

African mothers experiences of the “New Beginnings” mother-infant group psychotherapy programme: reflecting on mothering while living in a shelter.

Hasmita Hardudh-Dass

564428

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Supervisor: Dr Katherine Bain

DECLARATION

This work has not been previously submitted in whole, or in part, for the award of any Degree. It is my own work. Each significant contribution to and quotation in this dissertation from the work, or works, of other people has been attributed, and has been cited and referenced.

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ABSTRACT

Infant mental health in South Africa has been receiving more attention in recent years. Mothers appear to be the main caregivers of infants but they face many psychosocial, economic and cultural challenges. There exists very little evidence suggesting that mothers living in shelters or institutions have access to the necessary support and education to help them to understand their circumstances and how this may impact on the attachment with their infant. The New Beginnings Programme, as an early intervention model, is aimed at improving attachment between mother and infant so as to reduce the potential risk of mental health problems later in life for the infants, the mothers and future generations. This evidence based intervention focuses on the mother and her capacity for mentalisation, which refers to the mother's capacity to hold her infant in mind and recognise and respond to the inner states of the infant. The pilot study of the New Beginnings Programme within a South African context took place in two shelters in the Greater Johannesburg area. This particular study formed part of this bigger research effort. The aim of this study was to explore the experiences of the mothers who attended the New Beginnings programme. A secondary aim was to explore these mothers' experiences of the programme within the context of living in a shelter. The adaptation of this programme to a South African context could contribute significantly to bridging the gap in mother-infant attachment which could influence the future mental health of the infant and their ability to foster ongoing healthy attachments later in life. This qualitative study used semi-structured interviews and a narrative analysis from the theoretical perspective of psychoanalytic attachment theory. Thirteen mothers from two shelters participated in this research study.

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Chapter 1: Introduction

Many things can wait. Children cannot.

Today their bones are being formed, their blood

is being made, their senses are being developed.

To them we cannot say "tomorrow".

Their name is today"

Gabriela Mistral

1.1 Introduction and rationale

Numerous studies have revealed women to be more vulnerable to mental health problems citing that a lack of social and emotional support, the perceived inferiority of women's social status, as well as women's exposure to domestic and gender-based violence, has increased women's risk of mental health problems specifically depression and PTSD (Ardenenne & Balakrishna, 2001; Ritva & Punamaki, 2007; Roberts & Lewis, 2000; Tomlinson, Cooper & Murray, 2005). In the traditional cultural climate of Africa, women's social roles as mothers and the stressors that this role poses puts women further at risk (Freeman, 2004). African women are a marginalised and under-researched population, hence, this study will focus on thirteen women who are mothers living in deprived environments, i.e. in two shelters, who are mostly single (two of the mothers are married; one has a boyfriend and one has contact with the father of her children) and unemployed, making them a vulnerable population.

According to Berg (2003) infant mental health in South Africa has been receiving more attention in recent years. Mothers appear to be the main caregivers of infants but they face many psychosocial, economic and cultural challenges. These mothers often present with depression and the expression of this is not encouraged within the communities that they live; hence, they often 'suffer in silence' (Berg, 2003). Research conducted by Tomlinson, Cooper and Murray (2005) in Khayelitsha in the Western Cape, revealed that at the critical 2-month stage post birth, a high proportion of mothers living in lower socio-economic communities demonstrated 'maternal intrusiveness', 'maternal remoteness', and early 'maternal depression'.

These high rates of maternal depression were significantly associated with infant insecure attachment.

“Emotional availability...is conceived as a relational construct...reflecting the adaptive exchanges that regulate emotional communications between infants and caregivers” (Easterbrooks, Chaudhuri & Gestsdottir, 2005. p. 310). This construct supports Baradon and Broughton’s (2005) observations, that a caregiver who is able to emotionally engage with her infant creates the foundation for the infant to regulate its own emotions and to develop empathy. “Emotional availability in infancy helps to set the stage for organized socioemotional regulation in childhood” (Easterbrooks et al., 2005. p. 310). Ziv, Avictar, Gini, Sagi and Koren-Karie (2000) refer to the mother’s inability to adequately respond to her infant’s communications as ‘psychological unavailability’ and they observe the consequence of this to be infants who display signs of insecure and ambivalent attachment. Ziv et al. (2000) elucidate further that in some instances mothers may be ‘highly responsive’ to the infants display of negative emotions, such as crying or distress but they fail to respond to the infants positive displays of affect, such as laughter and smiles. This inability by the mother to be responsive to a continuum of emotional experiences expressed by the infant would be seen as the mother being emotionally unavailable.

Many mothers in South Africa live in impoverished conditions, are single parents and the sole breadwinners of their families. Seventy nine percent (79%) of African mothers in South Africa are single parents and of the entire population of single parents (males and females) in South Africa, 45.6 % are unemployed or not working (Target Group Index, database survey for 2007, cited in South African Survey 2009/2010). Many mothers also face the challenges of being homeless, living with HIV/AIDS or being victims of domestic violence (Freeman, 2004; Rohleder & Gibson, 2006). According to Stats SA (2010) cited in South African Survey (2009/2010), 19.2% of women in South Africa between the ages of 15-49 are HIV positive. There exists very little evidence suggesting that mothers living in shelters or institutions have access to the necessary support and education to help them to understand their circumstances (Wright, 2005) and how this may impact on the attachment with their infant.

Due to the fact that there is no recognised or efficacy-tested group psychotherapeutic treatment in South Africa for attachment difficulties occurring between infants and their caregivers (Bain, 2010); a group psychotherapy programme for mothers and their infants called New Beginnings was piloted in Johannesburg. The New Beginnings Programme has been shown to be effective in increasing the mother's capacity to mentalise about and reflect on her infant (Baradon, 2010). Hence, this type of early intervention could result in scaffolding the mother-infant dyad and thus, reduce the incidence of later mental health impediments in the infants and perhaps even their mothers. Early intervention programmes, and more specifically group interventions have the primary objective of being effective in a short space of time and with limited expenditure (McCrone et al., 2005).

The New Beginnings programme was designed by Tessa Baradon of the Anna Freud Centre in the UK in 2008. It is an early intervention model aimed at improving attachment between mother and infant so as to reduce the potential risk of mental health problems later in life for the infants, the mothers and future generations (Baradon, 2010). It is a 12 session parent–infant psychotherapy group programme, which was initially developed for the mother-baby prison units in the United Kingdom for infants with attachment difficulties and their primary caregivers. The content of the programme includes sessions on pregnancy; 'how does my baby get to know his world; the mothers' experiences of their own childhood, including what they would like to do differently from how their parents/caregivers raised them and issues related to separation and loss. Throughout the programme, mothers are encouraged to reflect on their babies' experiences of them as mothers. The programme is designed to reach mothers and infants, who by virtue of their challenging social, psychological and economic circumstances fall within a high risk category for future mental health problems (Tomas-Merrills & Chakraborty, 2010). The New Beginnings programme specifically takes cognisance of the infants' rapid developmental milestones, the socio-economic and cultural settings and the transient nature of the settings within which the mother-infant dyads operate (Baradon, 2010). This evidence based intervention focuses on the mother and her capacity for

mentalisation, which refers to the mother's capacity to hold her infant in mind and recognise and respond to the inner states of the infant (Fonagy, 2001). This reflective capacity is the cornerstone of healthy mother-infant attachment (Fonagy, 2001).

From September to December 2010 the New Beginnings programme was piloted in shelters for homeless women and their babies in Johannesburg. The facilitation of the New Beginnings programme took place in two shelters in the Greater Johannesburg area. The implementation of this programme is the first of its kind in South Africa. Dr Katherine Bain from Wits University is the coordinator of this study and the programme is receiving Carnegie funding. One of the aims of this pilot was to explore the current psychosocial, cultural and economic issues effecting attachment between mothers and infants living in deprived environments. Another aim was to evaluate the efficacy of the programme in improving the mother-infant attachment relationship so as to reduce the risk of later mental health problems for the infants. This particular study formed part of this bigger research effort and had the aim of exploring the mothers' experiences of the programme, including their perceptions of how being mothers in a shelter may have influenced this experience. Exploring how South African mothers experienced the New Beginnings programme, given that the programme was developed in England for the Mother-Baby units in prisons (Tomas-Merrills, & Chakraborty, 2010), would provide valuable information into the effectiveness of the programme within a South African context which is diverse on many levels. This is especially so for mothers living in shelter settings and the challenges that they may encounter with mothering whilst in a shelter setting. The adaptation of this programme to a South African context could contribute significantly to bridging the gap in mother-infant attachment which could influence the future mental health of the infant and their ability to foster ongoing healthy attachments later in life (Bretherton, 1990; Fonagy, 2001). The long term impact of healthy mother-infant attachment could include future generations of mothers and infants.

1.2 Aims

The aim of this study was to explore the experiences of the mothers who attended the New Beginnings programme. A secondary aim was to explore these mothers' experience of the programme within the context of living in a shelter.

Research questions:

- What are the mothers' experiences of the efficacy of the group?
- How did the mothers experience the content and therapists of the group psychotherapy?
- How does the context of living in a shelter influence the mothers' experiences of mothering?
- How does the context of living in a shelter influence the mothers' experience of being in a psychotherapy group, aimed at the relationship between the mother and her infant?

1.3 Methodology

This qualitative study used semi-structured interviews and a narrative analysis and it explored the mothers' stories of their experiences of the New Beginnings programmes from the theoretical perspective of psychoanalytic attachment theory. "From a narrative psychological perspective, concepts of self and morality are inextricably intertwined insofar as we are selves only in that certain issues matter for us" (Crossley, 2007, p. 134). According to Crossley (2007) narrative analysis is interested in creating links between experience, meaning, social structure and culture. Similarly, according to Cartwright (2004) narrative analysis is focused on three key elements i.e. the search for core narratives; matching narratives with transference-countertransference impressions; and tracking key identifications and object relations within dominant interview narratives. Therefore, although individual narratives were gathered, the research was not entirely focused on individual discourses or voices. Rather it anticipated that shared narratives would be identified and explored which would represent something of the theoretical constructs proposed in this research.

The data that was analysed was the transcripts of the semi-structured interviews conducted with the mothers and caregivers after the groups (by myself as the research assistant in 2010). The data was collected in November 2010 to January 2011. The New Beginnings programme had been implemented in September to December 2010 by Dr K Bain who was assisted by three co-investigators and one additional research assistant involved with the semi-structured post-group interviews. The groups were facilitated at two sites, which for the purposes of this study will be referred to as the first and the second shelter. Sixteen mothers participated in the New Beginnings groups. Eleven of the thirteen mothers from the first shelter and two of the three mothers from the second shelter participated in this research study.

Informed consent for the gathering of this data in the previous study was gained using a formal (signed) form. (See Appendix 3 for the original informed consent signed by participants of the New Beginnings research project). Participation in the original study where data was gathered was voluntary. Ethical clearance for this study was granted in conjunction with the original study in 2010– ethical clearance number M10562.

1.4 Theoretical framework

The theoretical framework within which this study is situated is psychoanalytic attachment theory. The New Beginnings Programme, as mentioned previously, is specifically designed to intervene in mother-infant relationships at the point where attachment and affectional bonds are being forged. The aims of this programme are to encourage normal attachment behaviours in the infant and to develop the mothers' insight into their own childhood experiences and gain an understanding of how this is impacting on their relationships with their infants. A further objective is also to develop the mothers' mentalising capacities towards their infants so that they can become more mindful of their infants and the infants' attachment needs. This type of reflective parenting approach (Allen, Fonagy & Bateman, 2008) is primarily aimed at strengthening the attachment relationship by virtue of helping the mother mentalise in relation to her child. It is facilitated in a group context which then acts as a model to mothers regarding caregiving. The use of countertransference in the

group context is the vehicle through which unconscious past experiences get reworked and symbolically significant relationships are relived.

Psychoanalytic attachment theory is the theory that guided the development of the New Beginnings programme, thus it seemed appropriate to use this theory when exploring the participants' experiences of the programme.

Chapter 2: Theoretical framework

2.1 Introduction

The theoretical framework within which this study is situated is psychoanalytic attachment theory. This chapter will cover the following areas: attachment in shelters; the intergenerational transmission of attachment; and mentalising and development of the self.

2.1.1 Attachment in shelters

According to Bowlby (1980) attachment theory generalises that attachment behaviours are seen to be any behaviour that facilitates a person gaining and retaining proximity to another person. Initially this proximity occurs between mother and infant and later between adult and adult. It is the former that this study is interested in, i.e. the affectional bonds or attachments between mother and infant. Attachment behaviour is seen as distinct from feeding behaviour and sexual behaviour in that the behavioural system involves inherent motivation and is not reducible to another drive (Fonagy, 2001). Bowlby opposed theories that suggested that attachment behaviour and bonding in the mother-infant relationship was a secondary drive based on achievement of oral needs (Fonagy, 2001). "Bowlby was the first to recognise that the human infant enters the world predisposed to participate in social interaction..." (Fonagy, 2001. p. 7). Attachment behaviour is also goal-orientated; however this goal differs from object relations theory in which the goal is the object. In attachment theory the initial desired goal is proximity to the mother and later a more psychological goal is one of emotional attachment/bonding. Bowlby (Fonagy, 2001) observed further that an infant, who did not attain secure attachment and was exposed to maternal deprivation, would be at high risk of detachment, distress and mental disorders. This attachment should be asymmetrical in that the infant seeks security from the mother and not the other way around (Fonagy, 2001).

The healthy mental development of the infant has its roots in this early caregiver relationship between mother and infant. The impact of this attachment is life-long.

This becomes the predictor of how children go on to experience relationships and develop effective emotional regulation and sense of self (Green, 2003). Healthy attachment also facilitates the child's interest and active engagement in exploring their world (Fonagy, 2001).

Whilst it is likely that many parents may be able to provide their children with healthy experiences that lead to secure attachment, this study locates itself in settings that are often, but not always, emotionally and psychologically neglectful of the infant and compounded with socio-economic challenges. Mothers in these settings are primarily concerned with survival and very little attention may be directed to the psychological and emotional needs of the infant and the mother-infant relationship (Berg, 2003). Of the mothers who had participated in this study, the majority of them reported, as part of the history taking, that they had experienced physical abuse as children and many reported to having experienced partner violence/rape. According to (De Voe & Smith, 2002):

A deficit model of parenting in battered women has been reported based on findings that some (sic) victims of domestic violence are more likely to be aggressive toward their children..., display less warmth in their parent-child interactions..., and be less consistent in their parenting efforts than are non abused mothers...It is not surprising that parent-child relationships can be deeply affected when battered mothers are forced to cope with their own physical injuries and emotional reactions to their victimization...In addition, when victims of domestic violence are necessarily preoccupied with basic safety and survival, their ability to attend to the emotional needs of their children is likely to be temporarily compromised... (p. 1077-1078).

It is important to bear in mind the emphasis on 'some' victims of domestic violence, as these authors also concluded that not all mothers who experience domestic/partner violence become neglectful or aggressive parents. However, they do fall into a higher risk group of mothers who may engage in neglectful and aggressive parenting. Howe (2011) concurs with this and details instances which may trigger unresolved feelings for the caregiver from their histories, which can impact negatively on the attachment and affectional bonds with their children.

“These unresolved feelings can be heightened even further when the parent is also in a violent relationship, in the throes of an ugly divorce, trapped in a war zone, feeling depressed, or burdened by relentless poverty” (Howe, 2011. p. 153). According to Howe (2011), under these intense, stressful conditions parents may struggle to cope. Defenses are activated to help the parent escape from her painful mental states, which can be triggered by the distress and attachment needs of the infant. Mothers may avoid memories and feelings which remind them of these unresolved matters. They may foster a defensive mental state which then precludes their capacity to process information generated in relationships specifically the mother-infant relationship. ‘Abdicated caregiving’ (Howe, 2011. p. 153) can therefore occur when the parent goes mentally ‘off-line’ under the stress of parenting itself.

Howe (2011) refers to two distinct types of parenting that emerge under these stressful conditions, i.e. ‘dysregulated caregiving’ and ‘constricted caregiving’. In the former the parent feels overwhelmed by the potential surfacing of old memories and fears. They also feel helpless, vulnerable and not in control. They might describe their children to be unmanageable and out of control. In the latter type of parenting, parents might not lose control however; they may abdicate responsibility for the caregiving. Thus when a child communicates their needs through crying the parent may leave the room, put headsets over their ears or ignore the child’s cries in other avoidant ways. In some instances some parents might not believe that their children need them or fear them, which is likely a part of their tendency to employ avoidant defenses.

Both of these types of caregiving, which fail to meet the child’s security and safety needs and which fail to regulate the child’s emotions, give rise to disorganized infants who may experience heightened arousal and possibly the development of psychopathology or even trauma (Howe, 2011). Howe (2011), citing Solomon and George states:

Fear pervades the internal working models of disorganized children. It dysregulates their emotions, overwhelms their cognitive capacities, and

damages their ability to develop an integrated state of mind with respect to all attachment matters. (p. 155)

Thus the impact of insecure patterns of attachment as a result of poor, unhealthy or neglectful caregiving/parenting is poor developmental outcomes for infants and includes the infant feeling unsafe, anxious, disengaged and disinterested in exploring their world, having restricted emotional expression, distress and disengagement from parents and at an extreme end of the continuum, dissociative disorders (Joyce, 2005).

2.1.2 Intergenerational transmission of attachment

Bowlby (cited in Bretherton, 1990) refers to the transactional patterns that develop between the caregiver and the infant, that are internalised by the infant, as 'internal working models' of self and other in the relationship. These internal working models function as a map for the infant to navigate the relationship with the caregiver. Where there is a distortion in the parent-infant relationship "...defensive processes may interfere with the adequate development and functioning of working models in the child" (Bretherton, 1990. p. 237). If these interactions are distorted sufficiently by the defensive processes and if the parent fails to respond to the infant in a helpful and informed way, the infants' construction of adequate working models becomes distorted. "Thus providing a potential explanation for the intergenerational transmission of insecure attachment relations in those cases where the parent has not been able to work through a rejecting or neglecting attachment relationship experienced in childhood" (Bretherton, 1990. p. 237).

Bowlby (cited in Bretherton, 1990) suggests that it is most likely parents who have experienced insecure patterns of attachment with their own caregivers, who will develop inadequate patterns of communications with their infants; thus supporting the notion that patterns of parenting can be intergenerationally transmitted. A parent with an insecure attachment style may fail to read the signals transmitted by the infant and thus respond inadequately. This might leave the infant confused and contribute to the infant's struggle to 'get it right' and to develop a well organised internal working model. "The parent, it would seem is condemned to repeat the tragedy of his own childhood with his own baby in terrible and exacting detail"

(Fraiberg, Adelson & Shapiro, 1980. p. 88). According to Fraiberg's well-known paper, *'Ghosts in the Nursery'*, parent-infant interventions were designed to intervene at the level of the intergenerational transmission of attachment and to attempt to create meaningful links between the parent's past and present in the hope of exorcising the ghosts that invade the nursery, which often disturb, sometimes drastically, the parent-infant relationships (Allen et al., 2008; Fonagy, 2001). Fraiberg, cited in Allen et al. (2008) views the baby as "a silent partner in a family tragedy...burdened by the oppressive past of his parents from the moment he enters the world" (p. 245). According to Allen et al. (2008) these ghosts characterise the absence of mentalising and the presence of parental defences such as projection. Fraiberg's work conveys the essential message that parents need help, first to recognise the ghosts, second to explore their meaning and develop insight and thirdly to lay them to rest so as to facilitate healthy parent-infant relationships and ultimately, hopefully, securely attached babies (Allen et al., 2008). "We move back and forth, between past and present, parent and baby, but we always return to the baby" (Fraiberg cited in Allen et al., 2008. p. 153). The New Beginnings Programme is an intervention that has similar aims and objectives, in that it hopes to interrupt the intergenerational transmission of insecure attachment styles from mother to infant.

The New Beginnings Programme aims to intervene at the point where the internal working models of the infants are being strongly influenced by the mother-infant relationship and this happens from birth to approximately 18 months, although Bowlby suggests that this is most significant around 9 months of age (Bowlby, cited in Bretherton, 1990). The supportive experience of being in a psychotherapeutic group and exploring how one's own childhood may influence the mother-infant relationship could spare the infant the potential re-enactment of the mother's insecure attachment patterns (Reynolds, 2003). The infant could develop healthy, secure attachment patterns despite the mothers own childhood experiences and perhaps her failure to have reworked this. According to Allen et al. (2008):

...mentalising develops best in the context of secure attachment relationships and, concomitantly, under conditions of optimal emotional arousal...we [therapists] endeavour to create these same conditions in the treatment milieu [group context]. That is, for mentalisation to flourish, patients must have a

basic sense of safety and trust in each other as well as in us as clinicians. (p. 298).

The supportive 'holding environment' offered by the therapists and the structured nature of the psychotherapy group could facilitate some reconstruction of healthy mother-infant attachment and thus contribute to healthy organised intergenerational transmissions of attachment (Bretherton, 1990).

2.1.3 Mentalising and development of the self

According to Fonagy, Gergely, Jurist and Target (2002), attachment theory provides some empirical support for the idea that an infant's sense of self develops as a result of the affective quality of its relationship with its primary caregiver. Furthermore, attachment theory is not the end point but rather a revolving representational system which is produced to aid in human survival. "Mentalisation is intrinsically linked to the development of the self, to its gradually elaborated inner organisation, and to its participation in human society, a network of human relationships with other beings who share this unique capacity" (Fonagy et al., 2002. p. 3). 'Reflective function' is the operationalisation of these mental capacities that create mentalisation. According to Fonagy et al. (2002), mentalisation, as opposed to being merely a cognitive process, essentially develops through understanding the affects of the primary-object relations. "Affect regulation, the capacity to modulate affect states, is closely related to mentalisation in that it plays a fundamental role in the unfolding of a sense of self and agency" (Fonagy et al., 2002. p. 4).

Reflective functioning as an operationalisation of mentalisation allows for a means by which interpretations of one's own and other mental states can be measured. This includes the mother's capacity for narrating her understanding of her own and her infant's "actions in terms of beliefs, desires, plans and so on" (Fonagy et al., 2002. p. 27). Reflective function is not to be confused with introspection or self reflection: "The shape and coherence lent to self-organisation by reflective function is entirely outside awareness, in contrast to introspection, which has a clear impact on experience of oneself" (Fonagy et al., 2002. p. 27).

The converse of reflective function is nonreflectiveness (Fonagy et al., 2002). These theorists propose that nonreflectiveness arises out of conflict present in interpersonal relationships. This often results in behaviour characteristic of personality disordered adults and characterological difficulties in children. “Abnormalities of parenting represent but one route to limitations on reflective functioning” (Fonagy et al., 2002. p. 63). The result of this could be disorganised attachment in the infant. Disorganised attachment tends to result when the caregiver is either emotionally detached or over involved with the infant and the affectional bonds are characterised by ambivalence and insecurity. This places the infant at a higher risk for psychopathology (Fonagy, 2001).

Fonagy, cited in Allen et al. (2008) conducted extensive research with pregnant mothers with the aim of gaining some understanding on how attachment security is mediated through mentalisation. The research question was: “What are the origins of parental mind-mindedness?” (Allen et al., 2008. p. 99). They proposed that infant attachment security was in part transmitted by a securely attached parent’s capacity for mentalisation. The two factors in the research that they focused upon were: a) the parents’ internal working models; and b) the parents’ capacity to reflect on their child’s mental state. This model of the intergenerational transmission of attachment was further validated by other therapists such as Slade and colleagues (Allen et al., 2008). Commenting on good enough parenting, Slade, Grienenberger, Bernbach, Levy and Locker (2005) state that “it is proposed that it is her [the mother’s] capacity to understand the nature and function of her own as well as her child’s mental states that allows her to create both a physical and psychological experience of comfort and safety for her child” (p. 284). The mother’s observations of the continuous changes in her child’s mental state, and her capacity to represent these first behaviourally, and later verbally and through play, is at the core of sensitive caregiving, and is essential to the child’s development of his own mentalising capacities (Slade, 2005). According to Slade (2005) the absence of this type of caregiving may lead to compromised developmental processes in the child and facilitate the development of psychopathology instead.

Schore (2003) refers to the misattunement of the primary caregiver towards the infant that result in ruptures to the bonds of attachment. Infrequent or short term misattunement may not have such a profound effect on the infants' development of self. However, prolonged and intense dysregulations in attunement may lead to related levels of psychopathology. Schore (2003) suggests that the caregivers' ability to regulate and monitor her own affect is essential in counteracting the negative effects of low intensity dysregulations. "The reattuning, comforting mother and infant thus dyadically negotiate a stressful transition of affect, cognition and behaviour...in which the participation of the caregiver is responsible for the regulation of the reparation of dyadic misattunements" (Schore, cited in Schore, 2003. p. 33). However, Schore (2003) further explains that this reattunement offered by the mother to repair the dysregulation is not the only requirement for the establishment of the infants' security. It's the amplification of the positive effects and communications of the attachment that significantly influence affect regulation in the infant.

Explaining this type of dysregulation in the mother-infant dyad further is Slade et al. (2005) citing Lyons-Ruth and Spielman who describe caregiver behaviour to include the mother's capacity to regulate the infant's fear and distress and her failure to do so. When a child has fear or distress it is part of the mothers' role to provide a secure base for the infant, so as to effectively regulate these feelings in the infant. The mother's capacity to manage this heightened arousal in the infant is crucial for the infant's development of self. However, in terms of the intergenerational transmission of attachment, Grienberger, Kelly and Slade (2005) describe it as follows:

Unresolved trauma and loss in mothers may result in multiple and incoherent internal working models of attachment that are often characterised by unintegrated fear, anxiety, or hostility. Frightened and frightening maternal behavior emerges as the intensity of the attachment relationship stimulates the emergence of dissociated affect left over from the parent's own early attachment relationships (p. 300).

It is therefore theorized that in cases where the mother holds unresolved trauma and loss, the mother or caregiver is both the root cause and the solution to the infants'

fears and distress. Extensive studies cited by Grienenberger et al. (2005) validate this, in that the mother's insecure and disorganized attachment is often transferred onto the infant and significantly impacts on the infant's secure base. One of these studies cited by Grienenberger et al. (2005) is that of Lyons-Ruth who unveiled evidence that the mothers' disattunement and lack of capacity to self-regulate and to regulate the emotions of the infant produces intense frightening feelings and behaviour in the infant who then has little hope of influencing the attachment figure at times of her distress. "A mentalising stance is also unlikely to develop in a child who generally feels treated as an uncared-for physical object" (Fonagy et al., 2002. p. 353). Under these conditions when the infant experiences the caregiver's failure to produce adequate thoughtful, facial or verbal mirroring, the infant is less likely to develop a capacity for reflective functioning and representation-building. This last statement highlights the psychological processes which underlie the infant's capacity to develop mentalisation, and the operationalisation of mentalisation as mentioned in the beginning of this section which is reflective function (RF). Basically, mentalising is becoming aware of one's own internal state and that of others, asking oneself 'why did I do that?' or 'did I hurt her feelings?' These types of questions help you to make sense of behaviour – your own and that of others. Slade (2005) citing Target states it quite simply: "Mentalization integrates ways of knowing that are at once cognitive and affective; it is, in effect, the capacity to think about feeling and to feel about thinking" (p. 272).

From the above discussion it is clear that mentalisation will not emerge in emotionally neglectful caregiving relationships. Rather, it develops in attachment relationships which engender a sense of trust and safety in the infant. The long-term benefits of developing a mentalising capacity are firstly experienced by the caregiver and then the infant. The benefit is then transferred through the secure attachment relationship to the infant. Then both mother and infant can move forward and develop fulfilling, satisfying relationships later with others. "Mentalising – each person having the other's mind in mind – lies at the heart of intimacy" (Allen et al., 2008. p. 318).

The New Beginnings Programme may be seen as a mentalisation development intervention which begins with the mothers, in order to help them to develop greater awareness of their own mental states and then subsequently for them to begin to mentalise about their infants and the infant's feelings, desires and behaviour (Allen et al., 2008) Ultimately the aim of the programme is to enable mothers to offer their infant a more secure attachment base. It is hoped that interventions such as this one will enhance the mothers and infants development of self, leading the infant perhaps to engage in healthy emotional relationships later down the line as an adolescent and then as an adult.

Overall, this study is situated within a psychoanalytic attachment theoretical framework. Certain conditions need to be present for the infant to feel securely attached so as to be able to develop healthy attachment relationship later as an adolescent and then as an adult. These conditions include the caregiver being able to mentalise and have a capacity for reflective functioning, which is about helping to regulate the infants' feelings and behaviour and allowing the infant proximity to the caregiver. This early relationship, which influences the development of effective emotional regulation and a sense of future relationships, is achieved through the construction of internal working models for the infant. These internal working models act as a guide or a map of patterns of future relationships. Extremes of failure in caregiving may lead the infant to develop insecure attachment and/or psychopathology where the infant's heightened arousal remains activated and dysregulated. The mother's capacity to hold her infant in mind and to regulate his emotions including fear and worry is influenced by her own attachment experiences in childhood and her capacity to understand and regulate her emotions. In order to achieve this, the mother needs to gain insight into the impact of this intergenerational transmission of attachment on the mother-infant relationship. Living in a shelter context may have a significant impact on the caregiver's capacity for mothering; mentalising and for creating a secure attachment base, so as to develop a healthy mother-infant relationship.

Chapter 3: Literature review

3.1 Introduction

Since the New Beginnings programme facilitated in the UK developed from a psychoanalytic attachment perspective and was designed as a mother-infant group psychotherapy intervention to be facilitated in a deprived environment it makes sense that this study adheres to the same perspective. This chapter will cover the following areas: general parenting experiences in deprived and shelter settings; parent-infant work and group therapy in South Africa; mother-infant psychotherapy with a focus on groupwork; and an overview of the New Beginnings programme.

3.1.1 General parenting experiences in deprived and shelter settings

Tomlinson, Cooper and Murray (2005) question the level of parenting that can be expected to take place under the challenging conditions often associated with living in shelters and deprived environments. Women's social status in South Africa and internationally is often described as being one of inferiority and subjugation more specifically in impoverished environments (Andrenne & Balakrishna, 2001; Meadows-Oliver, 2003; Tomlinson et al., 2005). These authors further state that women are often exposed to gender-based atrocities and their vulnerabilities are further compounded by a lack of social and emotional support. They are at higher risk of mental health problems (Meadows-Oliver, 2003). Tomlinson et al. (2005) postulate that all of the above factors have a direct effect on mothers' capacity for infant caregiving. Their extensive study on mothers in Khayelitsha also revealed an alarming high rate of post-partum depression which is 3 times higher than amongst urban mothers. However, in respect of secure infant attachment, their findings revealed, surprisingly, high rates of secure attachment despite these adverse socio-economic conditions. They postulated one plausible reason for this outcome could be the traditional social and cultural organisation of African communities which stresses collectiveness and 'ubuntu' in raising children.

In sheltered environments, such as the ones in which this study is located, mothers can often find themselves removed from their community and family support and this

can compound their challenges as they would be expected to care for their children by themselves as well as to provide for their material and social wellbeing (Meadows-Oliver, 2003).

Tomlinson et al.'s (2005) findings were of high rates of disorganised attachment, which was evident in about 25% of the population under study. They attributed the mothers' internal and external psychological states as contributing to this. These could include the mothers' experiences of family abuse/violence and HIV/AIDS.

These contextual challenges best describe those of the mothers who did participate in the original study. Eleven of the mothers were HIV positive; several of them had been exposed to domestic and community violence which included child abuse and neglect, rape and incest. Furthermore, these mothers describe a lack of support from the other parent as well as from their extended families. Many of them describe themselves to be in a situation where they feel alone and are struggling.

Meadows-Oliver (2003), in a study on 'Mothering in public: A meta-synthesis of homeless women with children living in shelters', found that for most homeless mothers, entering a shelter was a last resort as they had tried to stay with friends and relatives first. Protective mothering was the main mothering that took place and as such mothers and children were in almost 24 hour close proximity to each other. The children were exposed to the mothers' myriad of emotions (Meadows-Oliver, 2003). Mothers at the shelters immediately experienced strong feelings of loss at being in the shelter. This loss was not only for their homes but also for their privacy, freedom, parental authority and respect from others. Finally, these mothers had to develop survival strategies just to cope in these shelters let alone in other areas of their lives. If trust was established then many of these mothers were able to find solace and support amongst the other mothers who came to be regarded as 'family' and an essential source of support to each other (Meadows-Oliver, 2003).

As mentioned previously, poverty, HIV/AIDS, poor socio-economic conditions and interpersonal and community violence leave little room for mothers to reflect on the inner states of their infant when all their attention is focused on day-to-day survival (Berg, 2003). "In a community (Khayelitsha) where unemployment is unimaginably

high, where families are disrupted, where there is no food, the emotional life of the infant is not a priority” (Berg 2003. p. 268).

The New Beginnings Programme as a potential mother-infant group psychotherapy intervention model for South African mothers and infants could offer a cost effective and time saving intervention if rolled out in many impoverished and under resourced settings such as in clinics and shelters. However, it has the enormous task of providing evidence based reports that highlight its effectiveness within a South African context. This study hopes to contribute toward this greater goal by examining the experiences of the groups’ participants. A positive though, is that as a group intervention modality, it might already give credence to collective thinking and community child rearing which is part of the South African culture of child rearing (Berg, 2003).

3.1.2 Parent-infant work and group therapy in South Africa

Group psychotherapy may be considered an effective method of treatment, which is also cost effective. According to an extensive study undertaken by Lazarus & Freeman (2009):

Peer support offered through group psychotherapy appears to offer a relatively low-cost, but apparently effective mental health intervention at primary care level. Barriers to participation (such as transport costs, time of week/day) may however, restrict the reach and effectiveness – subsidising attendance may be a cost effective use of resources (p. 66).

According to Corey (1990) group psychotherapy is a re-education process that explores the participant’s awareness, both of the conscious and unconscious. It further explores both the past and the present with the primary objective being to redress those behavioural and emotional impediments that affect one’s functioning. Group psychotherapy has many goals which include to develop trust of others and of self; to develop self-awareness, self regulation and a firm sense of identity; to recognise the universality of problems and issues affecting a group of individuals who share common needs and challenges; to explore alternative ways of doing things and managing normal developmental issues; to explore different styles of

relating and develop the necessary social skills; to make commitments to change certain behaviours and make plans for these; and to become sensitive to the needs and feelings of others (Corey, 1990).

Psychoanalytic group psychotherapy focuses on the unconscious, past experiences and the reliving of symbolic significant relationships (Corey, 1990). This study explores how the mothers who participated in this programme describe this reliving of symbolic significant relationships as being part of their experiences. As mentioned previously in this chapter, Fraiberg (1980) refers to these symbolic significant relationships as 'ghosts in the nursery' and asks "How is it that the ghosts of the parental past can invade the nursery with such insistency and ownership, claiming their rights above the baby's own rights?" (p. 89).

There is a multitude of evidence recorded around the effective utilisation of group psychotherapy internationally (Corey, 1990; James, 2005; McCann, et al., 2005; Reynolds, 2003; Ritva, & Punamaki, 2007). However, the picture in Africa and South Africa is dismal as either not much evidence exists of effective group psychotherapy interventions or group psychotherapy interventions have been poorly utilised in South Africa. According to a study conducted by Nel, Rich and Joubert (2007) group psychotherapy is not effectively used in South Africa as an effective intervention method. "An electronic search of articles in the *South African Journal of Psychology (SAJP)* bears testimony to the fact that very limited research is available regarding the use of group psychotherapy as only 3 articles dealing with group therapy were published since 1987" (Nel et al., 2007. p. 285).

The challenge of mother-infant group psychotherapy interventions in South Africa could be considered to be the use of western models within a uniquely culturally diverse melting pot such as South Africa.

Several interventions have been designed and implemented by mental health services nationally in South Africa to cater for the specific population of mothers and their infants. These interventions have focused on the mother-infant dyad on a one-to-one basis. These include the 'Baby Mat' project at Alexandra Clinic and the parent-infant services at Rahima Moosa Mother and Child Hospital (Bain, 2010). The University of Cape Town is also involved in providing parent-infant

psychotherapy at the Red Cross Children's Hospital and at Khayelitsha Clinic (Berg, 2003). These interventions, as individual dyad services, can be therapeutically effective, but are not cost effective and can be time consuming considering the limited human resources generally experienced within the public mental health sector. Hence, the move within the field of parent-infant psychotherapy towards the use of group therapy in order to reach greater numbers of mothers and infants.

3.1.3 Mother-Infant psychotherapy with a focus on groupwork

According to Baradon and Joyce (2005), parent-infant psychotherapy is an effective intervention aimed at facilitating the optimal emotional and psychological development of an infant. Psychodynamic psychotherapy interventions focus on both conscious and unconscious elements of the mother-infant dynamic. Baradon and Joyce (2005) outline the general and specific aims of psychotherapy when focusing on the parents. This includes to “enable parents to reflect upon states of mind in themselves, in their infant and in the relationship between them” (p. 25). Reynolds (2003) introduces the idea of ‘mindful parenting’ facilitated in a group context. Reynolds (2003) builds upon Fonagy's idea of mentalising:

Evocative moments from the group experience are interwoven in an effort to make plain the ways that Mindful Parenting seeks to restore, cultivate, and sustain the most basic verbal and non-verbal, affective contacts between parent and child (p. 35).

Reynolds's (2003) innovative Mindful Parenting programme encapsulates all that this study aims to explore. Based on basic assumptions that the infant's mental health finds roots in secure attachment; the mothers' reflective capacity predicts the infants psychological and emotional developmental outcomes and the prevention of psychopathology in children is nestled within the mothers' capacity for meaningful reflection both of herself and of her infant.

Apart from the time and cost effectiveness of group psychotherapy interventions, both Baradon (2005) and Reynolds (2003) concur on the therapeutic benefits of a psychoanalytic parent-infant psychotherapy intervention process. Reynolds (2003) citing Winnicott describes the group experience as creating a potential analytic space

which facilitates the flow of parent-infant attachment and exploration whilst attempting to deepen this relationship within the context of mindfulness and safety.

The therapists and co-therapists' key roles would be to create the conditions necessary for these experiences to unfold. James (2005)

Co-therapists support and reinforce behaviours and attitudes that help mothers and babies to join into the group's shared psychic life. Interventions are framed to develop an intimate network of communications, so that the group becomes an attachment object for vulnerable mothers and babies (p. 127).

The conditions set in the group serve as a model to mothers regarding their caregiving. Furthermore, the use of counter-transference assists the group members to understand, reflect on and integrate past experiences into the here-and-now so as to facilitate the infants developmental adaptation and so that 'good enough' caregiving can be achieved by the mothers, (Baradon, 2005). The conditions of the group that fosters the above include structured physical and psychological space.

There is debate amongst various theorists and clinicians as to the focus of this kind of work. While Baradon (2005) states that it is of crucial importance in mother-infant psychotherapy that the focus is on the mother-infant *relationship*: "The interactions between the parents and their baby represent *their* unfolding relationship" (Baradon, 2005. p. 28). Salo (2007) is of the view that the *baby* should be the focus of the interventions. Both Baradon (2005) and Salo (2007) put forward important aspects and it may be worthwhile to keep both ideas in mind.

Salo (2007) citing Lieberman, Silverman and Pawl differentiates between what she terms *mother-infant* psychotherapy and *infant-mother* psychotherapy groups. In mother-infant psychotherapy, she suggested that the therapist's core interest is in understanding how the mothers' experiences have influenced her relating to her infant in terms of the infants feelings and behaviour. The role of the infant in the therapy may be seen as that of a protagonist whose behaviour and temperament in the room provokes meaningful interactional difficulties for the mother.

Salo (2007) questions the long-term sustainability of any changes in reflective functioning or mentalising that occurs in these mother focused interventions, observing that mothers who are depressed and emotionally unavailable to their infants' feelings and behaviours can rarely implement change through insight alone and that active changes to their internal object relations needs to take place so that they can develop more of a '*relational knowing*' (p. 974) in respect of the infant-mother interaction. Salo (2007) citing Lyons-Ruth described this relational knowing as "the implicit understanding of relationships" (p. 974). This implies that when the parents' ambivalence of their lack of confidence and competence in knowing their infant can be dispelled than relational knowing can begin to develop where the parent sees the infant as separate from themselves and their bodies and they develop an empathy for their infants unique internal state.

One could hypothesise this to be relevant to the mothers in this study. Most of the mothers who were interviewed for this study appeared depressed and this seemed to be compounded by additional challenges that they face, including a lack of family and partner support and their struggle to secure some material support in terms of basics such as food but also including employment. In the cases of depressed mothers, preoccupied with external concerns, she advocates for a more direct, hands-on approach. Like the New Beginnings programme (Baradon, 2010), the *infant-mother* psychotherapy groups developed by Salo (2007) and associates in Melbourne, Australia are focused specifically on the infant-mother interaction and specifically on the observations of the infants who are seen to have minds, capacities for empathy and agency. This understanding of the infant as a subject creates a different dynamic in the psychotherapy in that the therapist talks *to* the infant and not *about* the infant. The therapist thus contains the infant and encourages the infant to engage with the mother through interpreting for the mother the infant which the mother may be able to hear thus activating those parts of the infants' inner world that has been excluded previously from any containment offered by the mother. It is the objective that through this process, the disturbance in the mother-infant relationship may be worked through. The therapist's interaction with the infant also allows for modelling. A physical holding is also described by Salo (2007, citing Cramer) in that, at times, the therapist physically holds the infant whilst

creating a therapeutic alliance with it. Baradon et al. (2008) recommend that therapists' interaction with babies should be thoughtfully and carefully managed, in order to not provoke envy in the mothers.

Overall, given the variety of opinions, research and studies focusing on this kind of psychotherapy, it appears that the focus needs to be flexible in order to shift from the mother-infant relationship, to the mothers' self understandings, to the infants' needs and communication and back to the relationship. It would thus seem that all are important foci.

3.1.4 The 'New Beginnings' programme

Baradon (2003) states that parent and infant psychoanalytic psychotherapy involves the parents (specifically the mother as the primary caregiver) and the infant as well as the therapist in a three-way relationship. The mother contributes a myriad of feelings and thoughts which have developed through her own childhood experiences, her current relationships and her hopes and wishes for her infant and for herself as a mother. It is the objective of the psychotherapy to transform these thoughts and feelings into behaviours and healthy attachments with the infant. The infant contributes his/her attachment needs and potential for development of the self. Baradon (2003) defines the therapist's role as that of observer and as an object that the mother can project onto. "The mother's feelings and behaviours towards the therapist are similarly shaped by her representations of past and present relationships" (p. 129). Baradon (2003) highlights the role of the therapist in this three-way relationship and warns that the infants' presence serves to heighten any countertransference experienced by the therapist. The therapist makes a unique contribution as she consistently makes shifts between mother and infant with the explicit aim of understanding and symbolically representing, for mother and infant, their experience of relating to each other. Parent-infant group psychoanalytic psychotherapy such as the New Beginnings Programme is modelled on this dyadic psychotherapy.

"New Beginnings is an accredited learning and experience-based parenting programme that addresses the early attachment relationship between mothers and

babies in prison and prepares them for separation should that occur,” (Baradon et al., 2008. p. 241). The programme has been designed around three central assumptions, i.e. firstly the way in which the mother relates to her infant is determined by her own parenting experiences and how she has internalized this and how she symbolically represents this consciously and unconsciously; secondly how the prison environment impacts upon her capacity for mothering and mentalising and also what aspects of past experiences, memories and feelings may get triggered being in an environment such as the prison; and the third assumption is made about the symmetrical nature of the mother-infant relationship and the transactional nature of this interaction: “the infant’s responsiveness elicits more sensitive parenting behaviour, and caregiving behaviour in turn will strengthen the infant’s attachment” (Baradon et al., 2008. p. 242-243). Overall, the objective of the New Beginnings programme is that the prison environment will in fact impact on the mother-infant attachment but that this intervention can serve to create a healthy relationship between mother and infant and encourage the mother to provide a secure base of attachment for her infant despite mothering in these adverse circumstances. The programme design importantly situates the infant in the room as an active participant. Further descriptions of the design and facilitation of the programmed has been mentioned above. Importantly immediacy is utilized as an essential therapeutic tool to aid the mother in her awareness but specific discussions addressing the mother’s past childhood and parenting experiences is utilised to bridge the gap between past and present.

Quantitative and qualitative assessments were used to evaluate the impact of the programme on the mother, in view of the programmers’ specific aims and objectives. This included the Parent Development Interview (PDI) scored for reflective functioning (RF) and a video clip taken of the mother-infant interaction after the PDI also served to evaluate changes in the mothers’ behaviour (Baradon et al., 2008). The results of the above methods of evaluation identified several key themes which included that the mothers described themselves and their infants in idealised ways; that the mothers experienced guilt at having brought their infants into the prisons; the mothers wished for their infants to have a better future different from that of the mothers themselves; how the mother perceived the role of their infants in their lives

and minds; and anger and hostility that the mothers experiences towards themselves and towards other family members (Baradon et al., 2008).

Finally in respect of the outcome of New Beginnings programme which was implemented in the prisons it was found by Baradon et al. (2008) that:

Material we have analysed from these interviews confirmed our suppositions about the level of emotional deprivation and abuse that these mothers have experienced in their childhoods, the unresolved status of their pain and rage, and the insidious invasion of the past into current relationships with their babies (p. 253).

The results also indicated high levels of anger and hostility that the mothers experienced; their use of splitting as a defence against causing further harm to their infants; and despite an increase in their reflective functioning (RF) their levels of reflective functioning was fairly low and supported disorganised patterns of attachment and unhealthy internal working models.

However, the New Beginnings programme was evaluated to be effective in influencing the mothers' capacity for reflective functioning and mentalisation and thus contributing to a healthier base of attachment for their infants which was hopeful in view of the impending separation between mother and infant.

3.1.5 Conclusion

The above discussion assists in locating the relevance of this study in attempting to understand the South African mothers' experiences of mothering in a shelter and how this may impact on their capacity to be 'mindful' of the emotional and psychological needs of their infants as well as on how each mother's past may impact on her bonding with her infant as well as with other adults. It also covered the areas of group psychotherapy and parent-infant work in South Africa and discussed the New Beginnings programme, in particular.

Chapter 4: Research Methodology

4.1 Methodology

This study took a qualitative approach and explored Africans mother's experiences of the New Beginnings programme. "In contrast to quantitative research, qualitative research seeks to preserve the integrity of narrative data and attempts to use the data to exemplify unusual or core themes embedded in contexts" (Terre Blanche, Durrheim & Painter, 2006. p. 563). Qualitative studies attempt to describe and interpret participants' affect and their experiences in human terms rather than through statistics and quantification (Terre Blanche et al., 2006). Thus, each participant's narrative is considered unique and subjective which effectively accommodates the aim of this study.

The implementation of the New Beginnings programme within a South African setting was a Carnegie funded research project and the data collection phase of this project occurred from November 2010 to January 2011. The research team consisted of Dr K Bain and three co-investigators. The groups were facilitated at two shelters, both located in Johannesburg. The author of this research report, in her capacity as a social worker, was also involved as a research assistant on the project and collected data in November and December 2010 and January 2011 in the form of semi-structured post-group interviews.

Semi-structured interviews were the most effective method for an in-depth exploration of the mothers' experiences of the group intervention. This open ended style permitted the interviewer access to the mothers' subjective experiences. The particular questions asked and the order of these varied from interview to interview depending on the flow of the conversation. Additional questions were asked to accommodate the unique nature of each interview (Saunders, Lewis & Thornhill, 2007). On average, each interview lasted approximately 30 minutes. Each participant's narrative was unique and did not follow a predictable plot which supported the aim of this study which was to explore the mothers' subjective experiences of the programme.

4.2 Participants

Having attended the New Beginnings Programme was the only criteria for participation in this research process. All mothers who had participated in the New Beginnings Programme facilitated at the two shelters during November and December 2010 were invited to participate in this research. Fifteen of the sixteen mothers who participated voluntarily agreed to be interviewed. The last mother had left the shelter and was not contactable. One of the fifteen mothers explained that she felt compelled to participate in the interview and appeared resentful of the process. This resentment was related to an upsetting administrative matter which occurred at the end of the group intervention process. The researcher gave her the opportunity to withdraw from the interview process. The mother, however, agreed to be interviewed but some resistance was evident during the interview. This did influence the quality of the narrative. Thirteen of the fifteen interviews were transcribed and analysed for this research report. The quality of the audio recordings of the other two interviews was distorted and thus could not be effectively transcribed. All of the mothers were Black African aged between 21 and 39 years with the exception of the one caregiver who was older than the rest of the mothers. The infants and toddlers accompanying the mothers during the group intervention were aged between 7 days and 4 years. Three of the mothers were caregivers at the first shelter and two of them assumed foster care for one toddler each, who had been orphaned. One caregiver attended with her own infant. She managed the baby-care facility at the shelter. The caregiver who was older than the rest of the mothers has a teenage son who lives separately from her.

All the mothers except for the mother who was also the baby-care manager lived at the shelter. The mothers had been living in these environments for between a few weeks and 2.5 years. The majority of the mothers living at the first shelter were HIV positive and some of their toddlers were HIV positive as well. It is unclear whether any of the caregivers were HIV positive. Most of the mothers living at this shelter were from South Africa, one was an orphan and the others had some family members living in the country. One of the mothers was Zimbabwean and one was from Malawi. Two of the mothers remained in a couple relationship with the father of their children but they lived separately from each other and saw each other

occasionally. The other mothers' had little or no contact with the fathers. One of the fathers had died in 2010. Four of the mothers had only this one child who attended the group with them. The other five mothers all had between two and five children ranging from ages 7 months to 16 years. All of the children were living with them at the first shelter with the exception of the one mother whose 16 year old son lived at another shelter. Most of the mothers were unemployed and were looking for work. One mother had recently completed a correspondence Diploma in Human Resource Management and was hoping to be employed soon.

Of the mothers living in the second shelter, they were both single and had limited contact with the fathers of their children. They received little or no financial support from them. They were unemployed and were from Zimbabwe.

The first shelter specifically for mothers and babies who were HIV positive provided for most of the material and educational requirements of the mothers and children. The mothers were involved in the upkeep of the shelter and engaged in various duties according to a weekly roster. The shelter appeared to be well run with regards to resources and organisation.

The second shelter provides temporary accommodation for women and their children if any. The women are provided with basic care in terms of facilities and some food. They are required to make arrangements to meet their own material needs and find suitable employment.

4.3 Data Collection

Due to the transient nature of the participants' living arrangements, time was crucial since the shelters are a short term solution for the mothers and their infants residing there. The data had to be collected within a few weeks after the mothers completed their participation in the programme. As a result of this, the data was collected in November and December 2010 and January 2011. The researcher was hired in her capacity as a social worker, as a research assistant onto the New Beginnings research team (approved by the ethics committee – 2010 ethical clearance number M10562), to conduct interviews with the mothers. The interview schedule that was followed was part of the original New Beginnings research proposal which received ethical clearance in 2010. Please see Appendix 1 for the interviewing schedule.

These questions were used as a guideline since the interviews followed a semi-structured format. The interviews were conducted and audio recorded with the informed consent of participants, which was gained at the start of the original New Beginnings research project. The mothers' participation in the programme was strictly voluntary and involved giving informed consent to pre- and post-testing of their reflective function, maternal sensitivity and their infants' development, participation in the groups and a post-group interview regarding their experiences. The interviewer also made notes regarding any strong emotions evoked in either the interviewer or the participants during the interviews and the topic of conversation at the time of the emotion (Cartwright, 2004). The audio recordings of the post-group interviews were the raw data that was used in this study. Transcripts of these semi-structured interviews with the mothers were made and these, together with the interviewer's notes, became the data that was analysed.

Interviews were conducted with fifteen of the sixteen mothers who had participated in the New Beginnings Programme. Three mothers were interviewed in November at the second shelter. The interviewer established telephonic contact with the shelter co-ordinator who arranged for a day and time when all the mothers would be available for the interviews. On arrival at the second shelter, the interviewer was assisted by one of the residents to locate the mothers and organise a private room in which to conduct the interviews. The shelter co-ordinator was not available on that day but she had left word with the security guard of the interviewer's arrival. The aims and process of the interviews was explained to the mothers and they were invited to participate. They were also informed that they could withdraw from the interview process at any point and they could choose not to answer any questions that they were not comfortable with.

At the first shelter a similar process was followed with the residence co-ordinator but the interviewer was asked to liaise directly with the baby-care centre manager (this was a mother who had also participated in the New Beginnings Programme) to organise the interviews. The researcher co-ordinated dates and times suitable for participants with the baby-care centre manager and the first few interviews took place at the beginning of December 2010. Among this group were two caregivers who fostered two orphaned infants at the shelter who had been participants in the

first New Beginnings group conducted at the shelter over September and October 2010.

During this time the second group were completing the second New Beginnings group programme. The interviewer managed to interview seven of these mothers in December 2010 in the week after they had completed the programme and a further three mothers in January 2011. The number of interviews that had been completed was sufficient to gain a rich account of the mothers' experiences.

4.4 Data analysis

Narrative analysis was used to analyse the data from the theoretical perspective of psychoanalytic attachment theory, with the aim of presenting the mothers' stories of their experiences of the New Beginnings programmes. The data that was analysed were the transcripts of the semi-structured interviews conducted with the mothers and caregivers (by myself as the research assistant in 2010) and the notes made during these interviews.

Narrative analysis was an appropriate method of analysis for this study as it is being increasingly used in human and social sciences as a tool to create links between experience, meaning, social structure and culture (Avdi & Georgaca, 2007). The theoretical lens through which the analysis was conducted is also appropriate as it reflected the theoretical underpinnings of the New Beginnings programme itself (Baradon, 2010). The interviewer's role was seen as being central to the unfolding of the participants' narratives as both a witness and a co-editor.

Cartwright (2004) provides valuable guidelines on how to conduct a narrative analysis from a psychoanalytic perspective. He identifies 3 important tasks necessary for the analysis and interpretation of the interview. This involves "(1) the search for core narratives while exploring the interview text in its entirety; (2) matching narratives with initial transference-counter-transference impressions; and (3) tracking key identifications and object relations within dominant interview narratives" (Cartwright, 2004. p. 211). Crossley's (2007) view concurs with Cartwright's in that it is not an easy task to interpret a narrative text, since meaning is

not transparent: “It has to be achieved through a process of interpretation and engagement with the text (p. 139)”. Firstly the researcher listened to the audio taped interviews for the purpose of recollecting the mothers’ stories. Hereafter she transcribed each interview and read over it several times so as to facilitate her full focus on the individual data, so as to become totally familiar with it. This helped to deepen her understanding of the individual mother’s stories and their meaning inherent in the data. The transcripts, together with some observational notes that the researcher made in addition to the interviews regarding her countertransference and observations independent of the participants, were studied so as to gain an overall idea of each mothers narratives, making a note of core themes that emerged throughout; not just in terms of the manifest content but also searching for the latent content which related to the objectives of this study. The researcher also searched for connections and differences between the stories which gave rise to several core themes identified across all the data. These core themes were then colour coded on each transcript and differences across the transcripts were also highlighted, using different colour pens. These colour coded themes were then electronically copied and pasted into a new document which become the ‘data analysis document’. Each heading in this new document related to a core theme or category of data that had been identified by the researcher whilst studying the transcripts and keeping the objective of the research in mind. Her own observations, countertransference and comments were also reflected in this document.

This form of analysis was used in an attempt to understand the psychodynamics and unconscious meaning that the mothers attached to their role as mothers and their relationships to their infants and how these manifested in their experience of the ‘New Beginnings’ groups. The mothers themselves may not have directly described this in their interviews and as such the researcher, during the analysis of the data, searched for identifications and object relations and core narratives (Cartwright, 2004). Understandings of these meanings took into account the mothers’ behaviours, psychological processes, social actions and life situations. Thus, each mother’s narratives of her own upbringing, her description of her capacity for mothering and her core relationships with caregivers and other adults provided valuable insight into her internal working models or mental representations of her

infant, interactional patterns with her infant, her capacity for mentalisation and general mental health. How the mothers experienced the therapists, co-therapists and other mothers in the group also revealed transference and countertransference issues which were vital in understanding her experiences of being in the mother-infant group. The interviewer paid careful attention to her own engagement with the mothers during the interviews so as to explore her emotional reactions and feeling states during the interviews. The interviewer being a mother herself was aware of her own feelings whilst observing some mothers who appeared disinterested or depressed. The interviewer felt empathy for a lot of the mothers but also felt distressed and concerned for some of the infants due to their mothers' low moods and lack of interest. The interviewer also recognised that she felt irritated and frustrated with two of the mothers. This was mainly during the interview process when these mothers appeared defensive, rigid and moralistic of their own experiences of the group and appearing judgemental of some of the other mothers who participated in the groups. However, Cartwright (2004) does emphasise that this counter-transference starts before the interview is conducted, such as when the researcher is in the planning and organising phase of the research interview process. Hence, the researcher did engage in a careful process of self-reflection around her feelings and thoughts about mothers in shelter settings and her presumptions around the interview process. These were also processed with the research supervisor during the preparation for the interviews. These will all form part of the analytic interpretations and meanings found from the data. According to Cartwright (2004):

In the process of analysis, we are essentially interested in understanding how the individual, consciously or unconsciously, locates him-or herself in the narratives constructed in relation to objects. This allows us to develop an account of the individual's objects, fantasy life, and related defensive organisations (p. 232).

Crossley (2007) also outlines some very clear analytic guidelines that can be utilised in narrative analysis culminating in a coherent story and a rich research report. This includes the essential steps of the researcher engaging with the transcripts quite rigorously, before identifying important concepts, tones, themes and images. In

analysing the transcripts, the researcher's countertransference was again evoked in relation to the two caregivers' narratives. These narratives were devoid of a personal account of their experiences and instead they presented with a very rigid and distancing account focusing on generalising the experiences or on the other mothers' experiences. The researcher found it difficult to find meaningful statements in the narratives with these particular mothers and these transcripts were then analysed with her research supervisor. These two transcripts are discussed in greater detail in the results section of this research report.

Two important further points noted by Cartwright (2004) that lend credence to the suitability of narrative data analysis for this study are as follows: firstly it is a 'meaning centred approach' which aims to explore unconscious processes through the analysis of narratives and how they are constructed by the participant being interviewed. Secondly, the predominantly unstructured nature of the interview allows for an in-depth study of feelings and experiences as contextualised by the mothers, which is essential for understanding unconscious meaning. Crossley (2007) supports this view in that he sees the narrative analysis process as not being a structured step-by-step process but rather a process in which the researcher aims to understand and interpret the personal and cultural meanings of the text.

Both Cartwright (2004) and Crossley (2007) refer to the validity of the methodology. Although qualitative research has been deemed to be 'not scientific' in that data cannot be quantified and measured and due to the fact that it is not independent of the researcher's personal influence, the validity of this approach rests in its' ability to accurately depict subjective accounts without the aim of generalisability (McLeod, 2001). This approach is in contrast to quantitative research as it aims "to produce in-depth analyses and insight into individual case histories which appreciate the complexities and ambiguities of the interrelationships between individuals and society" (Crossley, 2007. p. 143).

The overall aim of this analysis was to inform the New Beginnings programme within a South African context, with regards to the suitability and efficacy of the programme as a potential preventative solution to poor mother-infant attachment and thus as a

contribution towards improvement in the long term mental health of mothers and infants. Valuable information was obtained about the mothers' experiences of being part of this programme and the programme's overall efficacy in the minds of the mothers.

4.5 Interviewer countertransference/observations

This section is written as a first person account. As the researcher in question, I came to engage in this research via a personal interest in mother-infant relationships being a mother to two daughters. From my own experience in giving birth to and raising my two daughters, and more so after the birth of my first daughter, retrospectively I wondered what I could have done differently or better had I had someone who offered me additional guidance on how to improve on my untutored ways of providing my daughters with a secure base for attachment. I would have also valued deeper insight into how my own childhood experience of attachment may have contributed to my capacity to provide this secure base that is so needed. Having these thoughts in the back of my mind I undertook this research with the knowledge that already my empathy for these mothers would be enhanced. However, at the same time I was also aware of the flipside of this coin in that I may risk over identifying with the mothers and that this would bias my results. In view of this personal interest in this research, several mechanisms were put in place to minimise the risks. This included firstly, keeping the questions posed to the mothers' as neutral as possible so as to forestall the possibility of prescribing the direction of the narratives and secondly, the raw data (transcripts) was also carefully scrutinised by my supervisor. I was able to consciously hold in mind my personal experience and interest, as well as to discuss this with my supervisor throughout the various stages of the research process. This helped to ensure the development of an account both derived from and grounded in the collected data.

When beginning the data collection phase of the study, at the second shelter I observed the surrounding area to be very crowded and dingy and the shelter was difficult to access. The shelter itself was dark and depressed with long dark passageways and staircases. I was able to interview the mothers in a room marked 'counselling'. The door to the room had a small window in it and throughout the

interviews with the mothers – someone from outside would put their head against the window to have a look at what was happening inside. This was disruptive and invasive to the mothers' privacy. The mothers themselves seemed unperturbed by this.

The mothers were cooperative and willing to talk to the interviewer. One mother demonstrated how the group had helped her to respond better to her baby. I was startled when she threw the baby on the coach and indicated that she would just ignore her in the past and now she wanted to have her baby close to her and so picked her baby up and held her close. When she threw her baby I became concerned for the baby's wellbeing. I soon realised though that the baby was heavily swathed in blankets and well protected from any light thumps.

The mothers appeared to be very attentive to their babies and one mother constantly rocked herself because she had her baby on her back. The mothers at this more temporary shelter seemed very impoverished and destitute and I felt helpless when interviewing them. They seemed to lack basic needs such as food and it seemed that they had to fend for themselves in a foreign country with access to very limited resources.

At the first more resourced shelter most of the mothers were very cooperative with the exception of one as discussed earlier on. This mother was very angry with the group therapists and this anger was transferred to the interviewer. I reflected this to the mother and gave her an option to continue. I felt internally compelled to try and assist her with the cause of her anger, but resisted the urge to become therapeutic. She was able to engage in the interview specifically in the middle of it but at the beginning and again at the end her anger was evident and this impacted on the nature of her responses to the questions.

Most of the mothers had struggled to talk about themselves and their pasts in the group and due to this I found it difficult to ask them about their own 'mothering' which they received as children. With three of the mothers I struggled to maintain the momentum of the interview because the mothers appeared distracted and tired. Two of these mothers didn't understand English very well and this too detracted from the flow of the process. At one point in the interview one mother indicated that she

had nothing further to add and ended the interview abruptly. This mother did struggle to trust others in group and in the shelter. Another mother gave very limited responses in the interview and at some point I became aware that some questions could not be asked of her because she seemed very guarded in her responses.

Of the caregivers, one was very vocal about her irritation at having to answer questions and do interviews both before and after the groups and during the research interview. I felt a little apprehensive about interviewing her in view of this reluctance. During the interview I experienced strong countertransference towards this mother as I perceived her as rigid and moralistic and that she gave learned answers as opposed to more thoughtful and authentic responses. My feelings toward her seemed to oscillate and at some point I felt empathy towards her despite her detached manner of engaging. I worked harder and listened more actively and I maintained an interest in what she shared. I believe that it was this attempt to maintain interest and engage with her that allowed her to offer an apology to me later for her 'rude' behaviour at the beginning of the interview. This surprised me. It was observed that this mother became visibly calmer as the interview progressed and she became more open to sharing her views, to the point that she interrupted any questions or reflections that I attempted to make.

With respect to another of the other caregivers, I again experienced strong countertransference. I felt upset at what I perceived to be her judgemental and resistant attitude towards the other mothers attending the group. However, retrospectively I was able to recognise in consultation with the research supervisor, the difficulty that she had experienced in her dual role as mother and as staff member in the group. She had hoped that the group process would help her in her job with the mothers and that they would become more thoughtful towards her than they did.

Overall, I felt huge empathy towards most of the mothers. Many seemed to have a strong women's narrative of hope for a better future for their children and their survival. The qualitative methodology employed to conduct this research study together with the use of narrative analysis was essential in its ability to encounter the

unique and universal perspectives of the mothers in view of the objective of this research study.

4.6 Ethical considerations

Research is answerable to ethical scientific procedures, ensuring high standards of research, having value and purpose to scientific knowledge, and maintaining integrity (Baker, 1994). In this study the researcher needed to remain sensitive to the confidentiality of the participants whose transcripts were being analysed and she needed to maintain professional integrity throughout the process of analysis.

Ethical clearance for the study in which the data was collected was granted in 2010—ethical clearance number M10562.

The original contract with the participants was honoured during the interviewing process and continued to be honoured throughout this study (see Appendix 2, 3, 4). This included confidentiality and the right to withdraw participation. Permission was gained for the audio recording of the interviews (see Appendix 5) where the participants' identities remained confidential but that excerpts and quotes could be used for research, learning and publishing purposes, both nationally and internationally. Anonymity of participants was maintained throughout the data analysis. A pseudonym was applied to each participant at the point of data analysis. Participants were informed that they could withdraw from the study at any time without any disadvantage to themselves. The participants were fully informed prior to the commencement of the New Beginnings programme of the purpose of the study and the main features of the research design which included qualitative and quantitative data collection.

The quantitative data does not form part of the scope of this study.

Since the researcher would be analysing transcripts she needed to maintain the principles of confidentiality and anonymity, thus no identifying information has been disclosed.

The researcher understands that the interpretation of the transcripts was not free of counter-transference issues and whilst this forms part of the process of narrative analysis of the data, all efforts to reflect on the role of these processes will be made.

Chapter 5: Research results

5.1 Introduction

This chapter presents the results of the study. It is divided into two main sections, namely: experience of the group and experience of the programme. Within each of these sections a number of themes that emerged from the study will be discussed. The chapter concludes with a brief discussion on the mothers' experiences of mothering in a shelter, which was one of the secondary aims of the study.

5.2 Experience of the group

This section outlines the mothers' experiences of being in a therapeutic group and focuses on their reactions to the setting and the other group members. The themes that will be discussed in this are: defensiveness/reluctance to engage; safety and structure; therapists' emotional availability; and deprivation and abandonment.

5.2.1 Defensiveness/reluctance to engage

Ten of the thirteen mothers who were interviewed shared narratives which included a core theme of defensiveness or a reluctance to engage. Much of this defensiveness was evident in the fact that mothers often held contradictory views of the programme, their opinions oscillating throughout the interviews. Hence, while a mother may comment that she found the groups irritating, boring or difficult, this was later belied by a sense that she felt she had gained from the group, learned from it and enjoyed certain aspects of the group space. The defensiveness appeared to be mostly around the parts of the group that required reflection back to the mothers' own childhoods. This defensiveness was mostly evident in the beginning of interviews and once most of the mothers had settled into the conversation they were more able to reflect on the programme as a whole, including both the aspects of it that they found challenging and the aspects that they enjoyed.

From the first sentence of her interview Pixie said that she thought that being in the group was at first difficult and boring. This may partly have been indicative of her unwillingness to engage. She described struggling to adjust to the group. Pixie

seemed to be resentful that she, together with some of the other mothers were 'just' told to attend the group: "You know we've got duties and then they just arrived and said that we have to go to the sessions". Several of the other mothers also described this experience of being compelled to attend the group and feeling the unfairness and sense of helplessness attached to such compulsory attendance as stated by Pixie: "It's not a matter of whether you want to come or not". This idea was echoed by several other mothers who attended the groups as well, including Sami: "Mmm this group just started suddenly we were just called here we were so many and we were just told that we had to be in this group...". Hannah said "We feel like we were forced to go there. Sometimes it was difficult sometimes we become angry. Even before I tell [therapist], 'see [therapist] I'm not happy about this thing because I feel like I am forced to come here'".

Although all the mothers received participant information sheets before the start of the groups and were told by the group therapists that the groups were voluntary, many of the mothers still felt obliged to attend the groups. While this could have been related to how the shelter management approached the topic of the groups with the mothers, it also appeared to become a way for the mothers to express their ambivalence about attending the groups.

Pixie also seemed to struggle with the fact that several of the mothers at the first shelter were experiencing difficult relations with each other prior to the onset of the group, so from this perspective, being in a group with these same mothers held little appeal to her and was also part of her reluctance to engage in such an intimate set up. A lack of trust and suspiciousness of both the management and the other mothers at the shelter was evident. Pixie stated: "At first I didn't like it because the mothers here we don't talk to each other because there is this thing that some of them will report to the management. We were not very comfortable with each other".

Pretty described a similar experience in that she didn't fully trust the space to share about herself in the group in the beginning. She described feeling obliged to attend and to disclose some personal information about herself. Evident in the following statement was also a fear of being judged, which to some extent prevented her from fully engaging in the group process at the beginning:

“So when we started the group... And you look at these people that you did not know and talk about these things in front of them. The thing that was really difficult for me in the group... You never knew what the other one was going to say or what the other one was going to say. So when I was saying something I was looking in the group who was listening to what I said. This was not nice. So it was not nice”.

Linked to the sense of mistrust was also a sense of ambivalence and uncertainty about the objective of the group. For Sami this also included her uncertainty about the purpose of being recorded on camera which Sami said: “Just being questioned like what’s your name here and there and that way of being recorded like on the camera and I thought maybe you are going to use them in the television. Gonna be for the media I thought that maybe they got something that they are going to let it out later”. This mother had experienced difficulties with trust and even in this post group interview there were some remnants of not having been completely comfortable with being recorded and being asked to disclose personal information. Abby disclosed: “Before I was confused because I didn’t really know because they didn’t really explain much. At first I didn’t really know what this was about, you know. It was a workshop for mothers and babies. I didn’t understand” and “I remember I was sitting here on the floor and I was thinking ‘what we are doing here’. I was wondering...here are other mothers and babies and we are having coffee and I was confused now about this”.

Abby also explained that because she was initially confused about the purpose of the group she found it difficult to explain to others (those not in the group) what she was doing in the group. This fueled her resistance and uncertainty because she herself was struggling to understand. However, what is also evident in her narrative was that she struggled with being the focus of attention and learning about herself and her baby. Being part of a group that was all about her and her baby was not a familiar experience for Abby and she struggled within herself to make sense of this:

The thing is they would ask us what kind of course are you guys doing. I was just telling them ‘no it was mothers and their babies’. What about them? I can’t explain more. I know what we are doing I understand but to explain more it

was hard to explain to someone else (laughs). What are you guys doing? What you going to get? Are you going to get a certificate? Is it like a child minding course? I would just say no, it was hard for me. I even said to [the therapists] that I am finding it hard to explain, I know what we are doing but I can't explain.

Hannah echoed similar sentiments to the above, reflecting a level of uncertainty and ambivalence. Some underlying resentment and anger was also expressed:

They told us we supposed to go there because this thing is very necessary. Because it help us and our kids. So it was very hard by that time because we didn't understand what happened. Because we didn't understand how it will help us...I was not really there. I'm not there with that thing I'm thinking about my duties. Yah I was not in the group, my mind was out of the group.

This mother also revealed that despite her initial ambivalence and resistance to engage, she found the ending of the group very painful as well: "Yah it is fine because even then I wanted them to make it fast because there were so many things to do. Because you don't concentrate so much in the group. Because maybe I'm here but my mind is not here. That thing is not good [the group ending]". Hannah's initial struggle to engage and then at the end her apparent struggle to disengage may be about the group offering her a sense of being cared for which was an experience not familiar to her in view of her upbringing and her current life circumstances. Also having to think and reflect was very painful for her and this may be reflected in her contradictory feelings.

Pretty described a sense of futility in attending a group about herself and her baby when one had so many other pressing stressors to cope with:

When you wake up in the morning there are problems... When you go to the kitchen there are problems. The things you can't keep out of your mind. That's why I couldn't...couldn't even go to their group, whatever they say I must go when I was having this. Why must I go when I'm having this problem? So it was a problem for myself it was a problem for me.

Pretty really struggled to be in the group because it seemed that the group experience evoked thoughts for her about overwhelming things that she preferred not to deal with right then:

So every time this thing is in your mind and you go to the cottage and you crying alone. I would say why should I go, or why should I come here. Maybe it was the day we had to come here and do you sleep at night with those things you feel angry. And then you have to come here and you thinking why'd you have to come here. You have to talk about these things in the interview and that day you are stressed because it is something that is happening a lot.

Some compliant behaviour in attending the groups was evident in some of the mothers descriptions which alluded to a fear of authority figures and again a lack of agency to make up their own mind and to participate in a decision making process. Abby stated: "I just went because I had to, but I wasn't myself". Fikile said the following: "So when you come to the group, it does take you away from things that you suppose to do. So most of them didn't like it because of this, they see that attitude as frustrating. Either you get a demerit, or you get shouting [from management of the shelter in response to not attending group]". This perception of something punitive seemed to fuel the mothers' resistance to engaging in the group where they may have seen the therapists in a similar 'authority' role and as a result a sense of powerlessness seemed to prevail in the mothers in the beginning.

Chrissy was one mother who experienced the ending of the group to be very punitive and rejecting of her. As a result of this she was very upset in the interview and she presented with a lot of resentment and anger at being asked to share further about the group experience with the researcher. Chrissy described an initial resistance to the group experience followed by her finding value in it and ending with her feeling angry that she was rejected by the therapists. This last experience seemed to cloud her entire experience of the group. Chrissy was unable to attend the last session and as such was not present to receive her 'certificate of attendance':

For the last one I wasn't there when she [therapist] came. She met up with the others. Then she came again just for me. She saw me but she didn't give it to

me. Yah I was surprised like, why are they still continuing with me because they don't give me the certificate?

Chrissy's experience of the group, especially regarding this last session, alludes to her feeling victimized, excluded and persecuted. Her feelings were very powerful and hurt and rejection appeared to be her primary feelings although she did not allow these feelings to come through verbally. It was however observed in her closed posture and her resistance to being interviewed by the researcher. Subsequently Chrissy did receive her certificate.

For many of these mothers who described an initial resistance and ambivalence to attending the group they were later able to overcome this and find value in the group experience. Sami stated: "It didn't make sense to me. In the beginning I just wanted to drop out. But then later on I discovered that maybe there is something hidden behind it". Nomsa said the following in this regard: "So sometimes I would feel that time is been wasted because there are stuff waiting for me. But I will just be like that for this minute and when I get here I will focus on what I've come for". This latter statement is also indicative of an interest and an openness to be part of the group that developed over time in some of the mothers.

Of the three caregivers who participated in the group, two maintained a professional distance during the facilitation of the group. Sue indicated the following about her experience of the group: "Most of this I knew myself although I did learn a little in the group". It seemed that it was difficult for her to find value in the group experience due to her own defendedness and need to feel knowledgeable. Sue was also reluctant to be interviewed by the researcher, but she did eventually apologise for this attitude. This apology was surprising but may have been forthcoming due to the interest and attention that the researcher paid to her, which she may have received from the therapists in the group as well. Rose indicated that due to her employment at the shelter, she felt caught between the mothers' reluctance to attend the groups and shelter management's expectations that she would get the other mothers to attend the groups:

So I was caught in the middle because they are... The board expects something like most from being a mother but from a work type of thing. ..They

don't like it. So I felt that I was caught in the middle because I was pushing them to do like this and like that. At the end of the day I have to see that they attend the group. And the mothers didn't like it so I was caught in the middle.

Rose's participation in the group was riddled with her own ambivalence and uncertainty of the dual role she was undertaking by attending the group sessions with her own son. She felt compelled to attend by management as a potential role model to the mothers but she was also attending as a mother with her son. Her own experiences of the mothers outside of the group were reflected in her difficulties observing them with their babies in the group: "I was supposed to be like some kind of a role model. Every mother wants to be a kind of perfect mother. They were saying things that they would not be doing and it was getting to me".

Themes of resistance and defensiveness with regard to feeling compelled by the management to attend the groups; feelings of mistrust of the therapists and the other mothers; ambivalence and uncertainty about the objective of the groups and their (mothers) role in it and the initial description of overall inconvenience of attending the groups seemed to reveal unconscious resistances and fears of being exposed and judged by the therapists and other mothers in the group. An underlying fear of sharing and thinking about painful aspects of their lives when they may not have sufficient skills to cope with this was evident in these mothers' initial reluctance and unwillingness to engage in the group experience. This was also evident in some mothers' unconscious descriptions of feelings of being rejected and not cared for due to the group ending. The fact that most mothers were eventually able to engage actively in the group processes (as will be seen later in this chapter) suggested that the therapists' acceptance of their resistance and perhaps giving them unspoken permission to share only as much or as little as they felt comfortable with, may have lessened some of the patterns of defensive interacting which these mothers have used in other areas of their lives, both in the present and specifically in the past. This seemed to allow most of the mothers to choose more direct ways of dealing with the anxiety that being in this group situation may have produced. These ways seemed to include openly sharing and participating more actively in the group process. This safety and security of the group setting seemed to significantly contribute to reduced levels of anxiety and a willingness in the mothers' to engage.

5.2.2 Safety/structure

Eleven of the 13 mothers found the group experience to be safe. In terms of safety, the group was described by the mothers as offering them a sense of being able to express often intense feelings that they may have consciously kept out of awareness. Several mothers' acknowledged that they were able to talk about their feelings and issues, for some of them for the first time. They also reflected that they felt a sense of relief at having done so. This relief was also experienced as a result of them being able to establish relationships in the group in a setting that felt safe and was conducive to a more favourable outcome for these relationships. Though they experienced some initial resistant feelings towards the other mothers and the therapists, they described feeling more able to overcome and manage these and they reported on an increase in self-understanding as a result. The structure and safety of the group was described as creating an awareness amongst themselves of the universal struggles that they experienced, enabling them to feel supported and to support the other mothers too.

The knowledge that their sharing in the group was voluntary and that all information shared would remain in the group in terms of confidentiality, encouraged the mothers to more fully participate and benefit from the group experience.

The experience of discovering that the other mothers and the therapists could tolerate their very difficult emotions and experiences, made sharing for them in the group more bearable and encouraging.

Pixie who initially described a lot of resistance to participating in the group, described experiencing a growing interest and sense of belonging in being part of it: "Yah as time went by I grew to like it. Because I realise that we could talk lots of things with them. You know sometimes we have too much but we don't have anyone to talk to". She was also able to experience the other mothers in the group as very supportive and as sharing a common bond. This was unlike her initial sense of a lack of trust in the others and an unwillingness to engage. Her improved experience reflected on the safety of the space offered by the group experience allowing her to feel valued and cared for: "But all of these mothers attend the group you see we become one

because as time goes on we could see that we were...everyone shared their feelings what is in their hearts and you could see they all in the same situation... in the same boat. We started to trust each other very, very quick". Pixie also reported a growing empathy for the other mothers who shared similar experiences to herself: "It was very sad because I could see that they were having the same feelings that I was having. Because we could decide from each other's background and how we are living here we can see that we are in the same boat".

Several of the other mothers were also able to describe this sense of oneness that they felt with the other mothers who found themselves in similar context to themselves. Sami was one of these mothers. She also found solace in the empathy, warmth and support offered by the group:

We had to talk...we talk especially for the first time and we talk and talk with these ladies about our private lives and in the way that we talk with them about our lives we got counselling here and there. I feel that I am not the only one with problems. We all have problems and we could share the problems...ya. So at least I got relief here and there.

Sami also felt comfortable to be in the group and she really enjoyed her experience in it. She noted changes within herself as a mother and in the other mothers as a result of this common bond. Her experience of spending time with her baby in a safe and structured environment was clearly unusual for her but very welcoming:

I could even see changes. With the group we had enough time to relax and sit with our babies. Talking with them and sometimes you can spend the whole day with them. Take your baby, breast feed your baby, you don't have enough time to play with your baby you just put it down or go with your baby and you don't have enough time to relax with your baby.

Sami also had an initial resistance to attending the group but she was able to overcome this and develop important support systems within the group for herself and for her baby. The hope that her baby would have the same experience as she had is evident in the following statement: "At first I just did it unwillingly but later on I discovered that it's nice and it creates friends even within the complex[shelter] ya

and even to our babies if they are sensitive then they could become friends with others”.

Abby concurred with this sense of support and togetherness offered by the safety of the group experience: “Yes, yes even we would remind each other and we even tell each other, no remember you must do this and this. But this people in the group I find them like they are my friends and we can talk about many things about our babies and about other things and they can help”. For her, being able to observe the other mothers as having similar conflicts to her own helped to melt away some of her resistance and encouraged deeper personal exploration within the safe structure of the group experience.

The safety offered in the group was further experienced as being able to help some of the mothers overcome their personal difficulties with each other. Abby put it as follows: “Yes, it improved because before we were shouting each other in front of the kids but afterwards after each session [the therapist] was teaching us. Now we helping each other, working together. It's fine now. This group was helping us a lot”.

Pretty found that she did not need to be anxious about her mood in the group as the group seemed to be able to tolerate her difficult affect. She learned that it was acceptable for her to express some of her intense emotions if she chose to or not and that the group would offer her a safe space within which to do either. This might also reflect an internal change from her experience in the group, in that Pretty herself may have found a way to accept her low mood and her own previously unbearable feelings: “Because we were very open there. Because if you don't want to talk like that or do that then we were just quiet and they don't say anything. So it never blocked me”.

Suki felt that she was lacking maternal skills before she came into the group and that the group offered her a new way of being with her baby which she found very valuable. The fact that she could be open about her struggles with motherhood, attests to the safety that the group experience offered her: “But we are not used to talking about our kids you know. We used to talk only about our stuff...But it was a nice experience together the talking, sharing...sharing notes and sharing about our

children, yes. Sharing everything about our children it was nice". This statement was also reflective of her developing a sense of awareness and interest in the development of her child. Suki did not struggle to be part of the group and volunteered to join the other mothers and the babies as opposed to some of the other mothers who felt compelled to attend the group: "No it was not difficult. Because I learned a lot and it was fun for me. And I enjoyed the group". Hence, for Suki the group felt safe and secure to her from the onset which facilitated her improved insight and some psychological growth as discussed further on.

In response to how she felt about being with other mothers in the group Nomsa replied: "Yeah I felt okay about them (other mothers) that ever since we have been together because sometimes we talk about our stuff here and then tomorrow you will hear it being talked about. But it is never happened like that again. They understood what [the therapists] told them". The group structure seemed to reduce her ambivalence and was able to offer her safety, which alleviated some of her trust concerns as well. Chrissy felt similarly: "They told us whatever we are discussing there is private and confidential. So no one is allowed to take it out. It's for the group only we mustn't share it outside. So we were comfortable because we knew that no one will talk about it. It was for the group only".

Rose was very supportive of the group experience and felt that it would be beneficial for all the mothers' to attend. However, she suggested that the mothers should participate voluntarily and not be compelled to attend and that this would lead to a more valuable, less emotionally threatening experience overall: "I think the group was perfect. I think that they should do it more often. I think they should find another way of making them to want to be in the group. Making them just feel it in their hearts. I don't know how we can do it. I don't know how someone can do it". Through this statement Rose seemed to be conveying a message that the structure offered in an intimate group such as this was essential for encouraging more mothers to attend since they would perceive it to be safe and they could be more open and expressive and achieve the necessary changes that would have a positive influence on their mothering.

Whilst the group was eventually perceived to be safe and offered the mothers structure within which to share openly and confidently, their responses clearly indicated that trust was a huge issue that needed to be overcome first. Sharing about themselves seemed to be an unfamiliar experience for most of the mothers and as such the group structure and safety provided the foundation upon which they could begin to take some risks in sharing and thus build trust in the process. They appeared to have gained significantly from this risk taking in the group. The mothers found solace in sharing because the group appeared to be able to tolerate their intense emotions. They also appeared to gain in terms of interpersonal relating and support and many of the mothers appeared to have been able to move forward by revealing aspects of themselves that they usually concealed and move into new ways of behaving and thinking about themselves, their babies and others.

5.2.3 Therapists' emotional availability

Many of the mothers' appeared defensive and anxious about being in the group as they had not been part of such a group experience before. As discussed above, they did not feel free initially to share about themselves. Some of the mothers described this initial feeling as being one of mistrust as they did not know who the therapists were and what they could expect of them. However, most of the mothers were able to overcome this anxiety and mistrust when they experienced the therapists as genuinely caring for them and interested in them and their babies. The mothers described the therapists as having created a climate that encouraged them to express themselves freely, or not if they preferred not to. The therapists were described as warm and supportive and tolerant of the mothers' resistances and difficult feelings. Their availability seemed to model to the mothers honesty, openness and genuineness which made participation in the group safer and worthwhile.

Seven mothers made direct reference to the value and understanding offered by the therapists' emotional availability in the group, however, some initial anxiety about the strangeness of the experience of disclosing personal information was also felt in relation to the therapists as indicated by Pixie's statements below and others that follow.

Pixie struggled initially with adapting to the group experience and she found herself feeling mistrustful of the therapists, which was similar to her initial experience of the other mothers' attending the group and was also reflective of her initial resistance to participating in the group: "At the same we also did not know them. We were just starting to know them (curiosity). They say we must talk the truth out. We must communicate. It was difficult because we don't trust them". Although talking about her difficult feelings and experiences was something that she struggled with initially, through the therapists' care and understanding, Pixie was later able to experience the therapists as empathetic and interested in her. Pixie described her experience of the therapists:

How she was talking with me and how she was listening to me. That she was real. You can see that emotionally...she is feeling for you. When we started this group [therapist] said that we will feel like we've changed on the inside. She feels for people's problems. She could not do too much but you can see when she talks to us that she really cares about people. So when we sharing with Dr [therapist] she could really understand and people felt comfortable and we could tell her all the truth and [therapist] said that it's okay.

Sami shared a similar experience of initial ambivalence but later she felt more understood and supported by the warmth, realness and positive regard offered by the therapists:

In fact they are so friendly because at first we couldn't tell them our problems but later on we discovered they are so open to us so we joke with them here and there and they bring this and that we telling them ah we don't like this to eat so they later on they brought us ama muffins plus bread so we had ourselves a snack and they served us with...

This experience of having someone holding them in mind, listening to them and caring for them seemed strange and unusual initially. However, it formed an essential part of the foundation of the group structure that enabled the mothers to

move forward and gain from the group experience. The therapists were also able to demonstrate that they could tolerate the difficult experiences of the mothers, as they remained emotionally attuned to them and they encouraged them to be themselves in the group. Abby said the following relating to this:

‘Cos they... they... they understand... if you...like maybe we you know we’re use to each other so they can notice if someone is not happy today... if they ask you what’s wrong... if you don’t want to talk about it they will say its fine... they don’t force say anything. They will say ok if you don’t feel like saying anything its fine but when you feel like talking to us we are here for you. I like that because I remember this day I was...off they were asking me what’s wrong and I say no I am not ready to talk about it I’m..I’m just disturbed in my mind and they didn’t wouldn’t force me like say something so that we can give you advice. No no.

The therapists were also perceived as being able to offer them emotional and practical support as Abby put it: “The other thing that I learnt about the group is that we are sharing our problems, our secrets and we get advice. [Therapists] were nice people you know they gave advice. Especially about the baby. I learnt a lot I enjoyed it (laughs)”. Her laugh at the end of this statement seemed to reflect her surprise at being able to enjoy the group.

The presence of the therapists and their attentiveness, not just to them but also to their babies seemed not to be a common experience for these mothers and this may have to do with being a mother in a huge shelter with many other mothers, and rules and strict protocols. It may also be related to their own deprived histories and their current separation from family and other support structures. Abby stated: “They were nice and it was so patient. Even with all our problems they were so patient with us. I think they were nice people and they love our kids and those kids we are going to them and they were happy. I think they are good people”.

Abby was also able to succinctly summarise the progress from ambivalence and resistance to a positive outcome of the group experience for herself as well as for other mothers in view of the therapists being warm, caring and accepting:

For that thing that they came here and help us learn and know about our babies for that I want to thank them. I want to thank the two ladies for coming here. Everything that we learn of my baby was so good. For that thing that I was getting...With my mom...For fighting with my mom...For those things that happen in the past. Now I don't hold that thing, I wanted to thank them because it helped me so much.

For Sami, a strong bond was described between herself and one of the therapists. This may allude to her strong desire to gain comfort and security from this relationship, a relationship in which she may have felt cared for, perhaps an experience which she did not have as a child growing up: "I like them, especially [therapist] I was very close to her. She was a very sweet person". Sophie echoed Sami's sense of feeling a deep connection to the therapists: "The way they learned us... I think with them... I think I got another sister. They support a lot".

Rose's description of the therapists alluded to an additional sense of support and fellowship that she felt with them in view of her dual role as a mother and as a staff member:

Oh they are so lovely people. Even before we go to the group when we sit down it is the first thing that we talk about. You know they feel for those people and they want it to be sorted before they start. It's not like they were just all about the group. They were also getting involved in whatever was going on here and trying to understand the mothers as well.

Thus, from the interviews, it appeared that it was the therapists' perceived emotional availability that contributed significantly to a sense of safety and care that the mothers felt, which encouraged them to be more open and expressive. The therapists were observed by the mothers to display a sincere interest in and empathic attunement to their emotional and physical well being and psychological growth. This message was received clearly by most of the mothers and was

highlighted by their experience of the therapists as being genuine, sincere and authentic. The therapists also seemed to have been able to effectively handle the mothers' resistances and defenses which may have further endeared them to the mothers. The therapists' modeling of effective ways of relating both with other adults and with the babies may have also contributed significantly in moving the mothers towards important physical and emotional changes.

5.2.4 Deprivation (wanting more) and abandonment

Six of the mothers referred to a sense of the group having stirred up feelings of wanting more and of feeling a sense of abandonment when the group ended. This deprivation and feeling of abandonment was mostly described in respect of the group ending. At this point many of the mothers felt safe and supported in the group and they were able to share more freely and openly about themselves. Hence the group ending was possibly seen as the loss of an atmosphere of closeness, support and care that had been created in the group over time. The mothers described feelings of loss and sadness at the group ending and that they felt that they needed more as they had gained much but not quite enough yet. Genuine bonds of intimacy, trust and safety were established at the end where the mothers felt like they could fully be themselves in the absence of being judged and rejected as they feared at the beginning. This ending may have felt like other painful endings that they have experienced in their lives.

Pixie was surprisingly articulate about her struggle with the group ending. This was surprising in view of her huge initial resistance to the whole group experience and to a sense of mistrust of the therapists and her unwillingness to divulge too much personal information. The following statement made by Pixie indicated a deep attachment and a sense of support and realness that she had experienced through being in the group:

That maybe when we finished the group...maybe they could...maybe when we say goodbye...like me I don't like saying goodbye. I don't like it because I am not going to see the people again. So we just think that ah we are finish now. We did have a tea party on that day and we feel now we're going. I don't

like that, I think we should just say that we're going to see each other again and then we go because I don't like that goodbye.

Linked to this sense of abandonment and wanting more was the sense that many of the mothers are unskilled and unemployed and as much as they had gained psychologically from the group experience there was also a sense of needing something more concrete that would assist them with creating a better future for themselves and their children. Sami felt that the group ended nicely but that more was needed in the future to go into more depth and greater detail. However, she also seemed to be confused as indicated earlier on about the objective of the group: "I was just joking with my friends I was just saying that today we are going for an exam and we are going to work in a crèche (laughs). But I was just joking. I just wanted to know really what will it be written [on the certificate] like." This statement seemed to indicate her needing something more concrete that might assist her in the future. It might also allude to a sense that despite a growing understanding of psychological growth, the fact that physical needs were of paramount importance for many of the mothers who were struggling to survive financially and who may desire some financial independence. She went on to add:

But, this group and I was just thinking something to add. Maybe they must teach us like now we are here we can spend maybe the whole day in the group cos right now we are here [shelter] and we are doing nothing. Maybe they must think for us something that we can do that will give us a source of income so that maybe we can take it and then I can buy porridge for my baby then I am not stressing about this. Because here (the group) we are not stressing and if I get stressed about porridge then I won't be relieved.

There was an expressed need for resources and material assistance or the need to have skills that will improve their circumstances for themselves and their babies. This need was only expressed by mothers from the second shelter, where the mothers are only given a place to stay, but needed to find their own food and nappies. At the first shelter the mothers have access to more resources, a longer term stay and the mothers earn their stay by doing chores at the shelter, as opposed

to the other mothers who have to look for employment outside of the Shelter. Sami said:

Being a mother in the group, as a mother you have to be strong no matter what situation comes across you, you have to be strong ya. Like now my boyfriend is away and I have to try by all means to give my baby something even I can starve myself. Maybe I can think of buying bread but in a way if I think about my baby's porridge and I just stop everything and eat whatever is there in the dining room and I feed my baby.

Having to sacrifice their own needs for their babies and the hardships of being a mother in a challenging situation were evident throughout the interviews. Other challenges were also experienced by the mothers at the first shelter despite them getting a lot of material support.

Deprivation, material or emotional, was a prominent theme for the mothers living in these structured, sheltered environments. While providing much needed shelter and material assistance, both settings seemed to deprive the mothers of a sense of competence and worthiness and emphasised their lack of agency and helplessness.

Abby appeared to have ambivalent feelings regarding the ending of the group and a sense of ongoing deprivation and abandonment was alluded to:

Ah you know we were like friends. You know even with the other mothers we become friends. Even when [therapists] were not here we would become friends talking. It is hard for us that we won't see [therapists] again they were so nice they were good people but us mothers we will still see each other around here.

However, her sense that friendships remained among the mothers also alluded to a sense that something lasting from the groups remained after the ending. The importance of these lasting connections appeared to be linked to the fact that many of the mothers had experienced another form of abandonment and deprivation, in a lack of supportive families and not being able to return to their families. This was noted in Abby's following statement, which was in response to a question about what

it felt like to be such a small group (the group that began with eleven mothers and finished with three):

The thing is that they [other mothers] dropped out because others they left the shelter because they were going back to their homes or to their husbands. So it was painful because we use to being many and then we ended up being three. But I think that it was good for them because they were going back to their families. Of course the group was important to everyone but you know being reunited with your family is a nice thing you know.

Pretty very briefly described another sense of deprivation, in the form of a feeling that she lost out on the group experience if she was unable to attend the session. This statement reflected how she may have bonded in the group and how difficult it was for her to not be part of it at times for reasons beyond her control: "Sometimes it was uncomfortable because you come late and they have started and they are saying things and you were late". This sense of being left out might also have been a familiar feeling evoked from her past.

Suki also struggled with the group ending and a feeling of being left 'short-changed': "No it is sad, because I thought maybe I will learn more than I have learned in the group yah. With my child. About bonding with my child. It is very sad".

On a conscious level the sense of deprivation and abandonment described and experienced by the mothers might have arisen out of the anxiety about the group ending and a fear that they may no longer have the encouragement and support offered by the therapists and the other mothers in view of their challenges with motherhood. Unconsciously there might also have been a sense that they won't find people like those who were with them in the group, in their everyday lives. The loss of the therapists, who gave them the kind of support that they needed to keep experimenting with thinking differently and engaging in different behaviours, seemed to evoke a fear that the changes they had experienced may not be sustainable and that they would regress to previous modes of being.

5.3 Experience of the Programme

This section focuses on how the mothers' experienced the programme that was run during the course of the groups. The themes that will be discussed in this section are: the past; achievement, behaviour change and empowerment; and development of reflective functioning.

5.3.1 The Past

Eleven of the thirteen mothers' talked about what it meant to them to talk about their past and how difficult or relieving it was for them to share or think about their own childhood upbringings and other past experiences. There were mixed feelings amongst the mothers with respect to sharing about their past experiences. For some of the mothers it felt difficult and intrusive to talk and think about their past. They struggled to understand the relevance of this in view of their present circumstances. The sharing in the group seemed to evoke a multitude of feelings, including shame, embarrassment, pain and anger. For some other mothers whilst it was painful to share about their past, their pain was outweighed by the solace and relief they felt in being able to do so. One of their main fears regarding their pasts was that they would raise their children similarly to the way they were raised. Their sense of hope was that they would not and that they could offer their children a better future to the one that they as mothers were currently experiencing.

Pixie and Sue expressed that they hoped that by talking about their past and perhaps understanding it a little better, that this may assist them with raising their own children differently to the way they were raised. Pixie stated: "You know you talk about the past and things, some of the things you might not like that when you think about it, it was good because it helps you. It reminds you so that you don't repeat it with your kids. You won't let it happen to your kids. So...I think I liked it. It was good". Sue said:

The thing is when you grow up badly you cannot take it and do the same thing to your kids. You try to love them and cherish them and you try to do the right things. Like you try to correct whatever was done to you, you try to do it properly to your kids. Like you cannot take your frustration out on your kids you understand. And you cannot say that I grew up like this, you must do the same things I did.

Pretty and Rubi both felt that sharing about their pasts was shameful and exposing. This led to some behaviour of resistance and avoidance in their participation in the group and feelings of guilt were also evident in their responses. Pretty said: "They asked me about my past, what was happening in my past these things. So when they asked me about these things I think that this was the first time that I lie a little. Because I have this problem in the past with my mum. Because it was not good with my mom in the past". Rubi said: "Because in my past was very difficult. I was talking about it but it was very difficult. I talk about it but other things I didn't tell. I just keep it. Yah because I have forgotten about it".

Rubi seemed to experience a lot of ambivalence and uncertainty about how she responded in the group and whether this was the best way for her to manage these difficult feelings. However, she was able to assert herself and express her reluctance to share about her past as well as to listen to the other mothers talk about their past experiences:

Yah, Yah I told them that it was difficult for me to talk about it. I did think about, to think about the past what happened before. It was very difficult. I think it was okay. I think it was good to let go. Not to talk about it, just to forget about it. I think it's okay from my side. Ay my past was very painful. I feel very sad when I listen to the other mothers. I don't want to listen about the past. It feels very hurt.

Abby, Hannah, Fikile, Sue and Rose were all able to describe very painful feelings that were evoked when asked to talk about their past and also after the group when they reflected on this in private. Abby stated the following:

Yah it was painful, cos when I think about my childhood you know my mother was beating me. I think it was because she didn't have...she didn't attend programmes like this or because maybe...I don't know what was going on because she was beating me every time, I remember that every time. I remember my childhood because even the little things she was beating me. I don't know. It was a bit bad and painful and we were talking about how we were before and it was a bit painful. I can still remember this.

Hannah concurred with this: "Sometimes in the group it was difficult to talk about your life... your past. It was very difficult. Because... because some of us we don't want to talk about our past. You feeling you are embarrassing yourself yah. That thing was very difficult" and "That maybe they were asking... when you were small child what were you doing? Those things (laughs) they were difficult... to talk about the past".

As will be discussed later, Hannah was able to overcome this difficulty in thinking and sharing about her past and find relief and hope for the future in doing so.

Fikile's vulnerability and fear of exposure was evident. Along with these painful feelings Fikile expressed lots of anger about having to share about her past experiences. Her angry feelings which seemed to be about protecting her from being vulnerable and exposed seemed to be more accessible to her than her painful ones. The following statement also demonstrates Fikile's understanding of herself:

I feel angry when I talk about my past. Although I don't show it, I feel angry talking about my past. I think they saw... I think they saw that I was holding my tears back but they could see that I wanted to cry. The other mothers were crying. But I was... I don't like crying around people so I was holding my tears. I was feeling very angry. But I think that they thought that I was hurt, but I was feeling very angry. Talking about my past makes me very angry. I feel very angry when I talk about my past!

Sue surprised herself in that she was able to acknowledge some of her painful feelings despite an initial resistance to sharing about herself in the group. She was able to share and acknowledge the value in talking about these difficult feelings:

I don't see anything difficult but you know what I noticed, when we come to the group we realise that we have something in the past that we are counting on. And we never realise that when we grew up certain things that happened to us, we never realised it was so painful but when we spoke about it we were crying it was healing. I was treated badly and now you cry and you feel better.

Sue was able to indirectly acknowledge the value of sharing and being part of a group whose other members shared similar experiences to her, although there is evidence of her trying to rationalize these painful feelings:

Sometimes you might think that you are the only one and that your stories are better than the others. So it was quite painful but now you are living in the world and some of the things that happened to us make us grow and teach about our pain. If you, if your life is not quite nice and there is pain and tears. But God is taking you somewhere because one day you're going to be a leader and you are going to teach people about what happened to you.

Initially in the interview Rose shared what she observed about the other mothers' difficulty and courage in sharing about their past experiences:

I think it was good for them to reveal the past to [the therapists] because even though I have been here for a year and four months, you never learn about their past...If you see a mother opening up about her past, it's really... she's got courage. They don't talk about the past.

Later she was able to link their struggles with her own difficulties in sharing about her past:

With me I know that if you talk about your past it helps you overcome it than just keeping quiet and keeping it inside yourself. So for me it was quite a relief that I had to talk about my experiences as a young child and I think I'm getting it right. And I think I'm even trying to forgive and to try to think about that person [past relationships] about why they were behaving like that. What made them do that?

Rose's statement seemed to reflect some of the value that some of the group members were able to take from the experience of discussing their past experiences in the group, which was a sense of being able to start making sense of the experiences, why they may have occurred and what may have been the intentions behind their parents' behaviours.

Sue and Rose's feelings of being relieved after sharing were also described by several other mothers' in the group. Hannah's eventual willingness to share and her openness was reflected in this statement:

Yah, but sometimes if we start to talk about that thing you feel relieved. Your stress is relieved. You keep on talking with anything and it pass away and you understand it passed away. Some of the stories it makes you cry because it is very, very difficult but you learn something. If you talk about your past you become an older [wiser] person. Your mind becomes older and you know how to talk or how to teach others if they were having problems. Because here we having so many problems. Because some of us are coming from bad backgrounds.

Hannah was also able to think about a hopeful future where the painful memories of her past would be less painful and more manageable; however, it was also observed that when Hannah felt vulnerable, such as during these times when sharing about the past, her defenses appeared to become activated and she used the future defensively in order to not think about the past: "Here you are going faraway. You are not living in your past you are moving faraway to your future. You are not going back to your past. Now your past is your past. You are going forward".

Sophie felt that talking about the past was made more bearable by the fact that the group did not 'hurt' her as she had expected. In her experience the group was able to tolerate difficult feelings and offer her a sense of relief and hope as well: "It was difficult when we think of about that, the past. To be in orphan, you remember those days. I felt that it will hurt me. No one hurt me because I go to the group. I was relieved after that".

Nomsa also struggled with sharing about her past and felt that the remnants of sharing remained with her beyond the group experience:

Like sometimes we had to discuss things like...which happened when we were still growing up. Like me my mother left me when I was three months old. So sometimes we will be asked about those things but not that I didn't like

talking about that. But after talking about it, it takes time to go away. Like it takes me back.

Further probing revealed that sharing brought her a sense of relief and was also reflective of some of her understanding of the transmission of attachment:

They [therapists] always say that the things that I was talking about, that we must always talk about it so that we cannot, we cannot...so that we can be able to treat our children differently. Not the way we were brought up. I think it helped me in the sense that I must always be there for them. Not repeat the things that my mom did to me.

Painful experiences of childhood and other past early relationships seemed to be aspects of their experience that they would prefer to avoid. Many of the mothers found thinking about or talking about these experiences very distressing and painful. However, as the group progressed many of the mothers were able to develop some self awareness regarding the present and were able to link this to their past experiences. This allowed them to start to think about the root of some of their behaviours and how they may go about further understanding and managing this. An intense relief was experienced when the mothers were able to talk about the past and not feel judged, exposed or shamed in doing so within the safety of the group.

5.3.2 Achievement/empowerment/behaviour change

Eight of the thirteen mothers' who were interviewed described significant changes in their behaviour towards their babies as a result of participating in the groups. They acknowledged the challenges of being a mother but they felt more able to refrain from being overwhelmed and paralysed by these challenges since being in the group and instead engaged in more productive ways of relating to their babies and their older children who might not have been in the group with them. Most of these mothers spoke about a feeling of helplessness, either because they were first time mothers and didn't know how to manage with a baby or because they were focused on the task of surviving and getting on with things, that they neglected to pay closer attention to the needs of their babies. This feeling of helplessness was often

accompanied by feelings of guilt for not having known how to manage with their babies. Pixie spoke more indirectly about this:

Most of the time people here they don't know what to do. Most of the time they are leaving the children alone because they could be encouraged. Because most of them are the first time mothers. Because if they have to come to a group like this they will see how they were doing wrong. Even we ourselves we could see ourselves that we were doing wrong things.

While this recognition of having been doing 'wrong things' may have been painful for many of the mothers, they also seemed to be very open about the benefit and support offered by the group and having a sense of achievement at becoming a better mother. Abby stated:

Before, I didn't understand you know I just had a baby and my mother being far away and nobody telling me about the baby you know. But now I understand since they were explaining to us that you must talk to your baby must tell him even if you are feeling angry you must tell your baby "my baby I am angry today I'm not fine". The baby understands you know, before I didn't know that the baby he understand you know. I would just think that the baby...was annoying.

Hannah displayed an increased level of self-awareness and a willingness to learn. She said: "The group was teaching us to handle the situation... Whatever situation you come in there you supposed to take it easy and not become like... If you have a problem you become sad or crying or shouting with other mothers here. You supposed to take care of your baby and taking of yourself and after you handle the situation". This statement seemed to reflect a sense that the mothers experienced the group as helping them find space for their own feelings and those of their baby.

Pretty was also open about sharing her initial feelings of helplessness and her struggles with managing this and then gaining support, self-awareness and some understanding of her baby and encouragement within the group to attempt to do things differently:

In the group I learned to take care of my baby and to be...To know what my baby needs and to know how to take care of my baby. Because she's the first one. Because before I was in the group I didn't know that if she has this, what to do. How am I going to make her fine without slapping her? I was always shouting. So I think I have learned a lot about my baby needs. Because you don't know that you are having problems, even your baby can get those problems. Because we do... you cry, you just cry. Because now I know that even when you feeling like this your baby also feeling like this. I think that let me help her and make her to be happy and not leave her to cry or shout her. So this was what I liked about the group.

The change in Pretty's physical reactions and behaviours towards her baby was shared by several other mothers who also described previously acting out their feelings but through the group experience learning how to manage this differently. Pixie said: "I used to hit him. Yes I use to take my anger out on him. I don't shout at him like before. Sometimes I just put my earphones on or I just put my radio on. I go out. I don't hit him. To love my kids and to be there for them always. As a mother you need to be there for your kids".

Abby reflected on changes in her physical behaviour towards her baby but the following statement also reflected some anxiety that she may have been feeling about the sustainability of these changes or it could be interpreted as a reflection of her having accepted the idea that you do not need to be a perfect mother, and that at times, you will make mistakes, and that is also okay: "Maybe before... sometimes I was screaming at him. But I can see...since this programme started I am not doing this anymore to him. Maybe one day I will do it...I will scream at him...maybe when he cried a lot. Cos he is naughty (laughs) also".

Hannah also reflected changes in her physical behaviour towards her baby and a sense of achievement of having moved beyond this behaviour to becoming more aware of the needs of her baby: "I used to keep on shouting, and she would keep on screaming and crying when I do this thing. But now she's fine because now we're talking. Now we learn something that if she's crying then I'm supposed to take her, and comfort her".

The fact that it came up in so many interviews seemed to reflect that this ability of the mothers to think about and to begin to know their own and their babies' feelings seemed to be a great achievement for many of them. Abby put this very eloquently:

I think that the programme was useful to me you know. Cos there was some of the things which I didn't know about the baby, you know. When the baby is crying I was just ignorant you know thinking that my baby is just naughty or something but. But I learnt that I must try to understand my baby, just to attend to him. It means, it means that when he is crying he is in need of something you know. He is not happy about something. I learnt that babies, even if they are small, they know their environment and they know even if I am angry, or sad or happy they know everything you know. So I learnt a lot of things which I didn't really know before.

Nomsa was able to summarise the aim and the importance of becoming more emotionally attuned and keeping baby in mind as a huge sense of accomplishment that contributed to her and other mothers feeling more competent and valued: "Yah as a mother I learned that you must always be supportive. You must always be there for your child. Because it encourages the development, self confidence as they grow up. The love you give and the time you give and the attachment".

Some of the mothers articulated the benefit of the programme as being that it encouraged engagement between group members. Sami felt that being in the group had also fostered more supportive relationships between the mothers and that she could access advice from the more experienced mothers:

When I meet a problem I just speak to one of them [other mothers] when my baby is not feeling well what can I do and they say what I must do this and do this. Because some people got lot of experience. So mina in the beginning I had to say to them I am encountering this problem, ya. Usually I tell these people.

Pretty also commented on the fact that being in the group allowed for the opportunity to learn from watching other mothers with their babies: "So when you come to the

group and you see other mothers with the kids and how they are with the kids. They lovingly and laughing and you also start being loving towards your child”.

Another change experienced by the mothers and the babies whilst participating in the group included a new, more thoughtful way of managing separations from their infants. Abby’s description reflected a new understanding of her baby’s experience of separation and how she could help her infant manage the feelings associated with separation:

Now I understand a lot of things about the baby like even if I am going out I am leaving him in the room and I must talk to him and I would explain to him I am going to the toilet and I am coming back now. I didn’t do that before I wasn’t doing it I was just thinking that babies doesn’t understand I would just leave him in the room and go to the toilet because I thought that he wouldn’t really understand you know.

Ruby shared Abby’s experience, as did several of the other mothers, of learning that when you leave your baby it is possible to do this while keeping your babies feelings in mind. Ruby’s statement captured this experience best:

I learned a lot. When you are going somewhere, you must tell them you are going somewhere. You don't go somewhere without saying goodbye to them. You don't go without telling them that you are coming now. If you don't tell her like that, she will cry. She will know, 'my mother is abandoning me. She don't want to comfort me'.

Most of the mothers seemed to describe more effective ways of holding their babies in mind. This seemed to be a result of the mothers’ more effective management of their own emotions which seemed to facilitate their ability to help their babies to manage certain emotions, which previously had seemed to be mutually frustrating and detrimental to the mother-infant interactions. The mothers were helped to articulate their concerns their fears and concerns regarding motherhood. This openness facilitated their increased self-awareness and awareness of the needs of their babies. This help seemed especially crucial for those mothers who described poor childhoods and poor adult interpersonal relationships.

5.3.3 Development of reflective functioning

This section represents the largest theme identified during the analysis of the interviews and one where the most changes were experienced by the mothers in terms of themselves and their experiences of motherhood. Almost all the mothers' interviewed, with the exception of the two caregivers seemed to demonstrate a capacity for reflective function which is an ability to understand themselves and their babies. Most of the mothers were able to describe their internal states of mind and those of their babies during the facilitation of the group and some attributed this to being as a result of being part of the group experience, where talking about difficult feelings and experiences, which initially were avoided, turned out to be relieving and useful. Some of the feelings that the group experience evoked were very difficult and some were very empowering. Being able to reflect on this also demonstrated the mothers' capacities to tolerate these difficult emotions and to think about them in depth, for some mothers more so than for others.

Pixie was very ambivalent in how she described her experience of the group. She was observed to be depressed and withdrawn during the interview. Pixie was also one of the mothers who struggled with trust and with the group ending and subsequently suggested avoiding saying goodbye to the therapists. However, she was able to reflect on strong feelings of anger and helplessness that she felt and fear that she experienced her children feeling towards her. Pixie said, "Because most of the time I'm very angry. I got to know how to deal with my anger. I was not happy and I didn't know what to do. And I did not know what to do with my kid. I got to know that my child comes first and I got to know when she's hurt and when she sad and when she's not happy" and "It was scary for my kids. My kids were very scared of me. But now they are getting good. Because they were really scared because if I was talking and used to be loud and at the same time I would hit them softly..." Her ability to reflect on the fact that she did not know how to deal with her anger suggested that through the group she became aware of the times she becomes overwhelmed by her emotion, which pointed towards the beginnings of self-awareness and a capacity to begin to tolerate her own affect better. She was even able to reflect on a sense of loss she experienced at not having had this kind of group support earlier in her life:

It made me feel good you know because I did notice... Because I used to think that raising kids is about this and about that. Because you know like being a wife and raise kids like this. Because we were not taught what to do or some of these things. You know we don't know. I just wish I'd known about this before I had all my kids.

Sami reflected similar feelings about wishing that she had known before what she knew now not only from a practical perspective but knowing your baby from an emotional perspective as well: "I understand that he is coming into the world now and he is becoming a human being, a real human being now." Nomsa was visibly distressed that she was initially unaware of the impact of her behaviour on her children but she stated that through the group she was able to overcome this and create a more positive outcome for her and her children. She reflected on the importance of being aware of how her child experiences her:

I think that it does make a difference because sometimes you will be angry with the child and he won't even know what has disturbed him. So that will make him to maybe be scared of you. So I think that it makes the child to be sensitive to just trust it be all right. 'My mum I can always talk with her whatever'. Because when you're always angry and shouting the child never feels safe with you.

Several of the other mothers revealed a lack of confidence and sense of competence in being a mother in not knowing the needs of their babies. However, they seemed able to reflect on this and track some changes that they observed in their behaviour in terms of becoming more capable mothers. These changes that they reflected seemed to manifest as a result of an increase in their self-awareness and their gradual, increased willingness to engage and better understand themselves and their babies. Abby stated the following:

I was thinking what I was doing before you know I was thinking that what I was doing before you know I wasn't being a good mother to my child (laughs). You know I was worried and I was thinking how am I going to be with this baby? What am I going to do with this baby like this you know? But now you know I understand a lot of things. I know many mothers out

there they...they don't know much ya, I can even see around here they way they treat their children. They don't know – just like I was like this before. Yes...yes cos this programme really changed me...yah it really changed me...cos before I didn't ...before I was just...a mother. Actually I am a better mother now (laughs).

Hannah also reflected a sense of feeling overwhelmed and helpless but moving towards more self acceptance and understanding, and being better able to manage these intense emotions: “Yah for the first time that, the first two weeks I was feeling very, very angry. I don't want to lie to you. Sometimes I was hitting her. Even if you have stress or you are not well yourself you are supposed to calm down yourself because before you always crying... I didn't always understand what was happening”.

Pretty experienced relief at having the support and care offered by the group and she felt that this help led to her increased capacity to hold her baby in mind. Her comments around what she felt she had learned from the group suggested a definite interest in what her baby was attempting to communicate to her, although it was apparent that at times, she muddled her baby's changes with those of her own:

Being in the group was good for me I can say...it was such a good thing...I never met a group like this before. ..I was having so much problems with my baby. Because my baby she used to cry and she don't stop. I had to think when I was with my baby. But the child changed. I remember one of them they do this thing with us. This is really helped me as a person. Because you know you end up pregnant and they just dump you and stuff. It was not easy to have this kids.

Pretty seemed to have some insight into her struggles before the group and her overwhelming feelings of being incapable, as reflected in the following statement :, “Because you see the children when she was crying I was even thinking about what is happening. Because this thing... when she was crying I was asking 'why are you crying?' 'What is happening?' 'Why can't you help the situation?' 'You keep on crying why?' So I was not feeling in command”. Fikile was able to ask similar questions

when her baby was distressed, leading her to become more attuned with her baby and her needs whilst at the same time managing her own overwhelming feelings:

Before I used to get angry when the baby was crying. I used to be upset, and I become sad, 'why is she crying?' But I know now that you should pick her up and try to understand, try to put yourself in your baby shoes and say 'maybe she wants milk, maybe she wants to bath, maybe the nappy is wet', yah try to understand your baby. That's what I learnt a lot. But sometimes it is hard, sometimes it is hard to understand the baby. But I do.

Suki also reflected on her internal struggles and seemed surprised at her discoveries and successes as a result of being in the group and getting to know her baby: "You know I used to ignore her most of the time before. I used to ignore her before. And I used to think that she's just the child. I never had to spend more time with her you know like to check on her. I feel more like a mother now. I feel more responsible, Eish. Yah I think it's good for me, I have learned so much." Suki, like Fikile, was also able to acknowledge how difficult it was for her to be with others who had different experiences from her own: "Sometimes it was very emotional because I have learnt that we are from different situations all of us we came here and we are from different situations. Others they are moody, they have had very bad experiences. So it was very emotional for me."

Sophie, like several of the other mothers, talked about how hard it was for her to think about her baby when she herself was struggling with feeling depressed, but she ended this statement on a more hopeful note with a sense of accomplishment: "There were times when my baby was crying and I was just depressed. But in the group I learned that when my baby is crying I must not shut him out. I must try to calm him and talk with him. Now I do that, it's what I learned". This statement seemed to reflect an awareness of how her own feelings had hindered her ability to think about the feelings and experiences of her baby. Again, this awareness suggested the beginnings of a capacity to self-monitor and consider the effects of her emotional experiences on her baby. Ruby reflected a similar sense of depression and anger at the difficulty in learning about her baby's experiences of

her, but also a sense of achievement at being able to tolerate these unbearable feelings and developing a space in her mind for her baby:

I remember before, when I was not in the group, I didn't care about my baby yah. When I go inside the group, I just feel so sad. I didn't say anything in the group. When I'm leaving, I'm just crying, crying. Until I come back. When I come back I don't make excuses like you don't care about us, you won't help us. Hey it was very difficult to learn about it. To learn how my baby feels about it. But now I'm fine I learn to comfort the baby. To take care of her.

While most of the mothers who were interviewed expressed a sense of having learned a great deal about themselves and their babies, some of the mothers did not seem to have developed a greater ability to manage their emotions or developed more capacity for reflection. Sue, as staff member employed at the shelter, seemed, at times, to have benefitted personally from the group, but she was unable to reflect on this. Sue appeared rigid and defended in her beliefs and actions throughout the interview and it was evident that she was continuing to use these well-entrenched defenses. She described the group experience and her participation using learned phrases that were devoid of meaning and depth, for example:

And the world is not my world but God's world and whatever happens, good or bad, I must try to accommodate and to forgive people. Because I believe that God has forgiven. I know I'm not a perfect person and I know that I've made mistakes but I'm trying to be good. I'm trying for perfection in other words.

This excerpt above from Sue's interview suggested that she feels that she has a set of rules to live by, those of her Christian God, and the sentiment expressed throughout the interview was that she did not need to learn anything further. This rigidity left the interviewer with the sense that Sue was not able to be reflective about her mothering or how the baby who she fosters experiences her. Rose's descriptions also reflected a similar kind of detachment from the group experience and a sense that she had not allowed herself to use the group fully and grow internally as a result of this: "Yes I can say that I I'm so proud of myself because some of the things that

they say there I can say that I was ready, I knew them and I can say that I was using those techniques I lot”.

With the exception of these two caregivers, Abby succinctly summarised the group experience for almost all the mothers who did demonstrate an increased ability to observe and think about their babies. She did this with a sense of humour in relation to herself and the mind of her baby, which suggested thoughtfulness and spontaneous playfulness:

Mmm. I think that I feel like I changed. I was not bothered with this before. I feel that this group really helped me because it changed me in another way because I am no longer who I was before. I have changed. I am happy and I feel bad sometimes cos before I was like...I feel like I was like bad mother. I feel that maybe my baby can notice that. I feel that he can notice the changes also so maybe he is asking himself “why is there a changed mother now?” Ya (laughs).

Most of the mothers who were interviewed seemed to have developed and demonstrated a growing awareness of what was happening inside of them as well as how they thought about and regarded the experiences of their babies. This awareness as to the internal states of others extended to the other mothers in the group. They explained that the group experience had assisted them in recognising that their babies, no matter how young, behave meaningfully and are communicating with them through behaviours that they previously perceived to be ‘naughty’ or confusing and meaningless. In respect of their own feelings, thoughts and behaviours the mothers also described significant changes. Many of the mothers were able to acknowledge difficulties that they experienced being mothers and not fully understanding their babies. They also acknowledged not understanding themselves either and how a growing understanding of themselves has helped them to foster better, more meaningful relationships with their babies and with their other older children not attending the group with them. They also described the group experience as having assisted them to tolerate feelings of uncertainty and not knowing and encouraged them to try and develop their understandings through the process of sharing about themselves and their past. The mothers could openly

share how frustrating and challenging motherhood was and that they felt, at times, useless and angry with themselves and/or at their babies for this feeling of helplessness that motherhood evoked. These painful acknowledgements together with their willingness to have a different experience and relationship with their babies appeared to contribute significantly to the changes in their behaviour as discussed above

5.4 Mothering in a shelter

There seemed to be mixed reactions to what it was like to be a mother in a shelter setting. Understandably many of the mothers found it difficult preferring if possible to be in their own homes or living with family. However, many of the mothers seemed to have resigned themselves for the moment to living in a shelter.

Pixie reflected a fear of exposure and mistrust in living in such a setting, especially where she felt the management to be unsympathetic and judgemental. However, she also recognised that the shelter could offer her and her children opportunities that they would not otherwise have been exposed to, which made living in the shelter slightly more tolerable for her: “I have to be strong for my kids because here for my kids for the education. Because me myself I did not finish school because my parents didn't have enough money and I like my children to finish school. So I have to stay here no matter what”. Her difficulty with this setting despite its advantages was reflected in the following statement: “You can even think of killing yourself at times. It's not easy”.

This double bind and ambivalence was also shared by Fikile, who was both a mother and employed as a caregiver at the shelter:

Being here [at the shelter] is a good thing and also a bad thing. I feel that most of the time we are told your how to do things, how to handle your baby, mostly everything. So you don't feel the foundation, your baby doesn't get, I have two babies here. I see more nicely to the older one because this one I have to keep hitting all the time, but you have to do things according to [the shelter], according to the management. According to what they want you to

do, you don't do what you want. You don't do things by yourself you have to accommodate for the rules you see.

Chrissy shared a similar experience with regard to living in the shelter, which suggested that she experiences the setting as depriving her of agency and self-determination:

I don't think there is someone who likes to stay in a home. All of us we don't like to stay here. But we stay here because we don't have an option. We don't have a choice so that is why we stay here. But if we had our own choice to stay in a big house in the big room and stuff we couldn't have been stay here. Yah we stay here because we don't have a choice. Like um. Like, um, everything is difficult. Here we stay under the rules of someone. You don't do the things the way you feel like no. You do the things according to the rules of this place.

Ruby felt the same level of ambivalence which highlighted for her the challenge of living in a structured, sheltered environment that was not her own: “It is difficult because sometimes you don't have the time. You are supposed to do duties, yah. It is difficult...”

Other mothers may have felt a similar way about living in a shelter where they had no agency and choice but they were able to focus on the advantages such as it being a fairly safe environment that made provision for basic needs, which made living at the shelter more bearable. Hannah said:

Here we are living in the village, you don't see your family. But even when I am here there are sisters and there is the small child. We are good family here. When you are hungry you go to the kitchen... If you have a problem of money you go to G and ask something. It's very easy now. Even now I'm coming from the crèche now. I am at home now. I understand. Before I was not understanding when I was coming here, eish. There were a lot of questions I asked myself what was I supposed to do here.

Suki felt that the sense of community in the shelter was what felt good for her, despite the difficulties of living in a shelter:

You know to tell you the truth it is very difficult to be stay in a home [shelter] being a mother with a child. But staying here with other mothers with other children I get very comforted, that I'm not alone, that we share our pain and that we share our experiences. So I feel much comfortable but being a mother with a child staying here is not right for me. But staying with other mothers and with other children is like much better...much better. Because we share a lot.

Nomsa felt similarly that the shelter was able to give her and her children something better than she may have had and that it was a holding, supportive type of environment: "I think that it is good because they are providing us with things that we...me and my children that we need. Place to sleep, food to eat and our children are being taken to crèche. So I think it's good because the kids are getting something". She recognised that this was what she was currently able to provide for her children in the hope that it would offer them a different future:

Yah sometimes it's hard because I always ask myself how long am I going to be living like this. How long am I going to be living a life like this? But at the end I tell myself that I have this problem with this disease [HIV], but I have to stay for my children so that they can have better education. Because I don't know what can happen to me.

As can be seen the mothers experienced mixed feelings about living in a shelter. Whilst the shelters are able to provide for the mothers and their children in terms of their basic needs, it does seem to deprive them of a sense of empowerment and agency which appeared to lead to feelings of ambivalence and unhappiness. Many of the mothers seemed to have taken solace in the sense of community offered by the shelter and the sense that together with other mothers who have similar experiences, they are much better off than on their own, despite the many hardships and challenges which they face living in a place that is not their own. The shelter, specifically the first one, seems to offer the mothers a level of hope that their children may have a different future to the one that they (mothers) are currently experiencing. This hope may be what makes living in the shelters bearable for the mothers.

5.5 Conclusion

In this results chapter key themes were discussed in relation to how the mothers described reacting to the group experience specifically in respect of their defensiveness and reluctance to engage as well as the safety and structure that they felt that that group offered them and their experience of the therapists' emotional availability throughout the group process. With regards to their experiences of the programme the results were captured under key themes as they emerged in the data collection and this included a sense of achievement and behaviour change as well as a sense of empowerment and the development of reflective functioning. The mothers' experiences of mothering in a shelter which was a secondary aim of this study were discussed under a separate theme.

In the discussion chapter that follows, the findings of this study will be discussed in relation to appropriate literature and theory.

Chapter 6: Discussion

6.1 Introduction

The primary aim of this research study was to explore African mothers' experiences of the "New Beginnings" mother-infant group psychotherapy programme, in particular, their experiences of the content of the New Beginnings Programme and the therapists of the group psychotherapy. The secondary aim of the study was to explore the mothers' experiences of mothering in a shelter, with specific reference to how this may have influenced their experiences of the programme. This, in part, was to determine how this Western-based programme was received within a South African context. Four key research questions were proposed for this study around the following areas: the mothers' experiences of the efficacy of this group; their experiences of the content of the programme and the therapists running the programme, how the context of living in a shelter may influence the mothers' experiences of mothering and; how this context may influence the mothers' experiences of participating in a psychotherapy group, which is specifically focused on the relationship between themselves and their babies.

Thirteen mothers from two shelters in the Greater Johannesburg area were interviewed shortly after they had completed attending the New Beginnings programme facilitated in 2010. Using semi structured interviews for the initial interviews and narrative analysis as a means of interpreting the data, this qualitative research study yielded a number of findings as reported in the previous chapter. A detailed discussion of these findings under a heading specific to each of the four questions listed above will follow. Whilst each of these questions is addressed under separate headings they all remain interlinked and the discussions follow on from the previous one.

Overall, this research study was able to provide some answers to these research questions and to validate, to some degree, the feasibility of the New Beginnings Programme in a South African context.

6.2 The mothers' experiences of the efficacy of the group

As discussed in the results chapter, most of the mothers who had participated in the New Beginnings programme felt that change had occurred in a number of ways. Most of the mothers felt that they had changed with regard to becoming more aware of the needs and communications of their infants. Many of the mothers also made comments that suggested an increased level of behavioural and emotional control, whereas before they felt unable to refrain from acting out their feelings due to their limited understanding of themselves. Many of the mothers also described a sense of accomplishment and achievement in that they were able to understand themselves and their babies better and they felt more confident and less overwhelmed with regards to their roles as mothers. They also described feeling more empowered in that they developed practical parenting skills as well as increased psychological insight into their own and their infants' states of mind.

Two of the mothers in the group who were part of the staff at the first shelter were not able to describe an increased level of reflective functioning. The one mother seemed to struggle to manage her own emotions and although she described gaining some benefit from the group experience she was unable to describe what this meant. She remained fairly rigid and defended in her descriptions and her interactions and she described the efficacy of the group using stilted language comprising of learnt phrases and clichés. As a caregiver, Sue felt that her role was very much as a teacher or a pastor. The other caregiver reflected a similar kind of detachment in benefitting from the group experience. This may have been complicated by the dual role she undertook whilst participating in the group. This bears further thought in terms of the future facilitation of the New Beginnings Programme which will be addressed under the section on clinical implications of the study.

While these two mothers, appeared to remain fairly defended throughout the programme, most of the other mothers, who had initially attempted to avoid talking about their fears and concerns regarding motherhood and about their relationships with their infants, were able to become less defended and acknowledge and express the difficulties they face as mothers. This reflected less of a tendency to idealise their babies and an ability to engage with the fact that "parenting children is probably one of the most demanding, stressful things we can do. Babies...can only

communicate their needs through behaviour and their behaviour is not always easy to read or manage” (Howe, 2011. p. 188). Hannah offered this:

You learnt that if you are a mother sometimes you feel so sad and sometimes you feel so happy. Sometimes you feeling strange and lonely. Sometimes you feeling in a depression. Because maybe she's sick and even you, you also become sick because you don't know what is happening to your child. You see your child is sick. You don't have anything to do with that thing but you feel pain.

This ability to view their babies and their roles as mothers in a more balanced, authentic way supported the findings of the original pilot study conducted on the New Beginnings programme in the UK, which also found that after completing the programme mothers described their relationships with their babies in more realistic terms, “allowing a measure of doubt and mixed feelings to punctuate the idealisations” (Baradon et al., 2008, p. 252). The mothers’ initial challenge to open up and share potentially painful and conflictual feelings could be understood as a form of resistance against exploring personal issues or painful feelings. This defensive approach, evident in most of the mothers, to life in general and motherhood in particular, could be interpreted as the mothers’ attempts to protect themselves from the anxieties that interacting with their infants evoked in them and may also have been related to being in the intimate setting of a psychotherapeutic group.

Many of the mothers spoke about becoming intensely angry with their babies before the programme and acting on this anger as opposed to thinking about it, thus, it could be hypothesized that many of these mothers exhibited “frightened and frightening maternal behaviour, [which] emerges as the intensity of the attachment relationship stimulates the emergence of dissociated affect left over from the parent’s own early attachment relationships” (Grienenberger, Kelly & Slade, 2005.p.300). Fraiberg and her colleagues (1980) referred to ‘ghosts in the nursery’ or re-enactments of the parent’s past in the new relationship with their infant, in which the infant is viewed as a silent partner in the caregivers’ previous experiences of trauma that unconsciously takes up residence in the mother-infant space. Howe (2011) referred to ‘abdicated caregiving’ where the mother disconnects from her infant when

the infant's needs are perceived to overwhelm her ability to meet these needs and when these needs evoke painful memories and feelings from her own childhood which then occupies the mother's mental state. This concurred with Fonagy's (2001; 2002) studies which highlighted the impact of the intergenerational transmission of attachment. His findings are supported by the findings in this study, in that mothers who were most likely insecurely attached themselves struggled to mentalise both their own internal states and those of their children, thereby influencing the development of their child's capacity to mentalise. Fonagy (2001) stated it as follows:

We believe that the parent's capacity to adopt the intentional stance towards a not-yet-intentional infant, to think about the infant in terms of thoughts, feelings and desires in the infant's mind and in their own mind in relation to the infant and his or her mental state, is the key mediator of the transmission of attachment and accounts for classical observations concerning the influence of caregiver sensitivity (p. 27).

The group experience seemed initially to evoke for many of the mothers a reluctance and fear to bring to consciousness threatening unconscious material. The group could be seen to have created high levels of anxiety for the mothers in their efforts to keep this unconscious painful material at bay. These dynamics may have been actively excluded from consciousness due to the intense, painful feelings and memories that it evoked of their own experiences of attachment. Hannah and several other mothers indicated that it was difficult to keep being reminded about their pasts and they preferred not to talk and think about it. Hannah said: You are not living in your past, you are moving to your future...now your past is your past". Rubi said: "I think it was good to let go. Not to think about it, just to forget about it." However, despite a wish to let go and avoid thinking about the past, an intense relief was described by the mothers when they were able to talk about their pasts and not feel judged, exposed or shamed in doing so within the safety of the group. For Fikile however, this was not easily achieved. She felt angry at being asked about her past. These angry feelings which seemed to be about protecting her from being vulnerable and exposed seemed to be more accessible to her than the painful feelings: "I was feeling very angry. But I think that they thought that I was hurt, but I was feeling very

angry. I feel angry when I talk about my past". Other evidence of their reluctance to bring to consciousness, painful unconscious material was the unwillingness that most mothers described in having to attend the groups. They described feeling forced, inconvenienced, irritated, angry and confused. An underlying fear of sharing and thinking about painful aspects of their lives when they perhaps felt that they did not have sufficient skills to cope with this, was evident in this initial unwillingness to engage. This was also evident in certain references toward feelings of being rejected and not cared for due to the group ending. This was especially evidenced by Chrissy who felt victimised and rejected at not having received her certificate despite her compliant behaviour in attending the group.

It is possible that the mothers' anxiety was partially alleviated by the homogeneity of the group. Some of them were able to voice these thoughts indirectly in their acknowledgement that they were not alone in their difficulties and that the other mothers in the group had similar experiences to them. While there is no research available regarding the characteristics and effectiveness of mother-infant group psychotherapy in South Africa, Paul and Thomson-Salo cited by Ritvabelt & Panamaki (2007) describe homogenous peer mother-infant groups conducted in Australia, as having the distinct advantage of offering mothers the space to explore any guilt feelings that they may have and it also provides a space for the mothers to achieve in-depth therapeutic identification, with the other mothers as well as with their own babies. One of the mothers in this study, Pixie, did, in fact, comment that she had gained a great deal from being able to watch the other mothers: "they loving and laughing and you also start being loving towards your child".

As the groups continued, the mothers, with the assistance of the therapists were helped to overcome some of these initial anxieties and they began to view the group as a safe place. A large contributor to this growing safety appeared to be the group's ability to tolerate the mothers' and infants' difficult affect in the here-and-now. The therapists were able to demonstrate that they could tolerate the difficult experiences of the mothers, as they remained consistently emotionally attuned to them and they encouraged emotional authenticity in the group. This appeared to help the mothers to gain an improved understanding of what in their pasts or in their relationships with their infants, triggered intense, anxiety provoking feelings. An

improved understanding of what left them feeling helpless and unsure about how to manage their own feelings and those of their infants was described to have been achieved by some of the mothers. An important focus of group mother-infant psychotherapy is to link past experiences to the here-and-now of the group context with the hope that the group will provide the mothers with experiences that can become new internal representations (Ritvabelt & Panamaki, 2007). This hope was also facilitated by the mothers' successful interactions with their babies which most of the mothers in this study were able to achieve to a greater or lesser degree.

The mothers were able to describe being content just to be in the group, spending time with their infants and talking about their infants and themselves in a safe, containing environment which they felt that the group offered them. Most of these programmes "provide an experiential arena where parents and infants could play and learn and simply be together in body-and-mindfulness" (Reynolds, 2003.p.362). Baradon et al. (2008) writes that the New Beginnings Programme, in particular, is geared towards evoking awareness in mothers of their infants' attachment and security needs. They describe mentalisation as being present when a mother is able to provide a three dimensional narrative of her infant's internal states as well as those of her own. The internal states of all the members of the group are also observed in the mother-infant interaction in the group and reflected on, so as to create an increased awareness in the mothers' minds. In some ways the emotional connections that the mothers experienced in the group with the other mothers and the therapists could be seen as attachment bonds: "A person can seek and maintain proximity to a group and use the group as a source of comfort, support and safety in times of need and as a secure base for exploration and growth" (Mikulinger & Shaver, 2007, p. 235).

The changes mentioned by the mothers, as discussed above, namely: an increased awareness of their infants' needs and communications, a greater capacity to tolerate affect and think about both their own and their babies' feelings, and the ability to use the group as a safe, supportive space and other mothers as support, seemed to increase the mothers' capacities for mentalization and give the mothers more confidence in themselves as mothers. Howe (2011) suggested that it's the parents' capacity to mentalise their own and their children's behaviour that acts as a buffer

and helps them to gain more confidence in coping with the demands of their children on them. A parent who has had a secure base would be able to mentalise with more ease than one who had a disorganised attachment (Fonagy, 2001). Mentalisation seems to be a central objective of several mother-infant group psychotherapy interventions that have been developed and facilitated internationally, including the New Beginnings Programme.

Parents who have endured difficulties, such as those that the mothers in this study have endured: being exposed to neglectful childhoods, domestic violence and rape, poverty, lack of family support and being HIV positive, may have difficulty with developing a capacity for reflective functioning and a capacity to hold their babies in mind (Howe, 2011). One mother said that before the programme when her baby cried she would leave the room or put on head phones to block out her babies cries. Maternal reflective functioning is the result of a secure base of attachment which provokes an active interest in the mothers' minds about their babies' internal states of mind (Slade et al., 2005). One mother wished that her mother had attended a 'parenting' course such as this one. She suggested that maybe then her mother would have behaved more like a loving mother towards her. Another mother expressed surprised at what she learned in the group, in that she did not think that babies had similar feelings or experiences to adults (Slade et al., 2005; Allen, Fonagy & Bateman, 2008; Fonagy, 2002; Green, 2003; Fonagy, et al., 2002 & Howe, 2011). Although the mothers did not use the term reflective functioning, most of the mothers reported some increase in their own reflective functioning, in that they expressed an improved awareness and understanding of their own and their infants' feelings and communications. They were able to describe their infants' feelings, behaviour and minds in ways that were more detailed and descriptive, linking behaviours to emotions such as fear, anxiety and distress that their infants may have been experiencing, for example, the mother who was able to acknowledge that her children feared her when she became angry. These findings of an apparent increase in reflective functioning concurs with Baradon et al's (2008) findings of the New Beginnings Programme implemented with mothers and infants in the Mother-Baby Units in prisons in the UK:

There was a significant increase in the mean overall level of RF from pre- to post-course. After the course, mothers were able to reflect more freely on how their emotions and behaviours might affect their infants, and the mothers were able more accurately to attribute their own and their infant's behaviour to internal mental states (p. 251).

The mothers in this study described feeling upset and initially helpless when witnessing their infants' distress and these seemed to trigger their own unresolved childhood memories and feelings. However, the group also appeared to assist the mothers to tolerate these difficult feelings. They expressed some amazement that their babies reacted to separations and changes in the mothers' moods, including when they were feeling depressed and uninterested. They also began to understand that until such time that they were able to understand their own internal states and understand their babies' communications as reflective of the infants' internal states; their babies would not feel secure and would remain aroused and needy.

Chrissy was also able to reflect on changes in herself and a growing sense of competence in meeting the needs of her baby: "I didn't know much about the babies and the feelings of the babies, like how they feel and everything. But after the group I benefited a lot because now I know the feelings. I can see if my baby feels something, now I can notice that". Her statement summarises many of the other mothers' experiences of the group as a place where they were able to see their babies and understand their own and their babies' needs, some perhaps for the first time since becoming mothers.

Some of the mothers were also helped to express their fears about motherhood, especially their fears that they would raise their children in the same way that they were raised. This ability to recognise that they did not want their babies to have the same upbringing as they had is a positive step towards curbing the intergenerational transmission of attachment (Baradon et al., 2008). This helped some of the mothers to explore the ghosts from their pasts, however, only to the extent that they were willing to explore their childhoods and their own parenting (Allen et al., 2008).

The group context seemed to offer the mothers a sense of hope that they could become better mothers. Several of the mothers expressed a willingness to learn

more about themselves and their babies despite their initial ambivalence about being in a psychotherapeutic group. This seemed to reflect a confidence in the group process as a vehicle for potential change in their mothering and a gaining of confidence and sense of relief. The group context seemed to offer these mothers a space where they could openly share their fears and anxieties and a space to reflect on the feelings of their babies. According to Grossmark (2007) the group has the potential to offer the mothers a mental and transitional space which encourages thinking and where the potential for psychological growth and insight is possible. Comparing group interactions to mother-infant interactions, he commented:

Like musicians or dancers improvising together, there emerges a sense of oneness and wholeness. The participants are responding to and accommodating to not simply one another but to the cocreated rhythms and oneness that they themselves are evolving and shifting. The emergence of this “rhythmic or harmonic element of oneness” ... is an unthought and essential part of the mother–infant synchrony and is crucial in the development of the child’s mind, the ability to mentalize and the sense of agency (p.531).

The mothers descriptions of improved ways of relating and interacting with their babies, with the other mothers in the group and with the therapists seemed to have resulted from their growing self awareness and increased capacity to tolerate their own difficult emotions, to develop empathy towards the other mothers and to trust the sincerity demonstrated by the therapists. The positive outcome described by most of the mothers of the group experience seemed to lie also in their sense of hope for a better, improved future for themselves and their children. The group seemed to encourage the mothers to strive towards a more aware, coherent sense of self. Interesting research conducted into the effectiveness of group psychotherapy as a means of reducing PTSD symptoms provides evidence for the effectiveness of group psychotherapy with specific groups of individuals that have experienced trauma: “The group therapy, involving relatively intensive confrontations with one’s own feelings and experiences, encouraging active cognitive efforts and emotional expression, and emphasizing strong group support, can thus effectively help severely traumatized women” (Sezgin & Panamaki, 2008, p. 571).

The mothers felt supported and understood and the shared experiences of the other mothers made it possible for them to take psychological risks in the groups and to talk about past pains and future hopes. The mothers seemed surprised by their new emotional awareness and capacity for reflective functioning. The capacity for mentalisation and to be emotionally attuned to their babies' needs was a huge achievement and was part of the objective for the facilitation of the New Beginnings Programme.

Overall, there was also a sense of an implicit relational knowing that appeared to develop in the mothers through being in a group and that allowed the mothers to find a knowing that is felt in their bodies as to how to be a good-enough mother. Sami captured the value of the group quite aptly in the following statement: "Eish I feel good because I feel motherhood is in me".

6.3 The mothers' experiences of the content of the programme and the therapists of the group psychotherapy

In this discussion, how the mothers experienced the therapists will be discussed first as this serves as a spring board for the discussion of their experience of the content of the programme. Their experiences of the content of the programme seemed in many respects to be directly related to how the therapists facilitated the groups and how they engaged with the mothers and their babies as the group progressed. As discussed above, most of the mothers described an initial resistance to participating in the mother-infant psychotherapy groups. However, they were later helped to overcome this resistance and they actively participated in the group process. Findings from this study indicate that one of the reasons that the mothers struggled, at times, to engage in the group process had to do with the discussion of the past and their own childhoods and upbringings. Although only expressed by one mother, another reason may possibly have been that they initially were wary of the therapists as they did not know who they were and what they would expect of them. However, this mistrust appeared to change slowly over the course of the groups. Their reactions to talking about their past will follow in the second part of this discussion.

The emotional availability of the therapists will be focused upon first and how trust and safety eventually unfolded within the intimacy of the group context will be focused upon next. The discussion will explain how this unfolding trust created a warm, nurturing environment that encouraged and supported the mothers to take psychological risks and share their fears and anxieties, relating both to their pasts and to motherhood in the present. Initially though, trusting the therapists was a very stressful and emotionally demanding task for most of the mothers in the group. Hence the therapists needed to possess certain skills and characteristics so as to encourage the mothers to start to deal with these. Many of the mothers reported a sense of feeling cared about and that the therapists cared for their babies too, which seemed surprising to some mothers: "I think they were nice people and they love our kids and those kids were going to them and they were happy". Several of the mothers described a deeper level of attachment that they felt towards the therapists, in that they felt they had acquired a genuine friend or trusted and reliable relative, such as a sister. This could be interpreted as possible projection of aspects of their own unmet attachment needs, but may also be descriptive of a type of close, trusted relationship that some of the mothers felt developed between them and the therapists.

From the very onset of the group experience there was a therapist and a co-therapist. This already provided a healthy working model of adults working together (Ritvabelt & Panamaki, 2007). Several characteristics are described to be essential for the therapist working in a psychoanalytically oriented mother-infant group context. These include that the therapist convey a sense of presence in the groups (Corey, 1990). The mothers in this study described the therapists to be caring and warm and genuinely interested in them and their babies. The therapists' emotional availability could also be considered to be unconsciously evident in their willingness to embark on the psychological journey with the mothers and to physically and emotionally enter their psychological world (Corey, 1990).

From the onset of the group experience the mothers brought resistance, defenses and anxiety as discussed previously. In a group situation such as this one, observation of defensive behaviours were very revealing of the mothers patterns of relating. The therapists' role was to gently challenge the resistances and defenses

and through non intrusive feedback to the mothers, the therapists could help the mothers to identify their patterns of relating (Baradon et al., 2008). Another role of the therapists was to empathically ease the mothers' anxiety so that they could more actively engage in the group process (Rosenthal, 1999). The mothers in this study described the support that they received from the therapists as having achieved this. The anxiety that was evident in the mothers' may be interpreted as a fear of vulnerable feelings and painful memories being activated by the content of the group. Without skilful management by the therapists to regulate this affect, many of the mothers may not have reported the changes that they had experienced through being in the group.

The therapists regularly provided a light snack for the mothers and babies and at one time they provided some basic baby care products for the mothers. This could be interpreted as the therapists' fulfilling a more maternal role which seemed to be needed especially at the beginning of the group process (Ritvabelt & Punamaki, 2007). An interesting study conducted by Truax, Carkuff & Kodman (1965) on the relationship between 'therapist-offered conditions and patients' change in group psychotherapy' revealed that the higher the levels of accurate empathy and unconditional positive regard received by patients from their therapist, in both individual and group psychotherapy settings, the greater the improvements in the patient, specifically with regards to personality change. It is significant then that the mothers in this study spontaneously highlighted that these were particular elements that they regarded as important in their relationships with the group therapists: "How she was talking to me and how she was listening to me. That she was real. You can see that emotionally...she is feeling for you".

As the therapists were able to contain (Allen et al., 2008) the mothers' difficult feelings and provide them with an accepting non-judgemental stance, the mothers seemed more able to relate beyond some of their initial defenses and voluntarily strived to achieve more meaningful goals, aimed at becoming better mothers and understanding themselves and their babies better, which was a step closer to mentalisation and reflective functioning. Trust and acceptance were obviously huge obstacles to be overcome so that the group as a whole, and the mothers and babies as parts of this whole, could move forward and reveal aspects of themselves that

they usually felt unable to do and to develop new ways of relating and behaving (Corey, 1990). These characteristics demonstrated by the therapists may also be seen to be modeling mentalising in that they were able to understand the communications of the mothers and their infants and they were able to interpret these so that the mothers could hear what was previously out of their awareness. According to Fonagy et al. (2002) there are three elements to mentalising affect, namely: “identifying, modulating and expressing affects” (p.437). The therapists effectively facilitated this mentalising in that they helped and encouraged the mothers to describe what they felt and what they thought their babies felt (identifying); they suggested and encouraged them to explore more productive ways of relating and interacting with their babies (modulating) which seemed to have led to behaviour change; and they helped and encouraged the mothers to express these affects, as was indicated in the details in the results section of this report. This ability of the mothers to appropriately narrate their understandings of their own and their baby’s thoughts, feelings and behaviours is indicative of the acquisition of the skills of reflective functioning and affect regulation (Fonagy et al., 2002).

Sophie reflected the following:

She's a happy child now. Because before she used to cry a lot, but now she don't really crying. Because I take another thing from the group and do it. Like when she's crying and she doesn't stop, I know that I must calm her down. I was shouting. Then in the group I learnt that if she's crying, I must do... I must calm her down.

The mothers themselves felt surprised at their new ways of thinking and emotional expression. It was their experience of the emotional availability of the therapists that seemed to contribute significantly to this change. The therapists’ emotional attunement, unconditional positive regard, empathy and genuine interest in the mothers and their babies, which was conveyed to the mothers, was eventually received by the mothers and the therapists were thereafter perceived as being authentic, genuinely caring, trustworthy and sincere. The therapists’ modeling of reflective functioning and mentalising and healthy ways of interacting may have also

facilitated the mothers' development of a reflective capacity of their own, which most of them were able to describe.

One of the first assumptions of the New Beginnings Programme was that a mother's caregiving towards her baby is deeply influenced by her own childhood parenting experiences and her symbolic representation of this in terms of her own internal working models (Baradon et al., 2008). Baradon et al. (2008) further assumed that some of these intergenerational transmissions are either part of the mothers' conscious awareness or they are symbolically represented through their interactions with their babies. One aim of the New Beginnings Programme was to bring this to the attention of the mothers in an attempt to improve the mother-infant attachment, as according to a psychoanalytic orientation, early learning is not irreversible (Baradon et al., 2008). In order to change its impact, the mothers needed to become aware of how their pasts were contributing to their current personality structure and patterns of mother-infant relating (Corey, 1990).

However, exploring their own early experiences of being parented was the part of the programme that was experienced as the most difficult by all the mothers. Almost all of the mothers described mixed feelings with respect to sharing information relating to their own childhoods. For some mothers talking about their past seemed irrelevant in view of their current difficulties; for others, talking or even thinking about this evoked a multitude of feelings, including shame, anger and pain. These were the conscious feelings that were expressed or acted out in the group setting: Two mothers said that for the first time they lied in the group, in that they were not honest about how they were mothered or how they mothered their children. This was confirmed by an observation that Rose (one of the staff members at the shelter who had attended the group with her own child) had made, in which she stated that firstly she knew very little about the mothers' backgrounds as they were resistant to talking about this and secondly, the way in which the mothers described themselves in the group was in conflict with how they actually behaved outside of the group towards their infants. Two mothers also described how, at times, they were physically present in the group but emotionally they were not there: "I was not in the group. My mind was out of the group". The feelings that the topic of their early childhoods seemed to evoke were varied levels of rage and abandonment. One mother said

that despite feeling sadness at having to talk about her past she felt obligated to talk. Another mother said: "At first I liked it but I ended up not liking it...I hate to talk about my past. I didn't like that!" Her strong use of language is indicative of an internal rage and a feeling of exposure and vulnerability having to share such difficult aspects of her life. Other mothers described feeling angry, and irritated at having to attend the group: "Oh not Friday again!" Or "Why must I go there when I am having this problem!" One mother said that she cried alone after the group when she thought about what had been discussed in the group. It was so painful in the group and then she had to go to her room and deal with it on her own. At times this made her feel like absconding from the sessions. However, after the programme had ended she felt a huge sense of accomplishment at having persevered. Whilst most of the mothers were able to overcome these intense feelings one mother was not able to overcome her angry feelings. She angrily suggested that the therapists should not push people in a corner to talk. She suggested that they try to understand that some mothers didn't like to talk about their pasts. She was only able to share this with the therapists when the group was ending. Apart from the anger that she described in relation to the content around the mothers' pasts and early experiences, she did find the practical skills that she had learnt worthwhile.

It was likely that much of this anger and fear around talking about difficult childhood memories was evocative of early experiences of intrusion and abuse; some of the mothers were able to risk sharing and managed to have a different experience. Whilst it was difficult to explore their pasts, the feelings of relief and comfort that they experienced after having shared experiences from their pasts seemed to outweigh the difficulties.

The absence or presence of a sense of awareness, at times, symbolically provided the therapists with insight into the mothers' pasts and their patterns of attachment and this was interpreted to the mothers in the group context with the intention of creating awareness. "It is essential that the therapist move back and forth in time, trying always to recapture the past or to see the repetition in the present and to become aware of the early traumatic event which made for the neurotic pattern of the individual" (Corey, 1990. p. 156). As such most of the mothers' feelings and unconscious patterns, as mentioned above, were interpreted by the therapists to the

mothers and the mothers described that they felt that the therapists really listened to them and understood their pain.

The therapists' emotional availability and their ability to tolerate the mothers' difficult affects, as discussed previously, seemed to facilitate effective conditions for psychological risk taking and ultimately for psychological growth of the mothers. The therapists contained the mothers' resistances and gave them the emotional space to share only that with which they felt comfortable. During the interviews, some mothers were able to talk about their pasts in a very limited manner, but their comments suggested that they felt that their sense of self awareness seemed increased.

The parenting skills aspects of the programme was what most mothers described to be the most enjoyable and beneficial for them since it helped them to become better mothers. This along with the sense of togetherness and support that they experienced from the therapists and the other mothers contributed significantly to their feelings of loss and sadness when the groups ended. Most mothers felt that they had gained 'too much but not enough'. They felt that they could finally be themselves in the absence of feeling judged and rejected. In the interviews it felt as if they wanted and needed more. Two mothers suggested that the group should be ongoing; focusing on all the different developmental milestones that their infants still needed to traverse. The safety of the group and attachment bonds that seemed to have been forged made the group highly meaningful for most of the mothers. For many of the mothers the loss of the group was also possibly experienced on an unconscious level as triggering previous losses and deprivations. This ending may also have felt like other painful endings and as such one mother said that she preferred not to say goodbye. She wanted to maintain a fantasy that she would see the therapists again. Another said that she did not like the idea of the final tea party that marked the ending of the group. She preferred that one just said goodbye and got it over with – quickly.

Overall, the content of the programme was evaluated to be helpful and beneficial with almost no changes suggested by the mothers to the programme. Their experiences of the therapists were of them being containing and offering safety.

Despite eventually being able to share about their pasts, most mothers did evaluate this to be the most difficult part of the group process. The parenting skills aspects of the programme and the notes that they received proved to be very valuable for almost all of the mothers, with a few mothers mentioning that they would refer back to the notes on occasion.

6.4 The context of living in a shelter and its influence on the mothers' experiences of mothering

According to the New Beginnings programme facilitated in the MBUs in prisons, Baradon et al. (2008) made an important assumption that the context or environment in which motherhood takes place will have an influence on the mother's state of mind and on her capacity to provide emotional support to her infant. This is the basic assumption of this study too and one of the aims of the study was to explore how the current psychosocial, cultural and economic factors affect the mothers' experiences of mothering their infants in deprived environments.

The mothers in this study described mixed feelings about living in a shelter. On the one hand they felt a sense of relief that their own and their children's basic needs were being provided for by the shelter. On the other hand they described a lack of agency and self-determination that living in a shelter seemed to set up. These opposing views often gave rise to ambivalent feelings and defensiveness. For most mothers, especially those in the second shelter, their children's immediate emotional needs appeared not to be as important to them as the need to survive and improve their physical and material circumstances. The mothers in the second shelter, when asked what they would change about the New Beginnings Programme suggested that the therapists include a course of some sort that would assist them in generating an income. These same mothers and two from the first shelter felt unable to understand the objective of the group and attending a group which focused on the relationship with their infants seemed strange and unfamiliar to them. A focus on emotional needs may have felt unnecessary when basic survival needs were not yet met.

Most of the mothers experienced the shelters as offering them a sense of community and togetherness with other mothers who shared similar experiences to themselves.

Their fear of being alone, with little or no support was evident in this description. This seemed to outweigh some of the negative experiences that they had, being mothers living in a shelter. The first shelter (that was better provisioned), in particular, seemed to evoke in the mothers a sense of hope that they were trying their best to improve their situations and the lives of their children. However, it was this shelter too that evoked the most ambivalence because the mothers sometimes described feeling disempowered whilst living there.

Tomlinson et al (2005) contend that the many social adversities that single mothers in South Africa face, places undue strain on their capacity for effective mothering. These social adversities are factors in the lives of the mothers in this study, in that they are single, unemployed, most are HIV positive, they lack facilities and partner support and they are living in shelters with other mothers who are experiencing similar circumstances. Gender-based atrocities and poor social set ups further compound the already too many challenges that mothers from low socio-economic circumstances face on a daily basis (Tomlinson et al., 2005). A study by Campbell, Sullivan and Davidson (1995) revealed that those mothers who lacked social support, experienced interpersonal violence and those who lacked control over their own lives were also more likely to become depressed. Thus shelter conditions place the mothers in high risk groups for becoming depressed and for developing other mental health problems (Campbell et al., 1995). Campbell et al. (1995) together with Meadow-Olivier (2003) and Howe (2011) question how effective mothers can be at caregiving when they themselves seem to be insecurely attached and lack reflective capacity. On a more positive note Campbell et al.'s (1995) study revealed that mothers who had more social support were more likely to experience a decrease in depression.

This does seem to best describe the conditions of the mothers in this study as many of them seemed to be depressed and lacked problem-solving and affect regulating skills. However, the context of living in a supportive environment such as a shelter could act as a potential buffer against them developing more serious mental illness.

Meadow-Olivier (2003) revealed that most mothers see the shelter option as a last resort. One mother in the second shelter narrated that although it was good to have

a place to stay with her child, nothing compared to being in your own home or with people you knew such as family and friends.

This same study revealed that the mothers living in shelters had little or no privacy and were with their children most of the day and night. This can lead either to over protectiveness or avoidance behaviour (Meadow-Olivier, 2003). Both of these types of behaviours were described by the mothers in the shelters in this study. Some mothers felt that they couldn't leave their children alone and two mothers described wanting to get away from the constant demands that mothering placed on them. Both types of mothering lack balance and appear unhelpful in creating healthy attachment relationships with their children. Mothers in shelters also report feelings of loss and abandonment - loss of their own material goods and loss of supportive family, partner and friend relationships (Meadow-Olivier, 2003). This sense of loss was also found in this study. Many of the mothers in this study had no family and partner support. While one mother described the other mothers and the management in the shelter to be her family and primary support system, most of the other mothers' experiences of living in a shelter seemed to be of loss of family and support. Other losses found in this study included the mothers' not being able to make their own decisions about matters related to everyday living, a loss of respect from their children and a loss of authority over raising their children.

Living in a shelter seemed to offer these mothers a basic means of survival but the many losses that the mothers described and the sense of futility that they sometimes experienced due to a lack of agency may have been contributing to their decreased capacities to be mindful of the emotional and psychological needs of their children. Shelter settings seem to undermine mothers' parental authority and, as such, little quality time between mother and children seems possible (Meadow-Olivier, 2003). Mothers often share rooms with other mothers and infants and this means that they often have no choice but to share feelings of love, anger and other feelings in the communal setting of the shelter (Meadow-Olivier, 2003). The stories of their lives are not kept confidential either, since being in a communal setting means that it is often likely that gossip and rumours get started about each other. One mother described that she always felt judged and that other mothers in the shelter and the management talked about how she dressed and questioned where she got money

from. Another mother said that when she went to the kitchen the other mothers would question her about what she had heard about the group. Still another said that she could not open up initially in the group because she knew that the other mothers would talk about her outside of the group. Only once the therapists addressed the issue of confidentiality did this mother feel more confident to open up in the group.

On the positive side, mothering in a shelter could be made easier by the mutual contact that mothers established with other mothers who have shared similar experiences to themselves. This mutual sharing has the effect of reducing the mothers' sense of isolation and marginalisation that women in domestic violence situations often experience (Ritvabelt & Punamaki, 2007). The first shelter was well resourced, in that it offered mothers parenting skills courses, employment skills, counselling and education and training. One of the mothers said that she had attended other courses before and found this one (New Beginnings programme) to be very worthwhile in that it was focused on them and their babies and the therapists were interested in what the mothers had to share. Their ability to reduce their stress and improve their lives whilst living in this shelter were made much more possible than if they were living outside of the shelter with little or no material resources and little or no social support. This additional support offered to the mothers may reduce the mothers' levels of stress and could create more opportunities for them to interact and relate to their children in a more meaningful, mindful manner.

Overall, living in a shelter was described in sometimes conflictual ways by the mothers. The mothers in both shelters felt supported by being in an environment with other mothers who had similar experiences to their own and thus reduced their feelings of being alone and isolated; having their own and their babies' basic needs met and having access to a variety of important resources, such as education for their children so as to help to improve their lives. The corollary of this though, was that many mothers described feelings of loss with regards to their privacy, parental authority, self determination and respect shown to them. Several mothers reported feeling depressed and disinterested and resentful of having to raise their children under the critical eyes of others. Several mothers also pined for family support.

Again, however, many mothers describe the shelters to provide them with social and emotional support, which many mothers had previously been deprived of.

6.5 The context of living in a shelter and its influence on the mothers' experiences of being in a psychotherapy group, aimed at the relationship between the mother and her infant

As indicated above, many of the mothers attended the group initially demonstrating a sense of reluctance to engage. Their defensiveness seemed to be related to them feeling compelled to attend these groups by the management of the shelters. They described feeling 'bored' or 'irritated' at having to attend this group whilst they had a myriad of other matters to attend to. Their descriptions seemed to oscillate from defendedness to curiosity. Their unwillingness to take part, however, was later belied by their descriptions of the benefits that the group experience offered them in terms of helping them to become more confident mothers.

The main obstacles to the mothers initially fully participating in the groups were described as firstly related to a lack of agency in being 'forced' to attend the groups by the shelter management; a sense of mistrust of these unknown therapists; a sense of confusion about the objectives of the group; a lack of trust in the other mothers who were attending with them and a fear of exposure, being judged and being made to feel vulnerable in such an intimate setting. Other fears about the content of the programme and their sharing of their early histories were discussed previously. While some of these anxieties were realistic given these mothers' contexts, some of the fears seemed to be related to their histories and previous experiences, and it appeared as if this, together with the context of the shelter may have been responsible for some of their initial responses to the group. The context of the shelter did not seem to give the mothers the confidence to openly participate in the groups. The mothers described the management of the shelters to be unempathic and judgemental and they feared that the group would be of a similar nature. Despite having been assured of confidentiality, one mother seemed to fear that the therapists would be giving feedback to the management about what they shared and another mother from the first shelter feared that her story would be shown to the media. She also felt that way about the researcher interviewing her

due to the fact that the interview was audio recorded. Although none of the mothers verbalised it, having the baby-daycare worker in the group with the mothers may have influenced the perceived safety of the group. She herself reported that she felt conflicted about being in the group and suggested that perhaps this prevented some of the mothers sharing more about themselves. This dual role that she undertook whilst being in the group certainly impacted upon her level of disclosure as her interview with the researcher suggested that she most likely remained wary and defended throughout most of the process of the group. Some mothers also felt that other mothers in the group would share their life stories outside of the group. All of these fears seemed to influence the mothers' initial perceptions regarding the safety of the group (Corey, 1990).

As mentioned in the previous section, the mothers also described a lack of agency in raising their children in a shelter setting, in that the shelter determined schooling, discipline, eating and any extra activities that their children needed to be involved in (Meadow-Olivier, 2003). They had very little time to spend with their children as most mothers reported having many duties to perform at the shelters. Thus, the group may initially have been perceived as a controlling parental figure, similar to that of the shelter (and maybe unconsciously similar to their childhood experiences of having been parented), who would tell them how to raise their children.

However, the mothers' defensiveness around attending and participating in the group dissipated significantly once they gained confidence that the group was safe and that a structured environment prevailed, aimed at assisting them to develop better ways of relating with their children (Corey, 1990). The safety in the group gave the mothers the confidence that they could share as much or as little as they felt comfortable with and that this would be acceptable. Later the mothers came to realise that they could share their fears, concerns and anxieties about motherhood and that the group could tolerate these difficult feelings and give them the support and guidance that they needed to move forward. The mothers felt a sense of relief as the group context seemed to contrast significantly with the shelter context. The structure of the group was also able to offer the mothers a sense of commonality with the other mothers who came to be seen as valuable support systems.

In some ways, for a few mothers, the group came to represent an intimate support system which they desperately wanted (Ritva & Punamaki, 2007). For them the ending of the group was extremely painful and difficult to bear as it seemed to evoke feelings of re-abandonment. The mothers' sense of deprivation and abandonment might be related, on one level, to a sense of reality that after they have engaged in such an intimate and intense experience they now had to go their separate ways taking their changes with them into their day-to-day lives. They seemed to fear no longer having the support and encouragement offered by the mothers and the therapists. They also seemed to fear that they would not be able to incorporate these changes in a sustainable manner outside of the group, nor would they be able to engage in such meaningful, interpersonal relationships outside of the group. On another level, few mothers were unable to fully comprehend how attending a group such as this one would improve their material lives, which seemed to be their priority. One mother in the second shelter said that whilst it was nice spending time with her baby and playing with her baby she did wonder what her certificate would say. She felt that if it had been a 'child-minders' course this might have been more worthwhile as she could get a job and not have to worry about how she was going to get porridge for her baby. This statement suggests a strong pull for the mothers to address the concrete levels of deprivation in their lives as opposed to the psychological. While it appeared that this was a constant worry for the mothers, acknowledged in the group, it appeared that important emotional work could occur in spite of the material worries.

6.6 Conclusion

From the above discussion of the four questions that this study aimed to address, it would seem that overall the mothers' descriptions of their experiences of the New Beginnings Programme, which is aimed at improving the mother-infant attachment relationship and the infants' later attachment patterns, may be quite adaptable to a uniquely South African context, specifically within shelter contexts, which was where this study was located. The shelter context, together with the objective of the mother-infant psychotherapy groups, seemed to meet all the requirements for the uniquely African concept of 'Ubuntu', meaning that a person is a person because of another person (Berg, 2003). A positive aspect of this mother-infant group

psychotherapy is that a group intervention might already give credence to collective thinking and community child rearing which is part of the South African culture of child rearing (Berg, 2003).

Several limitations of the groups and of this study will be highlighted in the conclusion chapter.

Chapter 7: Conclusion

7.1 Findings of the research

The theoretical foundation upon which this study was based was psychoanalytic attachment theory. This qualitative research design used semi-structured interviews to explore the experiences of fifteen mothers who had participated in the New Beginnings programme, facilitated at two shelters in the Greater Johannesburg area. While fifteen mothers were interviewed, only thirteen transcripts were made. The audio recordings of the other two interviews were of a poor audio quality and could not be fairly transcribed. The researcher included her own counter transference experiences during the interviews to aid in the analysis of the data. The data was analysed using narrative analysis.

This research study aimed to explore African mothers' experiences of the "New Beginnings' mother-infant group psychotherapy programme, including their experiences of the content of the programme and of the therapists who facilitated the programme. A secondary aim of the study was to explore the mothers' experiences of mothering while living in a shelter setting and how these experiences may have influenced how they experienced the programme. A central idea of this study was to explore the adaptability of a western based intervention programme to a uniquely South African context. Of central importance in this study was how current psychosocial, cultural and economic factors influenced attachment between mothers and infants living in deprived environments. In this study the shelter settings were considered deprived environments due to the social, economic and psychological limitations they placed upon the mother. More specifically, whilst the shelters provided for the mothers in terms of basic needs such as shelter and food, they were perceived by the mothers to impinge upon most of the mothers' rights to self-determination, self agency and privacy and perhaps, due to this, deprived the mothers of certain opportunities to develop affectional bonds with their infants. This was less applicable to the second than to the first shelter. However, despite, the mothers' ambivalence towards the first shelter, it tended to have more to offer the

mothers in terms of opportunities for self-development and for a chance at achieving some independence.

Thus to answer the third question of this study first: How did the context of living in a shelter influence the mothers' experiences of mothering? The findings of the study indicated that despite the difficulties that they encountered, as mentioned above, there was an overall positive view of the groups offered by the mothers. Many of the mothers seemed to have taken solace in the sense of community and support offered by the shelters and a mutual support offered by the other mothers who had had similar experiences to themselves. This seemed to bridge the gap of loneliness and marginalisation which many women in domestic violent and interpersonal neglectful relationships find themselves in (Ritva & Punamaki, 2007), which includes the mothers in this study. Despite the many hardships and challenges that the mothers encountered in life in general and in the shelters specifically, many of the mothers felt that the benefits of living in a shelter outweighed the limitations of it.

This experience however, did not seem to give the mothers the initial confidence to attend a mother-infant psychotherapeutic group in the shelter setting. In fact it was this very setting that gave rise to many of the mothers' resistances towards attending the groups. The mothers felt compelled to attend despite being given consent forms outlining the nature of the group and asking for their voluntary participation. This compulsion coupled with some of them experiencing the shelter management as unempathic, judgemental and controlling lead to many of the mothers' feeling unwilling to engage. The mothers were also understandably mistrustful of the therapists who were strangers and surprisingly mistrustful of the other mothers in whose company they felt unsafe to share the details of their lives. It was later revealed that some tension existed between some of the mothers before they arrived at the group and that most of the mothers felt high levels of anxiety being in a group setting with their infants. This anxiety was related to the potential threat of feeling vulnerable, exposed and shamed in front of the group. In response to this anxiety, some mothers acted out through not attending the groups regularly, which could be viewed as reflective of their lack of a capacity to mentalise. Confidentiality issues needed to be addressed early on in the life of the groups in order to increase safety for the mothers. This all formed part of the psychotherapy process and conscious

and unconscious material of the mothers was revealed from the onset to the therapists. The mothers' resistance conveyed to the therapists their apprehension at attending the groups and also that the mothers were attempting to protect themselves from the surfacing of painful past memories and feelings which they did not feel able to manage. As the therapists were able to tolerate the mothers' difficult feelings and as they gently dealt with the resistances of the mothers, whilst understanding that these were the mothers' ways of defending against their anxiety and fears, the mothers themselves began to feel more cared for and understood. As most of the mothers gained confidence in the process, their defences became less pronounced and they seemed more willing to engage and share. This was evidenced through the interviews with the mothers where the anxiety they expressed about the beginning of the groups gave way to comments that reflected a sense of having engaged in and benefited from the programme. Thus for most mothers their initial defences eased and were replaced with curiosity about the nature of the group and later still with a willingness to learn how to have a better relationships with their infants and their other children not attending the groups with them.

To answer the second and fourth questions it was found that through the therapists being seen to be genuinely caring, warm, empathic, sincere and present, most of the mothers were able to take more psychological risks in the groups. Their improved relationship with the other mothers and a growing identification with experiences similar to their own, allowed valuable support systems to form in the group which were then taken outside of the group. The therapeutic space offered by the therapists aided the mothers in becoming more aware of themselves and their ways of relating with their infants. Just sitting or playing with their children in the safety of the group allowed the mothers the opportunity to develop alternative forms of relational knowing on an implicit level (Salo, 2007)) which were not possible when they were outside of the group, in the shelter, surviving.

The most important focus of this study, however, was how the mothers experienced the efficacy of the group. Again the findings of this study supported the value of the therapists in the psychotherapeutic process. The therapists modelled empathy and a reflective stance which led the mothers to experience being cared for, understood and listened to. Through having their feelings contained in the group the mothers

were able to acknowledge how difficult motherhood was for them, however it took an increasing sense of safety in the group before they were able to do so. They admitted that they had often felt that their babies were impervious to their moods and feelings and thus not affected by these, including when they felt depressed or disinterested. During the interviews, the mothers appeared to be able to express and accept that at times they did feel overwhelmed by their babies' needs. Two mothers in particular expressed a wish to escape these demands. A hypothesis which did not form part of this study but that bears consideration for future studies is that the mothers may have felt guilty about raising their children in a shelter setting. The fact that most of the mothers frequently referred to a desire to give their children a better future than they had had suggested that these mothers wanted to be able to give their children more opportunities. While living in a shelter does not seem to suggest the idea of a better future, it may be seen as a means to an end at the present moment. Two mothers also wished that they did not have to live with their children in a shelter but felt that they had no other choice due to the opportunities that the shelter provided in terms of educating their children and also in view of the fact that they had no other alternative living options. This latter point may apply to several of the mothers in this study as a shelter option is often considered a last resort (Meadows-Olivier, 2003).

However, almost all the mothers and the two caregivers concurred that the most challenging aspect of the New Beginnings programme was sharing about their past experiences in the group. Focusing on the past was one of the assumptions of the original New Beginnings programme facilitated in the UK (Baradon et al., 2008). How one's past influences the attachment relationship between mother and infant is central to attachment theory (Fonagy, 2001). Most of the mothers in this study did describe deprived, neglectful childhoods directly, although some did not. Unresolved feelings of anger, rage and pain was evident in their apparent internal working models as these appeared to manifest within the context of the group experience. Many mothers described fearful and frightening feelings that their children were exposed to in their relationship with the mothers. They initially felt helpless to do anything different. Most of the mothers' reluctance to talk about the past, which felt intrusive and overwhelming to them, may be reflective of the difficulties that their

pasts imposed upon them. This resistance to talking about their pasts suggested a strong likelihood of emotional deprivation in the mothers' childhoods (Baradon et al., 2008). The mothers were able to reflect that they wished for their children to have a different future to what they currently had. This seemed to be a common goal for most of the mothers i.e. that they would raise their children differently from how they were raised. The acknowledgement of their desire to repair or to provide a different experience for their children to the one that they had, may have already interrupted and protected their infants and children from the intergenerational transmission of attachment (Baradon et al., 2008).

Most of the mothers' gained confidence to move beyond their initial anxiety and as a result they began to gain deeper insight into their behaviours and that of their infants. Reflective functioning was evident, in that some of the mothers were able to provide vivid, three dimensional narratives of their infant's feelings and behaviours as indicated in the results chapter of this report. They also demonstrated a capacity to adapt their behaviour accordingly. Lots of examples of this change in their behaviour were given by the mothers to substantiate the sense that they had changed their behaviour. This did not seem to be present before the programme as the mothers gave examples of previous occasions, describing how they would act out their feelings as opposed to think about them. Seeing their infants as separate to them may be understood as the mothers developing some capacity for mentalising, the operationalisation of which is reflective functioning (Allen et al., 2008). The mothers also described more of a relational knowing in that they understood the internal states of their infants (Salo, 2007). The mother-infant attachment relationships showed evidence of having improved from the mothers' perspectives, but because this study was conducted very shortly after the programmes ended it is unclear whether these new ways of relating and understanding themselves and their infants was sustained. Furthermore, the results of their capacity for reflective functioning although empirically tested before and after the groups as a part of the larger study, did not inform this study.

The structure of the New Beginnings programme was designed to offer mothers in high risk groups the opportunity of a 'thinking and behaving' space (Baradon et al., 2008) where their attitudes and ways of relating to their infants could be explored

and changed if possible. Most of the mothers in this study they seemed to have had a change of attitude and behaviour as evidenced by their narratives. They seemed to have benefitted significantly from participating in this programme, as they demonstrated an ability to think about their own and their infants' internal states over the course of the programme as well as afterwards. A number of factors may have contributed to this, as indicated above, such as: The therapists' observations of the mothers' feelings and behaviours and their interactions with their infants, their observations of the therapist and the other mother-baby dyads and their view of the therapists as offering them an empathic, containing group experience which lead them to feel secure and cared for. This last factor seemed to be the most pivotal aspect of the group experience that lead to the changes that they mothers described.

Overall, it would seem that the New Beginnings programme can effectively be adapted to a uniquely South African context. In many ways the group psychotherapy experience seemed to mimic the idea of 'ubuntu' in that a person is not a person without another person (Berg, 2003). This kind of communal thinking is what makes this programme specifically suitable to a South African context. The study also seemed to provide some findings to support the impact of the psychosocial, cultural and economic issues on the attachment relationship between mother and infant. Several limitations of the programme were identified as well. These have been alluded to above, but will now be highlighted below.

7.2 Clinical implications/Suggestions for the New Beginnings programme

- One suggestion that was evident in the results section was that it may not be a good idea to have mothers who are at different social and occupational levels in the same group such as single mothers who are HIV positive and staff from the shelters. This may cause an imbalance in the dynamics of the group and may also impact on the evaluation process. This was evident in the findings as the one caregiver in particular undertook a dual role as a mother and as a staff member. She felt that this dual role may have inhibited the mothers from fully being themselves in the group process. She certainly felt inhibited and detached in her participation and this was evident in the interviews as well. This mother also identified herself as having a different

relationship with the therapists in the group which had began before the groups actually commenced. This difference could potentially interfere with the group dynamics as it has the potential of triggering unconscious thinking and feeling of past relationship experiences in the other mothers.

- The fact of living in a shelter on its own may have deprived the mothers of the physical and emotional opportunities to develop affectional bonds and attachment relationships with their children. As discussed the mothers lacked privacy and parental authority especially the mothers from the first shelter. The communal nature of the shelter also implies that the mothers interacting with their children and their expressions of feelings towards their children is conducted under the critical eye of others such as the other mothers and the shelter management (Meadows-Olivier, 2003). For affectional bonds and attachment relationships to form, the mothers need to have a secure physical and emotional base (Howe, 2011). This may not be present in a shelter.
- An important consideration was that the most of the mothers presented themselves to the psychotherapy group process with many defences and resistances. Overt and covert anxiety was also present due to most of the mothers finding the group experience unfamiliar, initially not trusting the other mothers and the therapists and experiencing fear of feeling exposed, shamed and vulnerable. The mothers anxiety at the beginning of the psychotherapy process should remain a focus when facilitating the New Beginnings programme;
- The therapists' roles as indicated above remain pivotal in terms of creating a safe structure within which the above can be effectively managed and so as to encourage the mothers to engage in the group process. The idea of a safe space for thinking and feeling is an important aspect of this programme and the therapists facilitating this programme in the future should be well versed in the skills needed to facilitate this such as those offered by the therapists who had facilitated these pilot groups in Johannesburg.
- Issues of confidentiality and trust are essential considerations for the entire duration of the group process; and

- In respect of the content of the programme, discussions that focus on the mothers past childhood experiences should be undertaken with particular sensitivity as the findings from this study has indicated this to be the most emotionally provoking aspect of the programme.

7.3 Limitations of the current research

Several limitations have been identified:

- Since this study was conducted with a specific population of mother-infants, i.e. mothers living in shelter settings in Greater Johannesburg these findings cannot be generalised to the larger population of South African mothers and infants and as such they need to be interpreted with caution;
- Several factors may have impinged upon the data collection process such as the researcher's relative inexperience in interviewing; language barriers that may have been present and the context in which the mothers were interviewed may also have created some bias to the findings;
- The mothers' levels of depression may have influenced their narrations of the New Beginnings programme and their experiences of mothering in a shelter. Mothers who may be depressed may feel disinterested and lack motivation such as the researcher observed during the interviewing process. Mothers also tended to become easily fatigued and detached. This was again observed in some of the mothers during the interviews. Some mothers gave vague and limited descriptions of themselves and their infants as discussed in the results chapter.
- Since the mothers were interviewed very soon after they had completed attending the programme, it cannot be ruled out that perhaps insufficient time had elapsed to fully allow the changes that they had described to settle into their daily routines.

7.4 Recommendations for future research

Several suggestions can be made regarding future research:

- The mothers levels of depression prior to them attending a mother-infant group psychotherapy could be compared against the findings of the mothers' experiences of the groups to determine if this has an influence on the outcome of the programme;
- Empirical evaluations of reflective functioning and PDIs should be considered for all research concerning mother-infant attachment relationships;
- Cross sectional studies with different homogenous groups of mothers could be facilitated and results of these compared.
- The influence of fathers/parents in an African context could be considered as being the focus of some infant attachment groups.

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Appendix 1

New Beginnings Programme Interview Schedule

(Preamble: I would like to discuss with you your experience of having been in the mother-baby group that Katherine and Linda (for Nkosi's Haven)/Katharine and Melanie (for Usindiso) were running, and any thoughts and feelings you have around it. If you do not understand any of the questions you may ask for them to be explained differently and if there are any questions you do not want to answer, that is also ok, we will then talk about something else. You can take your time in answering the questions and please try to answer in as much detail as possible because I would like to learn from you so that we can make the group better for other mothers in the future).

What was your experience of being in the mother-baby group? What was the group like for you? (Allow mother's initial narrative to emerge – follow up on comments made to elicit more detail)

What did you think/feel about the group when you first heard about it?

What did you think/feel once you were in the group?

How are you feeling about the group now that it has ended?

What was being in the group with other mothers like for you?

What was the most enjoyable part of the group for you?

What was the least enjoyable/most difficult part of the group for you?

What do you think the other mothers who attended the group feel about it?

What were the therapists like?

What difficulties did you experience in being part of this programme?

Part of the programme asks you to think about your own childhood, which can be quite painful, but then asks you to use these memories of how you felt when you were little to help you think about how your child feels – how was this for you?

Was it at any time difficult for you to attend the programme?

If you could add or take out something about the programme what would it be?

- What would you suggest should be taken out of the programme when it is run with other mothers in the future?
- What would you suggest should be more focused on in the programme when it is run with other mothers in the future?

Were the hand-outs given in the groups useful for you?

Do you feel that any benefit was gained by you and your baby from the group?

If so, please elaborate. If not, please elaborate?

How have you come to understand your relationship with your baby since you both attended the programme?

Is there anything she is doing differently with her baby at the moment?

How does this new behaviour (if it has changed) differ from what you were doing before?

Has anyone commented on any changes in you or your baby/how you are with your baby, since you attended the group?

What are you doing now as a mother that you feel very comfortable/happy with?

What are you doing now/trying to do that is very challenging for you at the moment?

What have you learnt about being a mother from the group? If you have learnt something?

Was this very different from what you knew before about being a mother?

What do you feel was the most important bit of information that you were given about being a mother? Why was this important for you?

How has being part of the group affected your feelings toward yourself as a mother?

How has being part of the group affected your feelings towards your baby?

The group encourages talking to someone you trust when you are struggling – have you been able to do this at all? With someone in/outside of the group?

**Would you recommend that other mothers who have babies go through this programme in the future?
(Please elaborate on answer)**

If anything, what do you think they would gain from attending such a programme?

Is there anything you would like to add or anything that was important for you that we may not have talked about?

Thank you for your time.

Appendix 2

Letter to Nkosi's Haven Director



School of Human and Community Development
Private Bag 3, Wits 2050, Johannesburg, South Africa
Tel: (011) 717-4500 Fax: (011) 717-4559

Dear Ms. Heather Snyman

My name is Katherine Bain. I am a lecturer at the University of the Witwatersrand. I would like your permission to conduct research funded by the Carnegie Cooperation at Nkosi's Haven with a number of co-researchers, namely, Katherine Frost, Brenda Sephuma, Melanie Esterhuizen, Linda Rosenbaum and Tessa Baradon. We are interested in running psychotherapy groups for approximately 16 caregivers with their infants. The potential participants will be invited to participate and the groups will be run on-site at Nkosi's Haven. Two groups in total will be run. Pre- and post testing will be conducted in order to assess the efficacy of the group intervention and will consist of one self-report questionnaire to be completed by the caregiver, two structured interviews to be conducted by a psychologist (with a translator if necessary), observation of the interactions between caregiver and infant and a more formal cognitive assessment of the infant. Testing is estimated to last approximately 2 and a half hours and regular breaks will be given. The interviews will be audio recorded, however only the researchers, translator and research assistants will have access to them. The translator and research assistants will sign confidentiality agreements. The transcripts and the final report will not contain any identifying information of the caregivers involved in the study and as such their rights to confidentiality and anonymity are respected. Pre- and post testing sessions and all group sessions will be video recorded for research purposes and participants will be asked to give their informed consent in this regard. Excerpts from these video recordings will be used to make a training video and for conference purposes, however, the identities of participants who wish not to appear in this video will be disguised. The groups themselves will consist of 12 sessions designed to improve the caregivers' attachments to their infants. After the research is finished the caregivers' interview recordings and transcripts will be kept in password-protected file on a computer for 2 years if the study is published or 6 years if it is not published before it is destroyed. All participants will have the right not to answer any questions they may not wish to answer and to discontinue their participation in the study at any time. The risks of participation include possible emotional distress, however, this will be contained by the psychologists conducting the study and further referrals for individual counselling at Ububele (an NGO in Kew) free of charge will be made if necessary.

On completion of the research you will be informed of the findings through a letter. My contact details are attached to this form in the event that you may have any further questions or concerns.

Kind regards

Dr Katherine Bain

Phone: 011 717 4558

Email: Katherine.Bain@wits.ac.za

Appendix 3

Participant Information Sheet



School of Human and Community Development

Private Bag 3, Wits 2050, Johannesburg, South Africa

Tel: (011) 717-4500 Fax: (011) 717-4559

Email: 018lucy@muse.wits.ac.za

Hello.

My name is Katherine Bain. I am a lecturer and researcher from the University of the Witwatersrand. I am inviting you to take part in a research study that I am doing with other researchers: Katharine Frost, Brenda Sephuma, Melanie Esterhuizen and Tessa Baradon, on psychotherapy groups for caregivers and their babies. These groups focus on relationships between caregivers and their babies.

Taking part in the study would mean that first you would be interviewed about your relationship with your baby and your relationships with your family and that the researchers would measure the development of your baby. You would also be asked to fill in a short questionnaire about your mood and your feelings generally. The researchers would also watch how you and your baby relate to each other. Then you would either take part in the first group or the second group. The first group would start right away, while the second group would start two months later. The groups would meet either once or twice a week for 12 sessions and would be a time where you and your baby and other caregivers and their babies could think about their relationships with each other and could talk about the things that are easy and difficult about being a parent. At the end of the group you would be interviewed again and the development of your baby would be measured again. There will be about 8 caregivers and their babies in each group. The interviews and groups will take place at Ububele/Nkosi's Haven and would happen in a private room. The first interview will take about 2 and a half hours, but the researchers will make sure that you and your baby have rests if you get tired. If necessary, a translator will help you to understand what is being said and help the researcher to understand what you have to say. You can choose not to answer any questions that you do not want to, there is no right or wrong answers and you may stop the interview or stop coming to the group at any time. Choosing to be part of this study is up to you. Sometimes things may be spoken about that make you sad or upset. If this happens and you feel like you need to speak to someone alone, one of the researchers will arrange separate counselling for you.

If you decide to take part in the study, the interviews and groups will be tape- and video recorded and the researchers, the translator, the research assistants and the video editor will know who you are, but all these people will promise to keep your identity and your information private. If you give your permission though, some of the video recordings will be used to make a training video to train other people to run these groups and to show the results of the study to other researchers. Research assistants will write up your interview (transcript) and all your identifying information will be removed from it. Then the researchers will see it together with some researchers overseas. The audio and video recordings and the transcripts will be kept in a locked cupboard in the researcher's office or on her computer which has a password so only she can see the information. Quotes using your words will be used in the report, however, no identifying information will be included and they will be used with quotes from other interviews. After the report is finished the interviews and video recordings and transcripts will be kept in secure places for 2 years if the research is published in a journal or for 6 years if it is not published, before it is destroyed. General feedback will be given in the form of a letter to the CEO of Alexandra Clinic/the Director of Nkosi's Haven and the finished report will be seen by the public. Feedback can also be given to you in the form of a letter and if you would like more feedback I will give it to you with pleasure. My contact details are attached to this form.

If you do choose to participate please can you fill out the two consent forms attached and give them back to me: the one is consent to participate and the other is consent for the audio and video recording.

Please feel free to contact either me if you would like any further information, have any further questions, or would like to report any negative affects the study has had on you.

Kind regards

Dr. Katherine Bain

(Research Supervisor)

011 717 4558

Email: Katherine.Bain@wits.ac.za

If you would like to report any problems or complaints that you have with regard to any part of the research process you can also contact the University of the Witwatersrand's Human Research Ethics Committee chair, **Professor Peter Cleaton-Jones**, or administrator, **Anisa Keshav**, on 011 717 1234 or at anisa.keshav@wits.ac.za.

Counselling services

We do not expect that the interview will harm you in any way but if you feel that you are having difficulties after having participated you may access the following free therapy service: Ububele Umdlezane Parent Infant Psychotherapy service on 011 786 5085.

Appendix 4

Consent Form (Interview, assessment and group participation)

I _____ consent to myself and my baby _____ being interviewed, assessed and participating in group psychotherapy for the purposes of parent-infant group psychotherapy research being conducted by Katherine Bain, Katharine Frost, Melanie Esterhuizen, Brenda Sephuma and Tessa Baradon. I understand that:

- Participation in this research is voluntary.
- I have the choice to not answer any questions I do not want to answer.
- I may stop participating at any time.
- Direct quotes will be used in the report, however, no personal information that may identify me will be included in the report, and my responses will remain confidential.
- If I decide to give consent for myself and my baby to appear in the training/conference DVD my identity will not be kept confidential, but I can decide for both the identity of myself and my baby to be hidden if I would prefer that.
- After the report is finished, it will be published as an article which will be available to the public.
- After the journal article is published the audio and video recordings (or notes taken) as well the transcripts will be kept in password-protected files as well as in a locked cupboard for 2 years if the study is published or for six years if it is not published, and then destroyed.
- There are no anticipated risks for me participating in this study, but if I feel upset at any time I can be referred for individual counselling at Ububele (Counselling organisation in Kew) at no cost to myself.

Signed _____

Date _____

Appendix 5

Consent Form (Audio and Video Recording)

I _____ consent for the interviews, assessments and group sessions that myself and my baby _____ will have with Katherine Bain, Katharine Frost, Brenda Sephuma, Melanie Esterhuizen and Tessa Baradon to be tape- and video-recorded. I understand that:

- The tape and transcript (these are written documents which contain what has been said in the interview) will not be heard or seen by any people other than the researchers and research assistants, who will keep what I said private.
- The tapes will be heard by the researchers and the research assistants only.
- No personal information, such as names (yours, your infant's, your family etc.) or places (where you live, where you are from etc.) will be used in the transcripts or the report.
- The transcripts will be seen by other researchers overseas but they will not know my name or the name of my baby.
- After the report is finished my interview recording and transcript will be kept in a safe place, that only the researcher will have access to for 6 years.
- My identity in the video recordings will only be seen by the researchers and one video-editor (who will also sign a confidentiality agreement), unless I give my permission for myself and my baby to appear in a video for training other people to run groups or for showing other mental health workers the results of the study. If I do not wish for myself and my baby to appear in the video my identity and that of my baby will be hidden by the video-editor so that no-one can see me or my baby.

(Please tick next to the option you would like)

I give my permission for myself and my baby to appear in the video _____

I do not wish for myself and my baby to appear in the video _____

Signed _____

Date _____

Appendix 6

Translator/Research assistant/Video editor Confidentiality Contract

I _____, in my role as a _____ for Katherine Bain's research study on parent-infant psychotherapy groups, agree to keep all information regarding the identities of the participants and the contents of the interviews and groups (both live and audio or video recorded) in my strictest confidence, thereby ensuring the confidentiality of the study's participants. If I have any concerns regarding the study or any of the information I have been exposed to I will make contact with the researcher or co-investigators in order to obtain counselling.

Signed _____

Date _____

Thank you for assisting in the current study.