

1-1-2009

Working model of the child interview : a cross-cultural examination of attachment representations

Stephen Garfinkel
Ryerson University

Follow this and additional works at: <http://digitalcommons.ryerson.ca/dissertations>



Part of the [Child Psychology Commons](#)

Recommended Citation

Garfinkel, Stephen, "Working model of the child interview : a cross-cultural examination of attachment representations" (2009). *Theses and dissertations*. Paper 478.

This Major Research Paper is brought to you for free and open access by Digital Commons @ Ryerson. It has been accepted for inclusion in Theses and dissertations by an authorized administrator of Digital Commons @ Ryerson. For more information, please contact bcameron@ryerson.ca.

BF
723
A78
827
2009

WORKING MODEL OF THE CHILD INTERVIEW: A CROSS-CULTURAL
EXAMINATION OF ATTACHMENT REPRESENTATIONS

by

Stephen Garfinkel, BA (Child and Youth Care), University of Victoria, 2001

A Major Research Paper
presented to Ryerson University

in partial fulfillment of
the requirements for the degree of

Master of Arts
in the Program of
Early Childhood Studies

Toronto, Ontario, Canada, 2009

© Stephen Garfinkel 2009

PROPERTY OF
RYERSON UNIVERSITY LIBRARY

Author's Declaration

I hereby declare that I am the sole author of this major research paper.

I authorize Ryerson University to lend this paper to other institutions or individuals for the purpose of scholarly research.

Signature

I further authorize Ryerson University to reproduce this paper by photocopying or by other means, in total or in part, at the request of other institutions or individuals for the purpose of scholarly research.

Signature

WORKING MODEL OF THE CHILD INTERVIEW: A CROSS CULTURAL
EXAMINATION OF ATTACHMENT REPRESENTATIONS

© Stephen Garfinkel, 2009

Master of Arts
Early Childhood Studies
Ryerson University

ABSTRACT

This study examined ethno-cultural influences on attachment representations by using a Grounded Theory analysis of the Working Model of the Child Interview (WMCI). Six participant interviews were transcribed and coded. Four main themes related to caregivers and their children emerged from this qualitative analysis: *emotion regulation, stress response, caregiver roles* and *personality/relationship descriptors*. Results indicated that there are both universal and ethno-cultural variations related to different components of attachment representations. *Attachment story telling, caregiver language* and *parenting styles* reflected variations in cultural values and beliefs of independent and interdependent cultures. *Emotion regulation, stress response* and *caregiver roles* were more reflective of universal attachment. Recommendations for further inquiry into the ethno-cultural influences on attachment representations are discussed. Clinical implications suggest that ethno-cultural context must be acknowledged when interpreting WMCI interviews with non-dominant interviewee backgrounds. As well, evidence is provided to support developing a culturally sensitive system for interpreting WMCI interviews.

Table of Contents

	<u>Page</u>
AUTHOR’S DECLARATION	..... ii
ABSTRACT	..... iii
TABLE OF CONTENTS	..... iv
LIST OF TABLES	..... vi
LIST OF APPENDICES	..... vii
INTRODUCTION	..... 1
Overview of attachment theory	..... 1
Internal working models of attachment/attachment representations	..... 2
Measurement of attachment representations	..... 6
Working Model of the Child Interview	..... 9
Cross cultural attachment	..... 12
Attachment Across Cultures	..... 15
Purpose of the current study	..... 19
METHOD	..... 21
Setting and participants	..... 22
Data collection	..... 23
Data analysis	..... 25
RESULTS	..... 27
Emotion regulation	..... 27
Stress response	..... 29
Caregiver roles	..... 30

Personality/relationship descriptors	..... 32
DISCUSSION	..... 34
Attachment story telling related to ethno cultural context	..... 35
Language reflective of ethno-cultural context	..... 36
Parenting styles reflective of ethno-cultural context	..... 37
Emotion regulation reflective of universal attachment	..... 38
Caregiver stress response and roles reflective of universal attachment	..... 39
Implications for future research	..... 40
Implications for clinical practice	..... 41
Limitations	..... 42
Future directions	..... 42
TABLES	..... 44
APPENDICES	..... 48
REFERENCES	..... 51

List of Tables

	<u>Page</u>
Table 1- Thematic categories of data analysis	..... 44
Table 2- Significant discrepancies of attachment descriptors across groups	..... 45
Table 3- Comparison of frequency of caregiver roles	..... 45
Table 4- Personality descriptors	..... 46
Table 5- Relationship descriptors	..... 47

List of Appendices

	<u>Page</u>
Appendix A- Sample Consent Form	..... 48
Appendix B- Cultural and Ethnic Background Questionnaire (CEBQ)	..... 50

Working Model of the Child Interview: A Cross-Cultural Examination Of Attachment Representations

Overview of attachment theory

A child's attachment relationship with a primary caregiver is said to influence his or her ability to develop relationships with others and cope with stress throughout the lifespan. Research shows that caregiver attachment behaviours affect mental health outcomes in children in a variety of ways (Bowlby, 1969; Bretherton & Munholland, 1999). Caregiver-child attachments play a significant role in the development of social skills, self-esteem, ability to regulate emotions, and poor attachment formation has been linked with aggressive and anti-social behaviours (Ooi, Ang, Fung, Wong & Cai, 2007; Vando, Rhule-Louie, McMahon & Spieker, 2008). Insecure attachment relationships are a risk factor in the development of childhood psychopathology (Rosenstein & Horowitz, 1996) specifically symptoms of conduct problems (Vando et al., 2008) such as conduct disorder (Keiley, 2002). Secure attachment relationships with a primary caregiver can be a protective factor for a child's overall development (Bretherton & Munholland, 1999; Greenberg, 1999) and against childhood aggression or anti-social acts (Ainsworth, 1989; Ooi et al., 2007).

The term attachment was first referred to by Bowlby (1969) as a behavioural stress response system in infants that aims to reduce arousal and reinstate a sense of security, which is usually best achieved by contact comfort from a familiar caregiver. Caregiver-child attachment relationships can be classified in four ways: secure, insecure-resistant, insecure-avoidant and disorganized/disoriented. Each is said to develop depending on how a caregiver responds to their child, particularly when they are under stress. The well known procedure for measuring attachment classifications is the "Strange Situation Procedure" (SSP; Ainsworth, Blehar, Waters

& Wall, 1978). The SSP is designed to elicit attachment behaviours in 12-18 month old infants. It consists of a series of increasingly stressful episodes of separation and reunion with the infant's primary caregiver, including meeting with an unfamiliar adult (Zeanah et al., 1993). Infant behaviours are videotaped and coded for how they respond to their caregiver during the reunion episodes in reference to proximity seeking, contact maintaining, avoidance and resistance (Benoit, Parker & Zeanah, 1997). The quality of the infant's attachment to their caregiver is then classified as secure, resistant, avoidant or disorganized. Infant attachment classifications have been demonstrated to remain consistent over time if no changes to caregiver behaviour occur (Crowell & Treboux, 1995).

Internal working models of attachment/attachment representations

Caregiver responses to their children are said to be based on their attachment representations, or internal working models of attachment, which guide behaviour, emotional affect and perception in relationships and ultimately govern what an individual expects in relationships with others (Bretherton & Munholland, 1999; Simpson, Rholes, Orina & Grich, 2002). Internal representations are, "memory structures that re-present a version of lived experience to an individual" (Zeanah & Barton, 1989, p. 137). They consist of cognitive and emotional affective components that have a propensity for stability over time (Benoit, Parker et al., 1997). The term "working" reflects the unconscious use of the models to interpret and act on new experiences (Crowell & Feldman, 1991). A child develops their attachment representations based on how he or she individually perceives their parent-child relationship. It is believed by attachment theorists that working models are powerful guides to how individuals develop relationships as children and adults, with specific influences on their own parenting behaviours

(Crowell & Feldman, 1991). For the purposes of this paper, the term attachment representations will be used and is meant to be synonymous with internal working models of attachment.

It is believed that attachment representations develop based on early experiences with attachment figures (Crowell & Feldman, 1991; Simpson et al., 2002). As such, early attachment relationships can influence whether a child develops an attachment representation of the world as a trustworthy or malignant place. If feelings of being unsettled and afraid are persistent, they may take away from opportunities to explore the world and develop normatively (Bretherton & Munholland, 1999).

Insecure-avoidant children may develop as hostile, aggressive or antisocial in response to their experiences with a rejecting and emotionally unavailable attachment figure (Greenberg, 1999). Insecure-ambivalent children may present as aggressive for different reasons, such as being easily over-stimulated, impulsive, and restless, having a low tolerance of frustration (Greenberg, 1999). This is in response to their experiences with an attachment figure that are unpredictable and inadequate, though not rejecting (Main, 1996).

The examination of childhood psychopathology and attachment suggests that insecure attachment relationships increase risk but are not directly predictive of developmental outcomes (Greenberg, 1999). Other risk factors such as low SES, parental age and psychiatric history also contribute (Vando et al., 2008). However, children whose attachment style is consistent with the disorganized/disoriented classification are at high risk for psychopathology in childhood and throughout the lifespan (Lyons-Ruth, Alpern & Repacholi, 1993; Madigan, Hawkins, Goldberg & Benoit, 2006). They are at higher risk for developing externalizing toddler behaviours such as aggression toward others (Madigan, Moran, Schuengel, Pederson & Otten, 2007) and controlling behaviours with their caregivers (Main, 1996); problematic stress management, lower emotional

health, poor peer relationships, and higher incidence of internalizing and externalizing pathologies during school age (Green and Goldwyn, 2002). Other noted behavioural concerns include a tendency to experience dissociative episodes, increased internalizing behaviours, externalizing behaviours categorized by disruptive behaviour disorders such as Attention Deficit Hyperactivity Disorder, Oppositional Defiant Disorder and Conduct Disorder (American Psychiatric Association, 1994; Lyons-Ruth, 1996) and overall psychopathology in adolescence (Carlson, 1998).

Disorganized attachment develops when the attachment figure is not only the haven of safety for the child, but also a source of fear (Madigan et al., 2007). He or she may engage in frightened or frightening behaviours towards their infant or child which has a detrimental effect by creating an environment that is unpredictable and unsafe (Jacobvitz, Leon & Hazan, 2006). These caregivers themselves are disorganized/ disoriented, which may be due to unresolved mourning or loss from their own personal histories, unresolved attachment issues as recognized in their responses doing the "Adult Attachment Interview" (AAI; George, Kaplan & Main, 1985), or victims of marital discord and/ or domestic violence (Madigan et al., 2006).

Children and adolescents with insecure attachments have an increased risk for relationship disturbances in adulthood. The representations they develop based on their attachment figures in early childhood reflect how they are able to care for significant others such as romantic partners, children and other family members (Simpson et al., 2002). This is related to their ability to have empathy for others, self-regulate their emotions, seek help and provide help to others. For example, according to Simpson et al. (2002), secure individuals should provide support in a flexible and socially appropriate manner, and seek help when needed. Individuals who have experienced rejection frequently by their attachment figures manage distress in an

independent, self-reliant way, thereby isolating themselves from support. They do not read social cues for support appropriately, and provide and receive help less (Simpson et al., 2002). Persons who have received inconsistent or unpredictable care will tend to worry about the security of their relationships later in life. They often amplify relationship distress and attempt unreasonable closeness with their loved ones (Simpson et al., 2002), thereby confusing support giving and receiving.

Fonagy, Leigh et al. (1991) conducted a comprehensive study about psychopathology in adulthood related to attachment. Their results overwhelmingly supported the association of psychiatric disorders with unresolved early attachment relationships as outlined by the AAI. Specific associations were found between diagnoses of anxiety, eating disorders, bipolar disorder, and major depressive disorder with unresolved representations. The strongest correlation was between borderline personality disorder and unresolved attachment classification (Fonagy, Leigh et al., 1991).

As such, a child's relationship with an attachment figure is significant to his or her overall development. If provided with a stable caregiver who is responsive to their needs, the world becomes a more predictable place and children feel secure to explore the world in a normative way (Bowlby, 1969). Their attachment representations will guide them to develop healthy relationships with others as children and adults. Researchers believe that secure attachments in infancy help children develop a capacity for self-reflection, which enhances their ability to take another person's perspective and process interpersonal feedback (Bretherton & Munholland, 1999); essential skills for building healthy relationships.

Measurement of attachment representations

Bowlby (1969) originally assumed that a child's primary attachment figure is his or her mother. Other attachment theorists have since challenged this assumption and have looked at how fathers and other caregivers fulfill this role (Ainsworth et al., 1978; Liu, 2008). Unfortunately, there has been a scarcity of studies examining how fathers' behaviours influence a child's development of attachment representations (van IJzendoorn & De Wolff, 1997). A number of theories have been proposed, including: 1) "hierarchical", meaning that the mother's attachment is the dominant determinant, and other caregivers' attachments will support this primary relationship (Liu, 2008); 2) "integrative", where all attachment relationships are equal and independent, and a child's development of attachment classification is determined by all attachment relationships combined (Liu, 2008); and 3) "independent", which states that a child's development of attachment classification can differ between caregivers because each attachment representation is considered an independent entity (Liu, 2008). However due to the dearth of research in this area, it is not well understood how fathers and other attachment figures influence a child's development of attachment representations. It is for this reason that the term "caregiver" is used in the current study, to provide a broad examination of the influences on attachment representations, including fathers and other attachment figures.

Most of the literature examining caregiver development of attachment representations has focused on how a caregiver's early attachment experiences shape their models of how they interact and respond with their children (Simpson et al., 2002; Sokolowski, Hans, Bernstein & Cox, 2007). However, there has recently been an interest in examining other factors that influence a caregiver's development of attachment representations, such as social support, demographics, chronic stress or violence (Huth-Bocks, Levendosky, Bogat & von Eye 2004;

Huth-Bocks, Levendosky, Theran & Bogat 2004). Results from these studies indicate that maternal risk factors, such as poverty, low SES, single parenthood, chronic stress, and exposure to domestic violence were strongly related to prenatal attachment representations, with more risk related to less secure representations. This is due to the effects of risk factors have on the caregiver's functioning and how she thinks about her child (Huth-Bocks, Levendosky, Bogat et al., 2004; Huth-Bocks, Levendosky, Theran et al., 2004). This is further evidenced in research that demonstrates lower rates of secure attachment in children under stress than in low-stress families (Posada et al., 2002).

The most commonly used tool to measure attachment representations is the Adult Attachment Interview (George, Kaplan & Main, 1985). It is a semi-structured interview for adults containing 18 questions that are designed to elicit the individual's childhood attachment experiences and evaluate how those affect present day functioning (Fonagy, Steele & Steele, 1991). How the individual conveys the story of their attachment representations indicates a classification of their current attachment state of mind as adults. Adults fall into four classifications: autonomous, dismissing, preoccupied or unresolved (Rosenstein & Horowitz, 1996). Autonomous adults value attachment relationships and perceive their parents in a balanced way. They are objective, coherent and consistent and are open to incorporating new information based on relationship experiences (Rosenstein & Horowitz, 1996). Individuals with a dismissing attachment deny the importance of attachment relationships on their personality, and negative experiences with attachment figures are minimized by normalizing, idealizing their parents, or having a poor memory of childhood (Rosenstein & Horowitz, 1996). Adults with a preoccupied presentation appear confused by their attachment experiences and do not have the ability to make sense of or detach themselves from their confusion. Unresolved individuals are

disorganized and disoriented when describing their attachment relationships; they may be irrational about the trauma or loss and have disproportionate fears or guilt about negative events (Rosenstein & Horowitz, 1996).

These classifications have been linked to the attachment categories of the SSP in the following ways: autonomous (secure), dismissing (avoidant), preoccupied (resistant) and unresolved (disorganized), and are stable over time (Benoit, Parker et al., 1997; Bretherton & Munholland, 1999; Fonagy, Steele et al., 1991). The development of the AAI was a catalyst in broadening the perspectives of attachment researchers and clinicians as they moved away from exclusively assessing parent-child attachment based on infant behaviour (i.e. the SSP) toward measures that look at internal working models as well (Zeanah, 2007). Furthermore, research on the AAI indicates that attachment representations are transmitted inter generationally across caregiver-child attachment classifications (Bretherton & Munholland, 1999).

The shift in focus from infant behaviour toward attachment representations was significant because of emerging criticism of the SSP in the attachment literature. For example, Rutter (1995) identified the limits of the SSP which assumes that the experience of separation and reunion has the same meaning for all children. The procedure captures only a brief period of time (approximately 20 minutes), which may not reflect other infant-caregiver interactions throughout the day. As well, the SSP is used with a narrow age group (12-18 months), thereby severely limiting its' range of use. Though adaptations have been made to accommodate a wider range of ages, it has yet to be determined that the separation and reunion experiences have the same meaning in relation to attachment for older children (Rutter, 1995). A child's cognitive capacity will affect their interpretation of a separation and reunion and may not be as indicative of attachment security (Rutter, 1995). Fraley & Spieker (2003) also supported Rutter's (1995)

critique that the traditional attachment classifications as identified in the SSP are too narrowly defined in relation to infant attachment behaviours. They suggested using a wider scale to code the SSP that would allow for more flexibility in understanding an individual's behaviours within a classification (Fraley & Spieker, 2003; Rutter, 1995).

Working Model of the Child Interview

Caregiver attachment representations relate strongly to their parenting behaviours (Button, Pianta & Marvin, 2001). A number of measures have been developed to examine a caregiver's relationship with an individual child as related to their representations; unfortunately validity data about these instruments has been limited (Benoit, Zeanah, Parker, Nicholson & Coolbear, 1997). One measure does have a growing body of data suggesting its validity. The "Working Model of the Child Interview" (WMCI; Zeanah, Benoit, Hirshberg & Barton, 1986) is a structured interview designed to classify caregiver's perceptions and subjective experiences of their infant or child's individual characteristics and their relationship with that child (Benoit, Parker et al., 1997). As such, responses accurately reflect the caregivers' attachment representations. Though it was originally designed as a research tool, its clinical relevance has been demonstrated (Zeanah, 2007). The WMCI asks specifically about a caregiver's unique relationship with a particular child, which differs from the AAI as it provides a more generalized attachment categorization. It can be administered to male and female caregivers from as early as during pregnancy throughout the life span. It has important research implications because it can provide unique insights into the study of caregiver-infant relationships. As well, the specificity provided by the WMCI is important for clinicians because it allows them to tailor caregiver-infant/child interventions to meet the specific needs of each dyad (Benoit, Zeanah et al., 1997).

The WMCI has demonstrated predictive validity of attachment classifications in a number of studies (Zeanah, 2007; Benoit, Parker et al., 1997; Benoit, Zeanah et al., 1997; Zeanah, Benoit, Hirshberg, Barton & Regan, 1994). It is an hour long semi-structured interview that asks the caregiver to describe a number of areas including: 1) the caregiver's emotional reactions during the pregnancy; 2) the infant/child's personality and development; 3) characteristics of their relationship with the infant/child; 4) the caregiver's perceived and anticipated difficulties with infant/child characteristics; 5) their reactions to the infant/child's behaviour or distress in various contexts; 6) and anticipated difficulties in the infant/child's later development (Benoit, Zeanah et al., 1997).

Interview responses are audio or videotape recorded and transcribed for coding purposes according to eight primary qualitative rating scales: 1) richness of perceptions; 2) openness to change; 3) intensity of involvement; 4) coherence; 5) caregiving sensitivity; 6) acceptance; 7) infant difficulty; and 8) fear for infant safety. Scales are rated according to five point numerical scales. As well as these eight primary scales, the affective tone of the interviewee is measured using another eight secondary rating scales. These are used to score the amount of joy, anxiety, pride, anger, guilt, indifference, disappointment and other emotions expressed during the interview (Benoit, Parker et al., 1997; Benoit, Zeanah et al., 1997).

Results from these scales help coders to classify the caregiver's representations into three categories: 1) balanced; 2) disengaged; or 3) distorted. Interviews that are classified as balanced are characterized by moderate to high scores of coherence and responses provide a broad range of descriptions of their infant/child. Caregivers with balanced representations display an appropriate amount of interest and engrossment in their infant/child, and an acceptance of their individuality (Benoit, Parker et al., 1997; Benoit, Zeanah et al., 1997).

Alternatively, disengaged representations are characterized by interviewee's emotional distance from their infant/child as described during their interview. Caregivers with disengaged representations do not seem to be aware of their infant/child's subjective experience or see them as an individual (Benoit, Parker et al., 1997; Benoit, Zeanah et al., 1997). Their illustrations are absent of detail and demonstrate little curiosity or interest in their infant/child, often seeming to describe things in a more cognitive way apparently void of feeling.

Distorted representations are characterized by an interviewee's confused perceptions of their relationship with their infant/child. Distortion refers to an internal inconsistency within the representation rather than to a distortion of "objective" reality (Benoit, Parker, et al., 1997). Caregivers with distorted representations may be confused or are anxiously overwhelmed by their infant/child. They may have unrealistic expectations of their infant/child or have malevolent attributions towards them (Benoit, Parker et al., 1997; Benoit, Zeanah et al., 1997).

The WMCI has demonstrated an ability to predict attachment classification in accordance with the SSP and AAI (Benoit, Parker et al., 1997; Benoit, Zeanah et al., 1997; Zeanah et al., 1994). Specifically, concordance between mothers' WMCI classifications obtained two weeks before the SSP and their infants' SSP classification at 12 months was 69% (Zeanah et al., 1994) and 73% (Benoit, Zeanah et al., 1997). Results also indicate that attachment representations are stable over time, shown in WMCI classifications from the third trimester of pregnancy to 11 months after the child's birth (Benoit, Parker et al., 1997; Benoit, Zeanah et al., 1997) with WMCI results taken prenatally showing a 74% match with the SSP observed at 12 months (Benoit, Zeanah et al., 1997).

In comparisons of clinical vs. non-clinical populations, studies indicate that there is a strong correlation between disengaged and distorted representations with high risk and clinically

disordered infants, i.e. failure to thrive, serious sleep disorders, and other infant mental health disorders (Zeanah & Benoit, 1995). Balanced representations were found in only 7% of the clinical group, versus 42% in the control group (Zeanah & Benoit, 1995). These results are further supported by Benoit, Parker et al. (1997).

Cross-cultural attachment

Although the first empirical investigation of attachment theory by Mary Ainsworth in the 1950's occurred in a cross-cultural context in Uganda (Minde, Minde & Vogel, 2006), there has been a great deal of debate amongst attachment theorists about whether attachment theory is universally applicable or if it does not reflect all cultures (Minde et al., 2006; Rothbaum, Kakinuma, Nagaoka & Azuma, 2007; van IJzendoorn & Kroonenberg, 1988). Research has produced studies that support both positions examining a variety of factors including antecedents (Posada et al., 2002; True, Pisani & Oumer, 2001) and consequences (Posada et al., 1995; van IJzendoorn & Sagi, 1999).

Attachment theorists believe that there is a biological need for infants to have a secure attachment figure upon who can be relied for calming down in times of distress (Ainsworth & Marvin, 1995; van IJzendoorn & Sagi, 1999). This behaviour is common to all members of the human species (Posada et al., 1995), which is demonstrated by the fact that infants have common communication behaviours around the world, i.e. sucking, clinging, crying and following to maintain close proximity to a primary caregiver (Rothbaum et al., 2007). The universality of attachment is supported in a study of the African Efe people (Tronick, Winn & Morelli, 1985, cited in Bretherton, 1995), who observed that infants at 6 months old look to develop stronger relationships with their biological mothers even though they were part of a multiple mothering

system where the infants' needs for food and comfort were mostly met by a community of women.

Critics have challenged attachment theorists' view that there is a single universal pattern of optimal functioning and that other patterns are suboptimal (LeVine & Norman, 2001). They have recognized that optimal development- including caregiver behaviours, child competence and attachment behaviour-are culturally constructed. Rothbaum, Weisz, Pott, Miyake & Morelli (2000) believed that attachment theory is most relevant for cultures that value autonomy. They challenged attachment theory's main hypothesis that caregiver sensitivity leads to secure attachment which promotes children's competencies (Rothbaum et al., 2000). The authors suggested that attachment theorists have been spared criticism for being ethnocentric because they acknowledge cultural influences on a peripheral level. Remarkably little cross-cultural research has been done on attachment, compared to the thousands of attachment studies done with Western participants. As well, the measurements used in most studies were compiled by Western researchers using an attachment framework and ignored indigenous concepts that would inform the cultural understanding of attachment (Rothbaum et al., 2007). Rothbaum et al. (2000) instead proposed using indigenous theories to explain human attachment instead of a unified theory, which neglects unique cultural differences. Though supportive of the universality of attachment, van IJzendoorn & Sagi (1999) also contended that the development of attachment is sensitive to culturally specific influences and encourages the perspective that children adapt to their cultural niche in order to survive.

Harwood, Miller & Irizarry (1995) provided further evidence against the universality of attachment theory due to variations of cultural values. Their study contrasted Puerto Rican with Anglo American mother-child dyads. Their findings indicated that although Anglo Americans

viewed secure attachment primarily in terms of a balance between closeness and exploration, Puerto Ricans saw it primarily in terms of a balance of emotional connectedness and proper demeanour. In the United States, security was seen as leading primarily to autonomy, self-esteem and self-expression. In Puerto Rico, security was viewed in terms of respect, obedience and calmness. Antecedents as well were different, with Anglo mothers placing greater emphasis on autonomy fostering, while Puerto Rican mothers more on structuring the behaviour of their infants. Harwood et al. (1995) also revealed that Puerto Rican mothers exert more physical control over their infants, which is part of their goal to teach them to be attentive, calm and well-behaved. Attachment theorists would classify these behaviours as controlling or interfering and as intrusive to the infant (Carlson & Harwood, 2003).

In fact, Carlson & Harwood's (2003) study found that high maternal physical control was not related to insecure attachment, thereby challenging common beliefs of attachment theorists. They queried whether factors other than attachment representations, such as high rates of maternal employment, gender effects based on cultural roles and cultural differences in parenting behaviours led to high rates of insecure-avoidant attachment categorization (Carlson & Harwood, 2003). The authors suggested that this avoidant response was not necessarily associated with a rejecting or negative maternal emotional relationship. Instead, harmonious relationships, which are indicative of a secure attachment, could be achieved in different ways according to culturally constructed norms (Carlson & Haywood, 2003). All of these qualities represent normative socialization goals for Puerto Rican children (Carlson & Harwood, 2003), which need to be integrated into interpretations of caregiver attachment behaviours, specifically with regards to maternal sensitivity. This study was an important illustration of how critics of attachment theory feel that unique cultural goals are neglected in the universal model of attachment.

One thing that attachment universalists and critics have agreed on is that classification of attachment categories needs to be viewed from an alternative lens when considering ethno-cultural issues of autonomy and dependence. The use of the SSP has been particularly controversial (Bretherton, 1995; Harwood et al., 1995) because the procedure in a non-Western context could be considered traumatic to an infant who has never been separated from a caregiver (Minde et al., 2006). As well, it must occur in a laboratory setting, which is a Western construct and may not encourage non-Westerner's to be comfortable to participate (Posada et al., 1995). Other measures, such as the Attachment Q-Set (Waters, 1995), which was first proposed by Waters and Deane (1985), used behavioural observations of caregiver-child interactions in the home. This was developed as an alternative measure for classifying attachment categories that is culturally supportive, while ratings are highly correlated with those obtained during the SSP (van IJzendoorn, Vereijken, Bakermans-Kranenburg & Riksen-Walraven, 2004).

Attachment Across Cultures

Although there is controversy within the attachment field about whether attachment is universal or not, there is some interest in looking at how cultural values, beliefs and customs influence caregivers' attachment behaviours with their children. For example, one project based out of St. Joseph's Women's Health Centre facility in Toronto, Ontario, *Sharing Attachment Practices Across Cultures: Learning from Immigrants and Refugees* (AAC; <http://www.attachmentcrosscultures.org>), examined this issue in depth. Information from caregivers of various ethno-cultural backgrounds was gathered to gain insight into how they describe their attachment relationships to their children. The objective of this project was to assist human service organizations across Canada in promoting and maintaining positive cross cultural attachment practices among program participants by creating practical resources for

them. It was an exploratory research project, conducted as a qualitative study of parents, with children aged 0-5 years (http://www.attachmentcrosscultures.org/about/toolkit_eng.pdf). Researchers collected in-depth individual interviews and focus group discussions with 133 immigrant and refugee parents (126 mothers and 7 fathers) from 50 countries around the world, as well as in-depth individual interviews and focus group discussions with 20 service providers. It also collected 50 responses to a call for resources sent out to service providers across Canada. Data was collected in Vancouver, Calgary, Edmonton, the Waterloo region, Hamilton, Toronto, Montreal, Halifax, and Fredericton. Based on the results of their research, the researchers developed pamphlets, a tool kit and a web site for service providers and caregivers of newcomer families that encourage healthy attachment practices. AAC was an innovative project that provided research insight into cross cultural attachment relationships within a North American context.

Overall, findings confirmed the universality of attachment across cultures as evidenced in common caregiver-infant relationships and mothers' desire for securely attached children (http://www.attachmentcrosscultures.org/about/toolkit_eng.pdf). However, there are similarities and differences in attachment beliefs, values and practices amongst mothers from different countries of origin. The study highlighted the importance of recognizing the differences in beliefs and values because they influence mothers' attachment practices and perceptions of child development (http://www.attachmentcrosscultures.org/about/toolkit_eng.pdf). As well, findings noted that families who immigrate to Canada face obstacles in developing healthy attachment relationships i.e. loss of family home, family and community, trauma and culture shock. However, parents' wishes to provide a better life for their children are protective for developing healthy attachment relationships. Researchers highlighted that service providers

throughout Canada can better help immigrant and refugee parents by offering support to overcome the great challenges in promoting attachment within a different context from which the immigrant parents were raised.

Resources were developed by the authors to highlight similarities and bridge gaps between North American culture and newcomer parents' experiences. These included a poster series informing parents of the importance of developing healthy attachment practices. A web site was developed for community service providers to help parents develop healthy attachment practices with their children. As well, pamphlets were made in eight languages (Chinese, French, Somali, Spanish, Tamil, Urdu and Vietnamese) covering topics such as 1) Breastfeeding and Attachment; 2) Breastfeeding, Culture and Attachment; 3) Carrying, Culture and Attachment; 4) Sleeping, Culture and Attachment; 5) Touch, Culture & Attachment. These resources were aimed at informing service providers to be culturally sensitive to the caregivers with whom they work, as they may have different attachment beliefs, which may seem unhealthy by North American standards, but may not be given cultural variation. Service providers were encouraged to support immigrants' cultural beliefs and help them develop the confidence to parent in ways that may not be typically mainstream. Feedback from service providers and clients about the content and format of the posters and pamphlets has been overwhelmingly positive (A. Priego, personal communication, June 4, 2008).

The following three themes were developed by the AAC research team and are relevant to how the project team developed their practical resources:

Learned Parenting Practices. New parents who arrive to Canada do not have the same supports or resources as in their home countries. Many participants in this study expressed feeling lost and having a lack of confidence to parent in Canada. They miss the informal learning

opportunities from their elders and prefer sharing ideas with other parents in Canada as opposed to more formal learning environments (i.e. books/pamphlets, school classes, by professionals), which are not culturally sensitive as they are geared to more mainstream middle class parents.

Cultural and Societal Parenting Norms. Parents who immigrate to Canada face barriers in continuing attachment practices from their home countries. For example, breastfeeding in public makes many people in North America feel uncomfortable and may isolate immigrant mothers, which is in contrast to their cultural beliefs that value breastfeeding in public well past the first year of life (http://www.attachmentcrosscultures.org/about/toolkit_eng.pdf). Other issues include different parenting beliefs around ways of respecting elders, children voicing their opinions, sleeping arrangements, and feeding practices. All are significant opportunities for parents to develop healthy attachments with their children, however due to Canada's cultural value of developing autonomy in children, parents from interdependent cultures may find maintaining their historical beliefs and practices challenging. They often feel criticized for upholding their own cultural beliefs, for example if they feel that children should not challenge their elders when asked to do something.

Systemic barriers. Immigrant and refugee parents face systemic barriers that impact their development of healthy attachment practices including: a. socioeconomic status; b. racism and discrimination; c. the lack of validation of their effective attachment practices; d. stress within their families; e. violence in intimate relationships; f. lack of support (http://www.attachmentcrosscultures.org/about/toolkit_eng.pdf). Service providers need to be sensitive to these obstacles and support newcomer parents to feel confident in themselves as parents and find a balance between maintaining their cultural identity and assimilating into North American culture. Interviews with participants in this project highlighted specific themes about

adapting to North American culture. As such, specific posters and pamphlets included information about culture shock, surviving trauma and procedures for expectant mothers who do not know how to navigate the North American health system. Service providers were encouraged to be particularly sensitive to the stress newcomer parents may be under and can support them to access the appropriate resources themselves.

AAC was a large scale research study that provided innovative insight into the lives of newcomer parents and how they perceive attachment relationships within a North American context. It used qualitative data analysis to allow for multiplicity of themes in participants' responses, which can encourage further exploration into various areas of cross cultural attachment. It attempted to bridge the conflict within the attachment field that has polarized the question of whether attachment is universal or not. However, it discusses attachment in terms of how caregivers bond and feel closeness with their children. Though it makes the claim that attachment beliefs, values and behaviours are universal, it does not attempt to measure them or classify them in any way. It does not go into detail about what constitutes a healthy or unhealthy attachment, nor does it answer any questions about what to do with a newcomer family whose attachment practices are in conflict with North American values and laws. It also does not talk about attachment within Bowlby's (1969) original context of being a behavioural stress response system, nor does it connect its findings to a caregiver's attachment representations. This is likely due to the generative nature of the study and its focus on gathering information from a large lay sample.

Purpose of the current study

The role of ethno-cultural values and beliefs on caregivers' development of attachment representations as outlined in the literature remains unclear. What is missing is an integrative

approach that examines how immigrant populations and their children integrate attachment theory and practices within their multicultural societies.

The focus of the current study was on examining ethnic and cultural differences in descriptions of attachment representations based on the WMCI. It is important to note that the term "ethno-cultural" relates to the ethnic and cultural backgrounds of WMCI interviewees. Elements of an ethno-cultural background include an individual's nationality, language, and religion. These variables were examined when coding WMCI interviews to see if there were similarities and differences in interview responses between North American born and non-North American born interviewees.

Method

Interest in the current study emerged during my work in a children's mental health centre in Aurora, Ontario while administering the WMCI. My colleagues and I wondered about whether a client's ethno-cultural background influenced their responses during the interview. Questions about how their use of specific language and beliefs about parenting may influence the ways which interviewees described their relationships with their children. Prior to the current study, it was assumed that attachment representations were illustrated no matter what language or ethno-cultural beliefs are present in the interview. The current study thus aimed to further examine this assumption, thereby exploring the universality of attachment representations.

The primary objective of the current study was to examine similarities and differences in responses of North American born and non-North American born caregivers to attachment related questions in the Working Model of the Child Interview. A secondary objective was to examine similarities and differences in responses between North American-born and non-North American born caregivers who have been involved in children's mental health services (clinical) and those who have not (non-clinical). WMCI's of Non-North American and North American participants were analyzed and compared with their answers from the Cultural and Ethnic Background Questionnaire (CEBQ), a tool that gathered demographic data about participants' backgrounds. The WMCI was chosen in part because previous research supports the use of the WMCI in the study of cross-cultural attachment, though have questioned it's interpretation as being biased by Western values (Minde et al., 2006).

This research was guided by a Grounded Theory (GT) approach due to the nature of the inquiry. The rationale for this approach was because little is known about ethno-cultural influences on attachment representations; this study aimed to provide a richer theoretical context

about cultural impacts on their development. GT is a widely used qualitative methodology that allows a researcher to discover themes and relationships within rich, narrative data (Glaser and Strauss, 1967). GT has been demonstrated to be particularly useful in fairly unstudied areas and productive in the generation of hypotheses (Whitney, Easter & Tchanturia, 2008). In this approach, the researchers did not have any pre-existing ideas of what will emerge from the data. It was the view that knowledge that is relevant will begin to emerge as the analysis takes place (Whitney et al., 2008).

According to GT, data is broken down into units, and the smaller the unit, the more grounded in the data the analysis is presumed to be (Whitney et al., 2008). For the current study, WMCI interviews were transcribed and conversational units were reviewed. Themes were developed based on these units to describe the data. Researchers read through the transcripts with these themes in mind, more conceptual or theoretical categories emerged. The researchers used a constant comparative method in which the researcher generates as many themes as possible, while at the same time comparing them with previous incidents coded under the same theme (Whitney et al., 2008). Similarities and differences between themes were closely examined in relation to the objectives of the study, and a theoretical framework emerged. More will be said shortly in the Discussion section.

Setting and participants

Twelve female primary caregiver participants were the targeted goal for this study. It was hoped that six would be either current or former clients of Blue Hills Child and Family Centre (BHCFC), an accredited children's mental health clinical treatment centre in Aurora, Ontario; six would be from a non-clinical environment obtained from Durham Farm and Rural

Family Resources (DFRFR) in Uxbridge, Ontario. Three caregivers from each setting were to be North American born; three would be Non-North American born.

Six participants were recruited. All were female and were over the age of 19 years. The mean age at the time of being interviewed was 37.6 years, ranging from 26-44 years. The median age was 40 years. Non-North American participants in this study were born in Pakistan, Uganda and Portugal. Two North American participants came from what they described as British cultural backgrounds, while the other North American described herself as "white Dutch".

Four participants were current clients of BHCFC, two were from DFRFR. Three BHCFC participants were Non-North American born, one was North American born. Both DFRFR participants were North American born. Five participants were biological mothers to the child they were discussing during the interview, one (who was part of the BHCFC Non-North American group), was an adoptive mother.

Clinical participants were recruited at BHCFC. Non-clinical participants were recruited at DFRFR, a community organization based out of Uxbridge, Ontario that offers services to parents such as a drop-in centre and informal workshops. DFRFR was chosen due to the similar demographic composition of this community to BHCFC, which is characterized as rural with populations in various socio-economic situations. The principal investigator's previous professional affiliation with the program director at DFRFR was also a factor influencing recruitment.

Data collection

Research Ethics Board approval was obtained from Ryerson University prior to data collection. For BHCFC participants, candidates were identified by the WMCI team at the agency based on their completion of the WMCI. Suitability of candidates was considered based on

stability of their home situation and whether participation would interfere with their clinical treatment plan at BHCFC. Information about the nature of the study was then provided to candidates by their case-coordinator at BHCFC to see if they would be interested, and if they agreed they were contacted by the principal investigator to sign the appropriate consent forms. Potential participants were reassured by their case co-ordinator and the principal investigator that their decision to agree, disagree or withdraw at any time their participation in this study would not impact their clinical services received at BHCFC. This was stated on the consent form signed by the participants. It was decided by the principal investigator and the WMCI team at BHCFC that participants who had already completed the WMCI would be obtained for this study due to time constraints. Once consent forms were signed, video tapes were transcribed and reviewed. All BHCFC interviews were conducted between February 2007 and January 2008.

For non-clinical subjects, a flyer was posted at the drop-in centre to recruit participants. Candidates approached the DFRFR director if interested and were subsequently contacted by the principal investigator. Interviews were scheduled and consent forms were signed prior to participating in the interview. For the DFRFR participants, interviews were conducted in July and August 2008. Interviews were audio tape recorded to further ensure participant anonymity. The discrepancy between the video tapes from BHCFC and audio tapes from DFRFR did not impact the validity of the current study, as research indicates that reliability of data for the WMCI is uniform across video and audio tapes as non-verbal communication is not significant to coding (Rosenblum, Zeanah, McDonough & Muzik, 2004).

The CEBQ was also provided to participants from both groups at the time of signing consents. This was done to enhance the comparison between Non- North American born and North American born participants to see if there are similarities or differences in attachment

representations across ethno-cultural groups. The CEBQ was developed by the principal investigator for the current study to examine a caregiver's cultural and ethnic background. It is a simple information gathering measure that asks questions such as: 1) Languages spoken in your home; 2) Your country of birth; 3) Your mother's and father's country of birth; 4) How would you describe your cultural or ethnic background?; 5) How would you describe your mother's and father's cultural or ethnic background? 6) Are you a member of a cultural or ethnic group? Information from this questionnaire was analyzed and used when comparing similarities and differences across Non-North American and North American groups (See Appendix B).

Data analysis

Video and audio tapes were transcribed by the principal investigator. Transcripts were read and re-read several time to discover the general context using the GT approach of constant comparison method (Whitney et al., 2008). The principal investigator conducted substantive coding, which is a close, line-by-line reading of all the transcripts, comparing empirical indicators (i.e. stories or incidents) for similarities and differences to develop potential categories (Draucker & Martsof, 2008). Themes were developed and transcripts were re-read. Significant questions from the WMCI were identified as particularly indicative of a caregiver's attachment representations, such as: *1a* (caregiver's perceptions of child during pregnancy); *2*, *2a*, *2b*, *2c* (caregiver experiences of child being upset, hurt, or ill and caregiver responses to their distress); and *3* (caregiver descriptions of their child's personality). Ideas were discussed with the research supervisor and sub-themes were developed. Examples of themes include, "Descriptions of children's feelings and behaviours", "Descriptions of parent feelings and behaviours", "Parents' coping skills", "Child's coping skills", "Descriptions and reasons for pregnancy".

Key words related to attachment themes were identified. Three categories emerged: 1) Relationship descriptors such as “attachment”, “love”, “connection”; 2) Emotion descriptors such as “feeling”, “angry”, “sad”, “scared”; 3) Stress response descriptors such as “comfort”, “stress”, “respond”. Word counts were administered using 21 words in total (three from each category) to the whole transcript, clinical and non-clinical transcripts, and Non-North American and North American born transcripts. The ethno-cultural focus of this inquiry lead the researchers to analyze the Non-North American and North American transcripts in great depth, as such the comparison of clinical versus non-clinical was not developed.

Results

Caregiver attachment representations are illustrated through the WMCI in how a caregiver tells the story of their relationship with their child. Significant themes emerged within the caregiver transcripts, particularly in questions 2, 2a, 2b, and 2c, which describe their perceptions of how they and their children behave and feel under stress when they are upset, sick or hurt. Important information was also revealed in caregiver thoughts and feelings about how they react when their children are under stress. The language participants in this study used to describe their perceptions is important to this analysis and thus significantly influenced the categorization into four primary themes and sub-themes outlined in *Table 1*.

Insert Table 1 about here

Emotion regulation

Caregiver descriptions were categorized into their *awareness of feelings* and *caregiver responses*. North American and Non-North American transcripts revealed significant differences within caregiver perceptions of theirs and their children’s emotion regulation. They differed in the content of their stories, for example Non-North American caregivers described a balanced ratio of their awareness of feelings versus how they responded to their children. North American caregivers were more uniform in their descriptions of predominantly their responses and less of their awareness of their children’s feelings.

Non-North Americans gave richer details of theirs and their children’s emotional experiences. This is congruent with Non-North American caregivers expressing how they were more impacted by their children’s distress in comparison with North American caregivers. All three Non-North American caregivers described being significantly affected by their child’s feelings: one said that she is “sad when he’s sad”; one indicated that she used to panic when he

was upset or hurt; and another said that she feels guilty, worries and panics when their child is distressed. North American caregivers described their reactions much less frequently. When they did, they identified worry and “feeling badly for him when he is sick and sad.”

Non-North American and North American caregivers differed also in the feelings they identified in their children. When participants were asked to give an example of their child being sad, lonely, frightened or scared, all three Non-North American caregivers chose to describe sadness. They did not indicate that their children felt loneliness or fear. They discussed their child feeling sad due to circumstances such as when they were sick or rejected by their sibling. One caregiver indicated that her child cries very easily and is “usually sad.” In contrast, all three North American caregivers gave examples of their children being scared, but did not describe moments of sadness. As well, one North American caregiver described preferring her child to be scared or hurt versus angry, feeling that they did not know how to respond to anger. Another North American caregiver described herself as someone who is empathic to her child’s feelings and wanted him to understand the need behind his emotions.

Caregiver answers in the interviews also differed in how Non-North American and North Americans respond to their children’s emotions. Non-North American caregivers clearly identified the following ways they respond to their children’s feelings: 1) *Distraction*- ie. “watches cartoons”, “try to get his mind of whatever it is”, playing games; 2) *Affection*- ie. hugs and kisses, comforts with kisses, child asks for comfort when upset, tries to hug and soothe him physically; 3) *Leaves them alone*- “does not stay with him if he is hurting”; 4) *Calms themselves*- i.e. “remove myself”, “let him calm down”, “I go into prayer, breathe and stop what I am doing”; 5) *Rationalize*- i.e. “when afraid, [child] talks and asks questions”, “[caregiver] coerces him to talk”.

In contrast, North American caregivers used more discretion when responding to their children’s distress. They wanted to differentiate between their child being truly distressed or whether they were having a “tantrum”. Examples of theirs and their children’s responses include: 1) *Affection*- ie. “tries to comfort her”, administering band-aids, validates his feelings, reassures him that it will be okay, picks him up and hugs him.; 2) *Promoting child’s awareness*- “has him check in with his body and feelings”; 3) *Getting mad*- caregiver yells when she is frustrated. One similarity identified in the data is that both groups described using affection as a response to their children’s distress.

When analyzing words related to attachment representations, discrepancies emerged where Non-North American caregivers gave higher numbers related to “positive” emotions, ie. love, normal, happy, while North American caregivers used more “negative” descriptors, ie. trouble, stress, mad. Table 2 highlights significant discrepancies of attachment descriptors across the two groups.

Insert Table 2 about here

Stress response

Caregiver descriptions were categorized into *ways children ask for help* and *caregiver responses*. The way they told their stories differed again; Non-North Americans spoke equally about themselves and their children while North Americans spoke more about their own reactions than descriptions of their children. Otherwise, there were significant similarities between the two groups in both categories. Both describe their children to ask for help and affection when distressed, they each gave examples of their children withdrawing when under stress (though one Non-North American caregiver predominantly characterized her child as withdrawing when she is upset throughout her transcript). In this way, children from both groups

were perceived as liking to solve problems on their own. Both groups also identified their children as being aggressive, however Non-North Americans described it as “demanding” and “complaining”, while North American caregivers used words such as “angry”.

Similarities in how caregivers behaviourally respond to their children’s distress include: *teaching* and *listening*. Descriptions again differed in focus, though, as one Non-North American caregiver illustrated examples of teaching as teaching problem solving tools, while one North American was teaching to label feelings. Non-North American caregivers used listening to help solve the problem while a North American used listening to establish the problem. Differences in caregivers’ behavioural responses include: One Non-North American described *rationalizing* as “talking him out of it” and *resourcing* ways to solve the problem. North American caregivers described *coaching* to promote independence, “get back on your bike”; and *affection*, “let’s me cuddle him”, “lie down and hug him next to me”.

Caregivers also described different emotional responses when faced with their child’s distress. Non-North Americans illustrated screaming (twice), feeling bad when helpless, and wanting to be protective of their children. In contrast, North American emotional responses included one caregiver who stated on a few occasions that she wanted to withdraw and “go back to bed” to protect herself from further difficulties. Another felt frustrated and wanting to yell at her son. One similarity between the two groups is how caregivers, even if feeling unable to be affectionate with their children, yearned to “take their child’s pain away”.

Caregiver roles

Caregiver roles reflect attachment representations because how a caregiver feels about their child and how they perceive their role as an attachment figure relates to their expectations of themselves and their children in relationships. Caregivers between the two groups

characterized many similar roles when they responded to their children’s distress, for example *disciplinarian*, *nurturer*, *encouraging independence* and *teacher*. Differences occurred during descriptions of such roles. One Non North American caregiver described herself as a teacher when helping him to read and write, a *motivator* (“he’s lazy”), a *listener* and encouraging her child’s independence. Another Non-North American caregiver described her role to be a disciplinarian when her child is distressed. Her most frequently mentioned technique was using a “time out”, and she characterized her child’s behavioural motivations as being related to consequences. She also illustrated herself as a nurturer when she is physically affectionate. The third Non-North American caregiver also was primarily a disciplinarian. She employed “time out” as a common response to her child’s distress. She also used “1-2-3 Magic”. She illustrated herself as a when providing praise and encouragement to her child when they were upset.

One North American caregiver illustrated herself strongly as encouraging independence. She was ambivalent about helping her daughter as she felt that her daughter needed to do things “on her own”. She described herself as a nurturer when using empathy to better understand her child’s needs and a *protector* to “keep her safe”. However, she also described having a preference to take care of her daughter when she is sick, because she has difficulty managing her behaviour when she is her normal energetic self. She finds it easier to manage her because her energy is lower and she is not as overwhelmed. This caregiver is also a disciplinarian, using the ignoring technique aimed to reduce her daughter’s desire to ask for help. Another North American caregiver described herself as a nurturer primarily. She was sensitive to meeting her son’s emotional and physical needs. She was also a teacher when helping her son to develop empathy for others and was a disciplinarian when helping him to recognize that there are consequences to his actions. She also was a protector, identifying her son’s needs for safety

while going through a difficult time. The third North American caregiver was primarily a nurturer; she tried different strategies to support her son emotionally when he is upset. She demonstrated empathy, and hoped that her son would respond to her affection in a positive way even though she described feeling uncomfortable with affection herself due to her lack of receiving it as a child. Table 3 illustrates a comparison of frequency of caregiver roles across the two groups.

Insert Table 3 about here

Personality/relationship descriptors

Questions 3 and 7 of the WMCI ask caregivers to give adjectives describing their impressions of their child's personality (question 3) and their relationship with their child (question 7). These descriptors are significant to understanding caregiver attachment representations, because inherent to their characterizations are perceptions and expectations of their child and their relationships. Descriptors were separated into groups of *Positive*, *Negative* and *Neutral*. Of the Non-North American descriptors (N=39) taken from the two questions, 22 (56.4%) were positive. Most frequent examples include loving (5), happy (2), caring, helping, kind, gentle; descriptors exclusive to relationships were comforting, encouraging, fulfilling, playful, affectionate, compassionate. Ten (25.6%) descriptors were negative. Examples include annoying (2), messy, misbehave; evil, ignoring, lacks discipline. Seven (18%) descriptors were neutral. Examples included following (2), headstrong (2), perfectionist, shy (2).

North American transcripts produced slightly more total descriptors (N=48). 30 (62.5%) were positive. Examples include funny (3), fun (3), passionate (2), creative (3), smart, enthusiastic; descriptors exclusive to relationships include intimate, challenging, affectionate, and compatible. Negative descriptors were eight (16.7%), including motormouth, bossy, needy,

bad, stressful and not respectful enough. Ten (20.8%) were neutral, including clown, princess, shy (2), active, and complicated.

When comparing overall descriptors used by Non-North American and North American caregivers, relatively few words were used similarly across the two groups. Of the total personality descriptors (N=44), only 3 were similar across the board. For relationship descriptors (N=26), only 2 were similar across the two groups. Table 4 lists *personality descriptors* provided by caregivers, and Table 5 lists *relationship descriptors*. Though not commonly used in the GT approach, percentages were used in the current study to highlight the similarities and differences in attachment descriptors across the two groups.

Insert Table 4 about here

Insert Table 5 about here

Discussion

The current study was developed to provide insight into ethno-cultural influences on attachment representations, primarily because there has been an absence of research on this topic. It was unclear how participants whose natural language is not English describe their relationships with their children in the Working Model of the Child Interview, and if their varied descriptions may mislead clinicians when interpreting the interview. The objectives of this research project were to: 1) inform research about the ethno-cultural influences of attachment representations; and 2) provide clinicians with a deeper understanding of how to assess and plan interventions for Non-North American born clients. Part of this process includes suggestions for improvements to the WMCI, or informing clinicians how to utilize their knowledge of a client's ethno-cultural background to influence their analysis of the WMCI.

This project was an exploratory analysis of cross-cultural attachment representations. No hypotheses were used to predict the outcome of the research. Rather, a Grounded Theory approach was used to generate a meaningful and coherent set of concepts about cross-cultural attachment patterns to provide the groundwork for hypothesis driven research. The Grounded Theory approach provided an abundance of data within the WMCI transcripts, and four primary themes related to attachment theory were developed: 1) Emotion Regulation; 2) Stress Response; 3) Caregiver Roles; and 4) Personality/Relationship Descriptors. These categories were chosen within the context of Bowlby's (1969) description of an individual's attachment being a behavioural stress response system, and because there were valid indicators of how caregivers and their children respond under stressful situations. Overall results in the current study revealed that there were universal components of attachment representations across cultures, but how caregivers illustrated their perceptions of relationships in the data were ethno-culturally

influenced. This supports previous research indicating that caregiver narratives within the WMCI are more culturally determined than parent-child interactions (Minde et al., 2006).

Attachment story telling related to ethno-cultural context

The differences in how Non-North American and North American caregivers told the emotional content of their attachment relationships with their children may reflect varied ethno-cultural contexts. This is congruent with Harwood et al., 1995, who stated that "cultural meaning systems provide the conceptual frameworks that are likely to be used to interpret emotional cues and experiences" (p. 139). In the current study, Non-North American participants were born in the interdependent cultures of Pakistan, Uganda, and Portugal, which are characterized as "emphasizing the fundamental connectedness of human beings to one another" (Harwood, Schoelmerich, Shulze, & Gonazalez, 1999, p. 1005). Social relationships prevail in an interdependent culture and are significant to the cultural context of childhood. Alternatively, two North American participants came from what they described as British cultural backgrounds, while the other North American described herself as "white Dutch", all of which could be described as independent based cultures. These are characterized as focusing on an, "individual, self contained autonomous entity who is composed of a unique variety of internal attributes, which guides their behaviours" (Harwood et al., 1999, p. 1005).

The fundamental differences of cultural values were evidenced in relation to answers about *emotion regulation* and *stress response* in the present study. Non-North American caregivers spoke in a more balanced way, providing examples of theirs and their children's experiences. In contrast, North American caregivers spoke mainly about themselves and showed less awareness of their children's emotions. Further evidence could be found in the fact that Non-North American caregivers described being more impacted emotionally by their children's

distress. This demonstrates their strong connectedness to their children's emotional experiences, which is a value of their interdependent cultures. North American caregivers used more discretion when interpreting their children's behaviours before developing an appropriate response, while Non-North Americans did not. This could indicate that North Americans are more reflective of their relationships with their children and are not as trusting of them. By doing so, they are creating distance between themselves and their children, which reflects their cultural value of promoting independence (Bernstein, Harris, WeLaLa Long, Iida & Hans, 2005).

Language reflective of ethno-cultural context

Non-North American caregivers used more emotional language in their attachment descriptors (i.e. love, feeling, happy, sad) while North Americans used more behavioural words (i.e. "trouble", "stress", "mad", "scared"). This could also reflect cultural beliefs about expectations in relationships, where interdependent caregivers described more of their connectedness while independent caregivers related things to themselves. Both groups provided positive ratios when analyzing descriptors of their children's personalities and relationships (56.4% for Non-North American vs. 62.5% for North American), however significantly few words were used similarly between the two groups. Non-North Americans used more words related to connectedness such as "loving", "caring", "happy", "kind", "gentle" and "sensitive", while North Americans used more action-oriented descriptors such as "funny", "comedian", "fun", "passionate", "curious", and "creative". This again could indicate that caregiver descriptions differ and reflect cultural variation across the two groups.

The affective tones of a caregiver's attachment representation differed where Non-North American caregivers had a heightened state of emotional arousal while North Americans were more neutral. This is further evidenced in differences in how caregivers from the two groups

described their children's aggression. Non-North Americans used words such as "demanding" and "complaining", which indicate that their children's feelings are related to their caregivers, while North Americans used the words "mad" or "angry" which attribute the feelings as separate from themselves.

Parenting styles reflective of ethno-cultural context

Caregiver responses to their children's distress in the present study reflect ethno-cultural variation. Non-North American caregivers described themselves primarily as disciplinarians when responding to their children's distress. They used strategies such as "time out" and "1-2-3 Magic" to help manage their children when they were emotionally upset, physically hurt or ill. By doing so, they were teaching their children that they could not expect their caregivers to respond to their feelings, as they aren't as important as societal behavioural expectations. This corresponds with previous research on ethno-cultural variation on caregiver expectations in relationships, which states that one of the primary goals from caregivers in interdependent cultures is to have a child who is obedient and respectful (Harwood et al., 1999). Harwood et al. (1995) found that Puerto Rican mothers in their study emphasized *proper demeanor* and valued their children to be "respectful, calm, courteous, attentive to others, and able to cater their behaviours to different social contexts" (p. 143).

North American caregivers described themselves primarily as nurturers when their children were distressed. They tried different strategies to calm their children down and teach them to manage their feelings. By doing so, they were teaching their children to learn to calm themselves down when distressed, and that they could expect their caregivers to nurture their emotions. Correspondingly, Harwood et al. (1995) found that Anglo mothers valued *self maximization*, where they wanted their children to grow up to be self-confident, independent,

happy, and able to fulfill their inner talents and potential (p. 142). Thus, from an independent perspective, a child's emotional well-being is to be nurtured to the point where they can take care of themselves (Harwood et al., 1999). These distinct methods of teaching emotion regulation serve to fulfill immediate and long term goals for socialization (Cassidy, 1994), which in this study were ethno-culturally defined. Children from the two groups learn to regulate their emotions as an adaptive measure in order to be successful within their distinct cultures.

Emotion regulation reflective of universal attachment

Caregiver perceptions of emotions in themselves and their children were particularly significant to their descriptions of their stress response systems in the current study. This is congruent with Cassidy (1994), who highlights the importance of emotion regulation to the development of attachment relationships. Emotion regulation is an adaptive means which allows a child to have their needs met by a caregiver. Children's learning about emotion regulation is done inter generationally from their attachment figure based on their own attachment representations, which directly influence the child's perceptions and expectations in relationships (Cassidy, 1994).

As indicated above, attachment story telling relating to emotional affect differed significantly across ethno-cultural groups. Interestingly, caregiver descriptions of how they model and teach emotion regulation in the present study shared common characteristics that do not reflect the differences in interdependent and independent cultures. Both groups described listening to their children's distress and teaching them problem solving tools. Non-North Americans significantly promoted distraction and rationalizing emotions in their children, which focus on the cognitive assets of problem solving. This is not reflective of an interdependent culture. North American caregivers promoted receiving support through encouragement of

independence, while at the same time acknowledging their children's' emotional distress and confirming help seeking behaviours. So in fact, North Americans reflected values of connectedness that would normally be associated with an interdependent culture when describing their expectations of emotion regulation. This discrepancy indicates that ethno-cultural contexts are not so cut and dried and must be viewed with a broad lens.

Caregiver stress response and roles reflective of universal attachment

Caregivers in the current study whose attachment representations showed differences in story telling and language would lead us to believe that their behaviours would overwhelmingly differ according to cultural variation. However, results suggested that they did not. Evidence of this is specifically related to descriptions of *stress response* and *caregiver roles*. For example, in both groups caregivers reported similar behavioural responses to listen, teach, and be affectionate when their children are distressed. This could indicate that how caregivers react and model their stress response behaviours is more universal, regardless of culture. As well, they described their children to similarly respond under stress by primarily asking for help and affection, and some in both groups preferred to cope with their distress on their own. Alternatively, this could be explained by the acculturation Non-North American caregivers have undergone since moving to North America.

Similar descriptions of caregiver roles across both groups could indicate that cultural variation does not impact behaviours to meet the needs they provide to their children. For example, being a disciplinarian, a nurturer, a teacher and promoting independence when their children are distressed are valued across cultures regardless of individual ethno-cultural beliefs. This supports research that identifies caregivers as having multiple roles separate from providing emotional and physical safety to their children, such as being a teacher, playmate, self-esteem

builder, and promoting independence (Button et al., 2001). These are universal core characteristics of parenting styles that are relevant across cultures (Bernstein et al., 2005).

Implications for future research

Overall, results from the current study lead us to believe that ethno-cultural influences on attachment representations are not clear cut and rigid. While ethno-cultural variation in beliefs and values are reflective of how caregivers describe the emotional affective tones in their interviews and are found in their parenting styles, aspects of emotion regulation, stress response and caregiver roles are more universal. This is an important insight that speaks to the different components of attachment representations, which include guiding behaviour, expectations, perceptions and emotional affect in relationships. The discrepancies found within the current study could indicate that one aspect of an individual's attachment representation does not necessarily determine an individual's entire attachment representation. This is significant to informing research on the development of caregiver representations, and is a starting point for further understanding ethno-cultural influences.

The varied nature of the caregiver's descriptions also reflects the confirmed notion that making cultural distinctions can lead to overgeneralization or stereotyping when describing a cultural group (Bernstein et al., 2005). This can be counterproductive as it leads to denying the range of individual differences which could be related to personality or other contextual influences. For Non-North American born participants, this could be particularly relevant as they may have an interdependent ethno-cultural background but are living in an independent North American society. As such, length of time in North America for immigrant populations would be a useful variable to include in future research.

Implications for clinical practice

Results from the current study revealed how caregivers illustrated their perceptions of relationships differently according to cultural variation. Although caregivers may have described similar roles or expectations in relationships, the language they used to describe their relationships differed. This reflects certain aspects of caregiver attachment representations, however did not always translate into their behaviours. Therefore, clinicians working with clients from Non-North American backgrounds need to take this into account when interpreting their WMCI interviews or observing their attachment relationships. Clients may uphold similar values and beliefs about attachment relationships, but may express themselves in different ways. Sensitivity to cultural variation in this way could lead clinicians to fully understand a client's attachment representation prior to suggesting treatment based on superficial analysis. Ultimately, the outcomes of this knowledge could lead to more effective interventions that appeal to and meet the needs of our diverse population. This supports Minde et al. (2006)'s suggestion that a culturally modified scoring system could be implemented for coding the WMCI based on their sample in a South African township.

As such, the WMCI proves to be a relevant assessment interview that can be applicable to individuals from a variety of backgrounds, as long as clinicians interpret it in an ethno-culturally sensitive way. Results from the present study do not support Bernstein et al.'s (2005) findings that "applying a research paradigm or assessment instrument developed in one culture to another is not considered best practice in cross-cultural measurement" (p. 243). The questions asked in the interview relate to people from all over the world, and there is insufficient evidence to conclude that the WMCI needs to undergo changes to become more culturally relevant. However, further exploration of coding systems is required.

Limitations

This study was an exploration of cross-cultural attachment representations, and may not necessarily reflect overall ethno-cultural values of the participants. The data provided rich details of caregiver representations, but a fuller account could be obtained from a broader sample. One of the tenets with the Grounded Theory approach is that sampling occurs until no new categories emerge. Given time limitations, this was not possible.

Additionally, having a very limited amount of time did not allow for comparisons amongst clinical and non-clinical samples. A study in the future could compare clinical transcripts across cultures, and separately non-clinical transcripts across cultures. Then a fuller understanding of how differences or similarities in attachment representations impact the healthy development of a child's attachment system could be determined.

As well, having a limited sample did not allow for exploration into the limitations of the WMCI. It remains unclear how participants with English as a second language or other participants who do not express themselves comfortably are affected by the verbal nature of the interview. The WMCI examines a caregiver's specific relationship with one child, and the question remains about whether caregiver representations are consistent between children. Benoit, Zeanah et al. (1997) suggest that caregivers may talk about specifics differently; however their attachment representations will not change. The limited scope of this study could not provide insights into this question.

Future Directions

Future studies to examine the ethno-cultural impacts on attachment representations using the WMCI would deepen the preliminary understandings developed from the current study. A broader sample would also allow for more specific discoveries to occur. The different

components of attachment representations could be examined individually to test the hypothesis that emotional affective tones, emotion regulation and perceptions of relationships are primarily culturally influenced, while caregiver roles, behaviours and expectations in relationships are more universal.

A proposed sample would include having participants from specific ethno-cultural backgrounds compiled and analyzed. For example, participant responses from Western or Eastern European, Southeast Asian, and South American backgrounds could be compared with North Americans; alternatively specific countries could be selected for comparison. This way, intra-cultural similarities and differences could be determined and analyzed across cultures as well.

Table 1- Thematic categories of data analysis

Themes	Sub-themes
Emotion Regulation	1) Awareness of feelings 2) Caregiver responses
Stress Response	1) Ways children ask for help 2) Caregiver behavioural responses 3) Caregiver emotional responses
Caregiver roles	Caregiver identified
Personality Descriptors	1) Positive 2) Negative 3) Neutral

Table 2 –Significant discrepancies of attachment descriptors across groups

Attachment Descriptors	Non-North American	North American
LOVE	50	21
FEELING	19	10
NORMAL	10	4
TROUBLE	1	5
STRESS	1	4
HAPPY	24	10
MAD	0	12
SAD	11	6
SCARED	3	8

Table 3- Comparison of frequency of caregiver roles

Non-North American	North American
Disciplinarian (3)	Disciplinarian (2)
Nurturer (2)	Nurturer (3)
Encouraging Independence	Encouraging Independence
Teacher	Teacher
Motivator (2)	Protector (2)
Listener	

Table 4- Personality descriptors

<i>Personality Characteristics</i>	<i>Non-North American</i>	<i>North American</i>
<i>Positive</i>	loving (3) caring carefree happy (2) kind gentle sensitive independent good natured	funny (3) comedian fun (2) sensitive well liked passionate (2) kind even tempered curious (2) creative (3) enthusiastic pretty smart cookie
<i>Negative</i>	loud cry messy (2) misbehave annoying (2)	centre of attention motormouth bossy needy bad not the most socially ept
<i>Neutral</i>	infectious following (2) headstrong (2) perfectionist shy (2)	clown princess shy (2) dichotomy active busy ham

Table 5- Relationship Descriptors

<i>Relationship Characteristics</i>	<i>Non-North American</i>	<i>North American</i>
<i>Positive</i>	helping loving fulfilling playful affectionate compassionate pretty good love eachother comforting encouraging	fun enjoyable love (2) loving open intimate challenging affectionate pretty cool compatible
<i>Negative</i>	evil ignoring lacks discipline	stressful not respectful enough
<i>Neutral</i>		complicated

Appendix A- Sample Consent form

**Ryerson University
Consent Agreement**

Master of Arts in Early Childhood Studies, Major Research Paper

You are being asked to participate in a research study. Before you give your consent to be a volunteer, it is important that you read the following information and ask as many questions as necessary to be sure you understand what you will be asked to do.

Investigators:

- 1) Stephen Garfinkel, B.A. (C.Y.C.), Master of Arts candidate in Early Childhood Studies, Ryerson University. (416) 576-5012 or stephen.garfinkel@ryerson.ca.
- 2) Dr. Jason Ramsay, Graduate Program supervisor, Member School of Graduate Studies, researcher, Li Ka Shing Knowledge Institute, St. Michael's Hospital, Toronto.
- 3) Dr. Judith Bernhard, Graduate Program Director, Early Childhood Studies, Ryerson University. bernhard@ryerson.ca.

Purpose of the Study: This study is aimed at better understanding the cultural and ethnic backgrounds of people who have completed the Working Model of the Child Interview (Zeanah, Benoit, Hirshberg & Barton, 1986). The information gathered hopes to improve the interview to better understand parent-child relationships and further support clinicians working with children and families to meet their needs in the future.

Description of the Study:

The following data collection techniques will be employed in this study:

- 1) You will be asked to participate in the Working Model of the Child Interview. Your interview will be audio or video taped.
- 2) You will be asked to fill out a brief questionnaire asking you questions about your cultural or ethnic background. Sample questions include: a) How would you describe your cultural or ethnic background? b) What is your mother's/father's cultural or ethnic background?
- 3) Transcription and review of audio or video taped sessions of the Working Model of the Child Interview.

LOCATION: Interviews will be conducted at Blue Hills Child and Family Centre in Aurora, Ontario or Durham Farm and Rural Family Resources in Uxbridge, Ontario.

TIME: The Working Model of the Child Interview will take 1 hour to complete. The questionnaire will likely take approximately 10 minutes to complete.

What is Experimental in this Study?: "None of the procedures used in this study are experimental in nature. The only experimental aspect of this study is the gathering of information for the purpose of analysis."

Benefits of the Study: This study will provide better understanding of how a parent's cultural and ethnic background may influence their perceptions of their child. This will help researchers better understand parent-child relationships and clinicians to develop effective practices with children and families they work with.

Potential Risks/Discomforts: You may experience some psychological discomfort during the interview; however your wish to take breaks or finish the interview will be accommodated at any time. The interviewer will be a clinician who has been trained to minimize distress during the interview and can intervene if necessary.

Confidentiality: 1) Your names or the names of your children will not be included in the data analysis or final report as they will be assigned a number when received. Only three people, the investigators, will be able to connect client names with file numbers. 2) Audio and videotapes and questionnaires compiled at Blue Hills Child and Family Centre will remain there at all times in your file in a locked cabinet in a locked room according to the Blue Hills client file storage policy. 2) Audio and video tapes compiled at Durham Farm and Rural Family Resources will remain confidential. They will be kept in a locked cabinet, and only the investigators and any researchers directly involved with the study will have access to these files. Once they are transcribed, the original will be kept for a period of 2 years. At the end of this period they will be destroyed using a confidential shredding service.

Voluntary Nature of Participation: Participation in this study is voluntary. Your choice of whether or not to participate will not influence your future relations with Blue Hills Child and Family Centre, it's affiliated centres, or Ryerson University. If you decide that you may participate, know that you are free to withdraw your consent and to stop your participation at any time without penalty or loss of benefits to which you are entitled.

Questions about the Study: If you have any questions about the research now, please ask. If you have questions later about the research, you may contact.

Principal Investigator/Study Coordinator: Stephen Garfinkel
Telephone Number: 416-576-5012

If you have questions regarding your rights as a human subject and participant in this study, you may contact the Ryerson University Research Ethics Board for information.

Research Ethics Board
c/o Office of the Vice President, Research and Innovation
Ryerson University
350 Victoria Street
Toronto, ON M5B 2K3
416-979-5042

Appendix B- Cultural and Ethnic Background Questionnaire (CEBQ)

1. Name: _____
2. Date of Birth: _____
3. Languages spoken in your home: _____
4. Your country of birth: _____
5. Your mother's country of birth: _____
6. Your father's country of birth: _____
7. How would you describe your cultural or ethnic background?

8. How would you describe your mother's cultural or ethnic background?

9. How would you describe your father's cultural or ethnic background?

10. Citizenship status: _____
11. Religious affiliation: _____
12. Are you a member of a cultural or ethnic group? (i.e. place of worship, cultural recreation group, cultural community program) _____
If yes, please indicate name of group: _____

References

- Ainsworth, M.D.S. (1989). Attachments beyond infancy. *American Psychologist*, 44(4), 709-716.
- Ainsworth, M.D.S., Blehar, M.C., Waters, E., & Wall, S. (1978). *Patterns of attachment*. Hillsdale, NJ: Erlbaum.
- Ainsworth, M.D.S., & Marvin, R.S. (1995). On the shaping of attachment theory and research: An interview with Mary D.S. Ainsworth, Fall 1994. *Monographs of the Society for Research in Child Development*, 60(2/3), 2-21.
- American Psychiatric Association. (1994). *Diagnostic and Statistical Manual of Mental Disorders (4th Edition revised)*. Washington: American Psychiatric Association.
- Attachment Across Cultures. (2003). Sharing attachment practices across cultures: Learning from immigrants and refugees. A Project of St. Joseph's Women's Health Centre, Toronto, Canada. <http://www.attachmentacrosscultures.org>.
- Benoit, D., Parker, K.C.H., & Zeanah, C.H. (1997). Mothers' representations of their infants assessed prenatally: Stability and association with infants' attachment classifications. *Journal of Child Psychology and Psychiatry*, 38(3), 307-313.
- Benoit, D., Zeanah, C.H., Parker, K.C.H., Nicholson, E., & Coolbear, J. (1997). Working model of the child interview: Infant clinical status related to maternal perceptions. *Infant Mental Health Journal*, 18(1), 107-121.
- Bernstein, V.J., Harris, E.J., WeLaLa Long, C., Iida, E., & Hans, S.L. (2005). Issues in the multi-cultural assessment of parent-child interaction: An exploratory study from the starting early starting smart collaboration. *Applied Developmental Psychology*, 26, 241-275.
- Bowlby, J. (1969). *Attachment and loss: Vol.1 Attachment*. New York: Basic Books.

- Bretherton, I. (1995). A communication perspective on attachment relationships and internal working models. *Monographs of the Society for Research in Child Development*, 60(2/3), 310-329.
- Bretherton, I., & Munholland, K.A. (1999). Internal working models in attachment relationships: A construct revisited. In Cassidy, J., & Shaver, P.R. (Eds.) *Handbook of attachment: Theory, research, and clinical applications*. New York: Guilford Press.
- Button, S., Pianta, R.C., & Marvin, R.S. (2001). Mothers' representations of relationships with their children: Relations with parenting behaviour, mother characteristics, and child disability status. *Social Development*, 10(4), 455-472.
- Carlson, E. A. (1998). A prospective longitudinal study of disorganized /disoriented attachment. *Child Development*, 69, 1970-1979.
- Carlson, V.J. & Harwood, R.L. (2003). Attachment, culture, and the caregiving system: The cultural patterning of everyday experiences among Anglo and Puerto Rican mother-infant pairs. *Infant Mental Health Journal*, 24(1), 53-73.
- Cassidy, J. (1994). Emotion regulation: Influences of attachment relationships. *Monographs of the Society for Research in Child Development*, Vol. 59, (2/3), 228-249.
- Crowell, J.A., & Feldman, S.S. (1991). Mothers' working models of attachment relationships and mother and child behaviour during separation and reunion. *Developmental Psychology*, 27(4), 597-605.
- Crowell, J.A., & Treboux, D. (1995). A review of adult attachment measures: Implications for theory and research. *Social Development*, 4(3), 294-327.
- Draucker, C.B., & Martself, D.S. (2008). Storying childhood sexual abuse. *Qualitative Health Research*, 18(8), 1034-1048.

- Fonagy, P., Leigh, T., Steele, M., Steele, H., Kennedy, R., Mattoon, G., Target, M., & Gerber, A. (1991). The relation of attachment status, psychiatric classification, and response to psychotherapy. *Journal of Consulting and Clinical Psychology*, 64(1), 22-31.
- Fonagy, P., Steele, H., & Steele, M. (1991). Maternal representations of attachment during pregnancy predict the organization of infant-mother attachment at one year of age. *Child Development*, 62, 891-905.
- Fraley, R.C., & Spieker, S.J. (2003). Are infant attachment patterns continuously or categorically distributed? A taxometric analysis of strange situation behaviour. *Developmental Psychology*, 39(3), 387-429.
- George, C., Kaplan, N., & Main, M. (1985). *Adult Attachment Interview*. Unpublished manual, Department of Psychology, University of California, Berkeley.
- Glaser, B.G., & Strauss, A.L. (1967). *The discovery of grounded theory: Strategies for qualitative research*. New York: Aldine Publishing Company.
- Green, J., & Goldwyn R. (2002). Annotation: Attachment disorganization and psychopathology: New findings in attachment research and their potential implications of developmental psychopathology in childhood. *Journal of Child Psychology and Psychiatry*, 53, 835-846.
- Greenberg, M.T. (1999). Attachment and psychopathology in childhood. In J. Cassidy & P.R. Shaver (Eds.), *Handbook of attachment*, (p. 469-496). New York: Guilford Press.
- Harwood, R.L., Miller, J.G., Irizarry, N.L. (1995). *Culture and attachment*. New York: Guilford Press.

- Harwood, R.L., Schoelmerich, A., Schulze, P.A., & Gonazalez, Z. (1999). Cultural differences in maternal beliefs and behaviors: A study of middle class Anglo and Puerto Rican mother-infant pairs in four everyday situations. *Child Development*, 70(4), 1005-1016.
- Huth-Bocks, A.C., Levendosky, A.A., Bogat, G.A., & von Eye, A. (2004). The impact of maternal characteristics and contextual variables on infant-mother attachment. *Child Development*, 75, 480-496.
- Huth-Bocks, A.C., Levendosky, A.A., Theran, S.A., & Bogat, G.A. (2004). The impact of domestic violence on mothers' prenatal representations of their infants. *Infant Mental Health Journal*, 25, 79-98.
- Jacobvitz, D., Leon, K., Hazen, N. (2006). Does expectant mothers' unresolved trauma predict frightened/frightening maternal behaviour? Risk and protective factors. *Development and Psychopathology*, 18, 363-379.
- Keiley, M.K. (2002). Attachment and affect regulation: A framework for family treatment of conduct disorder. *Family Process*, 41(3), 477-493.
- LeVine, R.A., & Normal, K. (2001). Strange situations in other cultures: An anthropological view of infant-mother attachment. *Human Development*, 33, 73-80.
- Liu, Y.-L. (2008). An examination of three models of the relationships between parental attachments and adolescents' social functioning and depressive symptoms. *Journal of Youth and Adolescence*, 37(8), 941-952.
- Lyons-Ruth, K. (1996). Attachment relationships among children with aggressive behaviour problems: The role of disorganized early attachment patterns. *Journal of Consulting and Clinical Psychology*, 64 (1), 64-73.

- Lyons-Ruth, K., Alpern, L., & Repacholi, B. (1993). Disorganized infant attachment classification and maternal psychosocial problems as predictors of hostile-aggressive behaviour in the preschool classroom. *Child Development*, 64, 572-585.
- Madigan, S., Hawkins, E., Goldberg, S., & Benoit, D. (2006). Reduction of disrupted caregiver behaviour using Modified Interaction Guidance. *Infant Mental Health Journal*, 27(5), 509-527.
- Madigan, S., Moran, G., Schuengel, C., Pederson, D.R., & Otten, R. (2007). Unresolved maternal attachment representations, disrupted maternal behaviour and disorganized attachment in infancy: Links to toddler behaviour problems. *Journal of Child Psychology and Psychiatry*, 48 (10), 1042-1050.
- Main, M. (1996). Introduction to the special section on attachment and psychopathology 2: Overview of the field of attachment. *Journal of Consulting and Clinical Psychology*, 64(2), 237-243.
- Minde, K., Minde, R., & Vogel, W. (2006). Culturally sensitive assessment of attachment in children aged 18-40 months in a South African township. *Infant Mental Health Journal*, 27(6), 544-558.
- Ooi, Y.P., Ang, R.P, Fung, D.S., Wong, G., & Cai, Y. (2006). The impact of parent-child attachment on aggression, social stress and self-esteem. *School Psychology International*, 27(5), 552-566.
- Posada, G., Gao, Y., Wu, F., Posada, R., Tascon, M., Schoelmerich, A., Sagi, A., Kondo-Ikemura, K., Haaland, W., & Synnevaag, B. (1995). The secure-base phenomena across cultures: Children's behaviour, mothers' preferences and experts' concepts. *Monographs of the Society for Research in Child Development*, 60 (2/3), 27-48.

- Posada, G., Jacobs, A., Richmond, M.K., Carbonell, O.A., Alzate, G., Bustamante, M.R., & Quiceno, J. (2002). Maternal caregiving and infant security in two cultures. *Developmental Psychology*, 38(1), 67-78.
- Rosenblum, R.L., Zeanah, C.H., McDonough, S., & Muzik, M. (2004). Video-taped coding of working model of the child interviews: A viable and useful alternative to verbatim transcripts? *Infant Behavior & Development*, (27), 544-549.
- Rosenstein, D.S., & Horowitz, H.A. (1996). Adolescent attachment and psychopathology. *Journal of Consulting and Clinical Psychology*, 64(2), 244-253.
- Rothbaum, F., Kakinuma, M., Nagaoka, R., & Azuma, H. (2007). Attachment and amae: Parent-child closeness in the United States and Japan. *Journal of Cross-Cultural Psychology*, 38(4), 465-486.
- Rothbaum, F., Weisz, J., Pott, M., Miyake, K., Morelli, G. (2000). Attachment and culture: Security in the United States and Japan. *American Psychologist*, 55(10), 1093-1104.
- Rutter, M. (1995). Clinical implications of attachment concepts: Retrospect and prospect. *Journal of Child Psychology and Psychiatry*, 36(4), 549-571.
- Simpson, J.A., Rholes, W.S., Orina, M.M., & Grich, J. (2002). Working models of attachment, support giving, and support seeking in a stressful situation. *Personality and Social Psychology Bulletin*, 28(5), 598-608.
- Sokolowski, M.S., Hans, S.L., Bernstein, V.J., Cox, S.M. (2007). Mothers' representations of their infants and parenting behaviour: Associations with personal and social-contextual variables in a high-risk sample. *Infant Mental Health Journal*, 28(3), 344-365.

- Tronick, E.Z., Winn, S., & Morelli, G.A. (1985). Multiple caretaking in the context of human evolution: Why don't the Efe know the western prescription to child care? In M. Reite & T. Fields (Eds.), *The psychology of attachment and separation*. San Diego: Academic.
- True, M.M., Pisani, L., & Oumer, F. (2001). Infant-mother attachment among the Dogon of Mali. *Child Development*, 72, 1451-1466.
- van IJzendoorn, M.H., & De Wolff, M.S. (1997). In search of the absent father-meta-analyses of infant-father attachment: A rejoinder to our discussants. *Child Development*, 68(4), 604-609.
- van IJzendoorn, M.H., & Kroonenberg, P.M. (1988). Cross-cultural patterns of attachment: A meta-analysis of the strange situation. *Child Development*, 59, 147-156.
- van IJzendoorn, M.H., & Sagi, A. (1999). Cross-cultural patterns of attachment. In J. Cassidy & P.R. Shaver (Eds.), *Handbook of attachment* (p. 713-734). New York: Guilford Press.
- van IJzendoorn, M.H., Vereijken, C.M.J.L., Bakermans-Kranenburg, M.J. & Riksen-Walraven, J.M. (2004). Assessing attachment security with the attachment q-sort: Meta-analytic evidence for the validity of the observer AQS. *Child Development*, 75, 1188-1213.
- Vando, J., Rhule-Louie, D.M., McMahon, R.J., & Spieker, S.J. (2008). Examining the link between infant attachment and child conduct problems in grade 1. *Journal of Child and Family Studies*, 17, 615-628.
- Waters, E. (1995). The attachment Q-set. *Monographs of the Society for Research in Child Development*, 60(2/3), 234-246.

- Waters, E., & Deane, K.E. (1985). Defining and assessing individual differences in attachment relationships: Q-methodology and the organization of behaviour in infancy and early childhood. *Monographs of the Society for Research in Child Development*, 50 (209), 41-65.
- Whitney, J., Easter, A., Tchanturia, K. (2008). Service users' feedback on cognitive training in the treatment of anorexia nervosa: A qualitative study. *International Journal of Eating Disorders*, 41, 542-550.
- Zeanah, C.H. (2007) Constructing a relationship formulation for mother and child: Clinical applications of the working model of the child interview. In Oppenheim, D., & Goldsmith, D.F. (Eds.), *Attachment theory in clinical work with children: Bridging the gap between research and practice* (p. 3-30). New York: Guilford Press.
- Zeanah, C.H., & Barton, M. (1989). Introduction: Internal representations and parent-infant relationships. *Infant Mental Health Journal*, 10(3), 135-141.
- Zeanah, C.H., Benoit, D., Barton, M., Regan, C., Hirshberg, L.M, & Lipsitt, L.P. (1993). Representations of attachment in mothers and their one-year-old infants. *Journal of the American Academy of Child and Adolescent Psychiatry*, 32(2), 278-286.
- Zeanah, C.H., & Benoit, D. (1995). Clinical applications of a parent perception interview in infant mental health. *Child and Adolescent Psychiatric Clinics of North America*, 4(3), 539-554.
- Zeanah, C.H., Benoit, D., Hirshberg, L., Barton, M. (1986). Working model of the child interview: Rating scales and classifications.

- Zeanah, C.H., Benoit, D., Hirshberg, L., Barton, M.L., & Regan, C. (1994). Mothers' representations of their infants are concordant with infant attachment classifications. *Developmental Issues in Psychiatry and Psychology*, 1, 1-14.

④ B-15-143