & Grossmann, 1988; Main & Goldwyn, 1984; Main et al., 1985; Ricks, 1985; Sroufe, Jacobvitz, Mangelsdorf, DeAngelo, & Ward, 1985).

George, Kaplan, and Main (1985) developed a means of assessing adults' mental representations of relationships that has become a relatively standard method in the research on intergenerational transmission of quality of attachment. This method, the Adult Attachment Interview (AAI), asks a series of questions about
childhood relationships with parents, the subject's assessment of how those relationships changed over time, and how those relationships impact their present functioning (described in Kobak & Sceery, 1988). Subjects are asked to recall specific memories of their parents' responses to their distress. In order to capture the internal representation of attachment relationships, the relevant information obtained from these interviews comes from how the respondent talks about all of these issues. From this, adults are classified into one of three attachment classifications: dismissing, preoccupied, or autonomous.

Fonagy et al. (1991, p. 892) describe the maternal styles that are associated with these categories. Mothers who are classified as dismissing are described as "cut off from the emotional nature of childhood attachment experiences"; "their current state of mind with respect to attachment is variously characterized by idealization, derogation, insistence on the inability to recall, and cognitive formulations divorced from affect." Those who are placed in the preoccupied category seem to remain "overinvolved with their sometimes traumatic childhood experiences"; in the interview, these mothers may be incoherent, preoccupied by anger, and they appear to be "overwhelmed and confused by the topic of attachment." In contrast to those mothers, the mothers rated as autonomous present a coherent narrative of childhood experiences that includes positive and negative features.

The adult categories are considered to be systematically related to the infant categories (Main et al., 1985). Thus, the dismissing adult is analogous to the avoidant infant; the resistant or ambivalent child category compares to the preoccupied adult;
and the autonomous adult parallels the secure child classification. Alexander (1992) describes a fourth category, the fearful adult, as "the disorganized child grown up," who has been left with no effective strategy to cope with others as a result of early experience in which the attachment figure was both the source of and solution for felt anxiety (p. 190).

In the pilot study using the AAI (Main & Goldwyn, 1985), parents' interviews were compared with the attachment classifications of their infants. Children who were securely attached had parents who were also identified as secure, or "free to evaluate attachment," with the features of the autonomous classification. The parents of children identified as avoidant in the Strange Situation tended to have the features of dismissing adults. They devalued the importance of attachment and had memories of rejection. The parents of ambivalently attached children seemed to be "enmeshed in attitudes toward attachment" and were categorized as preoccupied (Kobak & Sceery, 1988, p. 137).

A number of subsequent studies have shown that these maternal styles may affect infant attachment. For instance, in their prospective study, Fonagy et al. (1991) interviewed 100 expectant mothers to ascertain their adult attachment classification using the AAI. The sample consisted of middle class, white, and well-educated women. One year later, 96 of these mothers' infants were assessed in the Strange Situation. It was found that maternal attachment classifications of autonomous versus dismissing or preoccupied predicted secure versus insecure infant classifications 75% of the time. This percentage corresponds with the findings from other retrospective
studies (e.g., Grossmann et al., 1988). The adult autonomous classification powerfully predicted secure attachment classification in infants; the dismissing mothers predicted avoidant infant classification. They found no significant relationship between the preoccupied mothers and ambivalent/resistant infants. Mothers of securely attached children were able to "convey a global representation" (Fonagy et al., 1991, p. 901) of their childhood relationships with each parent. They were able to speak freely about positive and negative aspects of those relationships with a notable absence of idealization, and to elaborate with specific examples. They did not report an inability to recall periods from their childhood, and conveyed awareness of the motives that shaped their parents' behavior in relation to them. They were able to access and express emotions and valued attachment.

The prospective study of Belsky and Isabella (1988, cited in Fonagy et al., 1991) found little evidence of a predictive relationship between expectant mothers' developmental history and their infants' attachment status. The discrepant findings point to the importance of assessing how developmental experiences are internalized and integrated by individual mothers, that is, in their working models about attachment.

Others suggest that working models explain the intergenerational transmission of attachment patterns (Crowell & Feldman, 1988; Main et al., 1985; Ricks, 1985). As noted above, the AAI captures this dimension by attending to the integration of historical experience as evidenced in the language with which it is described. Crowell and Feldman (1988) used the AAI to assess mothers' internal models of relationships
based on their memories of childhood relationships and the language with which memories were accessed. The mothers were classified as secure, detached, or preoccupied/enmeshed. Their preschool children represented three groups: "developmentally intact," "developmentally delayed," and a matched "nonclinic" group. Crowell and Feldman then looked at the mother-child dyads in a problem-solving situation. The mothers were assessed on their help and support, a variable that combined two highly correlated categories of quality of assistance to child and supportive presence.

Their results showed that the mother's internal working model of relationships "selectively and qualitatively affects her responsiveness and sensitivity to her child" (Crowell & Feldman, 1988, p. 1,283), confirming the findings of Main et al. (1985). Children's behavior significantly "matched" mothers' behavior, which also matched mothers' attachment classification. That is, a mother's representation of relationships correlated with her behavior with the child, and also with the child's behavior in the problem-solving situation. The secure mothers were most warm and supportive, giving clear and helpful encouragement to their children. They endorsed learning and competence. Their children were most affectionate, mother-oriented, and emotionally positive. Mothers classified as detached were less helpful and supportive, using a cool and controlling, task-oriented style of assistance. They were more concerned with task completion than child learning. Their children were chilly with their mothers, but did not show much overt anger. Their affect was subdued and they showed anxiety. Mothers in the preoccupied group were not supportive and were confusing in their
presentation of directions and suggestions to their children and these children seemed overwhelmed with the task. The preoccupied mothers were inconsistent, alternating warmth and gentleness with anger and coerciveness. Their children were angry, noncompliant, and controlling. (It is interesting to note that the noncompliant and negative behavior of both clinic and nonclinic children were not significantly different in the laboratory setting. This suggests that the mothers had different responses to similar behaviors in the children.) The authors conclude that insecure models of relationships in the mother may pose a risk for behavior problems in the child.

The findings on the effect of maternal attachment styles on children above demonstrate that mothers with insecure internal working models of relationships often have insecurely attached children. The discussion that follows suggests that a particular kind of mother-child relationship—role-inversion—may ensue when mothers are distracted by their own problems.

Role Inversions Between Mothers and Children

The mother whose own needs are overwhelming her may be physically or psychologically unable to tend to the needs of her children. Further, the children may assume or be expected to assume the role of caregiver for the mother at an age when this is inappropriate. The task of caregiving distracts the child from pursuing her own developmental tasks.
Attachment Research Suggesting Role Inversions

This writer distinguishes two kinds of mother-child role inversions: active and passive. A passive role inversion may occur in the baby's early infancy (and at any later time) when the mother's needs and wishes take precedence over the child's. Thus, the mother becomes the center of the relationship and not the child. She views the baby through her own fears and needs, and cannot separate her own feelings and needs from her perceptions of the child's feelings and needs. Her boundaries of self and other are uncertain (Chodorow, 1989). What the baby does is interpreted by the mother as about her, and not about the baby. She is answering her own cues, not the baby's. In this way, she is asserting that her own activities and needs are more important than the baby's needs. Though not actively receiving caring and nurturing activities from her infant, the roles are distorted and subtly inverted.

Support for this conception of passive role inversions is suggested in some pertinent studies from attachment research. Maternal sensitivity and responsiveness to the child's needs and behaviors is a most critical characteristic associated with quality of attachment in infants. In the literature on childhood attachment status, this is referred to as maternal attunement, maternal sensitivity, and maternal responsiveness. All of these terms denote the way a mother "hears" or "reads" her baby's signals and responds to them. This entails a capacity for empathy in the mother, as well as her ability and willingness to respond appropriately, that is, her willingness and ability to "decenter" and attune to the needs of her child. Attachment research has shown that
the children of mothers who are unable to interpret or tend to the infants' needs, or who tend them inconsistently, have children classified as insecurely, or anxiously, attached.

Ainsworth et al. (1978) observed that mothers who were responsive to infant's cries and were more affectionate and tender in their physical contact were likely to have securely attached infants at one year (cited in Isabella & Belsky, 1991). These results have been replicated in other studies (e.g., Belsky, Rovine, & Taylor, 1984; Smith & Pederson, 1988). Grossmann, Grossmann, Spangler, Suess, and Unzner (1985) reported that maternal sensitivity in early infancy was related to later secure attachment in a sample of North German infants.

Others have explored mother-infant synchrony, tracking the harmonious interchange that occurs between an infant and its mother (Blehar, Lieberman, & Ainsworth, 1977; Brazelton, Koslowski, & Main, 1974; Isabella, Belsky, & von Eye, 1989). This implies that the mother is attuned to the baby and vice versa. Isabella and colleagues (1989) found that synchronous mother-infant behavior, assessed when the baby was one month and three months old, predicted later security of attachment, and asynchronous interactions predicted insecure attachment. Post hoc analyses of their results showed a relationship between maternal intrusiveness and avoidant attachment in the infant, and between detached, inconsistent responses from the mother and resistant attachment in the baby (Isabella & Belsky, 1991).

Maternal intrusiveness contrasts with maternal sensitivity insofar as the mother is not responding to the baby's signals, but is operating instead according to
her own agenda, thereby underentitling her baby. A number of studies have linked avoidant infants with the highest levels of maternal involvement (Belsky et al., 1984; Isabella & Belsky, 1991; Lewis & Feiring, 1989; Malatesta, Culver, Tesman, & Shepard, 1989; Smith & Pederson, 1988). Miyake, Chen, and Campos (1985) found that mothers of secure one-year-olds were less likely to intrude upon their infants' ongoing activities. Isabella and Belsky (1991) observed a sample of 153 white, middle and working class mothers and their infants in the home at 3 and 9 months, and in the Strange Situation at 12 months. They report that the mothers of children who were classified as avoidant at 12 months were more intrusive, notably in their steady stream of vocalizations and failure to respond to their infants' vocalizations.

At the other end of the spectrum, but still a failure in empathic response, is a low level of responsiveness to babies' signals (Belsky et al., 1984; Lewis & Feiring, 1989; Smith & Pederson, 1988). In the study cited above (Isabella & Belsky, 1991), the children later classified as resistant had mothers characterized in this manner. These mothers' interactions were also ill-coordinated with their babies' activities. For example, they were more likely to initiate interactions when the baby was apparently unwilling to engage. Isabella and Belsky suggest that there is a middle range of maternal involvement that is optimal in promoting secure attachment.

Nonchild-centered parenting is common to all of the anxiously attached classifications (avoidant, ambivalent, and disorganized) described in the attachment research using the Strange Situation. The caregiver who rejects or ignores her child's needs is clearly not considering the child. The preoccupied mother who attends to her
child's needs sporadically fluctuates depending on her own state at the moment of child need; this, too, indicates to the baby that mother's needs and moods come first. The mother, not the baby, has the right to define and decide which needs matter and when they matter.

If this pattern persists, when the infant matures and becomes physically capable of tending to her mother's needs, the role-inversion becomes more active. The child may assume or be assigned responsibilities that would normally be an adult's. These responsibilities may include physical household tasks, such as cleaning or preparing meals for the family. The more important dimension, however, is the child's (nonmutual) emotional provision of care for her parent (Boszormenyi-Nagy & Spark, 1973). Evidence for this more active role inversion is provided in research on child abuse and in attachment research on maternal depression.

Child Abuse and Role Inversions

Abusing parents' own early lives reflect mothering/caregiving deficits (Steele & Pollack, 1968, cited in DeLozier, 1982). By this, it is meant that they lacked sensitive responsiveness and empathy for their own needs as children. With or without actual abuse, the lack of sensitive mothering has left them without a "sense of being cared for and about" (DeLozier, p. 97, citing Steele & Pollack, 1968). Lacking the experience of "being the center" of someone else's regard, they do not know how to provide this to their own offspring.
DeLozier (1982) reviewed the literature on child abusers and noted several themes. First, many studies have shown that parents who abuse their children were often abused themselves when young. Abuse follows a generational pattern. Second, a set of characteristics have been found to be associated with abusing parents. They tend to be "isolated and distrustful, viewing the environment as hostile, and unable or unwilling to form close relationships with others" (p. 96). In addition to being isolated, abusing parents are often immature and impulsive. Steele's (1970) study revealed "an almost universal presence among abusing parents of some degree of depression, either overt or latent" (p. 450, cited in DeLozier, 1982). Depression, intense anger, and intense anxiety are consistently associated with abusing parents. These parents appear to have very strong "dependency needs" as well. They seem helpless, ambivalent, sensitive to criticism, unable to make decisions, and have low self-esteem (DeLozier, 1982, p. 96). These qualities are exacerbated by their social isolation: they lack relationships outside of the family to turn to for support. They present a "pseudo independence" to the world, having learned in childhood that "their needs will not be met" (DeLozier, 1982, p. 96). DeLozier notes that many of these parents turn to their children for their unmet needs for nurturance, resulting in an inverted parent-child relationship.

A number of researchers (e.g., Alexander, 1992; DeLozier, 1982; Egeland & Sroufe, 1981; Schneider-Rosen, Braunwald, & Cicchetti, 1985) have found a link between childhood abuse, maternal attachment behavior, and the attachment status of these mothers' children, suggesting an intergenerational pattern. A prospective study
by Egeland and Sroufe (1981) compared infant attachment in a "poverty sample" of
64 mother-infant pairs. Some of the children (n=33) had histories of excellent care,
and the remainder had histories of extreme neglect or abuse. Children were assessed
in the Strange Situation at 12 months and again at 18 months. The distribution of
attachment classifications and other associated characteristics were compared to that
of the larger poverty sample (N=267) of which these dyads were a subsample. It was
found that the maltreating mothers tended to be younger, less well-educated, and
single at the time of their child's birth than the more capable mothers. The authors
note that these confounding variables are a part of real-world interactive effects.
Economic levels were controlled for in the study.

In the larger sample, the proportion of securely attached children at 12 months
was 55%; in the set of maltreated infants, the percentage of secure infants was 38; this
percent soared to 75 in the excellent-care group of children. Fifty percent of the
insecurely attached maltreated one-year-old children were classified as
resistant/ambivalent (the "C" classification), compared to 21% in the total poverty
sample. The authors believe that the high incidence of C infants in this group reflects
their mothers' ability to care for their infants, but on an inconsistent basis, with many
of the mothers identified as drug-users. In the excellent-care group, the attachment
classification remained stable between 12 and 18 months. Slightly more than half of
the maltreated children tended to shift classifications over time, with most moving
from C (ambivalent) to A (avoidant) status. Four insecurely attached infants shifted to
a secure classification. This finding should be interpreted with caution, however,
since their analysis did not include the disorganized/disoriented classification. As Main and Solomon (1986) later observed, some insecurely attached children were inappropriately classified as secure before this category was included in Strange Situation analyses.

Schneider-Rosen et al. (1985) further studied insecurity of attachment in maltreated infants and instability of attachment status in that population. Although they, too, did not use the disorganized category in their analysis, they confirmed the findings above: the proportion of maltreated children in three age groups who were insecurely attached was significantly higher than in nonclinical samples. The influence of lower-class socioeconomic status on prevalence of maltreatment was ruled out by the use of a matched comparison group. Again, the shift from C to A status was observed over time in the maltreated group. The authors speculate that this shift represents an "increasingly organized effort on the part of the maltreated infant to cope with the inconsistent and problematic nature of the relationship with the caregiver " (Schneider-Rosen et al., 1985, pp. 205-206). From their perspective, the child's avoidance may be viewed as a functional adaptation to the necessities of a particular relationship, and therefore, as the most "competent" solution.

Schneider-Rosen et al. (1985) also found no clear relationship between the type of maltreatment (physical injury, emotional mistreatment, physical neglect, and sexual abuse) and the type of insecure attachment category (ambivalent or avoidant). However, more than half of the sample had experienced multiple types of abuse, so these results may reflect that overlap, or the possibility that some types of
maltreatment had not been detected.

Research on abused children presents the same emotional features as those found in abusing parents: abused children are "depressed, dependent, angry, anxious, and handicapped in their ability to form and maintain close relationships with peers or with caretakers" (DeLozier, 1982, p. 97). George and Main's (1979) study of abused one-to three-year-olds characterized these children as exhibiting more aggressive behavior toward other children and adults, and as especially cautious in response to friendly overtures by adults. Martin's longitudinal studies of abused children (1972, 1975, 1976; Martin, Breezley, Conway, & Kempe, 1974, cited in DeLozier) showed that they were exceptionally empathic with adults, and excessively eager for approval, but their relationships with adults were wary and superficial. They seemed to have adopted a heightened sensitivity to their parents' needs and to reading environmental cues, even though they maintained social distance.

In Martin's sample of 43 abused children, only 7% were difficult babies from birth. DeLozier's literature review explored other contextual variables that have been related to abusing parents, such as high stress, unemployment, and poverty; she notes that "not all or even the majority of families that fit any of these categories are abusive" (DeLozier, 1982, p. 97). DeLozier suggests that the patterns described above can be understood from an attachment perspective. The attachment pathology in abusing parents represents a carryover of their own childhood attachment and caretaker systems. She designed a study to test this and the hypotheses: (a) that more abusing mothers would report early attachment disruptions; (b) their current
significant relationships would reflect early insecure attachments; (c) they would show caretaking deficits right from the birth of their children; and (d) a current attachment disorder would be evident in their responses to separation. Using a matched low income sample that included 18 child-abusing parents, and 18 control group mothers, she assessed these mothers on separation anxiety and their own attachment history. Her hypotheses were all confirmed, except that the abusing mothers did not have significantly more actual separations from caretakers in childhood. The fathers of these women, however, were absent for much longer periods than the fathers of the control mothers.

DeLozier (1982) found a strong pattern of severe attachment disorders in the abusing mothers. Abusing mothers also differed significantly from the control mothers in childhood threat of separation from attachment figures or actual separation from them. Significant differences were found on the following separation anxiety measures, with abusing mothers scoring higher: affective response, strong anger, mild anxiety, rejection and self-blame, and mild separation attachment response. Abusing mothers were rated significantly lower on self-reliance. An analysis of the types of disciplinary threats by the abusing mother's parents showed that severity of threats was significantly different between groups: only one of the control mothers reported a history of severe threats; seven of the abusing mothers reported such a history. Threats included severe beating, killing the child, and threats that the child's behavior would kill the parent. Thus, physical danger and threat of abandonment figured prominently in abusing mothers' histories, and these were "an integral part of their
recalled childhood” (p. 108).

Results further suggested that the abusing mothers experienced role-reversals in childhood with their parents:

Almost two-thirds of the abusing group replied that they felt responsible for their parents; in contrast, two-thirds of the typical [mothers] group reported that they had not felt any such responsibility. In addition, more than three times as many abusing parents (39 percent) indicated that they had felt their own actions or attitudes would be the cause of harm to their parent, often because they had been told so repeatedly by the parent. (DeLozier, 1982, p. 110)

Significantly fewer abusing mothers stated that they had turned to their mothers for help. Many more abusing mothers also reported less expectation of help in their current lives, including from their husbands.

DeLozier believes that the repeated threats of abandonment and the excessive responsibility for the parents triggered an anger in these children that they could not express without exacerbating their parents' negative response to them. This anger was therefore repressed, and, as Bowlby (1977) suggested, persisted into their adult life where it finds expression toward a weaker person, such as their own child. This pattern is further exacerbated by abusing mothers' heightened sensitivity to separation: they may "interpret the normal behavior of their children as if it were actual or threatened rejection" (DeLozier, 1982, p. 114) and respond with anger, as opposed to encouraging the child's separation and self-reliance. Her study found that abusing mothers were more sensitive to separation from significant others, suggesting mothers' own insecure attachment.

Thus the attachment-related response of the mother may result in the inappropriate direction of anxiety and anger toward the child who, due to the
inverted parent-child relationship, may be viewed with the same expectations that the mother maintains regarding attachment figures—that they will be inaccessible and unreliable. (p. 114)

Egeland, Jacobvitz, and Sroufe (1988) studied abusing and nonabusing mothers. Both groups had been abused as children; the authors wanted to identify variables that helped the nonabusing mothers "break the cycle of abuse." They learned that the mothers who did not abuse their children, referred to as "exception mothers," were "significantly more likely to have received emotional support from a nonabusive adult during childhood, participated in therapy during any period of their lives for at least one year, and to have had a nonabusive and more stable, emotionally supportive, and satisfying relationship with a mate" (Egeland et al., 1988, p. 1,080) than the abusing mothers.

**Depression in Mothers and Role Inversions**

Role inversion can occur when the mother is debilitated by depression. Since maternal sensitivity weighs so heavily in the development of secure attachment, Pound (1982) hypothesized that maternal depression was likely to impact attachment. Mothers who are depressed would be less psychologically available and less sensitive to their babies' needs and signals. Children may fear the loss of their attachment figure, exposed to mothers' unhappiness and perhaps threats of suicide. Pound expected that preschool children with depressed mothers would have an insecure avoidant attachment relationship, and that this, in turn, would exacerbate the mother's depression as she experienced the avoidance as rejection. Thus, mother and child
would "become trapped in a vicious circle of mutual disappointment and distress" (Pound, 1982, p. 122), which would help explain an intergenerational pattern of disturbance.

Pound (1982) observed a sample of children and their mothers, some of whom were currently depressed and some who had been severely depressed in recent past. She offers the following conclusions:

There is indubitably a definite attachment between each of these children and their mothers, but it is of a very unusual kind. It is intimate, even intense, but not warm; continuous but also continuously threatened; and the only satisfaction seems to be that somehow the relationship is preserved intact. Some of the unusual features of the relationship can be seen as arising from reversals of the balance of power and resource that normally prevails between mother and child. Instead of the mother holding the child in her concerned attention, the child watches her, ready to respond to her need as it arises, though in his naivete he is likely to get it wrong. . . . While the healthy mother sees herself as responsible for the child's survival, in depression, the child may feel responsible for the mother's. In some cases he may indeed keep his mother alive by his expressions of love when there seems nothing else for her to live for. (p. 125)

In response to the mother's depression, the child may take charge or control. Pound views this as a way for the child to detach his identification with the mother's helplessness, and as a mother-child collusion of sorts: "both feel it is safer for the child to be in control" (Pound, 1982, p. 126), perhaps to avoid abuse. This child may be forced into a precocious maturity, perhaps tense and driven, unable and later unwilling to turn to mother for instruction. He may have to "become an attachment figure before he has had sufficient experience of being attached" (p. 126) at a cost to his own identity. In adult life, this person may find direct expression of need to be extremely difficult, both because the expectation of response is absent and because he
or she has not learned to even perceive his own needs, impulses, and emotions. This person seems to have developed a "false self," constructing behavior according to "conventional expectations, with a resulting sense of emptiness, frustration, and dissatisfaction" (p. 127).

Other empirical results support Pound's observations. A study by Radke-Yarrow, Cummings, Kuczynski, and Chapman (1985) examined patterns of attachment in normal and depressed mothers, using multiple scales to assess severity of depression and to differentiate this from temporary mood states. Mothers' affective behavior with their children was also assessed, and a modified Strange Situation procedure was used to classify their two- and three-year-old children's attachment status. The sample of 99 children included those with mothers diagnosed as having bipolar, major unipolar, and minor depression, along with a group who had no history of affective disorder. The percentage of time over the child's life in which he or she had been exposed to the mother's affective disturbance was considered. Influences from differences in age, sex, socioeconomic status, and race were ruled out.

It was found that 29% of the children with "normal" mothers were avoidantly attached; 71% were secure. Three-fourths of the children who had mothers with minor depression were securely attached, 17% were avoidant, and 8% were classified as resistant/ambivalent. Fifty-five percent of the children with mothers who had a major affective disorder were insecurely attached; of these, the highest percentage (79%) were children of mothers with bipolar disorder. Current mood state of the mother did not significantly affect attachment status in the children, but mothers' expression of
emotions, positive and negative, in interaction with their children was found to predict child attachment classification independent of their diagnosis. Mothers of securely attached children expressed more positive emotion than mothers of insecurely attached children.

A subsample of these families (n=18) had fathers also diagnosed with depression. The effect of father and mother depression on their children's attachment status was not significant, as compared to children with only mothers who were depressed. Although the subsample of single mothers was small (n<10), the presence or absence of a father in the home, however, did significantly impact the child's attachment to the mother. The availability of social supports for the mother may mitigate the effects of maternal depression and attachment problems (Crockenberg, 1981; Weinraub & Wolf, 1983).

The Radke-Yarrow et al. (1985) study assumed that since a "depressed parent is likely to be self-deprecating, it is quite possible that such views are conveyed to the child and extend to perceptions of the child" (p. 885). This hypothesis suggests a process of maternal identification with the children and poor self-other boundaries in the mother.

The research above identifies a pattern of parent-child relationships in which the roles are inverted. The mother's needs become the center of the child's concern, more or less without reciprocity. This describes an early underentitlement in relationship with the mother which shapes the child's working models about his or her place in relationships. Because internal working models tend to persist over time,
filtering and shaping new experiences (Main et al., 1985), this underentitlement in relationships is likely to carry forward into adult relationships. These adult relationships will therefore be nonmutual.

Feminist Object Relations Views of Role-Reversals in Mother-Daughter Relationships

A further hypothesis in this dissertation is that a particular pattern contributing to underentitlement in adult women may be a woman's history of mother-daughter role reversal. The theories proposed by Chodorow (1989) and Eichenbaum and Orbach (1983) elaborate upon the impact of mothering in the development of a gendered sense of self. Their conceptions are grounded in object relations theory, as is attachment theory, however, they bring a feminist perspective. They are concerned with explaining "power imbalances" in relationships, and the devaluation of women in the culture. Unlike other feminist theories that emphasize the social learning of gendered identity, these authors focus on internal, psychological processes that perpetuate the devaluation of women across generations. In particular, they consider the impact of mothering on development.

For both sexes, the project of the first years of life is separation and individuation--breaking the primary identification and developing a sense of a separate self. Object relations theory posits that personality emerges out of the relational experiences of the infant, beginning at birth. In very early life, a child has no conception of self as an entity separate from the primary provider. At the root of
development, according to object relations, is the fundamental requirement of infancy: the provision of care by another. Absolute dependence demands response. In the primary identification with mother, the world is experienced as a magical extension of self: what the child wants appears (more or less) when he or she wants it, as if gratification occurs simply by wishing. As the mother/caretaker gradually asserts boundaries, delaying gratification of the infant's needs to tend to something else, the child comes to realize a gap or separation between himself or herself and mother. Through this self/not-self distinction, the infant develops a sense of self (Grotstein, 1981).

According to Chodorow, the experience of separation will take a different course for boys and girls, due to differences in how the mother views and treats her different-sexed children. Mothers emphasize their sons' "masculinity in opposition" to their own femininity (Chodorow, 1989, p. 49). Further, Chodorow proposes that under prevailing (albeit changing) family structure, in which fathers are largely absent from the home and mothers are responsible for early socialization of children, boys, too, define their masculine identity by renouncing the feminine. Rather than a positive male identification growing out of a real, present, relationship with the father, a negative identification occurs: maleness is not-femaleness. Thus, little boys reject the feminine internally and externally.

Central to Chodorow's theory is the role of mothers in the perpetuation of women's subordination. Mothers tend to identify more with their daughters because they share the same sex. Specifically, the experience of mothering for a woman
involves a double identification:

A woman identifies with her own mother and, through identification with her child, she (re)experiences herself as a cared-for child. The particular nature of this double identification for the individual mother is closely bound up with her relationship to her own mother. (Chodorow, 1989, p. 48)

If that prior relationship has been problematic, it is likely that the current mother-child relationship will also be, as the nature of that earlier relationship is re-experienced. Chodorow cites, for example, Robert Fleiss's (1961) description of children who had psychotic mothers as an example of an extreme, in which it appears that

this sort of disturbed mother inflicts her pathology predominantly on daughters. The mothers Fleiss describes did not allow their daughters to perceive themselves as separate people, but simply acted as if their daughters were narcissistic extensions or doubles of themselves. . . . The daughters were bound into a mutually dependent "hypersymbiotic" relationship. These mothers, then, perpetuate a mutual relationship with their daughters of both primary identification and infantile dependence. (Chodorow, 1989, p. 49)

Even if the mother's early history with her own mother was relatively free of difficulties, the mere fact of shared gender between mother and daughter causes special problems in separation and individuation for girls. Chodorow believes that, in general, mothers provide less help in this process for their daughters than their sons, with the result that the establishment of adequate ego boundaries is impaired in females, and the sense of self is therefore less firm than it is in males. This situation replicates through generations of women:

A mother, on the one hand, grows up without establishing adequate ego boundaries or a firm sense of self. She tends to experience boundary confusion with her daughter, and does not provide experiences of differentiating ego development for her daughter or encourage the breaking of her daughter's dependence. (Chodorow, 1989, p. 59)
Like Chodorow, Eichenbaum and Orbach (1983) believe that boys' gender difference from their mothers helps them in their process of individuation. They also share Chodorow's premise that conscious and unconscious elements affect personality development.

The psychology that the infant girl will embody in the process of becoming a person will be imbued with the mother's sense of self. Growing up female and being a woman means that one's sense of self reflects what each woman has had to learn in her development. Aspects of the mother's psychology that are inextricably bound up with being socialized to the feminine role are absorbed and then shared by the daughter in her own psychology. (p. 38)

In particular, the daughter will experience her mother's conscious and unconscious ambivalence about being a woman:

At times the mother is able to see her daughter as a separate little person and to respond to her freely. At other times, however, the mother's unconscious identification makes her annoyed with the child for displaying her needs and for not controlling them as she herself does. At these times, the mother is unconsciously driven to respond to her daughter with resentment and disapproval, thus transmitting the message that there is something wrong with her daughter, something wrong with her desires, something that needs to be kept at bay. Unwittingly, mother provides her daughter with her first lesson in emotional deprivation. (pp. 43-44)

Triggered by the awareness of the daughter's neediness and vulnerability, which is real in childhood, the mother can readily project onto her daughter her own feelings about her disowned neediness, which the authors call the "little-girl" of the mother. The "little girl" self reflects the mother's internalized relationships from her own childhood, which have become a part of her self-concept. Projection implies a denial of the separateness of the daughter; the mother is "seeing her daughter not as another person but as an extension of herself" (Eichenbaum & Orbach, 1983, p. 41), and the process initiates the development of the daughter's own "little girl" self.
From this overidentification of the mother with the daughter, the female child begins to learn that she does not have a separate, distinct self. She will approach relationships with her continued yearning for mother and impaired psychological separation and individuation. She does not expect others to respond to her needs, so she becomes cautious. Each effort at separating from the mother will generate feelings of disloyalty, fear, and guilt. The mother opposes her separation because of her own unmet needs.

Inside each mother lives a hungry, needy, deprived, and angry little-girl. She turns to her daughter for nurturance, looking to the child to make up the loss of her own maternal nurturance and satisfy her continued yearnings. . . .

The daughter becomes involved in a cycle that is part of each woman's experience: attempting to care for mother. As the daughter learns her role as nurturer, her first child is her mother. (Eichenbaum & Orbach, 1983, p. 57, underlining theirs)

They do not turn to their little boys in this way. While girls are expected to care for their mothers for their entire lives, boys are seen as people who can leave to pursue their own interests, hopes, and abilities. Thus, like some attachment scholars (e.g., DeLozier, 1982), Eichenbaum and Orbach suggest a process of parentification and role reversal. And like Chodorow (1989), Eichenbaum and Orbach identify a mother-daughter role reversal that originates in their shared gender, and the resulting potential for underdeveloped boundaries between mothers and daughters. When mothers' needs and positive identities have been devalued historically, two outcomes may result in their mothering of girls: they may defensively deny the neediness and vulnerability of their daughters as part of their own self-denial; and they may turn to their daughters for the provision of their unmet needs—needs they do not expect to
have met in their peer relationships or their relationships with their own parents.

In this chapter, selected literature has been presented that applies to the hypothesis that one's sense of entitlement as an adult is related to relational expectations learned very early in life and internalized in working models of relationships, originating especially from the relationship with mother. It has been shown that one's early relational experience with mother shapes the development of internal working models about self and others and relationships. Evidence has been offered to demonstrate that these working models carry forward, affecting later social and cognitive development, and also mothering styles in adulthood. The hypothesis that a particular pattern contributing to underentitlement in adult women may be mother-daughter role reversal has also been discussed. A pattern of mother-child relationship in which the caregiving function is inverted has been identified and associated with depression in mothers, and in families with abusing parents. Feminist object relations perspectives have been offered to suggest that mother-daughter role reversals and underdeveloped identity in the daughter (self as separate from mother) may occur as a result of their shared gender.

The hypothesis, that women in problematic nonmutual adult relationships often have a dysfunctional sense of self in relationships and they perceive themselves as less entitled, will be explored in the following chapter. Clinical observations will illustrate this hypothesis.
CHAPTER IV

CLINICAL OBSERVATIONS RELEVANT TO THE HYPOTHESES

Introduction

The purpose of this study is to offer an explanation for a phenomenon frequently reported by depressed and/or anxious women in a clinical setting. That phenomenon is their past and current involvement in nonmutual relationships, in which they have the unilateral and ongoing "place" as the giver of care.

This chapter will apply the research presented in Chapter III and new observations from clinical practice to the hypothesis:

1. Women in problematic nonmutual adult relationships often have a dysfunctional sense of self in relationships; they may perceive themselves as less entitled.

2. One's sense of entitlement as an adult is often related to relational expectations learned very early in life and internalized in working models of self in relationships, originating especially from the relationship with mother. A particular pattern contributing to underentitlement in adult women may be mother-daughter role reversal. Some causes of underentitlement, therefore, can be sought in client histories.
Nonmutual Relationships

Nonmutual relationships are characterized by one person tending to be the "giver" and the other the "receiver" in an ongoing pattern. What is given and received includes attention and consideration, and also goods and services.

Mike works hard on the night shift at a mill, while his wife, Sara, stays home with their four young children, all of whom have serious behavior problems. When he comes home from work, he expects his wife to be up waiting for him, and becomes angry if she is in the bathroom or otherwise engaged. The children are not to disturb him, ever. When he works, he tells his wife to take the children outside during the day so he can have some peace to sleep, regardless of the weather. She is not permitted to have friends, to work, or to have any money except to buy groceries. The children are not allowed to have any toys, because they break them or leave them out; if he finds any, they go in the trash. He often listens to acid rock music with his stereo turned up as loud as it can go.

This example, adapted from clinical practice, demonstrates both "sides" of a nonmutual relationship. The man, who was abused as a child, is extremely entitled in his marital relationship: the wife and children are to accommodate his wishes, no matter the disturbance it causes them. The wife and the children, who are not allowed to have needs of their own, are underentitled.

The Entitlement Continuum

This study proposes a redefinition of the concept of entitlement. This redefinition offers a view of entitlement on a continuum ranging from overentitlement through healthy entitlement to underentitlement. Such a conception permits insight into nonmutual adult relationships and associated problems. More importantly, it suggests an emphasis for treatment that can facilitate clients' involvement in mutual
relationships. Thus, the conception of entitlement on a continuum from too little to
too much is clinically meaningful.

Entitlement is relational. The overentitled person expects certain things from
other people (e.g., services, special treatment), just as the underentitled person does
(e.g., the disregard of others). The expectation in relationships is often a result of
working models about one's place in relationships. Internal working models are both a
cause and a result of relational experiences (Main et al., 1985).

In some instances, underentitlement may be coerced, forced, or implied by the
fact of one person actually being stronger or more powerful than another, or who
possesses needed resources upon which the other person must rely. A corresponding
internal working model of underentitlement may not be present in such cases. The
overentitled other simply underentitles this person.

However, underentitlement often has an internal base in a person's working
models about self, others, and relationships. Clinical observation suggests that many
couples (both heterosexual and homosexual) who experience trouble in their
relationships have one person with an internal sense of overentitlement and the
partner with a sense of underentitlement. People from opposite poles on this
dimension seem to seek each other out. What sustains the lack of mutuality are the
beliefs internalized in each person's working models about entitlement. In each
position, there is a lack: one shuts down the world of others, or one shuts down the
world of self.
Based on their working models about entitlement, people make tacit relational "agreements" regarding "who gets the goods." These people are bound by the glue of their opposite positions on the entitlement continuum, with each regarding their relational place as the right and proper place to be. Their treatment of one another reinforces their internal working models in an escalating cycle. The more one person "allows" herself to be devalued (or valued only for her service to others), the more she "knows" her worthlessness. The more she knows this as "true" for herself, the more grateful and subservient she is to the other, believing, perhaps, that no one else would want her or appreciate her. The more a person devalues the other, the more powerful and self-righteous he may act. This may cover an internal sense of shame and worthlessness and require more adoration and assurance of the other to supplant his missing self-esteem.

Though this cycle is some kind of "solution" to the inner needs at play for both people, it is a cycle that only worsens or at least reinforces the original problems. The early relational experiences are replicated and confirmed, and the pathological working models of self, others, and relating are strengthened.

A person's level of entitlement is not a fixed state, but rather a tendency in particular relationships. The amount of entitlement granted to various people among the constellation of one's relationships depends on one's working models. If, in childhood, the father was more entitled than the mother, and the mother more than the children, these relative positions are internalized into one's working models about self in significant relationships.
Entitlement may gradually shift over time in particular relationships, or it may shift to meet special circumstances that arise in particular relationships. A gradual shift toward mutuality can occur when both people in the relationship work toward that goal, or when one person changes his or her level of entitlement, and the other adjusts. The entitlement of a more powerful person can be willingly relinquished in a relationship, as when a mother puts aside her needs to care for the needs of her child, or when another's illness, or some other crisis, demands heightened caregiving for a period of time. These adjustments can be made kindly or with resentment and anger.

It is not uncommon for people who are underentitled in many or most relationships to shift to a position of overentitlement in another relationship. This is an effort to correct the imbalance, but it perpetuates the problem instead. Individuals may shift along the continuum depending upon the perception of power and the covert negotiation of entitlement in specific relationships. For example, a man may feel underentitled at the workplace relative to his supervisor. At home, he may convey a sense of overentitlement relative to his wife and children. Or a mother may experience herself as underentitled relative to her spouse, parents, and coworkers, and as overentitled with her children.

The study of depressed mothers noted above (Weissman & Paykel, 1974, cited in Pound, 1982), in which it was observed that many of the mothers were more irritable and hostile with their children than with their spouses, other relatives, or associates, suggests this phenomenon. From the perspective presented here, the results of that study suggest a differing sense of entitlement in the mothers across
their relationships. If the mothers perceived themselves as underentitled in their relationships with spouses, other relatives, and associates, they would be less inclined to exhibit their hostility with those people than with their children, who are naturally "less powerful" others.

Entitlement shifts across one person's multiple relationships because human beings need the experience of feeling important and cared about. When this is not internally present or experienced in a particular relationship, it is often falsely assumed in another one. People turn to those who are "weaker" and more vulnerable to find a false sense of power. Often, these are women and children.

In overentitlement-underentitlement marriages, it may be said that the more overentitled one person is, the less entitled the spouse. In turn, the less entitled the spouse is in her marital relationship, the more overentitled she may be with her children. The children of overentitlement-underentitlement relationships are therefore at risk for becoming underentitled. In this way, underentitlement is transmitted to the next generation. The risk to children is one reason why it is so critical to address adult entitlement disorders in therapy.

This study is concerned with underentitlement in adult women who present for therapy with symptoms of depression and/or anxiety. To the extent that such women are situated in relationships with overentitled others, and have histories of relationships with overentitled others, overentitlement is coincidentally addressed.
Phenomenological Description of Underentitlement

The term "underentitlement" is employed to capture a set of characteristics commonly seen in and/or reported by people in therapy who are in nonmutual adult relationships where their role is almost always that of the "giver." The characteristics that suggest underentitlement are described below.

Underentitled clients tell many stories about being in relationships in which others' needs are met and their own are not. These relationships are with adults, and may include spouse, friends, parents and other adult relatives, and coworkers. The client's underentitlement shows across a number of relationships and over a long period of time, often since childhood. This suggests a pattern of underentitlement in relationships, which, in turn, suggests an internal working model of underentitlement. For example:

Sally worked full-time in a grocery store to support her two children and her husband, who worked only sporadically. She arranged and paid for child care, and also was responsible for all the household tasks, including cooking, running errands, and yard work. Her husband, Mark, did not allow her to wear makeup; she never bought clothes or nice things for herself, except as necessary. She was not permitted to have friends. Her husband physically abused her from time to time, and in the mornings expected to have sex with her, even if the children were hungry or crying. When Sally presented for therapy, she was exhausted, having had no more than four hours of sleep a night for several years. She was profoundly unhappy, and wished that she could find some way to manage all her responsibilities. She did not think of leaving him.

When Sally was young, her mother left her and her two siblings repeatedly and for months at a time, until she finally vanished from Sally's life. Her father seemed unable to manage the household, and Sally took over her mother's former responsibilities. She had been working for as long as she could remember.
Another suggestion of underentitlement is a pattern of passive-aggression in relationships, in which problems and feelings are not addressed directly. Likewise, when the client is afraid to ask for help, or to voice complaint to others for poor or inconsiderate treatment, underentitlement can be hypothesized. Frequent stories of numerous things she has done for others in the course of her daily living, while depressed and hopeless within herself, raise the question of her sense of entitlement. When a client typically avoids talking about herself at all, but rather tells of the hardships of her significant others, this is a clue about her sense of entitlement. Many clients, often women, say that they do not know who they are; this suggests that self exploration has been limited by the overentitlement of others and her own underentitlement. It is not uncommon to hear many of these characteristics in the underentitled client. For example:

Ann describes her husband's passion for fishing, her own fear of water, and her weekly fishing trips with her husband over many years. Later, she tells about providing an apartment in her home for her able mother and father, and her daily errands for them. Her mother no longer speaks to her, after accusing Ann of stealing her jewelry. Ann reports that she has no idea what her own dreams and hopes are. To even be asked the question makes her cry.

In addition to client stories of relationships, a number of themes recur in the client's self-representation and her relational positioning with the therapist (Trembley, 1996). An underentitled person will speak about her feelings of failure, guilt, and shame, and believe that all problems in relationships are the result of some inadequacy of her own. She will work hard to earn approval or praise, but often disbelieve it when it comes her way. When hurt, she will find ways to justify why a person was hurtful, seeking to understand and excuse it.
Emergence of Underentitlement

It is proposed that entitlement disorders emerge from sustained and/or traumatic relationships with overentitled others. The overentitled others who most impact the development of entitlement disorders are caregivers. The earlier in life a child experiences overentitled parenting, the more impact this has, through the still-developing working models.

Abuse and/or sustained disappointment in the caregiver-child relationship shapes the child's working models about self and others in one of two ways: the child may come to believe that the self must not "count" in relationships, becoming underentitled; or he may come to believe that others must not be taken into account in relationships, becoming overentitled.

Role-inverted parenting is overentitled parenting; it underentitles the child who must assume the adult's responsibilities to take care of family members, physically and/or emotionally. Overentitled parenting is evident in both active and passive role inversions. In both cases, the child's natural "place" as the receiver of care is sacrificed for the adult's agenda. In Chapter III it was argued that caregiving role inversions are more likely to occur between mothers and daughters than between mothers and sons, due to maternal identification arising from shared gender (Chodorow, 1989; Eichenbaum & Orbach, 1983). The girl in such role-inverted relationships will become the "little mother" who cooks, cleans, takes care of her siblings, and seeks ways of comforting or soothing her mother's unhappiness:
Kathy, the ten-year-old daughter of a substance-abusing mother, Pam, had been removed from her mother's custody several times. When Pam sought treatment, her five children were returned to her. The fourth child, Kathy, assumed the role of caretaker for her mother, monitoring her mother's every mood, tending her needs, trying to make sure her mom stayed happy and sober. When Pam cried, Kathy would comfort her every way she could think of, including hugging her mother, telling her she was beautiful, praying or performing little "magic" rituals over her, or making her things. When invited to a school game with her siblings, or some activity away from Pam, Kathy always stayed with her mom so her mother would not be alone.

Underentitlement in children may also emerge later in their development when, for example, the caregiver becomes overwhelmed by her or his own unmet needs. Chapter III described the potential for role inversions between mothers who are depressed and their children (Pound, 1982), which results in these children's underentitlement. Psychopathology, serious health problems, alcoholism or drug abuse, a financial crisis, or emerging problems in the relationship with the adult partner can overwhelm the caregiver, and invert the parent-child relationship.

Alcoholism or drug abuse in the parents can leave the children with parents who are absent, whether physically or emotionally and materially (Miller & Stiver, 1997). The children are deprived of essential care, and the substance of choice becomes the center of such parents' concern, not the children. This is demonstrated in the following clinical vignette:

Carol was the oldest child of three siblings. Both parents were cocaine addicts. Her father earned a good wage, but virtually all of his income went into their addictions. He and his wife went out "partying" every night immediately after he came home from work. The children had very few clothes, and no one cleaned them; they wore the same unwashed underwear for months. Carol's parents had a bed, sheets, and a pillow; the children had none of these, sleeping on the couch or floor without covers. Carol's father had his own padlocked refrigerator with steaks, cookies, chocolate milk, and other food; the children were not allowed to touch it, and lived on whatever they could put
together for themselves. After their parents came home from partying, the children could smell the delicious food their parents cooked for themselves. They had no bathtub and never bathed; they were not allowed to touch the parents' shampoo. They had no toothbrushes (the ones they were given at school each year were used by their mother to clean her combs), and all of them eventually had to have dentures. They never went to a doctor, even after an injury. They had no phone. The windows were covered with newspaper to keep curious neighbors from seeing that the children were alone every night, where they had to wait in the dark for their parents' return. Carol was responsible for raising her younger siblings as best as she could.

Virtually all of the adult women clients seen by this writer in a clinical setting who are underentitled in their relationships report early histories in which they were prematurely assigned the role of caregiver. Role-inverted parenting can foster working models that contain beliefs about self as underentitled in relationships. The working models about self in relationships that derive from the parent's unilateral expectation of regard from the child would incorporate such conclusions as: (a) I cannot expect my needs and hurts to matter to others; (b) my ways of communicating my needs are ineffective; (c) in relationships with significant others, I am powerless or invisible; and (d) in relationships with significant others, I am not entitled to care, nurturing, and love and the other is entitled. Therefore, I must give up the hope that I can rely on others, or, alternatively, I must try to find other, more effective ways to get the care I need, one of which may be to take care of the other so that I might then get a turn.

As the child whose needs are not tended matures, the early understanding that she is underentitled generalizes. The child's identity becomes centered around the other. Her own growth of selfhood is limited. This occurs in the emerging self-concept as the child is deprived of critical experiences needed for healthy maturation.
Most fundamentally, she does not learn a sense of worthiness for love that is free of her activities to earn it. Being cared for is a bargain, a conditional matter: if I do this, then you might get around to seeing me, caring for me. Her sense of efficacy is bound up with her caregiving abilities. If she is good enough at reading and providing others' needs, then she has power. She must forget about herself and silence herself when relating to others. She adopts a stance of patient waiting and active trying to please. Her consciousness is outwardly focussed on others.

Entitlement "Rules"

Recall that Main and her colleagues (1985) assessed how children and parents hold relationships in mind at the level of internal representations. They discovered that relational rules are apparent in the language used to describe relationships, and that the rules reflect internal working models. "Internal working models of relationships provide rules and rule systems for the direction of behavior and the felt appraisal of experience" (Main et al., 1985, p. 77). They also provide "rules for the direction and organization of attention and memory, rules that permit or limit the individual's access to certain forms of knowledge regarding the self, the attachment figure, and the relationship between the self and the attachment figure." Further, these rules will be apparent "in the organization of thought and language as it relates directly and indirectly to attachment. Many will be unconscious" (Main et al., 1985, p. 77).
Because these rules arise from internal working models, they mandate behavior and are life-shaping. This writer therefore refers to working model-related rules as "rules in living." Client rules about her place in relationships, embedded in the working models that reflect the internal sense of entitlement, are often discernable in her statements. These are signposts to entitlement deficiencies. "I feel guilty when I say no," suggests the rule, "What I want should not/does not matter." Some common relational rules for people who are underentitled include:

1. I must not think about or take care of myself. My place in life is to take care of others.

2. When I do something just for me, I am being selfish.

3. When I assert my preferences, I am being mean.

4. People will not love me unless I do something for them.

5. My hurts and needs are not important to others.

6. To be good is to sacrifice. It is bad is to ask for something, or to have fun, or to excel at something.

7. I must make sure that others are not angry or upset. This may include making sure they feel they are better than me at things. Part of my job in relationships is to minimize my strengths. Part of my job is to let others take out their hurts on me, and to not complain.

8. I cannot expect to be considered by others.

The meta-rule underlying all of these that leaves many women feeling trapped and hopeless is "I must keep my self buried or hidden in my relationships." This rule
implies a choice: one may tend to self or one may have relationships, not both. And either way, something critical is missing. This underlying rule is often present in women who seek therapy for anxiety and/or depression. This pattern is not to be confused with the fluctuating choice, a kind of "yes I can/no I cannot" be entitled in a particular relationship, that characterizes ambivalent personality styles. Here, the decision tends to remain stable in particular relationships, and to carry across most relationships. It is therefore not equivalent to the dynamics of the ambivalent personality style.

Underentitlement and Depression and Anxiety

It is suggested here that the internal sense of underentitlement underlies many problems that bring people in for therapy. In particular, clinical experience has provided many cases in which the client presented with symptoms of depression or anxiety that seem to result from a long history of underentitlement, with both the expectation of disregard and the real experience of disregard by others.

Often, people who have working models of underentitlement present for therapy with symptoms of depression. Their current relationships are lopsided and often abusive; at times, their spouses or partners have suddenly left them for another relationship. When this has occurred, these clients are mystified and cannot find their bearings in the world. They followed the rules, but this did not assure them love and security. Bereft of the other, they are faced with the realization that there is "no one home" inside either, because their own self does not provide them with a sense of

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security and worth. They do not know who they are or how to carry on. Life appears meaningless and hopeless. If uncomforted by others since their lives began, they do not know how to comfort themselves. Their loss, confusion, and sorrow feels like a deep hole that seems to have no bottom. Further, they are often physically and psychologically exhausted from years of self-neglect, unboundaried giving, and others' neglect.

Karen had been in and out of marital therapy for many years, in an effort to save her 22-year-long marriage. The couple had four children. In the early years of her marriage, she had suffered from anxiety and panic attacks, which eventually kept her housebound, afraid to go out into the world. This led her to a therapy group, which encouraged her to express her feelings to her husband. Their marriage began to deteriorate as she discovered her husband's reaction to her more honest communications: he would ignore her or walk away.

Mike, her husband worked at the family business, which was faltering. He worked long hours, trying to scheme ways to recover it. In addition, the couple had purchased a ramshackle house to fix up and sell. This project took 10 years; Karen worked on the home, raised the children, and worked part-time. When the house sold, Mike took the money and bought a motor home, his dream, without consulting Karen. Karen had hoped to use some of the money to start college. When she expressed her sense of betrayal and disappointment, he asked her how she could be so selfish as to want to deny him his dream.

When Karen came for individual therapy, she felt hopeless, guilty, and confused. As therapy unfolded, she admitted that she had not told her mother (or anyone) about these feelings, though she longed for her mother's comfort. Probing this revealed that her father was an alcoholic, either mean or absent from the family. Karen was the oldest of four children; she could see how overwhelmed and unhappy her mother was, and so never went to her mother with her own concerns.

She repeatedly expressed how mean she felt in her current communications with her husband. She had no patience, and would snap at him. After many years of marital therapy, she wanted out of the marriage. He accused her of ruining their lives. Karen found herself crying much of the time. She could understand how he felt, and she did not want to hurt him.

Alternatively, or often concomitantly, underentitlement may be associated
with anxiety, as the person strives to keep the self from coming forward and to maintain the rules of relationship. The self of this person begins to break down because it is finally overwhelmed: "What if I can't keep it up?" or "What if I am revealed?" It seems as if this person is using every last restraint to keep herself in check, but knows, at some level, that this bargain cannot be sustained much longer.

The anxiety is associated with her certainty that, if she lets herself out, she will be abandoned. She knows that she has to provide caregiving in order to have relationships. She is trying to live up to the rules.

Elizabeth came for therapy to find relief from panic attacks, which were so severe that she had gone to the emergency room, thinking she had a heart attack. She was middle-aged and briefly married in her early twenties. She had lost her job the year before. She had no friends or even acquaintances to talk to; her only contact with others was to visit her parents.

She sat in her house all day, her only company the television and her dog. By late afternoon, the anxiety would mount. She would think about her hopes for her life, and how she had nothing and no prospects of achieving them. She knew of no ways to comfort herself, or to envision herself through to a better life.

Her sheer isolation led her to visit her parents several times a week. Her mother also lived in isolation, with no social supports except her daughter, or activities she enjoyed. She had been in therapy for many years for depression. Elizabeth feared that she would end up like her mother.

Early in therapy, Elizabeth's anxiety abated and she began to mourn her lost life. Along with this, she found herself furious at her mother for not getting better, so that Elizabeth could be freed from her caregiving, and focus on her own needs.

It is important to assess for underentitlement as well as other factors that may contribute to the client's symptoms. Elizabeth was also menopausal, and was referred to her physician. Depression and anxiety may arise, of course, from sources other than underentitlement. However, in this writer's experience, a history of underentitlement in relationships is often present in women who seek therapy for depression or anxiety.
If the client's struggle is correctly diagnosed, treatment that addresses the underentitlement is possible.

In this chapter, a new perspective on nonmutual relationships has been described by introducing the concept of an entitlement continuum. It has been suggested that an internal sense of underentitlement contributes to many women's involvement in nonmutual relationships, and also to their symptoms of depression and anxiety. Some clinical examples have been offered to illustrate this conception. Further, it has been proposed that a history of underentitlement arising from role-inversions in their early life has often shaped these women's working models and their corresponding rules of living. Some manifestations of these working models as observed and reported in a clinical setting have been identified.

The following chapter will pursue some implications of the ideas presented in this chapter. Therapeutic provisions that address underentitlement will be discussed. Implications for therapist training styles will be suggested.
CHAPTER V

IMPLICATIONS

Introduction

This chapter explores some implications that arise from the conception of entitlement developed in Chapter IV. There, entitlement was described as a relative relational position along a continuum from overentitlement through healthy entitlement to underentitlement. Several features of this dynamic were discussed, including: (a) one's sense of entitlement is internalized in working models about self in relationships developed early in life; (b) working models of underentitlement often follow from caregiving role inversions in early life; (c) working models of underentitlement have corresponding rules about one's place in relationships, here referred to as "rules in living"; (d) and working models of underentitlement often underlie involvement in nonmutual relationships and symptoms of depression and anxiety in adult women who present for therapy.

This chapter will address some implications for therapy with underentitled clients. The development of a healthy sense of entitlement is presented as a guide for therapeutic provisions. This is followed by a discussion of training issues and the sense of entitlement in therapists. Finally, areas for future research related to entitlement are identified.
Implications for Treatment

Because one's working model regarding entitlement, like all working models, is learned and confirmed in relationships, changing the sense of entitlement hinges upon a different, disconfirming relational experience. Therapy that assists clients who are underentitled must offer this rule-breaking experience in a manner that is tolerable to the client. Some relational experiences not provided (or insufficiently provided) in the first or early attachment relationships will need to occur in treatment, albeit in an adult or "older" form, in order for the person to more fully grow into selfhood, and, from that base, into healthy relationships with others.

There are many theories about therapy. In addition, each therapist brings his or her own self and style of relating to the process, and every client is unique. Bearing this in mind, this chapter highlights the issues that this writer has encountered repeatedly in her work with those who are underentitled. This chapter also offers some suggestions for therapeutic provisions that, over the writer's years of clinical experience, have moved many women into the vitality, creativity, and relational fulfillment in their lives that comes out of selfhood.

Conceptual Framework

If the rules in living in working models arise from experiences with the earliest caregiving others, it follows that the client will require a new, yet comparably powerful experience with a caregiving other that engenders new, healthy working
models of self and one's place in relationships. Working models can be changed from relational experience and from therapy (Fraiberg et al., 1975; Lieberman, 1991; Lieberman et al., 1991). A simple yet effective base for all that follows in treatment is: what the client needed but did not get must be identified and provided to a degree in therapy so that those working models and their correlated rules in living may be changed. Therefore, an understanding of how a healthy sense of entitlement develops is needed.

**The Development of Healthy Entitlement**

We are born with a sense of entitlement. We are born with an inner urging that assumes by the fact of our existence that we should count enough to be cared for; without care, we die. Requiring care does not assure that one will receive it or will receive it in an adequate, consistent manner, but babies will do whatever is within their power to do to demand the care they need. Though there may be no sense of "self" per se in the child in early infancy (Mahler et al., 1975), there is a individual being that needs to be fed, to be changed, to be soothed, to be held in the care of another. And the other—the adult caregiver (most often the mother)—perceives the baby as a separate entity, a being for whom she is responsible. Though the mother may be especially attuned to the infant dependent on her care, still, there are a self and an other who are in a relationship with one another, at least from the perspective of the caregiver. And this relationship is characterized by absolute dependence on the part of the baby for the care of the mother (Winnicott, 1965). Mother is the "giver" of
care; the infant is the "receiver" of care. And both naturally "agree" by virtue of the helplessness of the baby that this is as it should be; the baby and the mother "expect" the child to be provided for. The infant is naturally entitled to this in the relationship; mother assumes the responsibility of providing.

In a sense, then, the mother is naturally underentitled in that relationship. The baby's needs must come first. If the baby wakes up crying in the middle of the night, the mother must tend it. Though the mother may want to get out of the house, she cannot just walk away from the baby. The nurturing of another must take precedence over her own needs. This is a nonreciprocal relationship; though in some ways it may be mutual (for example, both mother and infant may find satisfaction in the relationship), the caregiving is one-sided. In attachment terms, it is a secure mother-infant attachment relationship (Ainsworth et al., 1978).

From being the recipient of mother's care, the baby learns that she can count on this in relationships. She internalizes her mother's regard and love. The baby learns that she matters, and she has the ability to generate care for herself in relationships. Her needs are important to another. Life is mostly good. She is loved, and being worthy of love is not even an issue; it is just how it is. Unless she has experienced that her needs do not matter (repeatedly), she comes to hold this as an assumption; it is just how things are, and she has no reason to consider or expect anything different. She is simply entitled to it. This forms the early working model about self in relationships.
This state of being the center of someone else's world and the recipient of caregiving changes over time, though the basic lopsidedness of the relationship (the adult providing the care and nurturing and not vice versa) persists for many years about increasingly complex developmental issues. To parent is to provide for the needs of another who is dependent. Over time, though, while the child is still able to turn to the mother for some of her needs, she also relies her own increasing ability to meet her needs. The mother encourages this realistically. And as she develops her abilities to communicate her needs, she calls upon others from her expanding social world. But her sense of entitlement, internalized in her working model of herself in relationship and of the world as a place of relationships, remains within. Able to count on and expect that she will get her needs met, she feels secure. As Cassidy (1988) concluded, "experiencing the parent as available, sensitively responsive, and affectively accepting leads the child to develop simultaneously both a secure attachment and the sense that, as one who merits such treatment, he or she must be inherently worthy" (p. 122). From this base of positive expectation, she becomes able to increase her explorations of the world and self and to manage disappointments with hope and resilience.

Thus, the infant whose "natural entitlement" is respected carries it forward in her working models of self and relating and others. She is the securely attached child of a responsive, child-centered mother, and she learns a set of meanings about herself and others from that relationship that she will carry forward into other relationships as she matures.
Therapy for the Development of Healthy Entitlement

Object relations therapy focuses on using the therapist-client relationship as "a stepping stone to healthier object relationships and to promote positive changes in the client's sense of self" (Cashdan, 1988, p. xii). The changes that arise from the experience in the therapy relationship will facilitate changes in the client's working models about self and relationships, which will, in turn, lead to changes in other relationships outside of therapy.

The therapy relationship is created by the therapist and client together to provide the client with an adequate sense of psychological safety and mutuality so as to permit highly personal examinations of the client's "flaws," "sins," badness, and unlovability. A shared and safe reality is needed for this work. The relationship quality is a critical variable in successful treatment. A fundamental therapy premise in this model is that relationships make people disturbed and relationships and make people healthy. (Trembley, 1996, p. 33)

The conceptions for therapy developed here are based on that premise.

Therefore, a view of the internalized early relationships and how these continue to influence relationships should be a primary concern in therapy. Object relations theory and therapy offers this focus, and informs the treatment provisions that follow.

More particularly, the structure for treatment developed below is derived from Winnicott's (1953) ideas about good enough mothering, and Trembley's (1996) elaborations on relational therapy. Winnicott described the conditions for healthy development, which involve the caregiver processes and the corresponding processes in the child. Briefly, these are: the provision of a good holding environment, in which the client feels safe and secure enough to attach to the therapist; the provision of
contrasting or contradicting experiences, so that the client develops a more defined sense of self (differentiation); and the provision of an abiding presence ("staying put" or remaining in place), through which the client may integrate his or her changes. Therapy progresses through the three stages, with the hoped-for result of developing a new way of being in relationships. There are special concerns that arise in the various stages; these concerns and some therapist provisions that address them are presented below.

**Therapeutic Provisions for Developing Healthy Entitlement**

Direction for therapeutic provisions that address underentitlement comes from three sources: (a) the research on attachment; (b) the client's presentation, or style of relating; and (c) client reports (stated rules in living, and current and past relational stories).

The research from attachment, summarized in an earlier chapter of this dissertation, has shown what parental provisions promote or hinder secure attachment. The research indicates that good enough mothering is child-centered. Good enough mothers listen to and respond to what the child needs (Ainsworth et al., 1978; Belsky et al., 1984; Miyake et al., 1985; Pastor, 1981; Smith & Pederson, 1988). They place the child's needs first, more so in early development than later, when the child has increased resources on which to rely. They are capable of doing this because their own needs are adequately met and these mothers are able to form healthy attachment relationships (Crowell & Feldman, 1988). If the mothers have suffered from trauma in
their own histories, they have likely sought help for themselves and have come to terms with it (Egeland et al., 1988). Good enough mothers do not rely on their children to meet their needs or take care of them. They entitle their children to a full process of self-discovery with the support and delight of another in that process.

In this writer's experience, there are some essential provisions that encourage clients who are underentitled to reach that goal: client empowerment; therapist authenticity; comforting, emotional containment, and guidance; managing others' resistance and client guilt; managing risks of harm; working the therapy relationship; conveying concern, hope, and delight; and modeling a healthy sense of self in relationship with the client. These provisions are offered in the course of the three stages of therapy described above. Some are associated more with one stage than another; others are offered throughout the three stages to address the theme of entitlement.

The themes that require attention when working with people who are underentitled are related to the client's growing sense of self in relationship. This begins from the start of therapy with the provisions needed for a good hold or attachment relationship, namely responsive, client-centered care. These provisions break the internal rule that the client is not entitled to care from others and offer external supports that will gradually become internalized.

Middle therapy is concerned with the growth of client self in relationship. In order for the self to emerge, the old and limiting rules of self and relationships will need to be challenged and changed through new relational experience.
If working models are changed by the very information they accept, then a key to therapy success may be learning about the client's models, accessing them, exposing them, and then examining and challenging them if they are pathological. A change in one's working model enables one to rearrange the world and oneself in it . . . (Trembley, 1996, p. 20)

The therapy relationship becomes the focus of discussion and new experiences of self in relationships, which break the rule that the client cannot have both. As the client begins to challenge and break her relational rules, two issues come to the foreground: her own guilt and also others' pressures for her to give up on this project. Risks associated with the profundity of her changes must be monitored and addressed.

In late therapy, the therapist endorses and celebrates the client's expanding efficacy as she finds room for her self to live in the world with others. The client gathers and integrates her changes. At the end of therapy, the client experiences a new way for relationships to end, with the therapist as an internal presence that abides and herself as abiding in the therapist.

In every stage of therapy, the client-therapist relationship provides the matrix for change. Empowerment is always a concern and is overtly and covertly addressed from the very first session onward, and the therapist needs to be comfortable with his own "power" and entitlement so that he does not engage in "power-over, " underentitling tactics with this vulnerable client (or the reverse). Conveying that the client is heard and seen, not invisible or barely visible, is paramount; this is the natural result of therapist authenticity. Client opinions, especially those that differ from the therapist's, are welcomed and taken seriously. Empowering relates to entitlement in that it acknowledges the client's right and ability to choose her own life.
Conveying to the client that her thoughts, feelings, history, and being reaches us and impacts us is the most important process for the empowerment of such clients. This appears in the flow of discussion, through the therapist’s serious consideration of client words and emotions, and through the therapist’s overt, expanding response to these (Miller & Stiver, 1997; Teybur, 1992). It tells the client she has the power to affect another person.

Therapeutic provisions to promote healthy entitlement are discussed more fully below. For some therapists, these provisions may seem obvious elements of treatment. Others, especially those trained in more reflective or behavioral approaches, may find such provisions less familiar or even uncomfortable. What distinguishes this approach from others is its overall focus on developing a healthy sense of entitlement in relationships. If clients who are underentitled have experienced deficits in early attachment relationships, then therapy for such clients must provide a new experience in which the client is "the center" of the therapist’s concern and care. The client needs to experience entitlement in the therapy relationship. At some level, all therapy offers this provision to clients. It is understood that the task of therapy is centered on the client’s concerns and issues and not the therapist’s. But when seeking to assist clients with entitlement disorders, this task is not part of the assumptive background, but is the focal point of therapy.
Early Therapy: Therapist Holding and Client Attachment

Self-development only unfolds from the base of the client's experience of a secure attachment relationship (felt security). Client attachment is promoted by the therapist's awareness and understanding, acceptance of and adjustment to the client's ways of being. Therefore, laying this foundation is critical.

The strength of this foundation is contingent upon two essential features in the therapist. One of these relates to her training, that is, how she conceptualizes and understands what she is doing in her work. What is the goal? What does she "do" to help the client reach that goal? This theoretical perspective always guides her words, actions, and ways of being in relationship with the client. It is also important that the therapist bring herself into this relationship authentically and with emotional accessibility. These concerns are addressed later in this chapter.

Because the experience of a good holding environment is new and different for the client, it may take considerable time and testing before the therapist's good hold is believed and trusted. Very short-term therapy hampers the development of a solid and secure attachment relationship. If the therapist's holding provisions are inadequate, a secure attachment from which the client can develop will not arise. This seems a benign failure—the client simply not improving with this therapist. However, the consequences of poor holding by the therapist are much more serious, since poor holding replicates the client's early experience in relationships and confirms and strengthens the client's limiting working models regarding self in relationships.
If the therapist provides a good holding environment, the client will develop a sufficiently strong attachment to allow therapy to work. This close attachment is natural and even necessary with these clients, and should not to be demeaned or diminished by negatively-intended labels like dependency.

**Therapists' Responsibility, Responsiveness, and Pacing**

Attachment research provides guidance for the kinds of provisions that promote secure attachment and later adjustment and competence. Most important is responsiveness to the child. The caregiver adjusts to meet the child's needs. In therapy, this means that the therapist empathically attunes himself or herself to the client's particular issues and style of relating, and adjusts so that the client's needs are met. This requires keen attention to the client and the ability to be psychologically mobile. What helps one client may or may not help the next. The therapist meets the client where she is, so that growth can be facilitated. If for any reason the therapist is unable to do this, it is his responsibility to seek supervision or refer the client.

Trembley (1996) suggests that therapists adjust their relational style to that of their clients. For example, the avoidant client will be overwhelmed by an overly intrusive, intimate style of relating by the therapist; the client's rules of living are violated too quickly. This person is likely to leave therapy, or intensify his walls. Therapists must honor the client's unique relational style and move at the client's unique pace to be tolerated, and this is the therapist's responsibility. Clients let us
know when our pacing or provisions are poorly attuned through their resistance.

If the client resists an aspect of the therapy, the therapist does not enter a power struggle or blame the client; the therapist recognizes that she has moved into territory that threatens the client, either the clinical material or the relationship variables present in the therapy (Trembley, 1996). It may be that the client has not been sufficiently prepared to handle these. The therapist adjusts her approach so that psychological movement is bearable for the client. To do otherwise is analogous to expecting a child to cook dinner when she cannot reach the stove, or clean the house when she can barely walk. That one wants her to do this does not mean that she can, or will. The client is received at her own developmental, temperamental, and relational level. Her psychological world is entered. This actively constitutes the therapist's psychological holding environment.

**Comforting and Emotional Containment**

Clients often lack the ability to self-soothe. A child who serves as the caregiver to a parent does not receive comforting in her own distress. Lacking the external source, the ability to comfort and soothe oneself is not internalized. What is learned instead is that there will be no solace and support for one's own disappointments and sorrows. Without this critical experience of others' comforting, this person will have difficulty in managing the hardships of living. Losses, difficult for anyone, seem unredeemable. Arguments are irreparable. Mistakes cannot be corrected. Suffering seems unending. Not only does she lack the ability to envision
herself on the other side of her pain, she has a history of unmet need and sorrow that is opened anew when faced with a current problem. What was missing must be provided in a tolerable adult form and language, so that it may be internalized by the client. Early in therapy, when the client is distressed, the therapist must actively provide comfort and containment, and also "teach" the client how to comfort herself. If this is done adequately, later in therapy, the client will take over this provision for herself.

Comfort can be provided without physical contact, with words and a caring, soothing tone of voice. That one understands how the client sees her world and how she feels about it is communicated. More than that, she may need to be reminded that she will come through this in time and that you and others are available for help and support. The therapist helps the client locate hope by seeing new possibilities (Aardema, 1984) and a vision that the client lacks of herself as stronger and more capable of managing life.

Therapist confidence in the client is also conveyed in his calm demeanor when the client is upset or fearful. Just as passengers look to the airline personnel to see if they look worried when the plane encounters turbulence, so do clients look to the therapist to assess how serious their problems are. If the therapist seems alarmed or upset, the client will see this as confirmation of her worst fears: the problem is unresolvable and disastrous. Emotional containment is provided by receiving client fear and pain with calm acknowledgement and understanding (Trembley, 1996).
A seed of healthy entitlement arose from the client's pain, which brought her to therapy. Therapy is a beginning of self-care as well as a search for comforting and help. This can be openly discussed in terms of taking care of herself. She has begun to break the rules and challenge her working model of underentitlement. This emerging entitlement needs to be endorsed.

It is useful to explore and encourage client self-comforting as well. This, too, has been affected by her lack of entitlement. She has not only spent herself taking care of others; she has also believed that it is wrong/bad to do things to take care of herself, because these may make her unavailable to others. She needs to be entitled to do this.

Erika presented for therapy with symptoms of depression. Assessment suggested recurrent episodes of Major Depression, and Dysthymia. When she was a child, her father had little contact with his family, but when home, he was demanding and abusive. Her mother sought companionship in another relationship and was also rarely home to care for her children. When Erika was in her early teens, her mother committed suicide.

Erika was now in her third marriage, with three boys. Her first husband had been assaultive; her current husband was, according to her reports, avoidant in personality style. When he came home in the evening, Erika served him his dinner on a tray in front of the television, where he remained until bedtime.

Erika's boys, with various behavior problems, entered therapy by early elementary school after expressing their wish to die. They taxed her limited physical and emotional resources, and her husband did not participate in parenting them. Erika relied on her youngest son for her own comfort.

She had a pattern of overextending herself in the care of others (her father, her parents-in-law, her siblings, and any person she encountered who was in need of help), and then collapsing in bed for days with one physical ailment after another, along with feelings of abandonment and depression. These periods in bed were the only pause in her frantic efforts to assure that everyone she knew was taken care of. She blamed herself for her mother's suicide and feared that someone else close to her would do so.

She was taking a number of medications, prescribed by her
psychiatrist, yet her condition worsened. Erika described the feeling inside her as a "black hole." When her depression escalated, she was unable to stop her tears. Nothing touched the empty place inside her. She sounded like a lost child.

In one such session when Erika was unable to stop crying, the therapist handed her a stuffed pig she had in the room for children. Throughout the hour, Erika nestled it in her lap, stroking it as she talked. The therapist told her to keep it as long as she needed it and to get it out whenever she felt sad. Erika carried it in her purse for months.

Over time, Erika developed other ways to help and comfort herself when upset. She took up pottery, and devoted happy hours to making teapots. She began writing stories and poems, and eventually started college, where she made the dean's list. She began to paint and won a prize for a landscape. She listened to music to soothe herself. She thought of ways to help people that did not overtax her own self, like referring them for help or sending a card of support. She had never once gone out by herself with a friend just for fun; now she began to involve herself in pleasurable activities with others. She began to take care of her physical appearance, styling her hair, working out, and dressing in nice clothes, not the torn skirt that was her outfit in the past.

Providing comforting and emotional containment initiates a change in the working model of underentitlement. Once the client can begin to understand and experience that she is entitled to the care and support of another, she begins a new experience in self-care, taking her own needs and happiness seriously as Erika did, along with that of others.

**Therapist Guidance**

An important aspect of the parental holding environment is their wisdom in living and knowledge of the world. Responsibility for the growing child demands that parents call on and sometimes expand what they know to provide safety and direction until the child can assume this responsibility herself. This guiding function may have been denied an underentitled client. If so, the client requires an actively engaged other
who not only listens and understands, but offers support, knowledge, and wisdom as guidance to the client.

This does not mean that the therapist dictates action to the client, simply confirming the client's sense of self as inadequate. But it is not helpful to the underentitled client for the therapist to refrain from offering suggestions and guidance. The client comes to therapy, and pays for it, because she needs something that she has not been able to call out from within because it is not there, never having been "put" there in the first place.

At one level, therapist knowledge may be offered for the client's consideration in the form of ideas and possibilities of which the client may be unaware (Aardema, 1984). She has lived in her own limited world, often with limited resources. New possibilities are presented as ideas for the client to consider, expanding her awareness. They are not homework or advice. The client is free to discard them, to choose her own path.

Therapist guidance operates at other, unspoken, levels in the form of the values and beliefs of the therapist. Therapists always bring their values, their sense of good living and health, to their work. Therapists need to be comfortable with this responsibility, with bringing their values to the relationship.

Mary was the oldest of nine siblings. As a child in school, shorter and heavier than her peers, she was the target of bullying and abuse. Her father was rarely home, and her mother, busy with her younger children, did not take Mary's anguish seriously and help her with it. Mary retreated within herself, believing that people were cruel and did not care about her. She trusted no one. If someone was kind to her, she could not receive the kindness but waited for injury or betrayal to follow.
By the time she presented for therapy, seeking help to end her fourth marriage, she had no friends and never spoke of her feelings to anyone. She gave in to others without a fuss, because the possibility of their smallest expression of disapproval was unbearable to her. Her dilemma was how to get out of her marriage without a confrontation. As her marriage deteriorated, she did not let on that she was unhappy. In earlier marital therapy, she never spoke, believing that her feelings were not her husband's business. They were no one's business.

Although every client is unique, therapists, like parents, have some guiding theory of people's basic needs, the kinds of growth they hope to facilitate, and how to help the client move forward. Mary had adjusted herself to her isolated life; she was convinced, based on her real experience, that her way of being in relationship was the only way to survive in the world of others. The therapist must honor this position as the "solution" that helped the client survive, yet hold a vision of a different, happier, and more fulfilling way of being in relationships.

It is critical that therapists know what their values and working theories of therapy are. What are the basic needs assumed to benefit the client? What is the developmental goal and how does one "get there?" How does change happen? This dissertation has suggested that an important goal for good living and health is care for and from self and others, and the internal hope and expectation (a sense of entitlement) for that, and that the means of reaching this goal is through an entitling relationship.

Middle Therapy: Therapist Contrasting and Client Individuation

From the secure base offered by a good holding environment, the client will begin a process of self-discovery. No longer consumed by the project of tending
another in a relationship, a process which has distracted her from even listening to herself in relationships, she can now explore her internal world and reflect upon her external life.

In Winnicott's conception, the basis for this model of therapy, the second stage is concerned with promoting increased individuation or "separation." Here, this is understood to mean that the client begins to separate, or sort out, her own identity from the entanglements of past restricting demands on it. That is, the rules of underentitlement in relationships with others, which have limited her discovery and expression of self, are now viewed and experienced differently. It is more accurate to say that the client separates from her past meaning structures, which have bound her, than to say she separates from others. This is the central task of middle therapy. It occurs with the corresponding support of the therapist, whose task is now assisting the client in "unhooking" those meanings. This is best facilitated through the use of the therapy relationship itself.

The therapy relationship is rich with opportunities to help the client change her rules in living or to confirm them. Therefore, the therapist should be alert for these opportunities. The task of the therapist is to facilitate change of those rules that need changing, and to provide a new internal other, one who argues for the client's rights, strengths, happiness, and importance. Everything the therapist does in the room and that which he encourages in the client's life needs to endorse new healthy meanings for their client.
Some common rules of underentitled clients were presented in Chapter IV.

These include:

1. I must not think about or take care of myself. My place in life is to take care of others.

2. When I do something just for me, I am being selfish.

3. When I assert my preferences, I am being mean.

4. People will not love me unless I do something for them.

5. My hurts and needs are not important to others.

6. To be good is to sacrifice. It is bad is to ask for something, or to have fun, or to excel at something.

7. I must make sure that others are not angry or upset. This may include making sure they feel they are better than me at things. Part of my job in relationships is to minimize my strengths. Part of my job is to let others take out their hurts on me, and not to complain.

8. I cannot expect to be considered by others.

In addition, it was suggested that a meta-rule for many underentitled women is "I must keep my self buried or hidden in my relationships."

From the very first session, the therapist should make clear that this will be a different sort of relationship, one in which the client can explore and have a self present in the relationship. This is conveyed overtly and covertly. Overtly, the therapist may state from the outset that this is a place where the client's opinions are welcomed and valued. The client may feel free to disagree or express concern or
differences in perspective. Here, she gets to differentiate her self from the person of the therapist, to be her own unique person while being in a relationship with another. The goal is not to be a person who shuts out others, one who is overentitled; this would be as impairing as shutting out her self. The goal is that both self and others deserve and claim mutual value and importance in the relationship.

**Working the Relationship**

As therapy progresses, the unspoken relationship between the client and therapist becomes a matter of discussion. Already, through the establishment of a good hold, the therapist has provided an important contrasting experience or contradiction to the client's working models about her place in relationships. The therapist can now use their relationship to encourage further awareness and new ways of client relating to self and others.

Mary, described above, had never shared her inner life with others, considering it nobody's business. She described herself as avoidant. In childhood she had learned to keep silent about her sorrows and struggles so she would not be yet another burden on her mother. Over many weeks of therapy, she gradually disclosed stories about her current life, her history and her hidden self.

After a time, the therapist remarked that Mary had been willing to entrust her with her "business" and asked how this was possible. What was it like? Why was this relationship safer than others? Based on this experience, what might help her to find and build other relationships in which she could share her self?

Mary said that she brought different assumptions to this relationship: the therapist is supposed to help. She was so unhappy that she was willing to tell her secrets to help herself. The therapist seemed kind and interested in knowing her. She trusted that her secrets would be kept, and that the therapist would not judge her or criticize her.
People for whom underentitlement is an issue are not accustomed to being in relationships in which they find support. Now in a supportive relationship, what these people once took to be their own failures and inadequacies are seen in a new light. They find that their struggles had something to do with the kinds of relationships they had with certain kinds of people—often overentitled others. Being entitled to the care of the therapist changes the rules of their place in relationships, offering other possibilities. Given a relationship with another who empowers and cares, they discover that there is a whole new way of being that is possible.

When healthy entitlement is experienced in the therapy relationship, from the provisions identified in this chapter, it can be internalized. The client is changed from this relational experience because her working model of self in relationships is changed. The "I must always" shifts to "I may sometimes." She then searches for other exceptions in the world. She will begin to seek out different possibilities of being treated and different kinds of relationships outside of the therapy room. She will look for more mutual relationships in which she is valued and safe, not expected to take care of the other at the expense of self.

**Others' Resistance and Client Guilt**

As a rule, the other people in the client's life will pressure her to give up her new project of taking care of herself as well as others. The client's others have lived with the benefits of her other-focussed caregiving and will object to any changes in this arrangement. Often, the first target for attack by overentitled others is to try to
make her give up therapy, seen as the source of her new ability to set limits on her caregiving. The overentitled others with whom she has relationships echo the inner rules she has lived with all her life and she will struggle with guilt. This is a struggle of entitlement and is therefore an integral part of the therapy.

Women (at least married or partnered women) in the clinical setting almost invariably report that the new assertion of their feelings, wishes, and needs is countered by their spouses with the accusation, "You are so selfish!" Being selfless has been their job, their very identity, and this accusation cuts to the quick. Indeed, they are now being "selfish," and they know it. Counting themselves in their care constitutes the "bad girl." The "good girl" disregards her self and patiently tends to others. Breaking this rule is almost unbearable for the client. If her guilt is not addressed meaningfully, there is a strong possibility she may drop out of therapy.

She needs what she does not get from her world, encouragement to be self-centered in a mature way. The therapist provides this by expressing delight and reassurance for each small effort: for her coming to therapy and continuing to come; for the self-reflections that demonstrate she is now listening to her self; for reports of words and deeds in her life in which she has "taken her own side."

Countering the therapist's stance are the internal rules and the client's history of relationships. The contrasting relationship with the therapist, however, meets and joins with the client's need and hope for self development. The example below portrays client guilt and others' resistance.

Ellen, who presented for therapy at a friend's urging, reported constant
irritability and unhappiness. She lived with the father of her four-year-old daughter, but could not tolerate physical contact with him. He contributed nothing financially. He was allowed in her home only to provide fathering to their daughter and so she could monitor his activities. After discovering that he had been engaged to another girl at the same time he was engaged to her, she suspected his every word and deed.

Jim had been her high school sweetheart, the knight-in-shining-armor who would love her, in contrast to a childhood of abuse by her father. Jim's betrayal devastated her, confirming her belief that she could not expect care and regard in relationships. Her mother, who had been her refuge in childhood, had divorced her father and was involved in a new relationship with a man mean to both Ellen and her younger brother. Her mother had stated that she would not give up her new man under any circumstances.

Remembering her own feelings living with her father, Ellen took in her younger brother, his girlfriend, and their newborn baby. Ellen's mother detached herself from concern for her children and kept the child support payments intended for Ellen's brother. At age 23, Ellen was now financially and emotionally supporting herself, her daughter, her brother and his girlfriend, their baby, and her ex-boyfriend, the father of her child.

Ellen stated repeatedly that she could never hurt others as she had been hurt, not even her ex-boyfriend. She could not refuse anyone's request for an errand or money or babysitting; indeed, she often took care of her younger nephew for the day. She barely slept, working till the early hours of the morning, then waking her brother and the babies and taking care of the children while her brother and his girlfriend were in school and her ex was at work. When a child was sick, she took it to the doctor. Wishing to go shopping, she might find that her ex had taken her car. Sometimes before going to work, she would have to arrange child care on short notice, because her brother and her ex had not come home as promised. She had no support for herself whatsoever except for a friend who lived nearby and would take the children in an emergency. Ellen talked with her mother from time to time; when she told her mom about her frustrations, her mom would say, "I know what you mean," and then launch into her own problems.

In early therapy, Ellen and her therapist explored what would happen, internally and externally, if she were to assert some boundaries to her caregiving so that she could sleep. Ellen said that if she did, they would be ignored anyway, and that she would feel selfish and mean. No one would take care of the children if she did not. Her brother had a hard time getting up in the morning and Ellen felt sorry for him, with a new baby and nobody else to help him.

The therapist encouraged Ellen to engage in some activity that brought her pleasure. Having someone support her in taking care of herself, she began to change her inner belief that this was "bad." They discussed how her
mothering, the center of her life, would be enhanced if she were less irritable and unhappy. Soon, she spontaneously worked out a plan to have the children sleep at her friend's and come home when she awoke; this allowed her to sleep. She also found a health club that provided day care, so she could work out. She decided to ask her mother to allow her to claim her brother as a dependent on her taxes. She asked her ex to move out so she would not have to endure the daily aggravation of his presence. (She permitted weekly visits so that her daughter could see his dad.)

In helping clients manage their initial sense of guilt, several approaches are helpful. The therapist listens to and acknowledges her guilt, and helps her to understand why she feels this (the pressure of her culture, her past, her rules, and her current relationships). It is to be expected that others will object, and that she will feel guilty and "bad." The therapist also expresses that being "bad" in breaking these rules is a "good" thing to do. It shows courage to change what she has known and been all her life.

The therapist encourages and demonstrates patience and persistence. The client's process of challenging internal and external expectations will take time and practice which will require her follow-through when others do not listen. Saying what she feels or needs once or twice may not be enough. When courage falters, it is helpful to explore with the client how her self-sacrifice does not serve others well. Helping may need to be redefined. For example, does it help her children to witness and internalize her way of being in relationship? Does she wish them to learn that they do not count? That women do not count and are not entitled to self-expression and fulfillment? How does she feel inside toward the other for whom she sacrificed her voice and needs? Does he experience her genuine love and joy or does he experience her unhappiness and false self? What must it be for him to receive only
this small and bitter part of her? What would it be like for him to be in relationship with a whole and strong person? How does her caregiving limit his potential? She may be helping with small things like supplying him with clean clothes but limiting him in the larger experience of sharing a mutually responsible, rewarding, and authentically loving relationship.

Ann was in her early 60s. She had raised her two sons and daughter while her husband worked to provide for the family. For many years she also provided a home and care for her parents, until her mother accused her of stealing the jewelry, which she had not done. When Ann was a child, her father had been in the merchant marine; his absence had sent her mother into despair. As a result, 5-year-old Ann lost the support of both her parents and assumed the role of helping her mother.

Her brothers were encouraged to pursue their education. Although Ann dreamed of being a teacher, her parents objected to a woman going to college. Her role was to take care of her mother, whose hold on reality was fragile. When Ann decided to marry, her parents refused to speak to her for many years. This was a powerful lesson for Ann: she would be punished for pursuing her own hopes.

Ann loved her husband, but throughout her long marriage she was expected to follow whatever he wanted to do. She was torn in other directions as well, still trying to please her parents and caring for her children. When she was tending the parents, she felt she was neglecting her husband. When she was with her husband, her parents demanded that she do something for them. Exhausted and frustrated, she could never please everyone no matter how hard she tried.

She had learned long ago to keep silent about her own wishes, and by the time she came for therapy, she was unable to access her own feelings or wants. Asked how she felt, she was unable to answer. She said she had no idea who she was.

When Ann began to find herself and to express herself to her husband, he was angry, and he pressured her to drop out of therapy. Ann did leave treatment for a while, but came back because she was still unhappy and was now having trouble sleeping. Over time as she became stronger, she insisted that her husband take her needs into account with his own. They developed a plan for his retirement that would be wonderful for both of them.

Her husband came to a session late in therapy. He said that when Ann first began to speak for herself, he thought, "How dare she challenge me?" He said it was difficult to adjust to her changes, but that he had never been
happier in his life than he was now. His wife was happy and their relationship had come alive.

Another avenue for encouraging the client to take care of herself, as in the case of Ellen, is to emphasize how critical this is for her children. Rare is the woman who does not truly care that her children thrive. If she does not take care of herself, she may inadvertently teach her children (and particularly her daughters) that being in relationships means sacrificing one’s self for others. If she is depressed, moreover, she may rely more on her children to tend to her own unmet needs (Pound, 1982), thus passing her underentitlement to another generation.

**Risks of Harm**

Clients who are involved in abusive or violent relationships may be at risk for physical harm as they begin to assert rights for themselves. Therapists need to be alert to this potential.

Sara was referred by her physician for symptoms of anxiety. In her mid-30s, she was the mother of four children, ranging from 2-years-old to 15-years-old. Her oldest child demonstrated severe conduct disorder, the middle girl stuttered and was terrified to go to bed. (She shared a room with her older brother, himself given to violence.) Sara had a high-school education but was barely literate, and she had only worked for six months, right after high school.

Mike, her husband, worked nights. When he worked, he expected Sara to keep the children outside all day. He did not allow the children any toys, because they might leave them out or break them. If someone gave a child a toy, it went in the garbage. He played acid rock music at top volume when he was home. Sara was not allowed any money. He expected his meals on the table when he came home and Sara to be up waiting for him after working the night shift. If she was in the bathroom, he flew into a rage. The children became so distraught at bedtime that he had them sleep in the basement. Sara was not allowed to work or do anything else outside of the home. Mike criticized everything she did. She had no friends or supports; he had moved...
the family to the country where Sara was isolated even from neighbors. He was abusive with the children.

At first, he tolerated her therapy. But as Sara began to talk to him about her unhappiness and her needs, he refused to give her the money for her insurance co-pay. Sara kept coming, but she was afraid about her children—she had no skills to support her children if he left her and he had threatened to take them from her.

Therapy was a long process, with careful attention to the risks to Sara and her children and awareness of the real-world limitations she faced. Therapy focussed on building her sense of self that she recognized and appreciated within herself, so that, at the very least, she could withstand his criticism and slowly work her way to freedom.

Even if the external relationship does not improve, there is value in changing the client's inner sense of self. She has a right to her life, and is worthy of care. If nothing else is possible, this at least, is.

In addition, the pattern of underentitlement may place the client at risk for suicide. When a client's working models of underentitlement mandate that she must not expect fulfillment of her hopes and needs, she may feel truly hopeless. She often has suffered abuse. Without comfort or help from others, she does not know how to comfort herself. To ask for others' support would make her feel selfish and burdensome. She may feel that suicide is the only route to ending her sorrow and pain. This risk must be assessed and monitored as therapy unfolds.

Late Therapy: Client Integration and Therapist Remaining-in-Place

Clients who lacks a sense of entitlement have rarely experienced the delight and joy of another for their own being, courage and kindness, accomplishments, and strengths. On the contrary, they have typically encountered objections and resistance from others when expressing their wishes or pursuing something that pleases and
delights them. An important aspect of treatment throughout, reversing this is especially relevant the third stage, remaining in place (Kegan, 1982), or staying put (Trembley, 1996).

Trembley (1996) explains the function of the third stage, staying put, as helping the client integrate new meanings with the old. The client needs someone who has known her past self and now knows her transformed self, to provide a continuity of self over time.

The basic idea [in the third stage] is that as the self claims differentiation from others, the others need to stay in place for the newly differentiated person. One's others need to continue to hold the person while recognizing the person's changes. The notion is one of caring about and recognizing the newly differentiated, reintegrated self. If this function is provided well enough, then the person who has accomplished the differentiation will gradually learn how to reintegrate (to blend psychologically) both the self she or he once was and the views she or he had then of significant others into the new self, which must now relate differently to the old self and old relationships. (p. 60)

The therapist staying put as the client gathers her new self and prepares to leave therapy modifies earlier experiences of underentitlement. If the client was parentified (the caregiver) in her family of origin, leaving home may have been laden with guilt and resistance from the family members who relied on her caregiving. This was the case for Ann, described above, whose parents refused to speak to her for two years after she married. The therapy relationship can provide a new, celebrating experience for the client as she prepares to leave this undemanding relationship.
Client Self-Discovery and Therapist Delight

As the client comes to hold new beliefs about her place in relationships and to discover and develop new aspects of herself, therapy shifts to a new focus, that of joint celebration and endorsement of the client’s new self. This provision is as critical as those of earlier therapy, because it too is a new relational experience, one with which the client needs to become familiar, to integrate, and to internalize.

Betty came for therapy troubled by experiences in which she felt disconnected from herself and her environment. She was extremely bright and gifted, and she was in the honors program of her college, excelling in physics and chemistry. Her teachers praised her brilliance. She was also a talented artist. In treatment, she said she had always felt somewhat aloof from others; that people with whom she was in contact did not understand the things that she thought about nor share her passion for learning. She had long since learned to keep her internal life to herself. She felt very lonely.

Her teachers and parents had nurtured her mind for her achievements, but not her being. Intellectual activities had replaced human connection and she grew farther and farther from her self and from others. Therapy focussed on creating a real and warm relationship in which she could be her whole self.

Over time, Betty began to share her internal life with the therapist, presenting her thoughts and experiences as if they were gifts to be received. This included describing several experiences in which she felt dissociative. Through the very act of sharing these she was no longer cut off from others, and she began to connect herself with her experiences. No longer finding them frightening and strange, she began to appreciate them as interesting contemplations about the nature of life.

She started writing poetry as a means of connecting herself to her self. She pursued friendships with others, sharing simple pleasures and activities like camping and skiing. She recognized the value in these connections, despite others' inability to track the complexities of her intellect. She found a group of people who shared her values and went with them to an inner city neighborhood to remodel a recreation center. There, in her relationships with the children, she discovered a new and playful part of her self. She learned courage and resiliency from this adventure.

As Betty did, the client’s accomplishments and self-discoveries are brought to the therapist for endorsement and celebration. With the newly-developed sense of
entitlement, the client can hope that these expressions of self will be seen and appreciated. This is another test of the relationship: is it really all right for her to explore the world? How the therapist answers this question will further shape the client's working models about her right to pursue good life experiences. Also, from the therapist's delight and the client's expanded base of experience and confidence, her guilt about self-development is finally a thing of the past. She internalizes this delight in herself, and is exhilarated by her own being.

**Termination Issues**

The therapist must not keep the client in therapy to meet some need of the therapist. To do so would repeat earlier relationships in which the client's self was restrained from developing by the needs of parents or others. Good enough parenting anticipates the future development of the child. The expectation is for a healthy and strong human being capable of managing her life, reaching her dreams, and who is happy, at least much of the time. Just so, the therapist holds this vision for the client. While the early provisions promote client attachment and reliance on the therapist, their purpose is to allow the client to leave therapy with internal strength and self-reliance that is now hers, in herself alone and in her relationships with others.

Therefore, one of the tasks of late therapy is integration of the client's newfound strengths and abilities (Trembley, 1996). She has undertaken extensive changes in her ways of being with others and now has had some positive experiences with others which give her new self-confidence and hope. She may have new
relationships that are mutual and deeply satisfying, and she is learning to trust herself. She has discovered abilities and gifts she never knew were within her, opening new prospects for her life. She has survived hardships, challenges, and suffering, and has transformed and redeemed these experiences into growth-promoting ones. She now has a sense of self that is capable and strong and delighted in continual discovery. She is new in a new world.

The client should find her own right time for leaving. She herself realizes that she is strong and ready to pursue her life without further therapy. As a client approaches her leaving therapy, she spontaneously acknowledges her gains to the therapist, showing that she has absorbed the therapist's function within herself. Managed care that arbitrarily limits the number of reimbursed sessions can interfere with the client's choice of "right time" to leave treatment and the critical stage of integration.

In this writer's experience, a variation of object permanence arises as therapy reaches its end. Many clients want to know whether you will remain in place for them and whether that they will remain in place for you. They wonder what will happen to them if they do not see you. Will they forget you? They also wonder what will happen to them in you when they leave. Will you forget them?

This has to do with empowerment and presence. They have felt, in past relationships, that they lacked the ability to assure that others would care about them deeply and seriously. They felt invisible to others. Having been in relationships with overentitled others, they experienced how quickly they can be discarded. Will the
therapist do this too? Will they be invisible to you when they leave? Were they just a paycheck or did they make a difference in your being? They want to know that they will not be forgotten.

Presents are often given to this therapist at the end of treatment. These are small yet meaningful things intended to leave something of the client with the therapist, like a family photograph, a drawing, a song on a tape, or a poem she has written. These function as “reversed” transitional objects (Trembley, 1996; Winnicott, 1965) to help clients manage their leaving, and serve a healthy caregiving function. Now entitled, she does not feel she must leave her self with the therapist, but a representation of herself. The client leaves the gift to replace her presence, trusting that this will be sufficient. They represent the client’s new awareness that she is worthwhile, with much to offer her world. She assumes that you will be pleased by this gift. They also signify healthy entitlement and mutuality in the relationship. The client is saying that she no longer needs to be the center; she is ready to reciprocate from a different place in the relationship.

The client will leave therapy with new internal supports. Empowered, she can empower others and also stand for herself. Comforted, she can offer comfort and also comfort herself. Held, she can hold others with care, as well as herself. Seen, she can see beyond herself and into herself. Secure in herself, she can allow her children to grow into their own selfhood while she abides. Entitled, she can hope for and discover a good life and mutual relationships, and help others discover their own as well.
**Implications for Therapists and Therapist Training**

**Therapist Self in Relationships and Authenticity**

How does the therapist answer the client's termination question for himself? Has the client made a difference in his own being? The answer reflects his willingness and ability to be in an authentic relationship with the client.

Therapists' ability to be in an authentic and psychologically intimate relationship with clients is influenced by the training that developing therapists receive, discussed below. Another influence is the therapist's own attachment history and way of being in relationships.

Attachment research has shown that mothers who are able to recognize and respond to their infant's needs are those who have an integrated awareness of their own attachment relationships. That is, they are able to see the realities of their histories, without overidealizing or denial (Fonagy et al., 1991; Main et al., 1985). This suggests the importance of therapist self-awareness and emotional health. The therapist who himself fears attachments and who has not worked through this will experience fear or discomfort and be unable to allow the client to attach meaningfully to him. Fearing psychological intimacy, he may repeat the rejection the client needs to undo. Alternatively, the therapist may be poorly developed and boundaried in his sense of self and be intrusive in therapy, not allowing the client room to grow into her own way of being. Or he may countertransferentially read his own unresolved issues into the client's stories and not hear what the client needs.
Delores worked as a therapist in an inpatient addiction treatment center. She had a traumatic childhood, a history of substance abuse, and had also lost her husband in a drunk-driving accident the year before. Her stance toward her clients was openly hostile, demeaning, commanding, and cold. At staff meetings she expressed her view that the clients were manipulative and that the best therapists were the ones disliked by the clients. Clients avoided her as much as possible and reported that they felt invalidated by her in their genuine efforts to remake their lives.

When Delores was confronted by other staff about the fear her clients experienced in relation to her, she cited the "ethical guidelines" to not become involved with clients. For her, this was a rationale to keep her self closed off.

These clients did not need more time with Delores; they needed her caring presence during the time they were scheduled to meet with her. They needed to feel trusted, in order to trust themselves as they discovered a new way of being. The women in treatment had lives in which they had hidden themselves because their environments were not safe. They needed now to be safe, "seen," and nurtured.

Delores could not bear to open herself to her own emotions; she functioned by sealing them off. How then could she see and contain the emotions of her clients? She could not allow herself to be vulnerable; how then could she hold the vulnerability of the women and children with whom she worked?

Therapy for those who are underentitled must depart from some traditional notions of the therapist's stance in the therapy relationship. It requires an active and verbal (but nonintrusive) engagement on the part of the therapist. In this writer's experience, virtually every woman who has been in prior treatment with a therapist who was mostly a silent presence has reported the therapy as frustrating and disempowering. While a silent presence may be meant to "stay out of the client's way" and allow her to find her own way, these clients seem to interpret it differently.
To an underentitled woman, this kind of presence replicates her prior relational experience, in which she felt invisible or powerless to generate the responsiveness she needed. It leaves her disempowered because she feels she has made no impact on the other person.

The therapist's silence in the face of the client's confusion is unhelpful in another important way. When underentitled clients talk about this experience, they invariably say, "I can talk to myself any time, for free. If I knew what to do to help myself, I would have done it." There are important aspects of client self that are simply missing, because they were never experienced and internalized in relationships. They do not find what they need in themselves because it is not there. The therapist must help her develop these in treatment. Only then the client can find her own better way.

Empowerment nurtures personal power in another. Feeling empowered is a recognition of one's own personal efficacy to create good things. This is in contrast to disempowering, nurturing the belief in another's inability to manage life or create good things. Therapists who have a limited sense of their own efficacy can try to falsely inflate it by minimizing the power of others. That is, they may underentitle their clients.

In order to nurture the self of a client, therapists need to have a well-developed sense of self. From this comes the ability to be a self in relationships. Therapists model this in the clinical setting. This shows the client a whole new way of being in relationships herself.
Implications for Training and Supervision of Therapists

This chapter has emphasized that life-changing therapy involves the real relationship that is created between therapist and client, and how this relationship shapes the client's expectations in other relationships. The personhood of both therapist and client are therefore paramount; the self the therapist brings to that relationship is her single most important "tool" for facilitating client change.

Therapist training programs play a crucial role in therapists' future ability to empower their clients because the therapist's instrument--self--is impacted by her training relationships. Therapists grow more capable in exactly the same way their clients do: through nurturing and empowering relationships, in this case, with their trainers and supervisors. They may also be damaged by those relationships if their supervisors are themselves unhealthy, just as clients may be injured by therapists who are unhealthy.

Ideas about supervision are available that supervisors may use to justify damaging relationships, in the same manner that Delores cited the ethical code to justify her damaging relationships with her clients. In the name of "evaluation" and "teaching" supervisors can behave like critical parents, crushing the self and natural abilities of their fledgling supervisees. Their way, they think, is the right way. The growing therapist's own professional identity cannot develop under these conditions.

Beth worked as a therapist and trainer in an outpatient clinic affiliated with a large metropolitan hospital. She believed that clients had the abilities needed within to find their own way in recovery; her task as therapist was to help them find and experience the depths of their pain, and be a caring witness as
they found their way through it to the other side. In her own relationships, however, she was unable to bear being vulnerable. In a position of power, she maintained a "power-over" stance with her colleagues and trainees, encouraging their vulnerability, as she did her clients, while keeping herself aloof and hidden. The trainees and other staff felt disempowered and without a safe holding environment. One person after another floundered and struggled to maintain equilibrium; whoever confronted Beth was deemed defensive and unprofessional, and either threatened with the loss of their job or actually terminated.

Instead of a growth-promoting relationship, this example describes a relationship of underentitlement for the trainees, and overentitlement in the supervisor. It is comparable to the woman whose husband allows her no money or friends or experiences outside of his control, or the child who is not allowed to explore and develop because she is meeting the needs of her parent. With her own self silenced in a relationship of underentitlement, how does the therapist-in-training then approach her clients? This kind of supervision belies and undermines the very basis for the therapy described here. It asserts that development is best fostered by criticism and self-negation. There is a parallel process in place that some supervision styles seem to ignore.

Trembley (1996) describes an authoritarian model of therapy, in which the client is expected to adopt the therapist's views and obey his or her directives.

[This] common therapy model is characterized by a tendency to focus on client overt behaviors and changes in client life context, with relatively less attention given to client internal experiencing. . . . Here, the therapist is a representation of "reality" and the client is encouraged to adopt therapist perceptions of and judgements about reality and to act on them . . . (Trembley, 1996, p. 30).

This description parallels a way that some supervisors work with trainees. It instructs at the level of therapist behavior, while ignoring the consequences to the
person of the therapist, and the inherent messages about the entire change process and conditions for change and growth. It asks the therapist to do exactly what she should not ask her clients to do: silence her self.

In contrast, supervision can be a process of nurturing the self of the therapist through a healthy, engaged relationship.

Lisa was a therapist and supervisor to therapists-in-training in a hospital setting. Though her family experienced real hardships in her childhood, Lisa recalled many warm memories and the ever-present sense of being loved. She was warm and approachable in her relationships with supervisees, and entrusted them with new and challenging responsibilities, conveying her belief in their abilities. She monitored their progress without interfering. Comfortable with her own therapist-self, she was able to see the unique abilities in her trainees and nurtured these; Lisa did not expect every therapist to work the same way she did. She was willing to offer ideas, based on her experience, but did not assume the role of authority. When a supervisee encountered a difficulty, he or she felt safe to bring this to Lisa for her consideration and support. Lisa seemed to take pleasure in the growing confidence and ability of those she supervised.

From this kind of experience in relationship, the therapist can learn how positive growth unfolds in the context of a mutual relationship. With this as foundation, she can provide to others what was provided to her.

Implications for Future Research

In this dissertation, the phenomenon of nonmutual adult relationships has been considered. Hypotheses about etiological roots for underentitlement in women who present for therapy with symptoms of depression and/or anxiety have been offered and explored.

The ideas advanced in this study suggest future empirical research that may
validate these and other entitlement-related hypotheses. How can entitlement be measured? The characteristics of underentitlement, healthy entitlement, and overentitlement need to be adapted to an instrument that can assess occurrence of these positions in current and past relationships. After testing and adapting these constructs for validity and reliability, other research questions arising from the conception of an entitlement continuum can be tested. Is there a significant correlation between women’s histories of role inversions with their mothers and their current underentitled relational experiences? How does the frequency of occurrence of underentitlement, healthy entitlement, and overentitlement in a sample of women compare to the frequency of these relational positions in a sample of men? How commonly do overentitled people have relationships with underentitled people? What are the entitlement-related effects of a parent who is underentitled in most of her adult relationships on her children by gender? What are the entitlement-related effects of a parent who is overentitled in her or his adult relationships on her or his children by gender? How does parents’ healthy sense of entitlement correlate with their ability to entitle their children?

If a lack of a sense of entitlement contributes to maintaining relationships that are unhappy and dissatisfying, then a more complete understanding of the development of this problem may help to identify ways to correct it in psychotherapy. Answers to the research questions above may also suggest parental behavior that will enhance the development of a healthy sense of entitlement in children of both genders.
Appendix A

HSIRB Letter of Exemption
Date: 12 December 1996
To: Suzanne Wolfe
From: Richard Wright, Chair
Re: HSIRB Project Number 96-11-21

This letter will serve as confirmation that your research project entitled "The Development and Effects of a Sense of Entitlement to Self in Relationships: An Elaboration of Attachment and Feminist Object Relations Theories" has been approved under the exempt category of review by the Human Subjects Institutional Review Board. The conditions and duration of this approval are specified in the Policies of Western Michigan University. You may now begin to implement the research as described in the application.

Please note that you must seek specific approval for any changes in this design. You must also seek reapproval if the project extends beyond the termination date. In addition if there are any unanticipated adverse reactions or unanticipated events associated with the conduct of this research, you should immediately suspend the project and contact the Chair of the HSIRB for consultation.

The Board wishes you success in the pursuit of your research goals.

Approval Termination: 11 December 1997

xc: Edward Trembley
BIBLIOGRAPHY


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