

https://dspace.org/

# Psychoanalytic parent-infant psychotherapy in South Africa : opening ports of entry and flexing the frame.

**Dugmore, Nicola A.**

**2013-07-24**
http://hdl.handle.net/10539/12894

Downloaded from a DSpace repository. https://dspace.org/

# PSYCHOANALYTIC PARENT-INFANT PSYCHOTHERAPY IN SOUTH AFRICA: OPENING PORTS OF ENTRY AND FLEXING THE FRAME

**By**
**Nicola A. Dugmore**

**Supervisor: Prof Carol Long**

**2013**

**A thesis submitted in fulfilment of the requirements for the degree of Doctor of Philosophy in Psychology at the University of the Witwatersrand**

# Declaration

I declare that this is my own unaided work. It is being submitted for the degree of PhD in Psychology at the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination at another university.

Signed:

# Abstract

Parent-infant psychotherapy is a small but growing field in South Africa. Its potential to contribute to mental health services in South Africa is, by contrast, vast. This thesis contributes towards much-needed research on the state of the field in the country and its potential applications across different sectors. Drawing on Daniel Stern's concept of ports of entry, it is argued that an expansion of ports of entry offers an important integrating tool through which different aspects of parent-infant psychotherapy can be examined and adapted to the South African context. A history of parent-infant psychotherapy in South Africa is offered, together with an analysis of the experiences of current practitioners in the field. These aspects of the thesis draw on interviews with key stakeholders. The dominant context of private practice is then explored through two case study based papers. The first explores the meaning of symptoms in parent-infant psychotherapy. The second introduces the 'grandmaternal transference' as an important but under developed port of entry. These different aspects of parent-infant psychotherapy in South Africa are then considered through the prism of ports of entry in order to argue for a flexing of the psychoanalytic frame. Implications for the growth of the parent-infant psychotherapy field in South Africa are considered.

***Keywords***: parent-infant psychotherapy, parent-child psychotherapy, under fives counselling, ports of entry, motherhood constellation, psychoanalytic psychotherapy in South Africa, grandmother, grandmaternal transference, code of ethics.

# Acknowledgements

I wish to acknowledge, with gratitude, my supervisor Prof Carol Long who has been an invaluable source of encouragement, enthusiasm, knowledge and guidance. Her academic wisdom, her mindfulness and her careful attention to detail have helped shaped this thesis in significant ways.

Prof Gavin Ivey's vision of a PhD programme that would include publication gave me a platform to explore the interface between academic research and clinical practice and to advocate for early parent-infant psychotherapeutic interventions. Prof Gillian Eagle, Prof Garth Stevens and Prof Susan Van Zyl at the University of the Witwatersrand have all contributed in meaningful ways to this endeavour. I also extend thanks to Mellon Distinguished Scholars Prof Gillian Straker and Prof Juliet Mitchell who both reviewed early versions of my manuscript on the grandmaternal transference.

I am privileged to have been in a seminar group with three brilliant PhD candidates who reliably offered emotional, clinical and academic support. Karen Gubb, Yael Kadish and Clinton van der Walt are three of the finest clinicians and most generous people I could have wished for as colleagues and friends and their contributions are warmly acknowledged.

In different but meaningful ways Julie Green, Trevor Lubbe and Dilys Daws have helped me to find my voice and I am deeply grateful for all that they have helped me to learn about myself and my work.

I am truly appreciative of the sacrifices my family, particularly my children, and my friends have made in allowing me to be unavailable, distracted, preoccupied and downright boring. Finally, I wish to thank my husband for believing in me, for encouraging me and for giving me the space to complete this study — without him I would not have done it.

# Table of Contents


| | Page |
|---|---|
| **Declaration** | i |
| **Abstract** | ii |
| **Acknowledgements** | iii |
| **Chapter One:** Introduction | 1 |
| **Chapter Two:** Literature Review | 17 |
| **Chapter Three:** Research method and ethical considerations | 43 |
| **Chapter Four:** The history of parent-infant psychotherapy in South Africa: Theoretical roots and current practice | 70 |
| **Chapter Five:** Parent-infant psychotherapy in South Africa: Contextual challenges and adaptive responses | 97 |
| **Chapter Six:** Parent-infant psychotherapy described | 126 |
| **Chapter Seven:** The grandmaternal transference | 148 |
| **Chapter Eight:** Discussion | 174 |
| **Chapter Nine:** Limitations and directions for future research | 200 |
| **Chapter Ten:** Conclusion | 204 |
| **References** | 208 |
| **Appendix I:** Interview participants – research information sheet, participation informed consent form, audio recording consent form | 226 |
| **Appendix II:** Interview Schedule | 230 |
| **Appendix II:** Case study participants – research information sheet, participation informed consent form | 232 |
| **Appendix IV:** University of the Witwatersrand Human Research Ethics Committee (Non Medical) Clearance Certificate | 235 |

# CHAPTER ONE

## Introduction

In the broadest sense, infancy to early childhood is a critical time for the promotion of optimal emotional and social development. During this time, early interventions may carry great promise for establishing critical foundations to lifelong emotional health by addressing those issues that threaten to derail normal development. In spite of the promise of intervening early, in the South African mental health care field initiatives for addressing the emotional and relational health of infants and young children and their parents are largely lacking, or where they do exist, widely overlooked.

In terms of emotional and behavioural matters related to infancy and early childhood, many South African parents looking for advice, support and/or treatment will approach their primary care providers — paediatricians, family physicians and clinic sisters — as the first port of call. Without training or exposure to developments in infant mental health, these health service providers often dismiss or misdiagnose emotional difficulties in infants and young children and as a result rarely suggest psychotherapeutic treatment as an adjunct or alternative to pharmacological treatment or behaviour modification strategies. Of the treatment options that may be described as psychotherapeutic, parent-infant psychoanalytic psychotherapy is seldom considered a treatment option in South Africa. This can be attributed to both a dearth of such services, in both the public and private healthcare fields, and not surprisingly, an almost complete absence of knowledge of such treatments on the part of possible referring agents (such as primary health care providers, social workers or teachers).[1]

[1] The scales of balance may be tipped slightly towards provision as awareness of the importance of infant mental health is growing, arguably exponentially, within the psychotherapy field. This is evidenced by the large number of local delegates that attended the 2012 World Association of Infant Mental Health (WAIMH) Congress, held in Cape Town. The number of delegates exceeded the expectations of the local organizing committee.

The relative[2] paucity of such services in South Africa is not a reflection of their profile on the international mental health map. Increasingly, particularly since the 1990s, clinics offering counselling and psychotherapy treatment services (located in the psychoanalytic paradigm) to parents and their infants/young children have been established in public healthcare systems across the globe. Published articles and books describing the work done in such clinics have inspired a proliferation of clinical interventions and projects adapted to meet the needs of diverse communities in many countries. South Africa can be included in such a list and South African practitioners and stakeholders in the infant mental health field are increasingly contributing to the published literature. For such proponents and advocates of psychoanalytic psychotherapy with infants/young children and their parents, the greatest challenge is attracting the positive attention and support of the national health ministry, and governmental funding agencies. Increased research into and published writing on the practice of psychoanalytic psychotherapy with infants/young children and their parents is needed if the merits of such work are to be given due attention by South African health service practitioners (primary care providers as listed above), other professionals working in the early childhood field (teachers and social workers) and the relevant state authorities (including the health ministry and treasury).[3]

My own interest in parent-infant/young child psychotherapy evolved via my experiences of doing psychotherapy with young children. The orientation of my training has been broadly psychoanalytic and I would locate myself theoretically primarily in the Middle Group (the Independents) of British Object Relations with influences from other psychoanalytic paradigms that include the intersubjectivists, American Relational Psychoanalysis and Kleinian theory. Early in my professional development, from my internship year, I found myself thinking, when asked to treat families with young children, that the best intervention would be to see the parents and child together in a playroom setting. I felt that this would allow the child some agency while providing parents with the opportunity to reflect in vivo on their child's communications, thereby allowing me access to both the child's and the parents' internal representations. In terms of my training, such thoughts took me into uncharted territory as I had not been introduced to the possibilities of doing dyadic work with parents and children, neither by my lecturers nor through any literature. Fortuitously, I was lent a

[2] Given the large number of infants and young children, with their parents, that are in need of mental health interventions.
[3] This is particularly pertinent at the time of writing given the South African government's current focus on developing a National Health Insurance.

video recording of a Canadian Broadcasting Corporation television programme, titled *When the Bough Breaks* (Docherty, 1995), which had been screened on a local South African television channel. The documentary depicts a child-parent intervention model (described in Chapter Two, see also Cohen & Muir, 2002) and it inspired me to start a literature search for similar interventions. An early reading, one that remains critical in my own professional development and seminal to the field, was the article by Selma Fraiberg and collaborators widely referred to as "Ghosts in the Nursery" (Fraiberg, Adelson, & Shapiro, 1975). In stressing the significance of this text for me, I quote Hopkins (2008):

> The clarity with which Fraiberg formulated the essentials of infant-parent psychotherapy offered me security when I made my first tentative move from working exclusively with individual children and parents to working with mother-infant couples and young families. (Hopkins, 2008, p. 55)

It was not only the clarity with which Fraiberg and other early authors formulated the theory and techniques of mother- and parent-infant interventions, but also the clarity of the case material used by Fraiberg and later authors to illustrate the theory and techniques that served to inspire me. For myself (and others, see Chapters Four and Five) the emphasis on case material in the parent-infant psychotherapy literature has been an essential source of learning, particularly in the absence of formal training.[4]

The earliest efforts to introduce parent-infant psychotherapy in South Africa can be traced back to the mid-1990s, but it is really only in the last ten years that the practice has started to gain several, isolated footholds. I was interested in researching the history of the field and examining the kinds of theoretical and other influences that were shaping local practice. While Western models of intervention appeared to be the source of original inspiration, South African practitioners were responding uniquely to the contextual challenges they were facing in both introducing and implementing parent-infant psychotherapy services. I was interested in exploring the kinds of adaptive responses being developed in this country.

[4] Such in-depth and rich case descriptions arguably serve an important function both in terms of research and also in terms of advocacy and education and in this respect have influenced not only my practice but also my methodology in terms of this doctoral thesis including publication.

Parent-infant services have developed in three sectors of the South African mental health field; the community (largely non-governmental) sector, the public (governmental) sector and the private sector. There are several important factors pertaining to this that have influenced the focus of this research. I fall in the 90% of 5 651 (Smith, 2011) registered psychologists that work in the South African private sector. While it is to be expected, rightly, that Western parent-infant/young child psychotherapy practice requires unique adaptations when imported into South African community contexts, it would be erroneous to presume that there is a more equivalent fit between the public and private sectors of South Africa and those of Western nations. At many levels there are fundamental differences: in South Africa there is as yet no national health insurance; primary health care clinics do not offer emotional support for mothers and infants; there are no home visitation programmes; and referral networks for mental health interventions do not exist. Furthermore, there are no formal opportunities for training in infant mental health. The need for increased services is unquestioned, and this is true across all sectors.

In this research I explore the development of the South African field of parent-infant psychotherapy focusing on the ways in which local practitioners have applied, adapted and extended Western psychoanalytic treatment models. The specific and primary focus is on the ways in which the clinical system comprising parent(s) with infant/young child is accessed in psychotherapeutic interventions that take place within the private sector. Case material from my own private practice work is used to research these points of access, or ports of entry as termed by Daniel Stern (1995). The secondary focus is on the creative adaptations to contextual challenges, as described and reported by practitioners working across settings, and the implications this has for the psychoanalytic frame. Interviews with key stakeholders working in the broader parent-infant psychotherapy field in South Africa allow for the elaboration of ports of entry beyond the private practice setting and indeed beyond the primary clinical system of parents-with-infant.

This doctoral study is in large part motivated by a personal desire to advocate for early infant mental health interventions and in particular to promote parent-infant psychoanalytic psychotherapy as an early preventive intervention in South Africa, across all three sectors. The PhD, which is structured to include publication and requires in terms of course compliance that four papers (to be included as stand-alone articles within the four chapters) are accepted for publication in peer reviewed scientific journals (of which at least one is an

international publication), is well-tailored to support advocacy and promotion of a particular psychotherapy intervention.

## Aims

The broad aim of this thesis is to explore the parent-infant field in South Africa. Integral to this endeavour is the employment of the concept of ports of entry. Daniel Stern, infant researcher and psychoanalyst, introduced the term in his 1995 book *The Motherhood Constellation*. In this text, he proposed that the clinical system made up of parent(s) and infant, with therapist, can be accessed via different ports of entry. According to Stern's (1995) thesis, therapeutic action spreads throughout the system, regardless of the point of access into the system; that is regardless of the port of entry. My doctoral research, located in the South African context, examines and elaborates ports of entry, both those highlighted in the literature by Stern and subsequent commentators, and others not previously described..

The paucity of published literature on the practice of psychoanalytically-oriented parent-infant psychotherapy in South Africa (particularly relative to what has been an increasing number of practitioners in the field) invites redress, and this research endeavours to document both the history and the current status of parent-infant psychotherapy in this country. In order to address this objective, key stakeholders and practitioners working from a psychoanalytic paradigm within the infant mental health field have been interviewed. Stern (1995) has suggested that parent-infant psychotherapy must be seen as taking place in a "different clinical situation with its own imperatives and opportunities" (p. 17). As part of this investigation, the research aims to report on and explore challenges that arise in particular South African contexts and the adaptive responses formulated to deal with such challenges. These adaptations and the multiple ports of entry that they foreground impact the psychoanalytic frame and have implications for how we understand and define it. This research aims to deepen and extend our understanding of ports of entry in order to explore parent-infant psychotherapy across various South African contexts, including primarily private practice

The published sections of this research were not only directed at readers familiar with and involved in the field of parent-infant psychotherapy. They were also intended to meet a

further sub-aim, namely to introduce South African practitioners and stakeholders in the broader fields of infant mental health and psychoanalytic psychotherapy to the perhaps unfamiliar practice of psychotherapy with infants/young children together with their parents. Towards this endeavour, I describe my own parent-infant psychotherapy practice, illustrating it using case material. Two psychotherapy case studies — all with a similar (and common) presenting problem, namely a sleep disturbance — allow for the objectives of introducing this particular mode of psychotherapy and exploring how addressing a symptom within the context of a parent-infant interaction draws into focus various ports of entry.

Directly related to my own clinical experience has been the emergence of an interesting and largely unexplored dynamic, namely that of a grandmaternal transference. -The grandmaternal transference represents a new and additional port of entry and psychotherapy case studies are used to illuminate and explore it. This research aims to understand and develop the notion of the grandmaternal transferential (and countertransferential) dynamic more fully. The relationship between this additional port of entry and the psychoanalytic frame in parent-infant psychotherapy is discussed.

Although parent-infant psychotherapy developed out of the psychoanalytic tradition, it does not represent a simple fit. There are theoretical and practical challenges for the parent-infant psychotherapist wishing to work in a psychoanalytic way, and the psychoanalytic frame might need redefining in the context of an intervention that involves several different ports and sites of entry (for example child, parent, couple relationship, child-parent relationship, transferential relationships, community and cultural contexts etc.) into a psychoanalytic system made up of parent(s) and young child(ren). The final aim of this research is to explore the impact multiple ports of entry have on the psychoanalytic frame.

## Research Questions

The overriding research question and the title of this doctoral study concerns an examination of ports of entry in parent-infant psychotherapy and the possible implications for the psychoanalytic frame within the South African context. This over-arching research question has been divided into five sub-questions that are approached from two different perspectives. The first perspective is to understand the South African field and the challenges faced by practitioners working in different sectors. The second is to look at clinical material within a

private practice setting. In the light of this dual perspective, some sub-questions are addressed by analysing data gathered from interviews with key stakeholders and practitioners in the field, and others by analysing data that originate in the psychotherapy setting.

1. How does one understand different ports of entry in parent-infant psychotherapy in the South African context?
   1.1. What are the different contexts of practice?
   1.2. How do these relate to different ports of entry?
   1.3. How do we address a symptom as having meaning within a clinical model that allows for different ports of entry?
   1.4. How can our understanding of ports of entry be theoretically expanded in relation to the concept of a grandmaternal transference?
   1.5. How do we understand the psychoanalytic frame in relation to a clinical practice that utilises multiple ports of entry?

## Rationale

This PhD represents an opportunity to fulfil both a need for research in an emerging field and a need, through publication of the research, for public education and advocacy of a relevant form of clinical practice. Internationally, psychoanalytic parent-infant psychotherapy is increasingly and widely recognised as a critical early and preventative intervention in the field of infant and young child mental health (for example Fonagy, 1998; Pozzi, 2003; Reynolds, 2003). Both symptom relief and positive changes in the parent-infant relationship have been reported (Barrows, 1997; Cohen et al., 1999; Hofacker & Papousek, 1998; Hopkins, 1992; Lieberman, Weston, & Pawl, 1991; Robert-Tissot et al., 1996).

At time of initiating this research in 2008, South African authored or co-authored articles that had been published in the parent-infant psychotherapy field were limited to those by Astrid Berg (2001a, 2002b, 2003, 2007) and several that described a parent-infant intervention in relation to an epidemiological study into postnatal depression (Cooper et al., 2002; Cooper & Murray, 1995; Cooper et al., 1999). Berg's writings reported on critical interventions with vulnerable mother-baby dyads in public and community health settings in which she works in Cape Town, South Africa's second largest city. The epidemiological study, conducted in a

township outside Cape Town, may not fully qualify as a psychotherapeutic intervention as it was delivered by lay counsellors drawn from the township community.

The significance of this paucity of relevant South African-generated writings for the conceptualisation of this research was twofold. Firstly, any attempt to review the literature, an integral task of this doctoral study, would be heavily skewed in favour of international practice. Hence, the current status of the field in South Africa would need to be investigated by more direct means (as in interviews) in order to augment the distorted representation of the field suggested by a review of the literature. Secondly, if the published writings were taken wholly to represent the state of parent-infant *psychotherapy* in South Africa, it may be assumed that psychoanalytic psychotherapy for infants with their parents is not an available treatment choice outside of Cape Town and the city's environs.

Formal and informal networking with colleagues and my own experience of being a Johannesburg-based parent-infant psychotherapist, led me to speculate that as things stood in 2008, the status of current practice was inaccurately represented by a survey of the literature. In terms of the promotion and growth of the field in South Africa, as well as recognition of a diversity of practice more widely available, this warranted correction. A dearth of locally published literature (only two of Berg's papers were published in local journals) certainly limits awareness of parent-infant psychotherapy amongst South African health professionals. Arguably, greater showcasing of local practice is needed to encourage both an increase in parent-infant/young child referrals and an expansion of parent-infant psychotherapy services.

Further, the paucity of South African-authored literature exposes the gap between international research/practice and South African research. Despite fairly rapid growth, the South African field has yet to achieve the degree of awareness and recognition parent-infant psychotherapy commands internationally. One aspect of this terrain that warrants highlighting is the role of culture and the necessity of engaging with cultural diversity. Identifying adaptive responses to the challenges of working transculturally may serve to improve and enhance practice, both in South Africa where cultural diversity is a key defining feature, and abroad where multicultural societies are increasingly the norm.

If this research shows that parent-infant psychotherapy is not limited to Berg's work in Cape Town, then a gap between current practice and current academic research is indicated. The

establishment of a National Health Insurance, which would improve the access of all South Africans to health services, including mental health services, is very much on the agenda of the health ministry. However, in the absence of public and professional awareness of existing resources, training of future infant mental health practitioners and funding of parent-infant services, the field's potential growth and outreach are limited. Consolidation of the discrete pockets of parent-infant psychotherapy interventions that currently exist, primarily outside of the public sector, is essential if parent-infant mental health is to be acknowledged as critical for inclusion on the broader mental health agenda. This research is well-positioned to identify and report on pockets of practice in a published article, and through articulation of both common goals and contextual challenges to foster links and facilitate dialogue between key stakeholders in South Africa.

The South African field cannot be equated with the international field. There may be common multiplicities inherent in the practice of parent-infant psychotherapy that include: the persons present in the therapeutic encounter; the relational matrices that result; developmental theories of infant and early childhood and different models of clinical intervention. However, South African parent-infant psychotherapists working in diverse settings are presented with unique challenges and opportunities particularly in terms of the complexity of ports of entry required to access the clinical system and the potential impact this has on the psychoanalytic frame.

Several research opportunities exist in relation to Stern's (1995) notion of ports of entry and his ideas pertaining to the motherhood constellation and good-grandmother transference. In the parent-infant field, the elaboration of the grandmaternal transference proposes a novel positioning of the psychotherapist in relation to the concurrent presence of a mother with her infant or young child. This opening up of an additional port of entry may have implications for the holding of the psychoanalytic frame. This research motivates for a flexing of the frame that structures the psychoanalytic space in order that parent-infant psychotherapy as practised across contexts in South Africa remains true to its psychoanalytic roots.

## Theoretical orientation and conceptual framework

Psychoanalytic parent-infant psychotherapy as the object of this research is defined in terms of four fundamental features.

Firstly, parent-infant psychotherapy is located within the broad spectrum of infant (zero to three) mental health, which implies, by definition, that infant mental ill-health (or pathology) can be identified, described and 'treated'. Infant mental health is defined by the World Association for Infant Mental Health (WAIMH) as:

> … the ability to develop physically, cognitively, and socially in a manner which allows [infants] to master the primary emotional tasks of early childhood without serious disruption caused by harmful life events. Because infants grow in a context of nurturing environments, infant mental health involves the psychological balance of the infant-family system. (Osofsky & Fitzgerald, 2000, p. 25)

My preferred term 'parent-infant' implies, as used in the write up of this thesis, a slightly broader definition of the clinical population; I have extended the term infant to include young children in their fourth year of life; that is including three year olds. This inclusion of preschool children is not novel, rather it is intrinsic to several approaches in the field, particularly that of the Tavistock Clinic in London where 'under fives counselling' is broadly considered an extension of parent-infant psychotherapy (Emanuel & Bradley, 2008). 'Parent' is generally intended to refer to the mother and/or father and in some cases a non-parental but primary caregiver. Listing 'parent' upfront in the term foregrounds the importance of parental representations together with the importance of accessing this port of entry in my particular psychotherapeutic approach.

Secondly, the orientation from which infant mental health is explored is psychoanalytically informed. A psychoanalytic orientation implies working with the unconscious; both in terms of the internal world of the patient and in terms of the transferential dynamics in the patient-therapist relationship. In the context of parent-infant psychotherapy, the interplay between, and the inter-relatedness of, the internal and representational worlds of the infant and parent/s are conceptualised in the context of psychodynamic models of understanding the parent-infant relationship (Bowlby, 1969; Winnicott, 1960). This emphasis on early attachment and object relations is most clearly captured in Winnicott's 1940 statement: "There is no such thing as an infant…meaning of course that whenever one finds an infant one finds maternal care, and without maternal care there would be no infant" (Winnicott, 1960, p. 39). In terms of the here-and-now relationship between therapist and patient, attending to transferences and countertransference — if not interpreting, which is somewhat more controversial — is

considered a vital aspect of the psychoanalytic psychotherapy process. The psychoanalytic theoretical influences on parent-infant psychotherapy will be outlined below and then discussed in greater detail in the Literature Review chapter that follows.

Thirdly, it is the inextricable impact that a parent's (and particularly the mother's) representational world has on the relationship with the infant that led to the development of a therapeutic intervention that requires the presence of parents and infant or young child *together* in the same therapeutic space. Arguably, in contrast to psychodynamic family therapy, the infant or very young child is viewed as having a significant contribution to make to both the psychodiagnostic and treatment aspects of the therapy process.

Finally, the object of enquiry — parent-infant psychotherapy — is located in the South African field. There are both areas of correspondence and difference to psychoanalytic parent-infant psychotherapy as practised elsewhere in the world and these will be explored in later chapters.

For the purpose of this research, the theoretical orientation is broadly psychoanalytic; 'broadly' in that it is not purely Freudian but also draws from other schools of psychoanalysis including object relations (for example Bion, 1962a, 1962b; Klein, 1952a, 1952b), the independent school (for example Winnicott, 1957, 1960, 1963c), intersubjectivity (for example Stern, 1977, 1985) and attachment theory (Bowlby, 1969). Key defining concepts embedded in the broader theoretical foundations of both the research and the clinical practice that is the object of the research include: the unconscious, the meaning of symptoms and the role of interpretation (for example Freud, 1910, 1936), transference and countertransference (for example Freud, 1912; Heimann, 1950; Joseph, 1985; Klein, 1932, 1946), projective identification (Klein, 1946), the role of children's symbolic play in treatment (A. Freud, 1929, 1945; Klein, 1955; Segal, 1957), the container-contained relationship and the notion of maternal reverie (Bion, 1962a, 1962b), maternal preoccupation, the good-enough-mother and the holding she provides (Winnicott, 1960, 1963c), attachment disturbances in the parent-child relationship (Bowlby, 1958, 1960, 1969) and ports of entry and the motherhood constellation (Stern, 1995).

Parent-infant psychotherapy is primarily distinguished from other parent-child interventions (such as systemic family therapy and filial therapy) by the central role given to the notion of

the unconscious and an inner psychic life, both in terms of the role of unconscious dynamics in aetiology and in treatment (Barrows, 1997, 2003; Emanuel, 2007; Emanuel & Bradley, 2008). Drawing on a psychoanalytic understanding of the unconscious provides an explanation for how symptoms develop. In psychoanalytically-oriented parent-infant/child interventions the presenting problem or symptom is assumed to have psychodynamic meaning beneath and beyond its symptomatic manifestation (Sorensen, 2003). When help is sought for distress, the symptomatic behaviour is often part of the presenting problem. Psychoanalytic psychotherapy relies on interpretation — the attribution of meaning to such symptoms by the psychotherapist over and above the view held by the patient. According to psychoanalysis, such interpretation provides relief by addressing and alleviating the anxiety underlying the symptom (Freud, 1914, 1917).

As suggested by Laplanche and Pontalis (1950), transference is frequently used in a more extended meaning than that originally proposed by Freud. In respect of the use of the term in this thesis, two extensions of its meaning are foregrounded. Firstly, for Freud the transference may be connected with imagos other than those of the father and mother (Laplanche and Pontalis, 1950) and similarly for Klein (1946) the transference situation may represent "mother, father, or other people" (1946, p. 436). Secondly, although transfer from the past to the present, or the replacement of "some *earlier* person by the person of the physician" (Heimann, 1950, p. 456, my emphasis) is always implied in definitions of transference, given the primary timing of parent-infant interventions that address an infant/young child (in the context of his/her parent), the "earlier person" may well still be psychically active in the present and/or the very near-past. Klein (1952a) held that transference originates in the same processes which in the early stages of infancy determine object relations and as such positive and negative transferences need to be considered.

Within the parent-infant psychotherapy literature there has historically been a reluctance to make transferential interpretations (Barrows, 1997) although there is some shift towards this more recently (Emanuel, 2009). The concept of countertransference, particularly as defined by Heimann (1950), has received some foregrounding (Baradon, 2005; Baradon et al., 2005; Emanuel, 2009; Emanuel & Bradley, 2008; Likierman, 2003). The concepts of transference and countertransference serve to differentiate psychoanalytically-oriented parent-infant psychotherapy from more cognitive-behavioural and systemic family interventions. (The latter are beyond the focus of this research.)

Different models of parent-infant psychotherapy draw to differing degrees from various strands of psychoanalytic thinking but all are underpinned by a philosophy that recognises that in becoming a parent, past childhood experiences, unresolved conflicts and traumas, are reactivated and projected or re-enacted with the actual child in the present (Herman, 2005; Pozzi-Monzo & Tydeman, 2007). As within traditional psychoanalysis, the therapist-patient relationship provides a context in which two parties can together explore symptoms. However, the presence of an infant or young child adds to both the richness and the complexity of this endeavour as aspects of the parent's internal world may be transferred not only onto the therapist, but also projected onto the infant or young child. While these parental projections onto the infant may not arise because of the clinical situation, as is the case with transferences, they may manifest in the therapeutic encounter and key elements of the underlying anxiety and the symptomatic behaviour will become available for study, both in the relationship between parent and infant, and in the transferential and countertransferential relationships with the psychotherapist. This is well described in the literature (for example Baradon, 2005; Baradon & Joyce, 2005; Barrows, 2003; Emanuel, 2007).

A further defining and differentiating feature of psychoanalytic parent-infant psychotherapy is the central role of play. Very briefly, Melanie Klein (1955) claimed that play could have a manifest expression with a latent unconscious content and as such could be interpreted. Given that in this regard the use of play materials has particular symbolic value, parent-infant psychotherapy makes provision for a set of toys selected for their potential symbolic value and the therapeutic encounter often takes place in a playroom setting in order to maximise play opportunities. Toys offer young children both opportunities for communicating their external and internal (more unconscious) realities, and also for working through issues that might be causing anxiety. (This is significantly different from the idea of incorporating children in systemic family therapy where most often toys are provided merely as entertainment.)

In the parent-infant psychotherapy approach explored in this study, the infant/young child is never seen alone, although parents may be for purposes of gathering information or reviewing aspects of the process. Other significant members of the family (siblings, grandparents, caregivers) may also be included in sessions, but at its heart, parent-infant psychotherapy presumes the presence of parent(s) and infant/young child together in the therapy setting. Donald Winnicott's concepts of holding and primary maternal preoccupation (Winnicott,

1963c) and Wilfred Bion's concept of containment (Bion, 1962a) have been borrowed from the mother-infant relationship in which they are theoretically located, and applied to an understanding of the therapist-patient relationship generally in studies of psychoanalytic technique (for example Casement, 1985; Vivona, 2006). This is true too in psychoanalytic parent-infant psychotherapy (for example Hopkins, 1992), but the dual understanding and application of the concepts is exquisitely meaningful in a therapy encounter that embodies the parent-infant relationship both literally and figuratively.

## Structure of the Thesis

This introductory chapter will be followed by a chapter in which the parent-infant psychotherapy literature is reviewed. Chapter Three addresses the research method and ethical issues. Chapters Four to Seven contain the four journal articles necessary for the conferring of this doctoral degree. All four stand-alone manuscripts have been submitted to peer-reviewed scientific journals and accepted for publication. The manuscripts have been written to meet the editorial requirements of scientific journals and so in order to integrate the journal articles and make clearer the relationship between them and the research questions, each chapter commences with an introductory section. These introductory sections serve to contextualise the journal articles in relation to the study as a whole and to the research aims and questions more specifically. It is the journal-edited versions that constitute the body of the research and that are included in Chapters Four through Seven. These four chapters have different foci but are linked by the concept of multiple ports of entry. At date of submission, three of the four journal articles have been published.

Chapter Four is a history of the parent-infant psychotherapy field in South Africa and is primarily based on interviews with key stakeholders in the field supplemented by a survey of relevant literature. This chapter documents the current status and the growth of parent-infant psychotherapy in this country. In so doing the chapter explores the theoretical roots of various approaches while also relating developments in the South African context to those in the international field.

Chapter Five is in many ways a continuation of Chapter Four in that it extends the exploration of the evolution of parent-infant psychotherapy in South Africa and the various contexts in

which it is practised. However, the focus is primarily on exploring the various challenges faced by stakeholders and practitioners working in the parent-infant psychotherapy field as well as the adaptive responses that have been developed to address these challenges. The introduction to Chapter Five clarifies a proposed link between contexts of practice and levels of ports of entry. The included journal article was based on interviews with key stakeholders in the field and interviewees are extensively quoted. An argument for a positive relationship between psychoanalytic mindfulness and preservation of a psychoanalytic frame is introduced in this chapter.

Chapter Six is an illustration of parent-infant psychotherapy in the treatment of sleep disturbances. Paediatric research shows that neither medications nor sleep modification schemes provide effective long term management of most sleep problems (Adair & Bauchner, 1993), making difficulties with sleep a useful starting point for exploring the significance of a symptom and its meaning, both from a psychoanalytic orientation, and with reference to a parent-infant relationship. Sleep difficulties account for 17-30% of problems reported to paediatricians (Martin, Hiscock, Hardy, Davey, & Wake, 2007; Mindell, Owens, & Carskadon, 1999; Rosen, 1997). It is the frequency of sleep disturbances that informs their selection as a symptom around which to focus an illustration and discussion of the practice of parent-infant psychotherapy and the ports of entry typically employed to access the clinical system. In describing my approach to parent-infant psychotherapy and the role of the symptom in the psychotherapeutic process, this chapter/paper addresses the primary research question and particularly sub-question 1.3. Stern's (1995) concept of ports of entry is introduced and illustrated at the clinical level, providing a foundation from which it will later be elaborated.

A novel port of entry is introduced in Chapter Seven, namely that of the grandmaternal transference. Research sub-question 1.4 is addressed in this chapter and new theory is developed relating to three different proposed manifestations of the grandmaternal transference. In the journal article, the theory and application of a grandmaternal transference, which represents an arguably important port of entry given the comparable presence of therapist-as-grandmother with a mother and infant/young child, was illustrated by means of psychotherapy case studies (and case vignettes). This chapter provides additional material for an exploration of sub-question 1.1 in that the practice of parent-infant psychotherapy in the

context of a private setting is further demonstrated and explored and various ports of entry elaborated.

The Discussion chapter (Chapter Eight) integrates the arguments developed in the preceding four chapters. South African sites of intervention, as reported in Chapter Five, include a mat placed on the floor of a busy primary health care clinic floor, shacks in an informal settlement, mother-infant groups as well as the more traditional although differently populated playroom. Multiple ports of entry are opened when the multiplicities of persons, relationships, transferences and behaviours (including non-verbal behaviours) are considered in parent-infant psychotherapy. In this chapter these are classified as primary, however the notion of secondary ports of entry — linked to contexts of practice — is more comprehensively introduced and elaborated. The opening of so-termed secondary ports of entry is arguably necessitated given the specificities of the South African situation. The secondary ports of entry support access to the clinical system and to the primary ports of entry more particularly associated with the therapeutic encounter.

Opening up ports of entry invites questions pertaining to the possible impact on the psychoanalytic frame. Sub-question 1.5 is addressed in some detail in the Discussion chapter. An argument is developed, drawing on the previous chapters, for the employment of a more flexible frame. A case is made for engagement with the South African Psychoanalytic Confederation's Code of Ethics (Silove, Schön, Berg, Green, & Levy, 2011) in order to safeguard further psychoanalytic parent-infant psychotherapy interventions. In this chapter, psychotherapy case study material presented in earlier chapters is referenced for purposes of illustration and evidencing.

Limitations of the research and implications for future research are given in Chapter Nine. The final chapter of the thesis, Chapter Ten, serves as the Conclusion.

# CHAPTER TWO

# Literature review

## Introduction

This literature review will address three aspects of the literature pertaining to the research topic. Firstly, it will locate parent-infant psychotherapy in the broader psychoanalytic field in terms of both its theoretical and historical roots, with a special focus on the role of infant observation and infant research. Some of the key psychoanalytic concepts listed in the previous chapter will be elaborated briefly here as they are referenced within the parent-infant psychotherapy literature, or as they have informed its development. Secondly, diversity within the parent-infant psychotherapy field will be discussed in terms of the development of different models/approaches. This research adopts as its core research object *psychoanalytically-oriented* parent-infant psychotherapy. A brief summary of the principles underpinning a psychoanalytic orientation have been given in the previous chapter; here psychoanalytically-oriented parent-infant psychotherapy will be differentiated briefly from work with parents and infants located outside of the psychoanalytic paradigm. Some critiques leveled at various approaches to parent-infant psychotherapy will be raised. Attention will thereafter be paid to charting the development of the different models/approaches that have emerged within the psychoanalytic field. The literature pertaining to parent-infant/young child psychotherapy in South Africa will be mentioned briefly as it is surveyed in greater detail in Chapter Four. A conclusion that can be drawn from the literature review is that parent-infant/young child psychotherapies may have common theoretical roots, but these translate into varied practices. This invites discussion of the merits of a more unified approach to parent-infant/young child psychotherapy, which represents the third aspect of this literature review. Daniel Stern (1995) introduced the concept ports of entry in his own efforts to argue for a unified approach. This thesis significantly extends the concept and in particular applies it

to the various manifestations of parent-infant psychotherapy within South Africa, across private, public and community contexts.

I have chosen to use the term parent-infant psychotherapy to describe the treatment approach and the clinical population addressed in this research. In the service of easier reading my use of the term parent-infant psychotherapy implies the inclusion of toddlers, young children and preschoolers, however in later chapters parent-infant/child and parent-infant/young child may be used and defined in response to the particular requirements or readership of the journals to which parts of chapters (as manuscripts) were submitted for review.

The term 'parent-infant psychotherapy' is used more broadly and inclusively in this research than it may be by other authors. For example, at the Parent-Infant Project at the Anna Freud Centre, the infant is considered such up until two years of age (Baradon, et al., 2005; Baradon & Joyce, 2005). The World Association for Infant Mental Health defines infancy as the 0 to 36 month period. (At the most recent WAIMH Congress, however, held in Cape Town in April 2012, presenters described interventions with children both younger and older than 36 months). At the Tavistock Clinic, parent-infant psychotherapy is referred to as 'under fives' counselling with 'five' suggesting a preschool population (Emanuel & Bradley, 2008). Berlin (2008) describes a parent-child psychotherapy that she calls tripartite therapy and that allows for the inclusion of younger children as well as adolescents. Lieberman's (2004a) child-parent psychotherapy (CPP) foregrounds the child as a central and active participant, and she considers CPP an extension of infant-parent psychotherapy to the first 6 years of life. Other approaches may be infant-led (Cohen & Muir, 2002; Norman, 2001; Thomson-Salo et al., 1999) or parent-led (Barrows, 2008; Bower, 1995; A. Jones, 2006b; Ludwig-Korner, 1999; Palacio Espasa, 2004; D. Stern, 1995).

## Theoretical and historical roots of parent-infant psychotherapy

Sigmund Freud, the father of psychoanalysis, can in some way also be seen as the father of parent-infant psychotherapy although the field was neither outlined nor named until fifty years after his death. The roots of working with a child and parent can be traced back to Freud's work with Little Hans (Freud, 1909), an analysis that was conducted via the father and one in which on occasion father and son were reported to have been together in

consultations with Freud (Geissman & Geissman, 1992). The two 'daughters' of Freud, Anna Freud and Melanie Klein, are recognized as the pioneers of child analysis but their different approaches and the conflict generated by the proponents of each were to be the source of a series of intellectual discussions and confrontations that began in the 1920s and culminated in "The Controversial Discussions" (1941–1944). Midgley (2012), in a very recent paper, has argued that Anna Freud did in fact change her technique after 1929 in response to Klein's comments and that these changes have been overlooked historically. At the time, however, the discussions signalled a splitting of the British psychoanalytic community into three factions; the Klein group, the Anna Freud Group now called the Contemporary Freudians, and a Middle Group now known as the Independents (Geissman & Geissman, 1992).

Klein challenged Anna Freud's early claim that children in analysis cannot free associate and need to be of a verbal age through the creation of a technique of child analysis based on play: "[M]y contributions to psychoanalytic theory as a whole, derive ultimately from the play technique" she wrote (Klein, 1955, p. 123). Whereas for Anna Freud play was a source of clues to the child's inner life but not used for interpretation (Esman, 1983), Klein in her promotion of the use of play therapy likened the child's use of play materials to the dream in terms of an expression of unconscious communication and as something interpretable (Bateman & Holmes, 1995). She described her careful selection of "small" toys chosen for being unspecific and hence open to individual representation, and their storage in an individual box or locked drawer (Klein, 1955). Klein showed that the child, through symbolism, was able to transfer interests, phantasies, anxieties and guilt to objects and not only to people. According to Segal:

> Klein's stroke of genius lay in noticing that the child's natural mode of expressing himself was play, and that play could therefore be used as a means of communication with the child. Play for the child is not 'just play', it is also work … the child dramatizes his phantasies, and in doing so elaborates and works through his conflicts. (Segal, 1979, p. 36)

In her classic example (described in Klein, 1955), the three-and-a-half year old boy who banged two trucks together was told that he was thinking about his parent's sexual intercourse. For Klein, play was not so much a means to an end but the end in itself (Esman, 1983).

A key aspect of parent-infant psychotherapy is the addressing of the early and primitive anxieties associated with infancy, and indeed early parenthood. It is theoretically the presence of the infant/young child that facilitates the activation of these anxieties in the here-and-now of the therapeutic encounter (Fraiberg, et al., 1975). In this respect, a comment by Klein in a paper presented in 1955 seems to me to be a forerunner of the application of her clinical theory to work with infants:

> One of the many interesting and surprising experiences of the beginner in child analysis is to find in even very young children a capacity for insight which is often far greater than that of adults. To some extent this is explained by the fact that the connections between conscious and unconscious are closer in young children than in adults, and that infantile repressions are less powerful. I also believe that the infant's intellectual capacities are often underrated and that in fact he understands more than he is credited with. (Klein, 1955, p. 13-14)

Having indicated that the early controversial discussions of Klein's and Anna Freud's respective approaches to analysis of children served to divide the psychoanalytic community of the time, it is interesting to note that in the field of parent-infant psychotherapy ideas from the different psychoanalytic groups seem to be embraced across divisions. For example, Bion's (1962a, 1962b) concept of containment, which was a development of Klein's (1946) notion of projective identification, is considered a key issue in parent-infant psychotherapy and is frequently referenced in texts penned by parent-infant/child authors across the psychoanalytic spectrum, including those writing from a more Anna Freudian perspective who do not reference 'Klein' or index 'projective identification' at all – for example Baradon et al. (2005).[5]

As a paediatrician in terms of his initial training, and later a psychoanalyst located within what was identified after the Controversial Discussions as the Middle Group, Donald Winnicott contributed significantly to developmental theory and in so doing foregrounded the mother-infant relationship. Winnicott is considered by many authors to have practiced a kind

[5] This kind of adoption of the notion of containment would seem to be what has led Geissman and Geissman to suggest that Bion's ideas have been appropriated by more classical psychoanalysts "while emptying them of their Kleinian substance" (1992, p. 179).

of parent-infant psychotherapy (Acquarone, 2004; Barrows, 1999a; Dowling, 2006; Hopkins, 1992) even if it was not named as such. Certainly he consulted to mothers *with* infants and in 1941 famously described a simple intervention with an infant seated on her mother's lap that resulted in the relieving of wheezing symptoms in the child, with a report of the re-emergence of asthmatic symptoms in the mother thereafter (Winnicott, 1941). Important in terms of the development of parent-infant psychotherapy is that both this treatment of an infant by Winnicott and that of Little Hans by Freud implicated the parent in a young child's symptomatic expression.

As with Bion, Winnicott's developmental concepts were quickly incorporated into models of understanding the therapist-patient relationship, and then became fundamental in describing technical aspects of parent-infant psychotherapy. For example, Winnicott stressed the developmental function of 'holding' which takes the infant from absolute dependence to relative dependence and then towards independence (Winnicott, 1963c). Winnicott's ideas about the mothering relationship (Winnicott, 1960) have been readily adopted as assumptions about the parent-infant therapy relationship; the mother, like her baby, needs the experience of being emotionally held before she can offer the same to her infant and this can be provided by the therapist. A reflective transitional space between mother and therapist needs to be created before the mother can explore and develop empathy in the relationship with her baby (Dowling, 2006).

When introducing Klein at a 1953 scientific meeting, Winnicott said that he considered her introduction of tiny toys to be the most significant advance in child analysis (reported in Segal, 1979), but he did in fact contribute many of his own ideas on play and some of these ideas have also been borrowed by parent-infant psychotherapy authors. Winnicott saw play as originating in the early mother-infant relationship and he described psychotherapy as "learning to play" (Winnicott, 1971a). One of Winnicott's ideas was that play should not be seen as a direct manifestation of unconscious thought, but rather something creative and synthetic that took on meaning from the interpersonal and object-relations context (Bateman & Holmes, 1995). Winnicott wrote: "in the play area the child gathers objects or phenomena from external reality and uses these in the service of … inner or personal reality" (Winnicott, 1971a, p. 69). In a quote that can be read in relation to both the mother-infant and therapist-child relationship, he claimed: "Children play more easily when the other person is able and

free to be playful" (Winnicott, 1971a, p. 44-45). Thomson-Salo, an Australian based infant-parent psychotherapist quotes this comment by Winnicott in her co-authored paper titled *Free to be playful – therapeutic work with infants* (Thomson-Salo, et al., 1999).

The contributions made by Winnicottian developmental theory to our understanding of both the parent-infant and therapist-patient relationship are too numerous to summarise here, but one further aspect that is relevant is his treatment mode flexibility. Winnicott described what he called "therapeutic consultations" (Winnicott, 1971b) and while these have been referenced by authors writing from outside of the specialised parent-infant field (e.g. Geissman & Geissman, 1992; Lanyado, 2009; Weltner, 1982), within the field the adaptability and flexibility of his approach seem to have been somewhat less widely acknowledged, but nonetheless fundamentally incorporated.

Peter Fonagy's (2001) attempts to integrate attachment and psychoanalytic theories and his writings on attachment have done much to highlight the influence of John Bowlby's work in the field of parent-infant/young child psychotherapy. A controversial figure in the history of psychoanalysis, Bowlby's attachment theory has been criticized by many psychoanalysts, including Anna Freud, as mechanistic, non-dynamic and based on a misunderstanding of psychoanalytic theory (Brenman Pick, 2000; Fonagy, 2001; Ludwig-Korner, 2003). However, as the original author of attachment theory, Bowlby seems to have been embraced by all schools in the emergent field of parent-infant psychotherapy (for example Baradon, et al., 2005; Berlin, 2008; Emanuel & Bradley, 2008; Hopkins & Phillips, 2009; Raphael-Leff, 2003). Bowlby (1988) suggested that secure attachment develops through experiences that infants have with their mothers in relation to not only physical responsivity (the mother's capacity to for example feed, clean or protect her infant) but also to the mother's emotional responsivity. Currently, the attachment relationship between infants and their parents, and indeed a parent and his/her own parents, is recognized as a core concept by all authors writing and working in the field of parent-infant psychotherapy. For example, a central hypothesis of attachment theory and one that becomes critical when assessing and treating disturbances in the parent-child relationship, is that parental representations of attachment (to their own parents) determine parents' sensitive responsiveness to their infant, and that responsiveness in turn affects the attachment between the infant and parent (Barrows, 2003; Fonagy, Steele, Moran, Steele, & Higgitt, 1993).

It should be clear that several decades before clinicians began purposely working with mother-infant dyads, there was a clearly defined theoretical field that addressed the parent-infant relationship. Interest in the relationship between parents, particularly mothers, and their infants took several forms of which infant research and notably infant observation warrant special mention because of their contributions to the development of clinical practice.

### *The influence of infant observation and infant research*

There are clear distinctions between infant observation and infant research but it can be argued that out of these two endeavours an interest in actually *intervening* rather than just observing or researching aspects of the mother-child relationship evolved. The history and differences will be elaborated briefly below, but it may be useful to hold Grotstein's (1999) classification of Bick's method of infant observation as "experience-close" and intuitive; and the more empirical research of observers that include Trevarthen (Trevarthen & Aitken, 2001), Spitz (1998), Stern (1977), Emde (1991) and Mahler (1963) as "experience-distant", in mind.

Infant observation is attributed to Esther Bick, a Kleinian, who first introduced it as part of a psychoanalytic training at the Tavistock Clinic in 1948 (Bick, 1964). Infant observation, as practised according to Bick's method, requires that the student visit a family with a newborn baby for an hour a week, from the time of the baby's birth until either the end of the first or second year. The observer writes up the observation from memory and these notes are presented at a weekly observation seminar. The observer experiences what it is to be sufficiently immersed in the emotional experience of a family while resisting the urge to act out any role thrust upon him/her. The difficulty of observing — defined by Bick (1964) as collecting facts free from interpretation — is experienced. There are clear links described between infant observation and work with infants and young children and their families (Acquarone, 2004; Cudmore, 2009; Pozzi, 2003; Thomson-Salo, et al., 1999), including an emphasis on such aspects as the concepts of transference and countertransference (L. Miller, 1992); the recognizing of nonverbal patterns (Sossin, 2002); the tolerance of uncertainty and the development of a "psychoanalytic attitude" (Rustin, 1988).

Infant observation is increasingly considered to have a relevance and to be of critical importance in the training of professionals who work across the infant/child mental health field (see Coll, 2000; Russell et al., 1995; Trowell et al., 1998 among others). Certainly the introduction of infant observation into the training of child psychotherapists seems to have laid a foundation out of which parent-infant treatments evolved. Bick believed that the presence of the observer has a therapeutic effect on the family (Briggs, 2005). It would appear that the experience of doing an infant observation plays a positive role in the acquisition of both the confidence and skills needed for parent-infant child interventions (see L. Miller, 1992; Pozzi, 2003; Thomson-Salo, et al., 1999): from infant observation within a family's home setting to infant-parent therapy in the clinical setting appears to have been a natural next step (Harris & Carr, 1966; Watillon-Naveau, 1999, 2010). To illustrate: Harris (Harris & Carr, 1966) described what she called a "therapeutic consultation" (prior to any formal idea of parent-infant psychotherapy) at the Tavistock Clinic in 1966. Harris wrote "Mrs. J. related principally to me, concerned to get her story over. I said very little beyond asking an occasional question or prompting her to clarify. Meantime I also *observed* the child." (Harris & Carr, 1966, p. 15, my italics). The presenting patient, a 22-month old boy described as fretful, restless and not sleeping, showed improvement within three sessions of psychotherapy.

Although largely associated with Bick and the Tavistock clinic, observation of infants and young children was also a key aspect of the work and research done in Anna Freud's Hampstead War Nurseries and she is also seen by some as a significant pioneer in the field of observational research (Tyson, 1989).

Infant research began somewhat later than infant observation with the work of Spitz and Mahler (Tyson, 1989), and it was developed by the intersubjectivists Meltzoff, Trevarthen and Stern (discussed in Beebe, Sorter, Rustin, & Knoblauch, 2003). The contributions of interpersonal theorists such as Emde (1994) and Stern (1977, 1995) to the developmental field have been significant and they have impacted on the focus of parent-infant psychotherapy (Masur, 2009), particularly in terms of representations of interrelatedness between self and object, and also in terms of modes of exchange (Beebe, 1997). Infant research has highlighted the concept of intersubjectivity in the nonverbal relational mode which has been critical in contemplating interventions involving infants and young children with their parents when verbal relatedness is still undeveloped.

The interface between infancy research and mother-infant interactions is summed up by Frances Thomson-Salo (2002). She defends its usefulness firstly by arguing that infancy research confirms and refines psychoanalytic theory. In this respect she proposes that we need to consider the baby of infant research (the Trevarthen baby as she phrases it) alongside the clinical baby. It would seem that this is a useful endeavour in differentiating pathological from normative constructions of infancy. In terms of normative constructions of infancy, Thomson-Salo (2002) cites Trevarthen's (2001) research that indicates that the infant feeling states exist from earlier than psychoanalysis has historically suggested. She also gives examples of ways in which infant research influences our ideas of how change is effected in psychoanalytic interventions. This, together with recognition of infantile transferences significantly influences how we practice parent-infant psychotherapy. In terms of parent-infant work, the interface between infant research and psychoanalysis represents a transitional space in which cross-fertilisation occurs (Thomson-Salo, 2002)

Beatrice Beebe (2005), in a journal article titled *Mother-Infant Research Informs Mother-Infant Treatment,* describes the use of videotaped interactions, which are rooted in the research tradition, to describe how mother-infant face-to-face research impacts on a mother-infant treatment approach. The use of videotaped interactions does not constitute any part of this study but it has been incorporated fairly widely within the parent-infant psychotherapy field (e.g. Balbernie, 2007; A. Jones, 2006a, 2006b; Ludwig-Korner, 2003; Woodhead, Bland, & Baradon, 2006) and may indicate a more concrete influence of infant research.

## The development of diverse approaches to parent-infant psychotherapy

It should be apparent that parent-infant psychotherapy's theoretical and historical roots are located in the broader psychoanalytic field. In reviewing current parent-infant psychotherapy practice, both the diversity that results from this wide base of influence, as well commonalities across approaches, are evident.

It is worth noting that several treatment models that have close ties with the family therapy field make claims for a psychoanalytic *influence* but cannot, I would argue, be considered psychoanalytic. These are addressed here briefly in terms of their exclusion. The list of treatment models would include child family therapy, family play therapy, filial therapy and theraplay (see Busby and Lukin, 1992; Rotter & Bush, 2000; www.theraplay.org). Although

by definition family therapy implies the possible presence of children in treatment sessions, historically children have not always been included or taken notice of in family therapy (Botkin, 2000; Lund, Schindler Zimmerman, & Haddock, 2002; Rotter & Bush, 2000; Ruble, 1999), and infants are largely overlooked. This de-emphasis on the role of infants/young children is a clear differentiating factor. Additionally, while both family therapy (including the treatment models listed above) and parent-infant psychotherapy approaches address family relationships, psychoanalytic parent-infant psychotherapy directs its focus at the *internal* relationships (Milton, Polmear, & Fabricius, 2004) and the unconscious dynamics. Certainly the presence of the infant or child in parent-infant psychotherapy is motivated in part by the idea that the infant/young child facilitates access to internal representations (Stern, 1995). In non-psychoanalytic family therapies, the relationship between the family and the family therapist is not a primary concern. The typical referral problems addressed by each school of therapy further differentiate parent-infant psychotherapy from family psychotherapies with a focus on behavioural difficulties typifying the latter and the focus on symptoms as having meaning (Sorensen, 2003) an assumption in the former. Family therapists are also not clear on whether play has any therapeutic benefit (Rotter & Bush, 2000); the primary reliance is on verbal communications. Family therapists tend to employ play in a more educative rather than interpretive function (Griff, 1983; Lund, et al., 2002).

At the end of the previous section, I suggested that psychoanalytic parent-infant psychotherapy evolved at least in part out of incidental interventions in the pursuit of observing and/or treating infants. In this section a more detailed exploration of the parent-infant psychotherapy field, and its evolution from such incidental interventions to a delineated field with specific and outlined approaches, will be undertaken.

Various parent-infant psychotherapy approaches seem to have emerged simultaneously across the globe hence it would not be useful to employ a chronological survey in order to distinguish the various approaches from each other. Rather, similarities and differences may be better explained in terms of the predominant school of psychoanalysis in which their roots lie combined with the geographical location of the clinics in which the models emerged and the prevailing schools of thought and research associated with such regions (e.g. Klein and Anna Freud in London, attachment theory and infant research in the USA, interpersonal

psychoanalysis and infant research in Geneva etc.). I will begin this section of the literature review in Britain.

In what might be the first description of parent-infant psychotherapy, as suggested earlier, British paediatrician and psychoanalyst Winnicott (1941) described relieving a seven-month old girl of her asthmatic wheezing by allowing the infant to bite a metal spatula. In this case alone of the several described in the 'Set Situation' paper (Winnicott, 1941), Thomson-Salo et al. (1999) argue that Winnicott moved from "attuned observation to a position encompassing participation and action" (p. 47). Thomson-Salo et al. (1999), in exploring why he might have made this move, draw on the evolutionary link between infant observation and infant-parent psychotherapy as proposed earlier.

Not all authors agree that the earliest instances of parent-infant psychotherapy can be traced back to Winnicott; Ludwig-Korner (2003) claims that the beginnings of this type of early intervention are to be found in Anna Freud's and Dorothy Burlingham's work with young children. During the war these two women founded the Hampstead Nurseries in London to accommodate very young children (from birth to four years), and in 1948, after the closing of the nurseries, Anna Freud founded the Hampstead Clinic as a site of research, treatment and training (Geissman & Geissman, 1992). In 1954, Burlingham established a centre for mothers called the Well Baby Clinic (Ludwig-Korner, 2003). Of the different services offered by the clinic, the Mother/Toddler group brought mothers who needed support together each week and they met in the presence of professional staff while their children played together.

A very early case of co-joint work with one psychoanalyst treating both mother and child, albeit in separate sessions, is reported from this clinic by Hellman (1990). In charting some of the history, although not from a parent-infant psychotherapy perspective, Hellman (1990) notes that Anna Freud made a careful study of mother-child interactions and she used this detailed observational research to initiate what came to be known as simultaneous mother-child analyses. If a child was found to need analysis and the mother was assessed as disturbed both would be treated by different analysts who did not have contact with each other while a third analyst, called the coordinator, was kept informed of the material emerging in both treatments. Part of the rationale was to avoid the frequent situation where parents, struggling with feelings of anxiety and jealousy aroused in them by having a child in treatment, interfered with or even terminated the child's treatment. Although parent-infant

psychotherapy presumes the presence of child and parents together, these early simultaneous analyses may have prepared the groundwork.

The Hampstead Clinic was later renamed the Anna Freud Centre and in 1997 the Parent-Infant Project took over from the Well-Baby Clinic. This new project also integrated clinical services with training and research. Tessa Baradon, who runs this centre, co-edited a book (Baradon, et al., 2005) that describes the approach and the theoretical influences that inform the project. The project has been manualised since 2003 and the book is an adaptation of the manual. Baradon and Joyce (2005) state clearly that the patient in their model of infant (babies up till the age of two years) and parent psychotherapy is the parent-infant *relationship*. This relationship can be addressed via each of the participants; that is via the parent (fathers are always encouraged to attend although it is most frequently the mother; occasionally parents do not attend) or via the infant, but the therapist works towards the participation of all present (including siblings who sometimes attend). Both brief and open-ended treatment interventions may be considered.

Burlingham's Mother/Toddler Group may also be considered a forerunner of group parent-infant work. Group interventions under the auspices of the Anna Freud Centre are described in Baradon's more recent book (Baradon, 2009) as well as by authors practicing in other geographical domains including Australia (Paul & Thomson-Salo, 2007), Finland (Belt & Punamäki, 2007) and the USA (L. Hoffman, 2004; Reynolds, 2003; Slade, 2006). There are South African community projects employing a mother-infant group format that have been reported on in recent journal articles (Bain, Rosenbaum, Frost, & Esterhuizen, 2012; Rosenbaum, Bain, Esterhuizen, & Frost, 2012)

Several explanations and justifications are given for working with children and parents together in a broadly psychodynamic way. One explanation, not often mentioned but proffered in a very early mother-child therapy described as "brief conjoint psychotherapy" (Zadik, 1973), is that of logistics. Where time and resources are limited, a kind of doubling up with one therapist addressing both a child and parent together has common-sense appeal, and while Zadik (1973) described work in another busy out-patient clinic in London, it would appear that the economy of seeing parents and children together may also have contributed to the establishment of the Tavistock service.

The Tavistock Clinic in London had been set up after World War Two and it offered training for child psychotherapists, many of whom were followers of Klein. In the Eighties an Under Fives Service, located within the Child and Family Department and led by a multi-disciplinary team, started offering a fast-track service (no waiting list) to the surrounding community. In line with the argument presented above, Kahr (cited in Barrows, 1997) suggests the Tavistock Clinic's approach can be traced back to Winnicott's 'set situation' consultations, while other authors writing from within the Tavistock (Emanuel & Bradley, 2008) locate its origins in the clinical application of infant and young child observation. Mentioned in this regard are the "therapeutic consultations" Harris (1966) offered to families with babies or young children (one of which was referred to earlier) as a result of her interest in applying infant observation skills to work with children under five.

Much of the early journal-published literature on parent-infant psychotherapy was authored by clinicians and teachers associated with the Tavistock (e.g. Acquarone, 1992; Daws, 1985; Hopkins, 1992; L. Miller, 1992; Salzberger-Wittenberg, 1991). Dilys Daws (1989) penned what may be the first book that promoted parent-infant psychotherapy; the book's focus was helping parents and infants where the presenting concern was a sleep difficulty. In more recent years, several books describing parent-infant psychotherapy have been written by practitioners in the field who are either based at or have close ties with the Tavistock Clinic (e.g. Acquarone, 2004; Emanuel & Bradley, 2008; Pozzi-Monzo & Tydeman, 2007; Pozzi, 2003). Contributions to the field that seem to have originated within the extended group associated with this clinic include: the focus on brief intervention (Rustin & Emanuel, 2010); the extension of the parent-infant[6] field to include older children (under fives); the inclusion of other family members in the treatment process (Emanuel & Bradley, 2008), particularly fathers (Barrows, 1999b, 2004)[7]; and the focus on the parental couple's relationship (Barrows, 2003, 2008).

At the level of the physical setting, under fives counselling, as parent-infant psychotherapy is now commonly referred to at the Tavistock, takes place out of necessity in dual purpose

[6] In the book authored by the directors of the Under Five Service (Emanuel and Bradley, 2008) "infant" refers to the 0–5 age group.

[7] Although parent-infant psychotherapy is a widely accepted term, mother-infant psychotherapy may better reflect the presenting population. Fathers are largely neglected, both clinically and in the literature, and Barrows (1997) attributes this to the fact that parent-infant psychotherapists tend to accept whoever turns up, and fathers often don't.

rooms (often offices and/or individual therapy rooms) with the provision of adult seating and a child-sized table with chairs and a small, portable box of toys. The setting for the Tavistock approach is a less child-oriented setting than that described in the Anna Freudian model above, where therapist with parents and infant are seated on the floor (Baradon, et al., 2005) and in the Watch Wait and Wonder model (reported on below), where mother and infant are encouraged to sit together on the floor (Docherty, 1995). Partly this might be explained by what appears to be a different patient population; the Anna Freudian Parent-Infant Project identifies its target population as infants (and toddlers) under two whereas the Under Fives Service sees pre-school children, and partly because of the multiple demands placed on therapy rooms at the Tavistock Clinic itself. In terms of these diversely defined patient populations, Emanuel (2007) claims that there are many differences in work with toddlers and the rising fives with implications for technique and modes of intervention.

The theoretical approach of the Tavistock Clinic, as presented by Emanuel and Bradley (2008) and Rustin and Emanuel (2010), highlights Klein's contribution, particularly her description of the infant's primitive states of persecutory anxiety, as well as Bion's concept of containment (1962b), Winnicott's of holding (1960) and Bick's of second-skin containment (Bick, 1968, 1986). Also mentioned are contributions from infant research, neuroscience research and attachment theory. The approach is described as flexible (L. Miller, 1992; Pozzi, 2003). Although very firmly rooted in psychoanalytic and particularly object relations theory, the Tavistock service has also adopted systemic family therapy in the theoretical and clinical approach (Briggs, 2005; Emanuel & Bradley, 2008) and author Byng-Hall (1986, 1988, 1995) is included in Tavistock recommended reading lists.

The approach of the Parent Infant Project is informed by attachment theory as is evident in the use of the Adult Attachment Interview (AAI) as part of the history-taking (see Steele & Baradon, 2004; Steele, Steele, & Murphy, 2009). Although there are occasions when it might be felt that an unstructured, spontaneous approach should be used to taking the history (Baradon, et al., 2005), the use of a structured questionnaire (AAI) seems to be something that distinguishes the Parent Infant Project from the Under Fives Service of the Tavistock Clinic, and indeed attachment theory from Kleinian theory; the focus on technique in the former that is seen as something that can be systematically described. Manualisation in and of itself looks less likely to be a future differentiator; Emanuel (2012) in a symposium at the WAIMH

Congress held in Cape Town, April 2012, suggested that the Tavistock service is preparing a manual in response to endeavours to research the efficacy of their brief intervention.

Selma Fraiberg, a social worker trained as a psychoanalyst by Anna Freud, moved back to her home country, the USA, and pioneered a model of parent-infant psychotherapy that she described (Fraiberg, et al., 1975) in what is now recognized as a seminal paper (among others Barrows, 2003; Fonagy, 2001; Hopkins, 2008; Pozzi, 2003). Although this paper, abbreviated in many citations to *Ghosts in the Nursery*, was written with collaborators, Fraiberg is usually credited with being its main author, particularly in terms of the approach it describes. She is also credited with first using the term parent-infant psychotherapy (Hopkins, 1992).

Fraiberg's simple rationale was that disturbances in the infant-parent relationship are manifestations in the present of unresolved conflicts between either (or both) mother and father and significant figures in her/his past. Examining the parent's past and making meaningful links to the present through interpretations leads to insight and to freeing the baby and his parents from the "ghosts" that have invaded the nursery. Fraiberg's approach combined interpretative work with what she called "developmental guidance", which was less advice and more ecological support. The term she coined, "ghosts in the nursery" has become very much part of the infant-parent lexicon and widely imported into other fields (for example into industrial psychology, Oren & Solan, 2002).

In her final years, Anna Freud forged links with American psychoanalysts and her last books had a considerable impact in the USA (Geissman & Geissman, 1992), perhaps explaining why the parent-infant psychotherapy model of the Anna Freud Clinic has been more of an influence in the USA and Canada than the Tavistock Clinic approach. Certainly a close association with the Anna Freud Centre and the importing of Anna Freud's theories to America seem to have informed the particular theoretical development of parent-infant/child psychotherapy on the North American continent. Although Fraiberg herself might have tried to distance herself from attachment theory (Fonagy (2001) cites Fraiberg's (1975) comments on Ainsworth in making this point), she is seen as being a proponent of an attachment-informed approach to mother-infant work (Fonagy, 2001; Hopkins, 1992; Lieberman, 1991), and Bowlby is frequently referenced in texts by American authors (Lieberman & Van Horn, 2008; Sameroff, McDonough, & Rosenblum, 2004; Zeanah, 2009). A dissimilarity between the North American and English approaches is the relative emphasis on attachment theory as

an underpinning influence. This influence appears to have been reinforced by Fonagy whose ideas have found a foothold in the American literature: his writings on attachment theory are widely cited in the American parent-infant psychotherapy and infant research literature (for example Gerhardt, 2004; Lieberman, 1991, 1999; Schore, 2010; Shapiro, 2009; Shapiro & Gisynski, 1989; Tronick, 2003).

Alicia Lieberman, based at the University of California, San Francisco where Fraiberg initiated her parent infant project, is one of the most prolific contributors to the parent-infant psychotherapy literature (Lieberman, 1991, 1992, 2004a, 2004b, 2007; Lieberman, Padron, Van Horn, & Harris, 2005; Lieberman & Van Horn, 2008; Lieberman, et al., 1991). Her published work, describing a relationship-based approach (Lieberman, 2004a), and the theory underlying her approach, may have cemented the link between attachment theory and parent-infant/young child psychotherapy, but her mode of intervention is not seen as purely psychoanalytic; indeed there is a strong social work element (Fonagy, 2001).

Following Fonagy (2001), Lieberman's work has extended Fraiberg's thesis and endeavour by recognizing that there are obstacles for the therapist in just simply discovering the 'ghosts' in the mother's past. For example she introduces the idea that 'angels' from the past may afford the therapist and her child-parent patients access to more benevolent experiences and influences (Lieberman, 2007). Lieberman's Child-Parent Psychotherapy (CPP) addresses the intergenerational transmission of psychopathology through the impact of traumatic exposure. Her treatment model identifies the child as the agent of change (hence her foregrounding 'child' in her preferred term).

The Canadian Watch Wait and Wonder (WWW) model, which has been manualised, describes an infant-led approach (Cohen, Lojkasek, Muir, Muir, & Parker, 2002; Cohen & Muir, 2002; Cohen, et al., 1999). Contrasted with other parent-infant psychotherapies, the shift in the WWW approach is towards the infant with parents required to follow the infant's spontaneous activity and to refrain from initiating activities or intervening without the infant's invitation. As with CPP, WWW is clearly located in attachment theory in its search to prevent the intergenerational repetition of insecure attachment and compromised relational patterns. The parent(s) and infant are helped to discover for themselves a new way of relating. The therapist assumes a less interactive role whilst holding a reflective position that encourages and invites curiosity about and an exploration of the inner life and relational experiences of

the parent-infant dyad. Although the therapy is infant-led, maternal representations are foregrounded and parents are empowered to become more self-reflective and more knowledgeable. The session is divided into two portions; in the first both therapist and parent "watch" and "wait" for the infant to initiate within the play area, in the second half the parent is encouraged to comment on what she has observed and to "wonder" about its meaning. There is no particular emphasis on uncovering "ghosts" or investigating the parent's childhood. The therapist parallels the watching, waiting and wondering and refrains from offering advice or modelling interactions; s/he does not dispense expert advice but rather encourages the parent to develop his/her own insights. The authors of this approach (Cohen, et al., 2002; Cohen & Muir, 2002; Cohen, et al., 1999) claim positive success with regards attachment security, maternal satisfaction, infant cognitive development and a more *rapid* improvement in maternal sensitive responsiveness as compared with other parent-infant interventions.

On the European continent, parent-infant psychotherapy has a slightly different history and development. Published contributions from key European authors emerged somewhat earlier than those in London and most of the approaches described (Cramer & Palacio Espasa, 1993; Cramer & Stern, 1988) and Brazelton and Cramer (1991, cited in Pozzi & Tydeman, 2005), are representation-oriented psychoanalytic psychotherapies focusing on the mother's internal representations and how these impact on the mother-infant relationship. The Geneva School in Switzerland has in particular been the source of much contributing literature, not all, regrettably, translated into English. One arguably very useful paper to emerge from the European continent, and addressing an area of parent-infant/young child work widely neglected elsewhere, is the Palacio-Espasa (2004) paper exploring the impact of parental pathology on treatment.

Of the figures associated with the Geneva school, Daniel Stern is singled out for his contribution to the field as an infant researcher, as a theorist and as a clinician. Stern's (1995, 2004) coining and defining of the terms 'motherhood constellation', 'port of entry' and 'good grandmother transference' are key in this study and as such warrant some highlighting. The good grandmother transference will be introduced in Chapter Seven as an aspect of the motherhood constellation, and will be elaborated in terms of this research as an additional port of entry referred to as the 'grandmaternal transference'; the title of both the thesis chapter and

the associated journal article. Stern's notion of ports of entry is reviewed as part of the third section of this literature review.

Two particular approaches, from opposite ends of the world, warrant some attention. Both approaches, the work of Australians Thomson-Salo and her colleagues (Thomson-Salo, 2002, 2007; Thomson-Salo, et al., 1999) and the infant psychoanalysis described by Swedes Norman (2001, 2004) and Salomonsson (2007), identify the infant as the pathway to therapeutic change. Johan Norman (2001) describes the application of the theoretical tools of child and adult psychoanalysis to a new patient, the infant. In so doing he argues for activating and retrieving those parts of the infant that have been excluded from containment. Norman (2001) suggests that the infant-analyst relationship can be used to bring the disturbance within the infant into the here-and-now of the session and that the emotional distress can then be therapeutically contained in the infant-mother relationship. There have been criticisms of Norman's mother-infant psychoanalysis with strong criticisms leveled at claims that verbal interpretations can be used in an encounter with the non-verbal infant (Flink, 2001).[8]

Compared to other approaches that view the infant's symptomatology as an expression of the parent's unconscious representations, Thomson-Salo and colleagues at the Royal Children's Hospital in Melbourne, building on the work of Ann Morgan (see Thomson-Salo & Paul, 2001), stress the importance of addressing the infant directly. The primacy given to the baby is evident in how they refer to their work — infant-parent psychotherapy — and the title of the book describing the approach; *The Baby as Subject* (Thomson-Salo & Paul, 2004). The main rationale for focusing on the infant's mental state is that the infant's predicament and symptom can be urgent, as is the case with the many failure-to-thrive infants treated at the Royal Children's Hospital. Working with the parents may take too long for change to be effected, particularly when parents can't use their thinking to make links and when it is the parent's infant self that is called into focus (Thomson-Salo & Paul, 2001; Thomson-Salo, et al., 1999). The direct work with the infant takes place in the presence of the parents who are included in the process, but not primarily addressed. Emphasising the therapist-baby link in

[8] Flink (2002) also replied to Thomson-Salo's (2001) response to Norman's (2001) paper, a response and a reply that link Norman and Thomson-Salo beyond my comparison of them here.

the presence of the parents creates a space in which growth and thinking can occur (Thomson-Salo & Paul, 2001).

While also stressing that the infant is a person in his/her own right with his/her own history, the approach of Thomson-Salo and her colleagues is differentiated from that of infant psychoanalysis in respect of the Australians' lesser emphasis on verbal interpretation and greater emphasis on the person of the therapist. Thomson-Salo et al. (1999, 2007) describe interventions that incorporate both speaking to and touching their infant patients, and the role of gaze and play are highlighted. There is a distinction between the "infant as subject" approach of the Australians and the WWW model described earlier in that the latter is infant-led rather than infant-focused. Thomson-Salo and Paul (2001), citing Morgan, challenge Stern's (1995) emphasis on the couple made up of mother and mother's-mother. They prefer to stress and support the idea of a parental couple.

The South African literature is surveyed more carefully in Chapter Four and only a brief review of what is currently a limited body of literature is presented here.

By far the greatest number of locally and internationally published contributions have been authored by Cape Town based psychiatrist Astrid Berg (Berg, 2001a, 2002b, 2003, 2007, 2012a, 2012b, 2012c). Her primary contributions seem to be her highlighting and sensitive treatment of cultural issues (Baradon, et al., 2005) and her drawing attention at an international level to the work being done in the infant-parent field in South Africa. Berg (2002b, 2007, 2012a, 2012c) accentuates some of the necessary adjustments to an infant-parent psychotherapy model given the particular environment in which it takes place. She highlights what it means to work in a community where there are many hardships, language barriers and cultural differences. For example, Berg explores how a western tradition of parent-infant psychotherapy translates into a township setting by looking at the meaningless divide between physical and psychological, the particular cultural meaning of the motherhood constellation (Berg, 2007) and the role of traditional healers (Berg, 2003) in the primary health care clinic in which she works. Her most recent publication, a book (Berg, 2012a) that explores cultural communication in South Africa and draws on her Jungian roots, promotes the hopeful philosophy of *ubuntu.* Berg (2012a) defines *ubuntu* — literally translated from an African proverb as "a person is a person because of persons" (Berg, 2012, p. 93) — intersubjectively in her citing Stern's (1985) interpersonal research and his notion that for the

baby there is no self without an other, and indeed others (citing Von Klitzing, Simoni, & Bürgin, 1999). While not exclusively about parent-infant psychotherapy, Berg's (2012a) text underscores the cultural bridge-building necessary for the healing of mother-infant relationships individually in terms of the families she treats, and collectively in terms of the South African and indeed the human family.

In terms of other published writing, three of the chapters of this thesis (as of submission date) have been published as journal articles (Dugmore, 2009, 2011, 2012a) and an earlier article (Dugmore, 2007) discussed the Tavistock course on under fives counselling in relation to private practice in South Africa. Perkel (2007) has authored a book that promotes parent-infant psychotherapy to professionals and parents. Bain (2011) has published a moving account of parent-infant psychotherapy undertaken in a South African hospital setting, and in an earlier co-authored paper she (Bain, Gericke, & Harvey, 2010) reported on research into what may be considered an application of parent-infant psychotherapy theory to kangaroo mother care in a neo-natal unit. More recently, two papers on group mother-infant interventions (Bain, et al., 2012; Rosenbaum, et al., 2012) have been published by the South African psychoanalytic journal.

Several papers that arose out of a large epidemiological study of post natal depression in a township community (Cooper, et al., 2002; Cooper & Murray, 1995; Cooper et al., 2009; Cooper, et al., 1999; Tomlinson, 2001) have also been published. While not directly exploring parent-infant psychotherapy, the randomized control trial employed unqualified lay counsellors to deliver a parent-infant intervention and this is described. The author of the parent-infant training programme, training manual and the supervisory process is a psychoanalytic psychotherapist herself although the counsellors delivering the home visits were unprofessional women selected from the community (see Landman, 2009). Interesting questions about what constitutes psychoanalytic parent-infant psychotherapy in South Africa may be raised in response to these writings.

An increasingly widely accepted argument for promoting parent-infant psychotherapy interventions is because such work offers an opportunity to capitalise on the plasticity of the early childhood and parenthood years (Baradon et al., 2005; Pozzi, 2003). This idea of plasticity has been reported on at the neurological level by authors such as Balbernie (2001)

who talks about the malleability and the "neuroplasticity" of the brain in response to the environment (both abusive and healthy), Schore (2002, 2010) who has written widely on the neurobiology of attachment and Gerhardt (2004) whose book *Why Love Matters* has attracted the interest of both professionals and parents. I would anticipate that literature will increasingly address the critical interface between neurodevelopment and mother-infant attachment that is already under examination (Beebe, 1997; Beebe, et al., 2003; Cirulli, Berry, & Alleva, 2003; Gerhardt, 2004; Schore, 2002, 2010; Trevarthen & Aitken, 2001). While beyond the scope of this study, it would certainly seem that the future of parent-infant psychotherapy will be inextricably linked to developments in the field of infant research, particularly neurobiology.

The extent of international practice in the parent-infant field is not restricted to those authors and geographical areas described above. A list of further contributions includes work developed in Israel (Harel, Kaplan, Avimeir-Patt, & Ben-Aaron, 2006) and Germany (Hofacker & Papousek, 1998; Von Klitzing, 2003). Pozzi and Tydeman (2007) also include in their book chapters on innovative infant-parent psychotherapy elsewhere in Europe and in Japan. At the most recent World Association of Infant Mental Health (WAIMH) international congress, held in Cape Town, April 2012, the delegate list included representatives from all continents and many countries.

## Towards a unifying concept in parent-infant psychotherapy

This brief review of the literature has endeavoured to identify the different emphases of the theoretical roots of parent-infant psychotherapy interventions across the globe and then to chart the diverse development of approaches. Wallerstein (1992, cited in Bateman & Holmes, 1995) argues that the differences between different varieties of psychoanalysis (Kleinian, Freudian, Winnicottian, Object Relational etc.) are at the level of theory, and that in terms of clinical practice different schools of psychoanalysis have much in common. This would appear to be true too in the parent-infant field; what is actually practised by proponents of the various approaches may not be that clinically dissimilar. It would appear, for example, that the distinctions between the Anna Freudians and Kleinians are less divisive in the field of parent-infant psychotherapy than they were historically in the field of child analysis. Geissman and Geissman's (1992) description of the Independents as a group who "wanted to

be open-minded so as to be able to use, if they so desired, the work of Sigmund Freud, Melanie Klein, Anna Freud, or of others without being obliged to feel that they had to conform to any one of them in particular; they rejected conformity" (Geissman & Geissman, 1992, p. 236) contributes to an understanding of a more unified approach. Other authors who seem to opt for some kind of synthesis of diverse theories (but excluding Klein's who is not indexed at all) are Baradon et al. (2005) who claim to "[roam] between traditions and [use] each as convenient" (p. 4) and Stern (1995).

The "extraordinary speed of change" (Emanuel & Bradley, 2008, p. 14), "double speed" (Emanuel, 2008) and "miracle cures" (Barrows, 2003) used to describe parent-infant psychotherapy are claimed by both families (as reported in case studies) and by authors (Thomson-Salo & Paul, 2001). The possibility of change is widely argued for and evidenced across the diversity of approaches described above (Cohen, et al., 2002; Cohen, et al., 1999; Cramer & Stern, 1988; Lieberman, 1991; Lieberman, et al., 1991; Robert-Tissot, et al., 1996; Salomonsson & Sandell, 2011a, 2011b; Thomson-Salo, 2007; Wright, 1986). Positive outcome results were also obtained in an American study by Lieberman and collaborators (Lieberman, et al., 1991) that tested whether Child-Parent Psychotherapy can improve the quality of attachment and social-emotional functioning in mother-infant dyads. Canadian clinical researchers (Cohen, et al., 2002; Cohen, et al., 1999) conducted a study comparing their WWW model to a more traditional (their description) psychodynamic parent-infant psychotherapy and found both to have positive effects on the mother and infant, sustained at six-month follow-up (Cohen, et al., 2002). Positive outcomes for the brief intervention model employed at the Tavistock Clinic have been indicated in preliminary research (Emanuel, 2012; Emanuel & Bradley, 2008) and Thomson-Salo (2007) reports a 90 percent long-term gain using an infant-focused approach. Swedes Salomonsson and Sandell (2011a, 2011b) in a randomized controlled trial compared two groups of mother-infant dyads: one group received mother-infant psychoanalysis and the second the standard child care offered by the Swedish health services. Positive results were recorded for those dyads receiving the psychoanalytic treatment.

Several outcomes and efficacy research reports suggest that parent-infant psychotherapy is effective, and according to my review of the literature there is no published research to contradict these claims. What may be less clear is what contributes to change, and whether parent-infant psychotherapy interventions are preventative. In terms of the latter, Barrows

(1997) and England (1997) suggest that infant-parent work is not prevention but early intervention, whereas Fonagy (1998) and Pozzi (2003), for example, make claims for its preventative function.

It is in addressing the former question of what constitutes change that I wish to highlight Stern's (1995) thesis and in particular his coinage and description of "ports of entry" and their relation to the clinical system made up of parent, infant and therapist.

In an early co-authored article (Stern-Bruschweiler & Stern, 1989), Stern suggests that "good" therapeutic interventions, be they behaviourally-oriented or concerned with the mother's representational world or on a spectrum somewhere between,

> … always involve both a change in the overt interactive behaviors and a change in the mother's representation of her infant and herself in the mothering role, no matter whether the intervention was directed exclusively at the mother's representations or at the overt interactive behaviors of mother and infant (Stern-Bruschweiler & Stern, 1989, p. 144).

Following Stern's exposition, the basic elements that make up the parent-infant clinical system are progressive additions to a model that begins at the centre with the mother-infant (or if the father is present the mother-father-infant) interactions and includes thereafter the mother's representations, the infant's representations, the therapist's representations, the father's representations (if he is present) and finally the secondary and tertiary levels of caregivers and supportive social system which Stern refers to as the support system. These elements are interdependent but are dynamically and mutually interactive and they represent potential clinical ports of entry into the system. The ports of entry are used to access what Stern refers to as the theoretical target, defined as the element of the system that the therapist wants ultimately to be changed (Stern, 1995).

The five ports of entry Stern describes in his 1995 thesis are: the parent's representations; the infant's overt behaviour; the parent-infant interaction; the therapist's representations; and the infant's representations. According to Stern's (1995) unifying thesis, each port defines a therapeutic approach and he uses different theoretical (as opposed to technical) approaches to illustrate the main ports of entry and the therapeutic targets of the clinical system. He

commences with the parent's representations, quoting both Fraiberg's (1980) and Lieberman and Pawl's (1993) discussions of freeing infants from parental projections by altering parental representations of him/herself or the infant. The parental representations are seen as the "pathogenic agent" (Stern, 1995, p. 122). In the approaches that employ this port of entry, the emphasis is on the therapeutic alliance and possibly the transference. Approaches that prioritise the infant as port of entry focus on infant behaviour and hence, in Stern's (1995) definition, are commensurate with paediatric examinations, assessments and evaluations as well as with behavioural interventions that evoke the infant's responses in order to alter representations in the mother. The parent-infant interaction as port of entry accords with an intersubjectivist approach and Stern (1995) describes a focus on the interactive sequence of interactions; what may be referred to as a microanalytic interview. Using the therapist's representations as port of entry equates with employing a countertransferential approach. In this regard, Stern cites Bion's (1963, 1967) description of the therapist as container and Bick's (1964) method of observation as influences. The infant's *representations* as distinguished from *behaviour* represent the fifth port of entry and Stern (1995) qualifies these representations as "imagined". He describes the therapist using the infant's voice to speak, as it were, for the infant. This dramatization is intended to alter parental representations but verbal interpretations are also directed at the infant. Stern cites French parent-infant psychotherapist Dolto's (1971) work in this respect.

In a later discussion, Stern (2004) names and describes five slightly different ports of entry with corresponding therapeutic approaches. These are: the mother's representations (targeted in psychodynamic therapies); the infant's overt behaviour (targeted by what he refers to as developmental/paediatric therapies); the mother's representations as they arise in the presence of the therapist (he calls this a transference-attachment approach which is built on the benign grandmother fantasy); the parent-infant interactions (targeted by behavioural therapies) and finally a fifth port of entry that involves a systemic family approach and the essential inclusion of the father in order to explore triadic relationships. Although not directly stated, it would seem that this new, latter definition of a port of entry that explicitly acknowledges the father may be Stern's response to the criticisms (Barrows, 2003; England, 1997) levelled at his earlier (1995) exclusion of the father.

Stern (1995, 2004) uses his model to differentiate between behavioural, psychodynamic and other interventions, but he also claims that all therapeutic approaches are more or less equally

effective. This is a controversial claim, and Stern (2004) acknowledges this, commenting on the implication that there are non-specific common aspects to all treatment interventions. In his discussion of these commonalities, Stern concludes that the clinical-theoretical choice of port of entry will not determine the outcome; rather, because of the interdependence of the ports of entry, "once you have altered one element of the system all the others readjust correspondingly" (Stern, 2004, p. 38). In the later discussion of his clinical system model, Stern (2004) emphasises the central role of the "therapeutic holding environment" (p. 38) which he suggests is common to all approaches, whether it is explicitly or implicitly acknowledged. This leads him to discuss the intersubjective field and its role in the process of change.

It is perhaps important to point out that Stern's contribution to the parent-infant field is not without controversy. Brenman Pick (2000) criticizes him for according "scant space" to the inner world of the infant/child when attunement between mother and child breaks down. This criticism is echoed by Pozzi (2003) who accuses Stern of endorsing an approach that lacks "the richness and the depth of the unconscious phantasies" (Pozzi, 2003, p. 22). For England (1997), the shortage of clinical illustrations detracts from Stern's work. Perhaps most significantly in terms of a critique, Stern's 1995 book, which claims to be a unified view of parent-infant psychotherapy, does not include several key contributions; most notably the substantial contribution to parent-infant psychotherapy made by the British object-relationists at the Tavistock Clinic (Barrows, 1996; England, 1997).

Barrows (2003), in his article on the process of change in parent-infant psychotherapy[9], challenges Stern's thesis that change to one element of the interrelated clinical system will lead to change in the other elements. He cites a study (Juffer, Van Ijzendoorn, & Bakermans-Kranenburg, 1997) in which parental behaviours were improved but parental representations remained unchanged. Barrows also references outcome research that indicates that even when maternal representations are positively changed, the mother-infant relationship may not improve. As stated, Stern's 1995 text was criticized for his neglect and sidelining of fathers and the paternal role (Barrows, 2003; England, 1997); this is clearly evident in Stern's referencing *mother*-infant psychotherapies.

[9] Barrows actually uses the term "under fives work" which reflects his association with the Tavistock Clinic.

It is not Stern's claim that accessing any one element is sufficient in and of itself that is under examination in this study, rather it is an exploration of what it means to employ multiple ports of entry that is foregrounded. Altman (2002) applies Stern's framework to child psychoanalysis and in so doing highlights Stern's conceptual distinction of the child's, the parent's and briefly the therapist's representational worlds, as well as the overt interactions. The usefulness of these distinctions and interactions, as Altman (2000) suggests, is that the therapist can decide on the most productive area of intervention based on assessment criteria that include the relative contributions of each party's representational world to the problem and the openness of each party to work on their own representational world.

While Stern stresses the particular association of different therapies with different ports of entry, many psychoanalytically-oriented authors imply a less exclusive focus on the parental representations as the port of entry (although they may remain the theoretical target). In an extension of Stern's thesis, multiple elements and hence multiple ports of entry — for example, the parental couple (Emanuel, 2008), the infant's developmental needs (Onions, 2009; Thomson-Salo & Paul, 2004), the infant-analyst relationship (Norman, 2001), non-verbal behaviour (Sossin, 2002), practical issues (Renschler, 2009) — are described.

Stern (1995) makes the claim that combined approaches would best serve the interest of the parent-infant patient population. The unification of the South African parent-infant psychotherapy field may be necessary if parent-infant psychotherapy is to receive recognition and support as an early preventative intervention. For unification to occur, multiple ports of entry need to be recognised and utilised.

# CHAPTER THREE

# Research method and ethical considerations

## Introduction

There are two aspects to this doctoral research that will be addressed in this chapter. The first aspect of the research addresses the experiences of practitioners working in the South African parent-infant psychotherapy field. Henceforward I will refer to this as the interview based research. The second aspect, which concerns the process of psychoanalytic parent-infant psychotherapy, calls into focus a tension and scepticism that has been addressed in the literature (Midgley, 2004; Rustin, 2003). This aspect of the research is based on the psychotherapy case study and is referred to as case study based research. Both aspects of the research, however, fall under the broad umbrella of qualitative research.

## Qualitative Research

Broadly, this research is located within the qualitative tradition. Qualitative research might mean different things in different fields but a generic definition is given by Denzin & Lincoln:

> Qualitative research is a situated activity that locates the observer in the world. It consists of a set of interpretive, material practices that makes the world visible. These practices transform the world. They turn the world into a series of representations … [Q]ualitative researchers study things in their natural settings, attempting to make sense of, or to interpret, phenomena in terms of the meanings people bring to them. (Denzin & Lincoln, 2003, p. 4-5)

According to Mertens (2005) there are three possible inter-related reasons for choosing a qualitative method of research: the researcher's view of the world; the nature of the research questions; and practical reasons associated with the nature of qualitative methods. A fourth reason may be that the original data are best described as "thick", an adjective used by Midgley (2004) to differentiate semi-structured interviews, for example, from closed questionnaires. All four reasons inform both aspects of the research. In terms of this study, the psychoanalytic orientation that informs my worldview dictates a research method that is concerned with process, interpretation and representations. As Denzin and Lincoln observe, the word 'qualitative' implies an emphasis on "the qualities of entities and on processes and meanings" (Denzin & Lincoln, 2003, p. 13). Such qualities include the capturing of information that is only made possible by getting close to experience, particularly individual subjective or intrasubjective experience. Midgley (2004) proposes a useful definition of qualitative research by indicating what it does not propose to do: [Qualitative research] is an approach that aims less at prediction and statistical correlation, and more at discovery and increased understanding of the human world (Midgley, 2004, p. 92).

Of the many materials used in qualitative research, Denzin and Lincoln (2003) list interviews and the case study. These two methods represent the bases of the two aspects of this research.

## Psychoanalysis as research – researching psychoanalysis

Freud wrote that in psychoanalysis "… there has existed from the very first an inseparable bond between cure and research" (Freud, 1927, p. 256). This has been echoed by later commentators writing on the integral relationship between psychoanalytic practice and research (Greenwood & Loewenthal, 2005; Midgley, 2004; Rustin, 2003; Widlöcher, 1994). However, it has also been suggested that Freud had a nineteenth century understanding of research — "the intensive and disinterested study of phenomena" (Bateman & Holmes, 1995, p. 243) — which is not easily reconciled with the approach exercised by contemporary scientists towards research. The promotion of research within psychoanalytic practice is complex (Emde & Fonagy, 1997). Psychoanalysis is frequently seen as more about craft (Bateman & Holmes, 1995; Milton, et al., 2004; Rustin, 2003) or opinion (Greenwood & Loewenthal, 2005) than science which has led some to suggest that psychoanalytic practice is

inherently un-researchable (Steiner cited in Bateman & Holmes, 1995) and others to propose that it should be viewed as a hermeneutic discipline (Ricoeur, 1970 cited in Bateman & Holmes, 1995; Briggs, 2005; Emde & Fonagy, 1997) or one with a circular relationship between practice and theory (Widlöcher, 1994).

Certainly, commentators on methods of psychotherapy research more broadly, and on psychoanalytic research more particularly, seem repeatedly to struggle with trying to locate the research somewhere between what may be considered scientific in the positivist sense, and what may be described by critics as more anecdotal. For example, Edwards (2007), in discussing psychotherapy research, refers to an adversarial pole associated with critical demands for absolute standards of proof, and a collaborative pole characterised by an explorative stance and a degree of open-mindedness and trust. Widlöcher (1994) sets "scientific utopia" against "disillusioned observation" and Midgley (2004) makes use of a metaphor that he refers to as "sailing between Scylla and Charybdis" (Midgley, 2004, p. 89). Hilliard (1993) differentiates between a context of discovery and one of justification while other commentators refer to two traditions of research (Rustin, 2003) or the "opposing perils of objectivism and relativism" (Elliott, Fischer, & Rennie, 1999, p. 217).

In these kinds of polemic debates the tension appears to gather around efforts to justify using the psychotherapy situation for research and the defending of such endeavours from attacks of being unscientific. From my reading, it would appear that the central controversy concerns the issue of research as verification, with less apparent dissent between discussants of research as description and discovery. Exploring the issue of causality in the field of psychoanalytic practice is both interesting and arguably important (Emde & Fonagy, 1997), however this doctoral study is much more clearly located in the realm of theory-building. The focus is on generating rather than confirming theory and the process is essentially inductive rather than deductive (Midgley, 2004, 2006; Milton, et al., 2004). (This focus is reflected in the relationship between the research and the field of research; relative to psychoanalysis and indeed psychoanalytic psychotherapy, parent-infant psychotherapy is still novel and in the process of being if not discovered, then certainly developed and described.) Rather than addressing the issue of efficacy, I am in this section endeavouring to consolidate an argument for the use of a clinical research method with its locus, or "primary laboratory" (Rustin, 2003), in the consulting room. This is complicated because "processes of discovery are difficult if not impossible to routinize" (Rustin, 2003, p. 141).

Certainly psychoanalytic practice cannot be located in a positivist paradigm[10]. Rather, it would seem that psychoanalysis focuses on only one method of inquiry, namely the "psychoanalytic situation" (Emde & Fonagy, 1997). The psychoanalytic method can be understood as a research tool, and research using this tool is arguably the main source of psychoanalytic theory. Furthermore, the psychoanalytic method is also a treatment and as a result the most significant findings are made from inside psychoanalytic practice and by using its own methodology (Milton, et al., 2004). Psychoanalytic research may be concerned with both process and outcome, but following Milton et al.'s (2004) argument, rather than attempting to find external validation for truths, the criteria of internal coherence and narrative plausibility are used to test claims (Spence cited in Bateman & Holmes, 1995).

Researching psychoanalytic practice has historically relied on the case study method (Bateman & Holmes, 1995; Hilliard, 1993; Midgley, 2004, 2006; Rustin, 2003). In this study of psychoanalytic parent-infant psychotherapy, the case psychotherapy study is the preferred tool. It has been selected as it serves the broader exploratory aims and rationale of this research, and the specific research questions. I will justify this preferred method in part by citing authors who have substantially grappled with the issue themselves.

## *Case study method*

Stake (2000) recognises the difficulty of defining case study research in a unique way and proposes as a solution that the criterion that defines all case study research is not the specific methodology but rather the object of study. For Edwards (2007), case study research is relevant to the development and evaluation of practice in psychotherapy. This claim is supported by Yin's observation that the "case study is the method of choice when the phenomenon under study is not readily distinguishable from its context" (Yin, 1993, p. 3). The object of study, parent-infant psychotherapy in South Africa, is also the context of this research. Mertens (2005) recognises the reaching of an understanding within a complex context as a commonality across definitions of case study research.

[10] Interestingly, Edwards (2007) reminds his reader that "empirical" means "based on experience" and from this builds an argument that case studies should be considered empirical; that is they, as is science, are based on experience and observation.

Midgley (2006) writes that: "As well as providing 'evidence' or 'clarification' of certain theoretical ideas already held, case studies can also lead to the emergence of new ideas" (2006, p. 125). "Descriptive" and "exploratory" case studies comprise two of the three types of case study identified by Yin (1993) and both could be used to classify this research although primarily descriptive case studies were used to illustrate parent-infant psychotherapy (Chapters Six and Seven), and exploratory case studies to examine the use of the grandmaternal transference and the diversity of ports of entry (Chapters Seven and Eight).

Edwards (1998, 2007) claims that case based research has been undervalued. Of significance to this discussion are his assertions that case based data provide rich, in-depth material that is contextualised. Further, case centred research can be used to develop theory and usher in new understanding (Edwards, 1998). The emphasis in case centred research is on depth rather than breadth in terms of data collected (Mertens, 2005).

One advantage of the case study method is that it represents a powerful means to portray a treatment intervention to outsiders and this suits the advocacy aim (described in Chapter One) and the publication requirement that in part underpin this research.

## *The psychotherapy case study*

The knowledge out of which human and social sciences developed is based in the "careful observation, description, and comparative discussion of individual cases" (Edwards, 1998, p. 34). If we understand the psychotherapy case study to be "a detailed account of a specific psychological problem, issue or episode in the life of an individual (or couple/family/group), and how this is observed, understood and addressed in the context of the psychotherapy treatment setting" (Ivey, 2009, p. 2), we can make the claim that such psychotherapy case studies allow for a particular in-depth and close focus on both the individual's (the patient's) experience and the intersubjective (patient-psychotherapist relational) experience. This claim extends to the origins of psychoanalysis and Freud's clinical monographs (Widlöcher, 1994) through its developmental association with individual-centred case studies (Rustin, 2003) that have been written up and presented as theoretical evidence, to the reliance on case material in contemporary illustrations of approaches and models in the parent-infant field (see Chapter

Two: Literature Review). As Edwards (2007) claims: "Observations from within cases do not, by themselves, create effective psychotherapies … [h]owever they provide the building blocks out of which effective therapies are built" (p. 11).

The focus in this research is not on a linear, causal relationship between intervention and outcome, but rather on an exploration of the therapeutic process using observation and reflection to identify themes and develop theory and practice. As a result, the case based research method employed in this research is in many ways inseparable from the treatment method it is devised to explore. Psychotherapeutic events can be understood reliably within the context of the therapeutic process (Edwards, 2007) but it will then follow that the role of the researcher is inextricably bound up with the meaning-making process (Bromley, 1986), particularly in terms of the interaction between the minds of patient and therapist/researcher (Widlöcher, 1994). Importantly, the psychotherapy case study is considered flexible rather than rigid (Edwards, 2007) and selective rather than exhaustive in that it addresses some issues while overlooking others (Bromley, 1986; Edwards, 2007). Edwards (2007) reminds his reader that case based research has value, as evidence, in answering specific research questions related to clinical practice.

In drawing on the discussion above, I offer the following working definition of the psychotherapy case study:

> In this research the psychotherapy case study is defined as a clinically-contextualised research tool that initially describes and explores the psychotherapeutic process by illuminating aspects of the psychotherapeutic encounter in order ultimately to contribute to the development of theory. The psychotherapy case study focuses on the interplay between observation and understanding and the intersubjective process of meaning-making. Case studies may include more detailed case presentations as well as briefer case vignettes.

There have been criticisms of the case study method as methodologically weak. Midgley (2004) draws attention to weaknesses highlighted in an American Psychoanalytic Association report:

> … [I]t uses argument by authority, and presents evidence in so incomplete a way that it is hard for the reader to draw his or her own conclusions; it tends to be based around a unitary story, using narrative persuasion that invites conviction; very rarely is any data provided which could support other interpretations, and readers have little chance to make contact with the clinical data to reach their own conclusions. (Midgley, 2004, p. 91)

The argument by authority limitation has been expressed more cynically by those critics who suggest that the greatest danger of case studies is their seductive quality; for more detailed discussion see Tuckett (1993) and Widlöcher (1994).

In a later paper, Midgley (2006) draws attention to weaknesses related to problems with the data, with the analysis of data and with generalisability. In terms of the data themselves he refers to the unreliability of observations that are used in the clinical case study. The issue of validity is compromised during data analysis as truth and accuracy of particular interpretations cannot be assessed. The weakness in terms of generalisability is that even if we could overcome the reliability and validity problems, it is not possible to generalise beyond the particular case under study. Midgley's comments in many ways echo Edwards' (1998) earlier citation of other research commentators in questioning the substantiation of observations, the issues of reliability and validity, the unsystematic summation of therapy session content and the speculative and/or over-generalising conclusions drawn. All of these weaknesses and problems are accepted as legitimate criticisms and limitations of the case study method employed in this study. They are addressed briefly towards the end of this chapter.

## Participant and case selection

In qualitative research, 'sampling' is concerned with the richness of the information (Fossey, Harvey, McDermott, & Davidson, 2002). This pursuit of 'rich' information informed the selection of participants in this study. In terms of the data corpus, there are two broad populations from which participants were selected. The population for the interview based aspect is mental health practitioners currently working or who have worked in the parent-infant psychotherapy field in South Africa. This selection of participants can be described as purposive (Fossey, et al., 2002). For the case study research, the cases were selected from my

own parent-infant psychotherapy practice and selection was theoretically motivated (Fossey, et al., 2002). Selection of both interviewees and psychotherapy cases is discussed in more detail below.

## *Selection of interviewees*

There were two related aspects of this research that required interviewing key stakeholders and participants in the parent-infant psychotherapy field. Firstly, it was deemed necessary to augment a survey of the limited published literature with primary source research in order to more accurately and comprehensively document the history and the development of parent-infant psychotherapy in South Africa. Secondly, an exploration of the development of the field raised questions related to practitioners' perceived challenges and possible adaptive responses. It was determined that the research questions formulated with regard to these aspects of the study would best be addressed to practitioners and key stakeholders familiar with the parent-infant psychotherapy field in South Africa. Involvement in the parent-infant field was the primary selection criterion and for inclusion participants needed to identify themselves as either psychoanalytically orientated and/or aligned with attachment theory in terms of their conceptualisation of the parent-infant relationship.

Psychoanalytic parent-infant psychotherapy in South Africa is a relatively new field which simplified the task of identifying possible participants. The South African literature on parent-infant psychotherapy was reviewed and authors were contacted. Lists of delegates and presenters at the Infant Mental Health congress held in Cape Town, 1995, the Conference on Infant Mental Health also held in Cape Town, 2002 and the more recent Johannesburg Association of Psychoanalytic Psychotherapy Study Groups Conference held in 2009 were obtained and potential participants approached. Informal enquiries and word-of-mouth communications identified additional participants or confirmed the selection of those already on the list. Fifteen possible interview participants were identified and approached informally by myself, either in person or by email/telephone. All agreed to be interviewed. In addition to the 15 interviewees, a focus group of 10 participants was set up. All 10 focus group participants were members at the time of the Under Five Reading Group in Johannesburg (South Africa's biggest city and economic capital). These members were approached informally initially. These informal approaches of both interview and focus group participants were followed up by a formal emailed request that included presentation of a personalised

Information Sheet and Informed Consent Form and a Tape-recording Consent Form (see Appendix I).

The demographics (at time of being interviewed) of the 15 individual participants can be summarised as follows:

- 14 participants describe themselves as psychotherapy practitioners
- 12 practitioners are currently active in the parent-infant field
- 11 participants work(ed) in the private sector
- 6 participants work(ed) in the public sector – that is in state hospitals/clinics
- 8 participants work(ed) in the non-governmental/community sector
- 4 participants are affiliated to universities, another 5 participants are involved in the training of parent-infant practitioners and an additional 3 participants offer parent-infant psychotherapy supervision (but not training)
- 4 participants are/have been involved in research in the parent-infant psychotherapy and/or infant mental health field
- The ratio of male: female participants is 2:13
- There is an equal geographical distribution between Gauteng province and Western Cape province with one participant resident in KwaZulu Natal province.

Although the 15 individual interview participants were invited to describe the various contexts (public, private and non-governmental/community) in which they work (several participants are active in more than one context), the focus group was limited to discussion of parent-infant psychotherapy as practised in the private sector.

It was decided in the data selection phase to include one focus group primarily in order to economise on data collection. Focus groups are considered a form of group interviewing that is differentiated from individual interviewing by the crucial emphasis on interaction (Gibbs, 1997; J. Kitzinger, 1995) and this interaction added potentially to the richness of data collected. Following commentators, focus group research is also well suited for obtaining several perspectives about the same topic (Gibbs, 1997; J. Kitzinger, 1995). I am the facilitator of the Johannesburg Under Five Reading Group which at the time of data selection was made up of 25 professionals practising as parent-infant psychotherapists. Of the full list

of members, ten were available to stay for an hour after a monthly meeting in order to constitute the focus group. My familiar role as facilitator of our group meetings made the task of moderating the focus group easier.

For the purpose of further discussion, the focus group interview will be subsumed under the interview based aspect of the research. The same interview schedule was used in both the individual and group interviews and questions were similarly open-ended. I am aware that a particular aspect of data analysis when using a focus group should address the group dynamics. This was not a focus of the research and has not been included.

## *Selection of psychotherapy cases*

In exploring parent-infant psychotherapy in South Africa, one of the research aims of this study is to open up the concept of ports of entry (Stern, 1995) in order to understand and elaborate aspects of clinical practice and of the clinical process. Given the psychoanalytic orientation of the clinical practice and the clinical process, the psychotherapy case study as defined above was employed as a research method.

Initially and broadly, case selection was on the basis of the treatment approach demonstrated, that is psychoanalytic parent-infant psychotherapy. In order to use a parent-infant case for research purposes, either one or both parents needed to have attended the parent-infant psychotherapy sessions and the included infant had to be three years old or younger. When reviewing completed or current cases for possible selection, insufficiently comprehensive transcriptions and/or process notes became an exclusionary criterion. In terms of eligibility for selection, consent (see Appendix III) also needed to have been given for inclusion in the study. In half of the cases, consent was obtained after termination of treatment and in the other half consent had been sought at onset of treatment in anticipation of possible inclusion in this study. Although consent was obtained for many more cases than were finally selected, only those cases where anonymity could be assured were included in the study.

Cases seen in my private practice have either been referred to me by other professionals (e.g. health practitioners, teachers) or have presented as self-referrals. This is typical of most parent-infant psychotherapeutic encounters in a private practice setting in South Africa. No

cases were solicited or invited into therapy; all were drawn from past and current psychotherapies using a purposeful or theoretical selection method that allowed me to identify information-rich cases from my patient population and to study selected cases in-depth.

Of the many cases that may have met these criteria, the final selection of cases was determined on a theoretical or operationally constructed basis (Mertens, 2005); that is they exemplified a theoretical or operational construct that is the subject of a research question. In order to respond to those research sub-questions articulated to address clinical material within a private practice setting, I needed a selection of cases that would provide relevant and analysable data. The major rationale for selection was that of exemplary contribution. Following Yin (1993), exemplary cases will reflect strong and positive examples of the phenomenon of interest. There are three aspects of clinical practice under investigation in this study: firstly the concept of a symptom as having meaning within a clinical model that allows for different ports of entry; secondly the elaboration of the grandmaternal transference as a port of entry; and finally an examination of the impact of utilising multiple ports of entry on the psychoanalytic frame. Only those parent-infant psychotherapy cases that would allow for a gathering of data in relation to either the first and/or the second aspect would be included. In terms of the first aspect, it was decided on the basis of frequency of occurrence to focus on sleep difficulties as a presenting symptom.

As per the psychotherapy case study definition given above, case vignettes may be included. Of the eight selected cases, two in-depth case studies were chosen for their exemplary value in terms of a sleep difficulty symptom. Of the several psychotherapy cases I have treated in my practice, I selected two that best met the criterion of having been transcribed in sufficient detail (originally for purposes of clinical supervision). In both cases the father was involved in the treatment process and this allowed for the opening of possible ports of entry beyond those concerning the mother and the infant. Both cases were of brief duration, which meant that the whole process of therapy could be outlined. This felt preferable to focusing on a truncated section of treatment. The overarching research question of this study is not concerned with efficacy or outcome and hence it felt preferable to select ‘successful’ cases. This may represent a limitation of the study. A further four case studies were selected for their exemplifying a grandmaternal transference — this construct forms the focus of the four case studies rather than the various presenting symptoms.

Case *studies* include where relevant background history, the presenting problem and the therapy process over a period of time. The object of study emerges in the write-up as a theme that can be developed theoretically. Vignettes suggesting a grandmaternal transference (explored in the journal article included in Chapter Seven) were selected from two additional cases studies. The case *vignettes* offered a snapshot of psychotherapy case material in order to illustrate in a more condensed way an aspect of the object of study. To quote Widlöcher (1994), vignettes are "not designed to prove a theory from objective facts but to illustrate a particular clinical view" (p. 1233).

Ethical and feasibility issues may in principle have constrained selection of psychotherapy cases and in the final extent, convenience selection did prevail. I refer here to the intentional exclusion of those cases where ethical issues (for example a family that could not be disguised well enough to guarantee confidentiality) or feasibility issues (for example a family with too many members present in therapy sessions to allow for comprehensive data gathering) compromised suitability. I am aware that this does impact on generalisability/transferability over and above the issue as it pertains to all case study research (see the discussion below), but it was unavoidable given the necessity of selecting cases from a small population of parents-with-children who both voluntarily sought to receive psychotherapy from me, and then agreed to participate in the research (see Appendix III for a copy of the Informed Consent form).

## Data-gathering

Unlike a printed questionnaire or test that might be used in a quantitative study, in a qualitative study the researcher is the instrument for collecting data (Mertens, 2005, p. 247).

This quotation seems particularly apt in describing the method of total data collection proposed for this research, and echoes Michael Rustin's statement that psychoanalytic practice, "[so] far as data gathering is concerned … asks only that its practitioners should be properly prepared in their minds, and should make use of a consistent setting and technique" (Rustin, 2003, p. 141). Two primary methods of collecting data have been used; the semi-

structured interview (interview based research) and the psychotherapy case study (case study based research) and these are described separately below.

## *Data-gathering using the semi-structured interview*

Semi-structured interviews were used to collect data pertaining to research questions that addressed the history of parent-infant psychotherapy in South Africa, as well as the identified challenges and the responses to these challenges. The advantages of interview based data collection are that it allows the researcher to get a full range and depth of information, to develop a relationship with the participant that supports data collection, and it promotes flexibility (Mertens, 2005).

Fifteen participants were interviewed and one focus group discussion was held. The time and venue for the individual interviews were determined by the participants and all individual interviewees requested that they be interviewed at their place of work. This facilitated a discussion of work-related experiences because interviewees literally responded from a professional perspective. The focus group was interviewed at the venue in which the group meets on a monthly basis. The focus group discussion was 60 minutes in duration, whereas the 13 person-to-person interviews ranged in duration from 45 to 90 minutes. Two participants were interviewed via email as they were geographically unavailable. The interview schedule was sent to the two participants and they responded in writing. A follow-up, 20-minute recorded telephone interview was conducted with one of these participants as several responses required clarification.

Each interview began with an expression of gratitude for agreeing to participate in the research and for giving up time to be interviewed. Each Interviewee was presented with two forms that required their signature; the research participation consent form and the audio-recording consent form (see Appendix I).

An identical interview schedule (see Appendix II) provided the basis for all the interviews (individual and group) and interviewees received a copy with the formal email request before the interview. It was unclear at the time of conducting the interviews whether interviewees

had prepared responses to the anticipated questions, or not. The interview schedule consisted of 17 questions that guided the gathering of data and addressed the research questions. The questions were formulated in part as a result of the information that emerged from the literature review, in part as a result of personal knowledge of parent-infant projects currently in existence and in part to open up thinking about the future of the field. Given the nature of the enquiry it was felt that the 'voices' of the interview participants needed to be clear. With this in mind, interviewees were encouraged to express thoughts and ideas that may not necessarily have been direct responses to the 17 questions. The format of the interview was semi-structured with the schedule serving as a suggested guide to the discussion rather than a directive in terms of questions and responses. There was opportunity for dialogic interaction, particularly in relation to ideas for possible future developments in the field, but it was gathering the interviewees' experiences of working in the South African parent-infant field that was foregrounded. That the interviewer is also active in the parent-infant field may have represented both a strength in that there was familiarity with the subject under discussion, and a weakness in that interactive discussion could potentially obscure the interviewee's voice. It is suggested that the interviewer's experience as a psychotherapist who knows about the value of listening would minimise this risk. As Midgley (2004) argues, there is a great deal of overlap between interviewing and psychotherapy skills.

All 13 face-to-face interviews, the one telephonic interview and the focus group interview were tape-recorded and then manually transcribed by myself. The transcriptions were checked against the recordings for accuracy.

## *Data gathering using the psychotherapy case study*

The case study data in this research were generated by and collected from within the psychotherapeutic encounter. Case study data were gathered both prior to and during the active research phase. In those instances where data gathering took place before the final definition of the research topic, reliance was on my earlier methods of writing up sessions for non-research purposes. In defence of anticipated criticism that this was inherently flawed; my interest in the field of parent-child psychotherapy has coincided with my being in regular supervision. Not only were many early cases recorded in my personal session-by-session

process notes, but several sessions were transcribed in much greater detail for presentation to supervisors. Once this research was initiated, I began transcribing sessions of parent-infant cases that I anticipated may be useful later in terms of the research questions as they were formulated in the research proposal. All transcribing and note-taking was done from memory, and while there may be obvious limitations with respect to the reliability of such recorded data, there is also an argument to be presented in motivation for such a method of data gathering.

It is acknowledged that audio/videotaped recordings of sessions may have provided more accurate data in terms of the dialogue and visible non-verbal interactions, but the intrusiveness of such a method of data collection in the context of a psychotherapy setting has been documented and described (Fossey, et al., 2002; Midgley, 2004, 2006; Tuckett, 1993). Klein (1961) defends her use of notes written up *after* the session suggesting that taking notes during the session would disturb the patient and that notwithstanding errors of recall, her session notes provided the best picture of the analytic encounter and process. In defending the quality of my written up sessions I draw attention to the positive influence of having done three years of infant observation. Significantly, infant observation students do not take notes during the weekly observation hour but are required to write detailed notes after the observation. Learning acquired as a result of doing an infant observation includes skills in observation, improved memory and collection of facts (Bick, 1964; Coll, 2000; Maiello, 1995a; Russell, Grignon, & Royer, 1995; Rustin, 1988; Sorensen et al., 1997; Trowell, Paton, Davids, & Miles, 1998). The application of infant observation skills to forensic writing (Youell, 2005) and research (Midgley, 2004; Rustin, 2005) have been described.

My method of writing up both process notes and sessions transcriptions involved recording of recollections and reflections from memory, mostly in the form of typed notes and occasionally in the form of dictated notes that I could refer to/transcribe later. These notes/transcriptions would typically be typed up as soon after the session as a gap presented itself; certainly within 24 hours of the session having taken place. Where circumstances may have interfered with this opportunity, I used a Dictaphone to record my thoughts and observations. While useful in terms of time economy, my experience of oral recording as opposed to written recording is that the secondary process of reflecting on my countertransference responses was always less well attended to. (More case study material was gathered than was included in the research and ultimately none of the Dictaphone

recorded sessions were used.) Process notes are briefer accounts of the session with attention paid to the transference-countertransference manifestations, the emergence of major themes and significant events that may have occurred in the session or were referred to or related by the patient. Session transcriptions are more detailed and include a from-memory transcript of dialogue and sequenced observations of non-verbal behaviour, particularly play. My own recollections and reflections (reverie and countertransference) both during the session and in the process of writing it up were also noted. Supervision comments were added to the session notes as these represented additional processing and analysing of material as well as a third perspective outside of the therapist-patient interaction.

## Data analysis

While all research may be considered interpretive (Denzin & Lincoln, 2003), in this research psychoanalysis provides the interpretive tools. Both the interview and case study based data have been analysed using discovery-focused techniques. Useful in describing the process of qualitative data analysis are the principles and practices identified by Tesch (1990). These underpinned the analytic process of both the interview and case study based research:

1. Analysis occurs throughout the data collection process, beginning with the researcher's reflections while in the field and to a second level afterwards when the data are written up, organised and developed.
2. The process of analysis is not rigid but it is systematic and comprehensive.
3. Reflective activities are part of the data analysis. Outside referees can be asked to review the data analysis.
4. There is a move from reading the data as a whole to breaking it down into smaller and more meaningful units.
5. The data analysis process is inductive – research questions are used to guide the analysis but additional themes are allowed to emerge from the data.
6. Comparison is used to refine and build categories.
7. Categories are flexible and modifiable during the research process.
8. Qualitative data analysis is not mechanistic.

9. "The result of an analysis is some type of higher-order synthesis in the form of a descriptive picture, patterns or themes, or emerging or substantive theory"(Mertens, 2005, p. 422).

## *Interview data analysis*

Thematic analysis is well-documented as an appropriate method of qualitative data analysis (Braun & Clarke, 2006; Willig & Stainton, 2008). Defined as a method for "identifying, analysing and reporting patterns (themes) within data" (Braun & Clarke, 2006, p. 79), thematic analysis was the selected method of analysing the interview material, preferred because of its flexibility and its potential for minimally organising but then richly describing data (Braun & Clarke, 2006). Braun and Clarke (2006) describe both inductive and deductive approaches but the interview based data were primarily deductively analysed. The thematic analysis was also more explicitly analyst-driven (Braun & Clarke, 2006) given the researcher/analyst's personal involvement and interest in the field that is the object of study, that is parent-infant psychotherapy.

The recorded interviews were transcribed manually by me and then checked against the original recordings. This represented the first phase of the data analysis; familiarising oneself with the data (Braun & Clarke, 2006). Having assumed the roles of interviewer and transcriber and then having checked the transcripts against the recordings meant that I was fully immersed in the interview data before the next phases of analysis began.

The transcripts were coded for each interviewee and sorted into themes, initially based on responses to the 17 questions, but then re-sorted as other sub-themes emerged. Phase two, for Braun and Clarke (2006), should have involved the generating of initial codes but this aspect was largely subsumed into their phase three, the searching for themes. This process was recursive rather than linear. The interview schedule questions informed the search for themes but ultimately did not correlate entirely with the themes identified as most significant.

The process of analysis involves a progression from description – organising and summarising the data into patterns, to interpretation – theorising the significance and implications of the patterns (Braun & Clarke, 2006). The reviewing of the themes, phase four,

and the defining and naming of themes, phase five, also took place concurrently. The interview data were analysed with two aims in mind: to augment the published literature as part of the documenting of the history of parent-infant psychotherapy in South Africa; and to identify contextual areas of work and the associated challenges and responses to challenges. The former aim related to Chapter Four and the latter to Chapter Five.

The thematic analysis is substantially reflected in the journal article included in Chapter Five. Analysis of themes that emerged was undertaken with the intention of discovering both commonalities and differences across contexts and between projects. I felt it important to retain the individual voices of the 15 interview participants, particularly given their positions as stakeholders in the field, hence the foregrounding of quotations. The recursive method of analysis ultimately clustered pertinent quotes and commentary extracted from all the interviews (individual and group) into two main themes; the contextual challenges perceived and the adaptive responses described by participants. Within these two main themes, several sub-themes emerged: three perceived challenges and four reported adaptive responses.

Interpretation of the data represented the final phase of analysis and is presented primarily under the Discussion sub-heading of the stand-alone journal article that constitutes the essence of Chapter Five. The manuscripts included in this thesis (within Chapters Four and Five) were sent to all interview participants for review. Participants were invited to respond with corrections and further commentary and these amendments and additions were included before the manuscripts were submitted for journal review. An earlier version of the journal article included in Chapter Five was presented as a conference paper and audience commentary and feedback helped further refine the analytic process. Recursive analysis continued during the write-up of the thesis as a whole and further interpretive analysis contributed to the Discussion chapter (Chapter Eight).

## *Case study data analysis*

In case study research, the ongoing nature of the process of data analysis has been emphasised (Mertens, 2005) and case material is analysed at several levels. At the primary level clinical case material was analysed as it manifests in the psychotherapy encounter. This analysis is clinically and psychoanalytically informed, and as Michael Rustin stresses, "Since our subject matter is in part the emotions, therapist have to be able to feel them in order to be able to think

about them" (Rustin, 2003, p. 141). The psychoanalytic tools employed in data analysis of case study material include: interpretation (which is characterised by unconscious meanings attributed to conscious behaviour) and responses to therapist-given interpretations; transference and countertransference responses (as defined earlier); observing and noting affect and levels of arousal and shifts in these; paying attention to communication including silences and gaps and narrative shifts; careful observation of non-verbal behaviour and in relation to the latter as displayed by child participants, interpretation of their symbolic play. These tools are part of my normal clinical skills-set in my work as a psychotherapist and constituted the first, implicit phase of data analysis.

The analytic process was continued at the second level during the writing up of sessions. In this second phase, further analysis and interpretation of clinical material occurred. This included my own countertransference, feelings and reverie as recalled from the psychotherapy encounter and as evoked by the writing up process. Requisite skills in practising as a psychotherapist are "theoretical understandings of relevant ideas and clinical cases" (Rustin, 2003, p. 142). Such engagement with session material is a natural part of the psychotherapy process, but it takes on added weight when clinical case material is to be used as data for research purposes. Careful attention was paid to the analytic process during this write-up phase. Not all transcriptions of session material were presented in clinical supervision, but those that were benefited from an external analysis of the data that augmented my own.

Finally, the session notes were analysed from a research perspective. This required greater engagement with theoretical knowledge. Case study data were read through lenses focused on both developmental theory — intrinsic to the process given the participant population — and clinical theory. The results of the case study data analysis have relevance for the latter in terms of theory development. The analysed case study data represent the substance of the discussions in the journal articles included in Chapters Six and Seven. The case study data are also referred to in the discussion section of the thesis (Chapter Eight).

## Evaluating the quality of the research

Within positivist research, internal and external validity, reliability and objectivity are used to assess the quality of the research. Internal validity implies that a high degree of accuracy can

be achieved when testing the proposed causal relationship between two variables and external validity refers to the degree of generalisability (Lincoln & Guba, 1985). Reliability is concerned with the internal coherence of the enquiry and rests upon its replicability, and objectivity is concerned with neutral, bias- and value-free research (Lincoln & Guba, 1985). In positivist research, generalisability would be to the broader population from which the sample has been drawn.

It would be counter to the broader definition of qualitative research, and in particular the two methods of such research employed in this study, to evaluate the research using positivist measures. That an objective truth exists independent of the researchers and the research context has been criticised (Fossey, et al., 2002). Instead, qualitative research, and in particular the case study, needs to be "assessed by criteria appropriate to its own methods" (Midgley, 2006, p. 126). Following Midgley (2004) and his discussion of psychotherapy research, generalising is to *theory* and in his words the aim is not for "'absolute truth', but for a version of reality that is trustworthy, credible, coherent and reflexive" (p. 104).

In measuring the quality of this research, I propose adopting the alternative evaluation[11] described by Lincoln and Guba (1985), that is the concept of 'trustworthiness' and the associated criteria of credibility, transferability, dependability and confirmability. (These evaluative criteria are in part used to address the limitations and weaknesses of case study research as highlighted earlier.)

Lincoln and Guba's (1985) concept of credibility relates to the positivist measure of internal validity; that is the plausibility of the research data, the research findings and the interpretations. In terms of the case studies, internal validity is identified as an obstacle and a threat (Hilliard, 1993). Tuckett (1998) describes a scrutiny of validity that draws on Aristotelian and classical philosophy to examine the validity of the argument; the premises, the reasoning, the suitability of the form and the existence of fallacies. I would argue that both in terms of the interview based research and the more contentious case based research, measures were taken to improve credibility. Following Lincoln and Guba (1985), three measures are recommended.

[11] Widlöcher (1994) proposed an evaluation of the quality of case reports based on three criteria; economy of data, adequacy to the proposed thesis and convincingness/persuasion. Tuckett (1998) suggests four requirements; relevance, transparency, credibility and plausibility. These recommendations overlap with those proposed by Lincoln and Guba (1985).

Firstly, Lincoln and Guba (1985) and others (for example Fossey, et al., 2002) suggest that credibility in part rests upon the researcher having engaged sufficiently with the research subjects. In terms of the case based research, engagement is at the psychotherapeutic level and is in part determined by the quality of the therapeutic relationship. In terms of the interview based research, many of the participants are colleagues and/or known to me, the researcher. I was aware of, if not entirely familiar with, several of the projects represented by the interview participants. Sufficient time was allocated for each interview to encourage in-depth engagement. Establishing a working alliance is an intrinsic aspect of psychotherapy and in terms of the interview process this would have served me well.

Secondly, persistent observation is required. The role of observation and my particular training in observation have been noted above. Thirdly, 'member checks' and 'triangulation' are advised (Lincoln & Guba, 1985). Triangulation allows for comparison and convergence in order to identify corroborating and dissenting perspectives (Fossey, et al., 2002). The interplay and interaction of psychotherapist-patient engagement within a psychoanalytic psychotherapy context allows for multiple opportunities of checking meanings and understandings between patient and therapist. In terms of triangulation and the case study based research, data analysis was discussed and checked with two clinical supervisors, and a research supervisor who is also a clinician. Perhaps the best measure of validity in a case study is that proposed by Widlöcher (1994); "the case *well illustrates the fact* to be highlighted" (p. 1238). The internal validity of the interview based research has in part been verified by the process of data analysis that allowed for all interviewees to read and respond to the final research reports prior to journal submission. Aspects of Chapters Five, Six, Seven and Eight have all been presented at psychology conferences and the credibility of these presentations was not questioned by the professional audience. The manuscripts that essentially constitute Chapters Four to Seven have all been submitted to peer-reviewed scientific journals and accepted for publication. Arguably this confirms their credibility.

The further concepts of transferability, dependability and confirmability, as proposed by Lincoln and Guba (1985), can also be applied as evaluative measures.

In terms of transferability, data selection needs to begin with an identification of groups, settings, and individuals where and for whom the processes being studied are likely to occur. Every instance of a case is viewed as both an exemplar of a general class of phenomena *and*,

in its own way, particular and unique (Denzin & Lincoln, 2003). To reiterate, generalisation — the related positivist measure — is not necessarily the purpose of a research study (Midgley, 2006). This study does not aim to aggregate per se. The selection of participants for the interview based research, such that key stakeholders are represented, increases the possibility of transferring results from the data analysis to the parent-infant psychotherapy field across contexts.

More complex is the issue of transferability in relation to the case study based research. The case based research aims to look at the application of findings from the case studies chosen for inclusion to other clinical cases deemed similar. Similarities would be identified by considering: the nature of the presenting problems (the symptom); the multiple relationship dynamics between parents, infant and psychotherapist; the clinical setting (private practice in South Africa); and of course the particular treatment mode, in this research parent-infant psychotherapy. Following Yin (1993), theory can be the 'vehicle' for generalising from a case study. As Midgley (2006) argues, making an association to case law in legal practice, "the comparison of successive cases leads to incremental conceptual refinements and reformulations" (Midgley, 2006, p. 139). The burden of transferability lies with the reader who is assumed to be able to generalise in a subjective way from the case selected in the research to his/her own personal experience (Mertens, 2005). It is hoped that the psychotherapy case studies selected to explore the research questions may be used by the interested reader to cast light on and potentially enrich the practice of parent-infant psychotherapy in private practice settings, perhaps most notably within South Africa but also internationally.

Dependability is a more complicated criterion to meet in the context of any theoretical-heuristic research because it has to do with replicability. In part, Tuckett's (1998) idea of 'transparency' may inform the evaluation of dependability because what is required is a 'meaning context'; inferences made explicit. The interview based research lends itself more easily to replicability as the semi-structured interviews were guided by an interview schedule that elicited responses attributable to named individuals working in particular, described contexts. The heavy reliance on quotations increases the transparency of this data analysis. Given the uniqueness of individual patients/case study participants and psychotherapist/researcher and the intersubjectivity of the therapeutic encounter, it may be that the most useful assessment of dependability in the case study based research is if

differences inherent in replicated research studies are monitored and can be explained (Lincoln & Guba, 1985). Future research may be necessary to test the transferability of ideas generated in the case study based research.

Qualitative objectivity, discussed as the criterion of confirmability by Lincoln and Guba (1985), is inherently less problematic in the interview based research as the interview participants were all invited to comment on the final manuscripts, the second of which (see Chapter Five) incorporates quotations from the transcribed interviews. The double identity of the researcher — stakeholder in terms of the interview research, psychotherapist in relation to the case study based research — is acknowledged as a necessary limitation, more particularly in terms of the latter dual role (Edwards, 2007). Widlöcher (1994) suggests that it is "illusory to pretend to be able to present an objective clinical vignette" (Widlöcher, 1994, p. 1240) and he elaborates this when he observes that: "One cannot take an act of speech as an objective fact. Its meaning results from such a complex series of inferences that understanding is already an interpretation" (Widlöcher, 1994, p. 1242). I am not claiming objectivity here. Rather, efforts *towards* confirmability ─ or perhaps "plausibility" as Tuckett (1998) refers — have been upheld in this research by the use of triangulation through clinical supervision (discussed above) and research supervision by an academic who is also a clinician. Self-reflexivity on the part of the research (in acknowledging the double identities) may in some way mitigate by making researcher bias more transparent. It has been argued that the criteria for evaluating quality in research are related to standards of conduct and principles of good practice (Fossey, et al., 2002).

## Ethical Considerations

Fossey and collaborators state that ethical considerations are paramount in all research from its design to conclusion (Fossey, et al., 2002, p. 723). The following discussion applies broadly to both aspects of this research, however the psychotherapy case based aspect warrants particular ethical consideration.

In all psychoanalytic psychotherapy research, an ethical dilemma exists between the need for research and the continuing publication of clinical material, and the duty of the clinician/researcher to protect the patient (Furlong, 2006; Gabbard, 2000; Patterson, 1999; Stajner-Popovic, 2001). In an endeavour to straddle this dilemma, engagement with ethical

issues dominated early seminar discussions during the proposal-writing stage of this research. This is not to claim that the ethical dilemma was solved, but rather to alert the reader of this research to my determinations to behave ethically both as a psychotherapist and researcher. In this respect, I note that my ethical responsibilities have been determined by my professional and scholarly obligations. The South African Psychoanalytic Confederation Code of Ethics (Silove, et al., 2011) guides professional practice in terms of responsibilities to patients and also in terms of the research process. In the latter respect, the authors of the Code of Ethics write "The SAPC recognises the important role of research and critical scholarship in improving and refining theory, practice and efficacy" (Silove, et al., 2011, p. 11). As a student enrolled at the University of the Witwatersrand I am also subject to the regulations of its ethical committee, the Human Research Ethics Committee and its Code of Ethics for Research on Human Subjects. I have taken these dual responsibilities and obligations very seriously.

The benefits of participating in the interview based research were explained to interviewees (see Appendix I) in the context of the development and promotion of the particular area of mental health in which both they and the researcher are/have been involved. It was suggested to potential case study participants that their participation may contribute to the development of an important field (infant and young child mental health) in South Africa (see Appendix III).

There were no major identified risks for case study participants who agreed to take part in this research other than the possibility that in unforeseen ways being both a research participant and psychotherapy client might have complicated the latter relationship. For past clients (so determined at time of initiating the research), this was less of an issue but for current and future participants such a complication — which would in greatest likelihood have manifested in the transference (Patterson, 1999) — may have required address within the context of psychotherapy. While acknowledged as a possible ethical complication, this situation did not arise. I had taken the decision that if it had, safeguarding the psychotherapy would have been prioritised and withdrawal from the research insisted upon.

Respect for human dignity is identified as a fundamental and foundational ethical principle in the SAPC Code of Ethics and it subsumes the principles of confidentiality and informed consent (Silove, et al., 2011) which are critical ethical issues in terms of this research and are discussed below.

## *Informed consent*

An Information Sheet and an Informed Consent letter (Appendices I and III) were given to all the participants for perusal, in their own time. A separate form (included in Appendix I) was presented to interview participants obtaining permission to audio-record the interviews.

The essence of the principle of informed consent is that the human subjects of research should be allowed to agree or refuse to participate in the light of comprehensive information concerning the nature and purpose of the research (Homan, 1991, p. 69).

In breaking down the phrase 'informed consent', Homan (1991) identifies two elements pertaining to each of 'informed' (points 1 and 2 below) and 'consent' (points 3 and 4).

1. The researcher needs to disclose all pertinent aspects of what is going to occur or what may occur and
2. that this should be comprehensible to the subject.

*and*

3. It is implied that the subject can competently, rationally and maturely make a judgement and
4. that the agreement to contribute is free from coercion and influence.

In terms of obtaining informed consent from interview participants, all four points of Homan's (1991) commentary were easily met. As the commentary pertains to case study participants, Homan's (1991) first point requires some discussion. The subsequent points were deemed unproblematic. (With reference to point 2 it is important to acknowledge that all case study participants include an infant/young child-with-parent, and the parent's consent was sought not the child's. This may well be ethically problematic but it is accepted practice and hence no efforts were made to address this issue.) Informed consent was obtained for *research* participation — in terms of the *psychotherapy* consent was assumed.

In discussing point 1, Homan (1991) quotes the Social Research Association in Britain that allows that the full version of the principle may not be always possible. The SAPC Code of Ethics (Silove, et al., 2011) requires that researchers engage in debates and discussion concerning the acquiring of consent. Homan (1991) argues that information given to

prospective participants should be accurate but not necessarily comprehensive. This is a helpful argument given that participants agreed to participate in a study that had identified broader rather than narrow aims and research questions. Participants that gave informed consent did so with the proviso that they could withdraw at any time without giving a reason and without prejudice and this was made clear to the participants both verbally and on the consent form. The implications of a participant's subsequent withdrawal from the research were that those cases that might be considered negative (in terms of the transference relationship and/or in terms of therapeutic outcome) were more likely to be the ones that exercised self-exclusion. Fortunately, the exit proviso was not executed by any participant.

## *Confidentiality*

Confidentiality, which refers to the non-disclosure of the identities of the participants, was presented to interview participants as an option on the consent form (see Appendix I). All participants elected to be identified and cited/quoted by name. It had been anticipated that the interview based research participants, who represent key and public holders in the field of inquiry, would choose to be identified both by name and association to particular projects. Interviewees were offered an opportunity of reviewing the two interview based journal submissions in order to rule out any possible harm to their professional integrity and in order to double-check data. All amendments and additions to the text requested by interviewees during this double-check process were made.

With respect to the case study participants, confidentiality is a core ethic in all counselling, including psychoanalytic psychotherapy, and it also a requirement for ethical research (Patterson, 1999). At both levels, confidentiality of case study participants has been prioritised in this thesis.

Although some research participants may recognise themselves in the case studies should they come across the research in the public arena, their identities have been concealed from detection by friends/family/colleagues through the employment of false names and the removal of identifying personal details. In addition, a combination of thin and thick disguise (Gabbard, 2000) to conceal or obscure identifying features has been employed. Disguise has

been adopted without rendering evidence inadmissible. Similarly, false details were introduced in a red herring manner to further obscure the identities of participants from a reader. An example would be to report a parent's career inaccurately, but only if the participant's work was in no way linked to the particular aspects of the case study under scrutiny and discussion. In order to further guarantee the confidentiality of case study participants, the signed case informed consent letters have been stored by the researcher rather than being included in the final thesis.

This research is conducted within the guidelines of the Human Research Ethics Committee (HREC – non-medical) of the University of the Witwatersrand and was granted ethical clearance by the HREC.

# CHAPTER FOUR

## The history of parent-infant psychotherapy in South Africa: theoretical roots and current practice

Following the issues underpinning this research and outlined in Chapter One, the history and development of the South African parent-infant psychotherapy field warrant both investigation and documenting. This chapter forms the basis of the thesis; it explores and describes the roots of the field. It also primarily serves to orientate the reader of this thesis to the object of study, namely parent-infant psychotherapy in South Africa.

This chapter (and similarly Chapters Five to Seven) is structured in two parts; in the short, preliminary section the reader is provided with a background against which the stand-alone (published) manuscript that constitutes the remainder of the chapter can be read. Here I will focus on orientating the reader to the broader South African context in which parent-infant psychotherapy, and the practitioners of such, have had to fight to gain a foothold. Several core features are highlighted: the issue of training of infant mental health practitioners; the utilisation of lay counsellors; the lack of public awareness of and funding for infant mental health services; and the nature and structure of the health system in which these professionals work.

One of the rationales for this research was to advocate for early parent-infant interventions in this country. In this regard research findings would require publication in a widely-read scientific journal. The manuscript that constitutes the remainder of this chapter[12] was submitted to the *Journal of Child and Adolescent Mental Health*, a bi-annual publication

[12] The manuscript content is identical to the published journal article and accords with the requirements of the editor of *Journal of Child and Adolescent Mental Health* and the recommendations of the anonymous reviewers. The reader of this thesis is alerted to the fact that because this manuscript was submitted for review in 2010, content may not accurately reflect the status of parent-infant psychotherapy in South Africa as of 2012. The manuscript as included in this chapter has been formatted in accordance with the style of this thesis and this may differ from that of the journal article (Dugmore, 2011).

concerned primarily with publishing "work in the field of child and adolescent mental health from countries in Southern Africa and beyond" (http://www.ajol.info/index.php/jcamh). It was accepted for publication in 2011 (Dugmore, 2011)

The origins of parent-infant psychotherapy, both in terms of theory and in terms of influence, have never been documented. It would be sensible to assume that the roots of South African forms of parent-infant intervention and practice are located in Western modes of practice as this is true of all psychotherapies in this country. However, the route and manner of importation of such modes into various South African contexts has not been examined. Nor have the factors that inform and shape the diversity of practice been identified.

A core factor that opens rather than closes the range of possible shaping influences is the absence of any formal training for South African mental health professionals interested in working in the parent-infant field or in offering parent-infant psychotherapy. No South African university offers a complete and accredited training in infant mental health. I quote from a letter written to the South African Medical Formulary by Astrid Berg in her capacity as head of the University of Cape Town Parent-Infant Mental Health Service at the Red Cross War Memorial Children's Hospital[13]:

> The concept of infant mental health is generally not well known, particularly in communities. In the Western Cape there is one designated infant mental health service at primary level, which has a child psychiatrist and a community counsellor[14]. At an academic and educational level there are also considerable gaps. The University of Cape Town and the Department of Health of the Western Cape offer 1-hour training and supervision in infant and child mental health in the primary nurse education programmes. Medical students from both medical faculties in the Western Cape receive 2 hours in lectures and clinical tuition in this regard. Registrars in general psychiatry receive one seminar on infant mental health during their 4-year training period. Paediatric registrars are not formally taught or rotate through child psychiatry, despite the fact that paediatricians provide health care for young children. (Berg, 2011)

[13] The only dedicated children's hospital in South Africa.
[14] My footnote: Berg is referring to herself (child psychiatrist) and cultural mediator Nosisana Nama.

Social workers and psychologists who study towards their degrees at tertiary institutions in South Africa are similarly deprived of exposure to issues pertaining to infant mental health and to possible treatment interventions in the field. Those professionals working in the parent-infant psychotherapy field have clearly acquired their theoretical knowledge and technical skills outside of formal South African training opportunities. I considered it both interesting and important to investigate the sources of such learning and to explore the impact the various sources may have had on the shaping of the South African field.

A second factor that is key in understanding the diversity of parent-infant psychotherapy practice is the context in which broader mental health services are offered in South Africa. Following information and statistics sourced from a website (www.southafrica.info/about/health) that offers information on South Africa with references to policy documents and credible reports, South Africa's health care system is best described as two-tiered; consisting of a large public sector and a smaller but fast growing private sector. Details provided on the website indicate that the public sector contributes 40% of health spend and delivers health care services to 80% of the population. The private sector is commercially run, caters to middle- and high-income families and employs the majority of health professionals[15]. The National Treasury's Fiscal Review for 2011 summarises the GDP spend on health as follows: 48.5% in the private sector, which constitutes 16.2% of the population, most of whom have medical cover[16]; 49.2% in the public sector, which comprises 84% of the population who are also reliant on public health care; 2.3% which is donor and NGO spend. The disparities evident in the provision and spend of this two-tiered system are exacerbated by the poor management, underfunding and deteriorating infrastructure that characterise institutions in the public sector. Despite high expenditure (in 2011 total spend on health was 8.3% of GDP, more than the 5% recommended by the World Health Organisation), health outcomes in South Africa remain poor.

An internet search for information on maternal health in South Africa repeatedly refers to documents that highlight maternal mortality. For example, according to WHO statistics, the

[15] To illustrate, only 7% of psychologists in South Africa work in the public sector. This is according to a factsheet published online by the Perinatal Mental Health Project, an independent and non-profit initiative based at the University of Cape Town. It partners with the Western Cape Provincial Department of Health to offer support, screening and counselling for pregnant women and girls experiencing psychological distress. It is the only project of its kind in South Africa www.pmhp.za.org [Accessed 1 August 2012].

[16] South Africa has more than 110 registered medical schemes, with around 3,4-million principal members (1.7% of the population) and 7,8-million (3.9% of the population) beneficiaries. http://www.southafrica.info/about/health/health [Accessed 1 August 2012].

2010 maternal mortality rate was 31 per 10 000 live births (www.southafrica.info). In a country where so many mothers die, focusing on maternal *mental* health (or infant mental health for that matter) may seem less urgent. However, in a country where one out of three women living in poverty will suffer from a pregnancy-related mental health problem[17], this neglect appears short-sighted.

It is because the State or public sector of national health services cannot be relied on to meet the mental health needs of parents and infants that parent-infant psychotherapy has primarily been offered in the private sector and that parent-infant projects have for the most part been developed by non-governmental organisations (NGOs) in community contexts. According to the above-referenced website (www.southafrica.info/about/health), NGOs make an essential contribution to mental health, among other aspects of health care, and to the development of public health systems. I quote from the website: "The part played by NGOs – from a national level, through provincial and local, to their role in individual communities – is vitally important to the functioning of the overall system" (www.southafrica.info/about/health).

In order to investigate the parent-infant psychotherapy field, several key stakeholders and practitioners were identified and interviewed (see Chapter Three for details of participant selection, data gathering and data analysis). The results of these interviews were written up in two parts. The second set of results is presented in the next chapter (Chapter Five). In terms of the journal article that follows this introduction, a review of the published literature (particularly locally but also internationally) is augmented by data gathered during interviews with local stakeholders and interviewees. The South African history is inextricably linked to the growth of the international field and these links and influences are described.

[17] www.pmhp.za.org [Accessed 1 August 2012].

# The development of parent-infant/ child psychotherapy in South Africa: A review of the history from infancy towards maturity[18]

Abstract:

*This paper takes the form of an account of the emergence of the field of psychoanalytically informed parent-infant/child psychotherapy in South Africa. It traces the origins and the development of the South African field by locating local practice within the international field. The influential links between international approaches and local practice and services are described. The historical account is based on a review of published parent-infant/child literature, including South African authored texts. Interviews with key local stakeholders and practitioners supplement the literature review. This paper endeavours to locate parent-infant/child psychotherapy more clearly on the map of mental health work in South Africa, and in so doing to promote the work as both a relevant and valuable intervention.*

In the broadest sense, infancy to early childhood is a critical time for the promotion of optimal social and emotional development (Stern, 1985; Winnicott, 1963b). During this time, early parent-infant/child psychotherapy interventions may carry great promise for establishing critical foundations to lifelong emotional health by addressing those issues that threaten to derail normal development.

The aim of this paper is to do justice to the development of the parent-infant/child psychotherapy field in South Africa, from its infancy towards its more mature current status. Internationally, parent-infant/child psychotherapy is well recognised and highly regarded as a particular treatment mode within the broader field of child psychotherapy (Barrows, 1997; Stern, 1995). In South Africa, possibly because of political and professional isolation, the field emerged somewhat more belatedly. Despite fairly rapid growth, the South African

[18] Copyright for this manuscript resides with the publisher: *Journal of Child and Adolescent Mental Health*.
Citation: Dugmore, N. (2011). The development of parent-infant/ child psychotherapy in South Africa: A review of the history from infancy towards maturity. *Journal of Child and Adolescent Mental Health*, 23 (2), 75-90.

field has yet to achieve the degree of awareness and recognition it commands internationally. Although pockets of work in both the local private, public and community sectors are identifiable, these services have not all been documented. In the absence of public and professional awareness of existing resources, training of future practitioners and funding of services, the field's potential growth and outreach are limited. This account of the history and current status of the South African field is considered a necessary precursor to raising awareness of the field, and affording it the credibility it deserves.

Earlier attempts to review (Barrows, 1997) and integrate (Stern, 1995) the global history of and various approaches to parent-infant and parent-child psychotherapy have been made. Given the richness of the field and the pace and extent of developments globally, any further attempt to review and integrate the diversity of approaches would be challenging. This paper is not intended as a revision of earlier attempts to chart the full history of the field; rather it is an historical account of the emergence of the South African field.

Merely to update international accounts by including development in the contemporary South African field through a review of locally originated literature would address only some aspects of the history and status of parent-infant/child psychotherapy practice in this country. There is a paucity of published papers by South Africans working locally[19], and relying on text sources would limit the historical account. In this study published material is supplemented with information gathered through face-to-face and email interviews[20] with key stakeholders.

The South African history is accounted for in relation to particular developments in the international field, as will become apparent. The foregrounding and highlighting of particular international approaches at the expense of neglected others is intentional and determined by the aim of this paper which is to explore the links between the emergent and current South African parent-infant/ child practices, and their international sources of inspiration or influence. Other approaches[21] have much to offer the South African

[19] South-African authored/co-authored texts related to parent-infant/child psychotherapy include Berg (2001a, 2002, 2001, 2007), Cooper et al. (1999), Cooper et al. (2002) and Dugmore (2009).
[20] Where interview material represents source material, this is indicated in the referencing.
[21] Three key geographical pockets of development of international practice (each associated with particular authors) that may be of interest to readers are the Geneva- and Lausanne-based group (Cramer & Palacio Espasa, 1993; Cramer & Stern, 1988; Palacio Espasa, 2004; Robert-Tissot, et al., 1996; D. Stern, 1995), the Lieberman and

practitioner, but they have not directly contributed to the development of the field locally. This paper traces some of the direct influences on South African parent-infant/child psychotherapeutic work and explores the progression of the field in South Africa to date. Unlike internationally where the field has largely developed in mental health clinics, this progression has developed through private practitioners, through psychotherapeutic work and through community initiatives. These different pathways are explored in this paper.

## Defining the parent-infant/child psychotherapy field

In this paper the parent-infant/child psychotherapy field is defined in terms of three fundamental features.

Firstly, the field is located within the broad spectrum of infant (zero to three) mental health and child mental health, which implies, by definition, that infant/child mental ill-health (or pathology) can be identified, described and "treated". The World Association for Infant Mental Health (WAIMH) was originally founded in 1980 as the World Association for Infant Psychiatry (WAIP) and then renamed in 1992. Infant mental health is defined by the organisation as:

> … the ability to develop physically, cognitively, and socially in a manner which allows them to master the primary emotional tasks of early childhood without serious disruption caused by harmful life events. Because infants grow in a context of nurturing environments, infant mental health involves the psychological balance of the infant-family system. (Osofsky & Fitzgerald, 2000, p. 25)

'Infant' mental health has been formalised in the canon since 1980 when the then quarterly *Infant Mental Health Journal* was first launched.

Secondly, the orientation from which infant mental health is explored is psychoanalytically informed. A psychoanalytic orientation implies working with the

collaborators group in San Francisco, USA (Lieberman, 1991, 1992, 2004a, 2007; Lieberman, et al., 2005; Lieberman & Van Horn, 2008; Lieberman, et al., 1991; Silverman & Lieberman, 1999) and the Australian-based infant-led psychotherapists (Thomson-Salo, 2007; Thomson-Salo, et al., 1999).

unconscious both in terms of the internal world of the patient and in terms of the transferential dynamics in the patient-therapist relationship. In the context of parent-infant/child psychotherapy, *infant* mental health is understood to be inseparable from *parental* mental health. The interplay between and the inter-relatedness of the internal and representational worlds of the infant and parents are conceptualised in the context of psychodynamic models of understanding the parent-infant relationship (Bowlby, 1982; Winnicott, 1960). This is most clearly captured, theoretically and historically, in Winnicott's 1940 statement: "There is no such thing as an infant … meaning of course that whenever one finds an infant one finds maternal care, and without maternal care there would be no infant" (Winnicott, 1960, p. 39). In terms of the here-and-now relationship between therapist and patient, attending to transferences and countertransference is considered a critical aspect of the psychoanalytic process.

Thirdly, and more specifically, the inextricable impact that the parents' (and particularly the mother's) representational world has on the relationship with the infant has led to the development of forms of therapeutic intervention that require the presence of parents and infant or young child *together* in the same therapeutic space. Although different treatment foci are described, most commonly the relationship between parent and infant/child is identified as the primary "port of entry" (Stern, 1995). Arguably, in contrast to psychodynamic family therapy, the infant or very young child is viewed as having a significant contribution to make to both the psychodiagnostic and treatment aspects of the therapy process.[22]

The author's preferred term, 'parent-infant/child' psychotherapy, implies a broad definition of the field. 'Parent' is generally intended to refer to the mother and father and in some cases a non-parental but primary caregiver. 'Infant' is variously defined, most broadly as zero to three years, and 'child' in the psychotherapy field addressed in this article most often refers to the preschool child. Parent-child psychotherapy is broadly considered as an extension of parent-infant psychotherapy (Emanuel & Bradley, 2008).

[22] Readers interested in exploring the debates around the extent to which parent-infant psychotherapy and indeed psychoanalysis can be infant-led, are referred to the writings of Norman (2001, 2004) and his critic Flink (2001).

## The early international period

Anna Freud and Melanie Klein are widely recognised as pioneers of child analysis, but their different approaches and the conflict generated by the proponents of each were to be the source of a series of intellectual discussions and confrontations that began in the 1920s and culminated in "The Controversial Discussions", 1941–1944, (Bergmann, 1997). These discussions signalled a splitting of the British psychoanalytic community into three factions: the Klein group, the Anna Freud Group now called the Contemporary Freudians, and a Middle Group that included Donald Winnicott. The earliest roots of parent-child psychotherapy can be traced back to these pioneers in child psychotherapy, as can later divergences in the development of the international, and to a lesser extent, the local field. These divergent influences will be elaborated later.

Winnicott is credited with the first description of what might be considered infant-parent psychotherapy in respect of the three components to this field listed above. In his paper (Winnicott, 1941) on the "set situation" he described relieving a seven-month old girl of her asthmatic wheezing by allowing the infant to express her aggression, without guilt, by biting the spatula he presented to her. Winnicott reports that the infant was relieved of her asthma after this single consultation. In a twist, which further supports the mutual influences on the parent's and infant's mental health, Winnicott reports that the child's mother thereafter became bronchially asthmatic.

All approaches towards parent-infant/child psychotherapy included in the field are underpinned by a philosophy that recognises, as suggested initially by Fraiberg, Adelson and Shapiro (1975), that in becoming a parent, past childhood experiences and unresolved conflicts and traumas are reactivated and projected or re-enacted with the actual child in the present.

### *The contribution of infant observation*

Examining Esther Bick's method of infant observation (Bick, 1964) serves to illuminate the beginnings of the convergence of the three necessary precursors for the delimiting of the field, as defined earlier.

In 1964, Bick described in published form the process of infant observation that is widely credited as the "Bick Method". Infant observation, as introduced as part of psychoanalytic training in the Tavistock Clinic in 1948, requires that the student visits a family with a newborn baby for an hour a week from the time of the baby's birth until either the end of the first or second year. The observer pays careful attention to the development of an infant in the context of family relations and makes notes after each observation that are presented at a weekly group seminar for discussion (Bick, 1964). Students learn to experience what it is to be sufficiently immersed in the emotional experience of a family while resisting the urge to act out any role thrust upon them. The difficulty of observing — defined by Bick (1964) as collecting facts free from interpretation — is experienced, knowledge of aspects of psychotherapy such as the concepts of transference and countertransference (L. Miller, 1992) are acquired and the tolerance of uncertainty and the development of a "psychoanalytic attitude" (Rustin, 1988) are fostered.

Subsequent commentators have described the positive contribution infant observation has on the practice of psychotherapy with parents and infants (Coll, 2000; Russell, et al., 1995; Trowell, et al., 1998; Trowell & Rustin, 1991). However, not much has been written that clearly elucidates its role in the genesis of the practice.[23]

Bick believed that the presence of the observer has a therapeutic effect on the family (Briggs, 2002). In the author's professional experience as an infant observer and a leader of infant observation seminars, reflecting on the role of an interested and thinking observer in a family with a baby or young child, and looking closely at the observation material, often reveals moments of therapeutic potential. The possibility of transferring a passive process of infant-parent observation into an active and participatory therapeutic endeavour, where verbal reflections and interpretations can augment the inherent potential for transformation, would seem to be a natural next step: from infant observer in a family's home to parent-infant/child psychotherapist in the clinical setting. This natural next step is suggested by Harris who in describing a "therapeutic consultation" at the Tavistock Clinic in 1966, wrote "Mrs. J. related principally to me, concerned to get her story

[23] A recent article (Watillon-Naveau, 2010) implies rather than illustrates the influential relationship infant observation had (and has) on the development of parent-infant psychotherapy. The link between infant observation as a training exercise and its role in the ontogeny of parent-infant/child psychotherapy requires further illumination and possibly illustration.

over. I said very little beyond asking an occasional question or prompting her to clarify. Meantime I also observed the child."(Harris & Carr, 1966, p. 15). The presenting patient, a 22-month old boy described as fretful, restless and not sleeping, showed improvement within three sessions of parent-child psychotherapy.

In the late 1980s, Isca Wittenberg from the Tavistock Clinic in London led a series of seminar groups for the Johannesburg psychoanalytic community and used infant observation material as part of her teaching. The interest she generated in infant observation encouraged Johannesburg-based clinical psychologist Zelma Joffe, with the support of teachers from the Tavistock, to facilitate the first South African infant observation group a few years later.

### *Selma Fraiberg – parent-infant psychotherapy pioneer*

The first major development towards a clearly defined field was the emergence in the mid-1970s of the term 'parent-infant psychotherapy'. The first use of the term is credited to Selma Fraiberg, a social worker and psychoanalyst. She introduced infant mental interventions and health practitioner training into the Department of Psychiatry at the University of Michigan in 1973 (Kaplan-Solms & McLean, 1995). The ground-breaking work of parent-infant psychotherapy as practised by Fraiberg and colleagues (Fraiberg, et al., 1975) is widely considered the seminal paper in the parent-infant field.

Fraiberg had been heading a team that was researching the origins of mental health in infants/ toddlers and clinical approaches with infants and parents. Not only did Fraiberg coin the evocative phrase "ghosts in the nursery", but she also formalised a theory-based intervention that justified treating parents together with their infants in home- and clinic-based interventions. The intention was to understand the "ghosts" from the past (unconscious parental representations/projections/ transferences) that haunt the "nursery" (the infant's internal world and the parent's perception of the infant), thereby possibly impairing the mother-infant relationship. A basic premise is that the child's presence in the therapy setting evokes immediate and deeply significant transference phenomena for the parents, allowing a "window" onto their internal worlds (Fraiberg, et al., 1975). Subsequent commentators have suggested that this internal world might, in individual treatment, remain

inaccessible (Silverman & Lieberman, 1999). The presence and inclusion of the infant/child in the psychotherapy process is the key feature of parent-infant/child psychotherapy; it is intentional rather than accidental. The therapeutic exploration of the evoked parent's representational world is necessary to optimise the mental health of the infant/child.

## The middle international period and emergent South African period

The emergent international period had led by the mid to late 1980s to the development of key training and clinical centres, for example, at the Service de Guidance Infantile in Geneva, the Tavistock Clinic in London and later the Anna Freud Centre, also in London. In South Africa, pockets of interest and associated services began emerging.

Several key articles published in this middle period heralded the beginning of the wider theoretical and geographical interest in parent-infant/child psychotherapy. Of the key papers from this decade, *Standing next to the Weighing Scales* by Dilys Daws (1985) would play an inspirational role in the establishment of two major parent-infant psychotherapy interventions in South Africa (Berg, interview 02 March 2010[24] and Frost, interview 30 November 2009[25]) and as such is highlighted in this account. The Daws paper was a narration by the British child psychotherapist of her own early therapeutic endeavours with mothers and their babies in a baby clinic in London. Her interested-observer presence encouraged mothers to share with her their difficulties in relating emotionally to their infants. In effect, Daws describes a service offered to a clinical population that had not yet recognised its own need for help. This is arguably true of the emergent field in general; many parents of infants and young children are unaware of the emotional and relational bases for the difficulties they may be experiencing. This has had obvious implications for initiating services. Unlike many community interventions, a needs analysis would not necessarily identify on the part of the community a recognised gap for parent-infant services. In South Africa, the public-at-large is still insufficiently informed about developments in and the existence of parent-child focused psychotherapy services.

[24]Associate Professor Astrid Berg, Senior Consultant in Child and Adolescent Psychiatry, Red Cross Children's Hospital, Rondebosch, Cape Town.
[25]Katharine Frost, Programme Director of Ububele Umdlezane Parent-Infant Project, Kew, Johannesburg

The end of the 1980s saw an important progression in the field from describing early interventions, to researching them. In 1986, Wright (1986) reported the clinical findings of an American prevention project that had used infant-parent psychotherapy with high-risk families, claiming positive results. Two years later, infant researcher Daniel Stern co-authored a published report evaluating (positive) change in "brief mother-infant psychotherapy" (Cramer & Stern, 1988). These articles, and others that have followed (including Cohen, et al., 2002; Cohen, et al., 1999; Lieberman, et al., 1991; Robert-Tissot, et al., 1996) have been important in raising both awareness of the field and elevating its credibility. Notwithstanding these research contributions, it is the more widely used qualitative case study that has become synonymous with much of the literature in the field.

### *The Tavistock contributions and contributors*

As suggested earlier, parent-infant/child psychotherapy services started mushrooming across the globe after Fraiberg's paper was published. Of these, the London-based Tavistock Clinic has had a significant influence on developments in the field in the UK. The Tavistock contributions are highlighted because the Tavistock Clinic was one of the earliest sites to establish a dedicated service that offered counselling to parents and children together. (The Anna Freud Centre (AFC) consolidated its parent-infant services some years after the Tavistock launched its Under Fives Service, and the AFC is included in this historical account under the middle international period.)

The Tavistock Under Fives Counselling Service was established during the late 1980s. Several of the earliest published case study papers (Acquarone, 1992; Hopkins, 1992; Jackson, 1992; L. Miller, 1992) drew case material from work done at the Tavistock Clinic. The focus in that year on parent-infant/child work is indicative of the extent of British interest in parent-infant/child work evident at that time. The case studies have become key citations in later publications, drawing attention to the value of early parent-infant/child interventions and serving as illustrations of therapeutic process and change. In South Africa, these qualitative contributions would serve the dual function of inspiration and technical reference for practitioners entering and developing the field without any initial training (various interviews).

Located within the Child and Family Department at the Tavistock Clinic, The Under Fives Counselling Service represented an important development in the field: a clear extension of the parent-'infant' population (first targeted by Fraiberg and the focus of interventions during the early period) to include the preschool ('under five') child. If there is an essential difference between a parent-infant and parent-child approach, it would seem to be in the more active role taken up by the 'child'. The child's non-directed, complex, symbolic play and his/her verbal communications constitute a unique and important contribution to the interpretive matrix.

The contribution of Tavistock-trained analysts and psychotherapists to the emergence of a parent-infant/child field in South Africa cannot be understated. Since the 1980s, such practitioners have regularly visited the South African psychoanalytic community offering supervision, training and support. As with the influences on the development of infant observation (described above), some of the early roots of parent-child psychotherapy in South Africa can be traced to the influential roles played by such visitors.

As mentioned earlier, Tavistock psychoanalyst Isca Wittenberg ran seminars in South Africa during the late 1980s. Her interest in parent-infant work then was reflected in the section "Psychotherapy in Infancy" she contributed to a book published in 1991 (Salzberger-Wittenberg, 1991). The book, *Extending Horizons*, became a widely-read text for psychoanalytically-oriented psychotherapists practising in South Africa, not least because it was co-edited by ex-South African and Tavistock-trained child psychotherapist Sheila Miller (Szur & Miller, 1991). Both Miller and Wittenberg have had close personal and professional ties to South Africa and both clinicians facilitated bridge-building at a time when South African practitioners were professionally isolated from their international peers. The Tavistock (and later the AFC) influence needs also to be understood in the context of the close relationship between expatriates and the London psychoanalytic community. Most South Africans psychologists who pursued psychoanalytic training abroad did so in the UK. Of these, Miller and Judith Davies returned to live in South Africa in the mid-1990s. They facilitated infant observation groups in Cape Town, Johannesburg and Durban and made a significant contribution to the wider promotion of infant observation in this country. Miller and Davies also founded the Tavistock accredited Institute for Psychoanalytic Child Psychotherapy (IPCP). The IPCP was established, in association with the non-profit organisation Siya Phulaphula, to provide training to South

African clinicians working in the child psychotherapy field. The further involvement of IPCP in supporting parent-child psychotherapy will be indicated later. Davies had been working in the parent-infant field in the UK and she pursued this area of interest through her Cape Town-based private practice.

Miller also collaborated with two Johannesburg-based psychologists (Lauren Gower and Lesley Caplan) on a programme called "The Goodstart Programme", 1994–1999, that aimed to offer support to mothers of infants and young children through community initiatives. One aspect of the work was to offer work discussion seminars to the crèche 'teachers' in the African Self-Help Association in order to help them think about the emotional world of the children in their care. A second aspect of the programme was to try and raise funding for the establishment of an Under Fives Counselling Centre following the Tavistock approach. The programme founders hoped that funded training would facilitate the delivery of psychological services to vulnerable mothers and children. This vision of a training centre was not realised and The Goodstart Programme had largely ended its activities by the time Miller returned permanently to the UK in 2001. Gower and Caplan, however, continued to offer psychotherapy and later supervision in the parent-infant/child field through their private practices.

### *The emergent role of infant mental health in South Africa*

In 1993 an international Jungian analyst, Mara Sidoli, visited the Cape Town-based Jungian Centre and showed an infant observation video to its members. This inspired local Jungian analyst and child psychiatrist Astrid Berg to contemplate the subject of infant mental health treatment and its place in South Africa. In January 1995 Berg organised the first Congress of Infant Mental Health at the University of Cape Town. The conference attracted over 200 delegates, including ex-South African Peter Cooper and his wife Lynne Murray, both of whom were actively involved in research in the mother-infant field through their then associations with Cambridge University, England. In his opening address at the congress, Cooper asked the audience two fundamental questions: what is the subject of infant psychiatry and whether it should be given a priority place in the new South Africa. In terms of the first question, he summarised the developments, particularly in infant research over the previous two decades that had led to a shift from understanding

infants primarily in terms of cognitive capacities, as described by Piaget (1952) to recognising their emotional and social capacities, particularly their sensitivity to the communication of human emotions in relation to the mother. Cooper's own response to the second question was to suggest that the future of South Africa depends on breaking the cycles of disadvantage and that infant mental health would be a good place to commence such an endeavour (Cooper, 1995).

Although the emphasis on the psychiatry of infancy in the opening address might best be understood in terms of conference organiser Berg's position as a senior consultant in Child and Adolescent Psychiatry at the Red Cross Children's Hospital, the list of presenters of papers at this first South African congress included psychologists, researchers, a music therapist and social workers, all working in the infant mental health field.

Mireille Landman, a South African clinical psychologist, presented a paper (Landman, 1995) at the conference in which she described a then-ongoing project that had been initiated by the Parent Centre, an NGO operating in greater Cape Town. The project was offered in Hanover Park, a Cape Town suburb of mostly working class Coloured families. A local adaptation of an American project, it involved neo-natal home visits by lay community members whose task was to provide support to mothers in an effort to reduce the high incidence of child maltreatment. The project did not clearly fall within the parameters of the parent-infant/child field, as defined earlier, because it did not specifically target a mother-with-infant/child client and because the service agents were not psychotherapists. The Hanover Park project, however, served as a springboard into community work in the field for Landman and others, as indicated below.

Other papers were presented by key international parent-infant/child practitioners (Acquarone, 1995a, 1995b; Jackson, 1995a, 1995b; Maiello, 1995a, 1995b). Of these presenters, ex-South African Judith Jackson has since made several visits to South Africa by invitation of the IPCP and offered support and supervision of parent-child work in Johannesburg. Suzanne Maiello has used infant observation conducted in South Africa to research cultural aspects of mother-infant relating (Maiello, 2000, 2003) and has also taught and supervised infant observation and parent-infant/child work in the country.

Parent-infant researchers Cooper and Murray, who also presented a paper (Cooper & Murray, 1995), invited interested parties at the congress to discuss participation in a Cape Town community-based project focusing on post-partum depression and the mother-infant relationship. A pilot epidemiological study later evolved into a randomised control trial researching a mother-infant treatment intervention in Khayelitsha, a township on the outskirts of Cape Town. In the treatment trial, lay community workers, supervised and trained by Landman, offered at-home counselling to mothers at risk of or with symptoms of post-partum depression. The collaborators on this project published several articles that reported positive results related to the work done (Cooper, et al., 2002; Cooper, et al., 2009; Cooper, et al., 1999; Tomlinson, 2001, 2003).

The 1995 congress also inspired the establishment of a two-pillared parent-infant mental health service headed by Berg. The Out-Patient Unit of the now Division of Child and Adolescent Psychiatry of the Red Cross Children's Hospital provides a parent-infant service that is accessed by families from all socio-economic levels across the peninsula. A clinic site in Khayelitsha (unrelated to the Parent-Intervention Programme described above) provides a consultative service to mothers with infants referred by clinic nurses. Berg heads both these services and they have become established sites for offering parent-infant/child psychotherapy.

If the 1994–1995 period represents a flourishing of interest in the infant mental health field in South Africa, it can partly be understood in terms of the emergence of the local psychoanalytic field from a period of relative isolation, coupled with the inspiring political promise of liberation and transformation of our country into a Rainbow Nation. The period represented a reinvestment of international — particularly British — clinical expertise in South Africa, largely by ex-South Africans. For example, when Cooper expressed an interest in attending the 1995 Congress he asked for reassurance from Berg that the congress would be "open to all" (Berg, interview 2 March 2010).

At the time, and more broadly in terms of the psychoanalytically oriented practitioners, this investment in the psychoanalytic future of South Africa, by professionals who had left the country earlier, was met with ambivalence and some resistance, particularly on the part of those who had chosen to stay. For a fuller discussion of the ambivalence with

which "psychoanalytic food" was received from international visitors by local practitioners, see Swartz (2007). What is worth hypothesising, is that the field of infant mental health in particular may have been spared some of the more complex issues related to "the intrusion of parental authorities [visiting analysts]" (S. Swartz, 2007, p. 11). Interest and investment in developing this field seemed to make sense for both local and visiting practitioners given the time of new beginnings. Applying new psychoanalytic ways of thinking to the needs of the youngest members of our then-infant democracy felt meaningful and hopeful given the optimism associated with the political climate. Investing in change and transformation at the level of the South African parent-infant constituency appealed to those wanting to make a difference.

## The contemporary period

Since the beginning of this century, there has been a burgeoning of service provision in the South African field (various interviews). Internationally there has also been a greater consolidation of the field and increased recognition of the place it occupies within the mainstream psychoanalytic psychotherapy field. This is evidenced by the proliferation of internationally published books dedicated to work in the field. For example: Pozzi (1999), Acquarone (2004), Sameroff, McDonough and Rosenblum (2004), Baradon et al. (2005), Pozzi-Monzo and Tydeman (2007), Emanuel and Bradley (2008) and Baradon (2009). Swartz (2007) said, when describing the negative impact of geography on local psychoanalytic practitioners accessing international training, that "[t]exts, rather than teachers, are of necessity central to learning" (p 2). Local practitioners (various interviews) claim that the introductory parent-infant/child literature has been indispensable in acquiring the skills and confidence needed to venture as untrained parent-infant/child psychotherapists into the field.

In 2002, Berg convened a second Infant Mental Health Conference in Cape Town. This was hosted by the Western Cape Association for Infant Mental Health, which is affiliated to WAIMH. The conference provided a further platform for exposure of parent-infant/child psychotherapy to a mixed South African and international audience. The 120-plus delegate list included presenters Daws (2002), Emanuel (2002) and Raphael-Leff (2002) who are key practitioners and authors in the international field. Local

presentations on work in the parent-infant field were made by Davies (2002), Richter (2002a) and Tomlinson (2002) among others. In her letter to delegates, Berg (2002a) described a bi-directional influence between the international and emerging local infant mental health field. It is, however, her own influence on the international field that arguably represents the most significant individual contribution by a South African.

### *Astrid Berg's contributions to contemporary parent-infant psychotherapy*

Berg has described and documented her work in the parent-infant psychotherapy field in journal articles (Berg, 2002b, 2003), a book chapter (Berg, 2007) and a soon to be published book (Berg, 2012a). Over and above drawing attention to work done locally in the field, Berg's primary contribution has been her description and sensitive treatment of cultural issues and in this regard she is cited internationally (for example Baradon, et al., 2005). She is the recipient of the 2010 WAIMH Award. Her recent lecture series given at Texas University A&M University, to be published as a book (Berg, 2012a), looks at linking infants and finding the other in terms of intercultural dialogue. Generally in her published work, Berg (2001a, 2002b, 2003, 2007) identifies necessary adjustments to a parent-infant psychotherapy model given the particular cultural environment in which a treatment service is offered. Her writings highlight what it means to work in a community such as Khayelitsha, where she has developed a parent-infant service, and where there is much hardship as well as a language barrier and cultural differences. For example, Berg (2007) explores how a western tradition of parent-infant psychotherapy translates into a township setting by looking at the meaningless divide between physical and psychological and the particular cultural meaning of the "motherhood constellation" (Stern, 1995). She also examines the not-to-be-ignored and near-tragic impact of "two cultures meeting without sufficient awareness of difference" (Berg, 2003, p. 265). Berg has also served as an inspiration and her published work as a reference for other community projects in South Africa (Frost, interview 30 November 2009).

In order to track the origins of two developments in Johannesburg, three short and final detours through the international historical field are necessary.

### *The influence of the Watch, Wait and Wonder approach*

An infant-led infant-parent psychotherapy approach was developed during the 1990s in Canada at the Toronto Infant-Parent Program. Called Watch, Wait and Wonder (WWW), the clinical project described a manualised approach (Cohen & Muir, 2002; Cohen, et al., 1999). Located in attachment theory, WWW seeks to prevent the intergenerational repetition of insecure attachment patterns by addressing the attachment relationship in the presence of parent(s) and child. The project drew enough interest and attention to be the subject of a Canadian Broadcasting Corporation documentary *When the Bough Breaks* (Docherty, 1995). This documentary was also screened in South Africa and first inspired the author of this paper to consider seeing parents and young children together for psychotherapy.

### *The Tavistock influences on South African parent-infant/child psychotherapy approaches*

The Tavistock service continues to offer a fast-track (no waiting list), short-term service to parents and their young children who are seen together. Emanuel and Bradley write: "The underlying approach requires the clinician to maintain a thoughtful and observant attentiveness when seeing families, without a set structure for interventions" (Emanuel & Bradley, 2008, p. 1). Contributions to the field that seem to have originated within the extended group of practitioners/authors associated with the Tavistock Under Fives Counselling Service include the focus on a short-term intervention, the inclusion of other family members in the treatment process (Emanuel & Bradley, 2008), particularly fathers (Barrows, 1997, 1999b, 2004), and the importance of acknowledging and treating difficulties in the parental couple's relationship (Barrows, 2008). Although very firmly rooted in object relations theory, the Tavistock service has also adopted systemic family therapy in the theoretical and clinical approach (Briggs, 2002; Emanuel & Bradley, 2008).

In Cape Town, Tavistock-trained Davies has been responsible for promoting parent-infant/child work to child psychotherapists working in private practice. This has been effected through infant observation training, the IPCP Tavistock-accredited course and her

personal involvement in the field. To a more limited degree, Davies has also recently extended her training and support to Durban-based and Zimbabwean practitioners.

In Johannesburg, the Under Five Reading and Work Discussion Group (U5 Group) was founded by the author after attending the Short Course on Infant Mental Health and Work with Under Fives: The Tavistock Clinic Model, in 2007 (Dugmore, 2007). The U5 Group falls under the IPCP umbrella and benefits from the ongoing support of visiting Tavistock psychotherapists that have included expatriate Louise Emanuel, Chair of the Tavistock Under Fives Service and Co-Convener of its training programme. The U5 Group currently has 26 members. Membership reflects a diversity of disciplines (psychologists, play therapists, social workers and an occupational therapist) as well as theoretical orientations. In part this can be understood as the inevitable result of a wide range of professionals being attracted to work in the field without having had training orientated to a particular theory. The author's own eclectic psychoanalytic approach has been illustrated with case study material elsewhere (Dugmore, 2009).

### *The influence of the Anna Freud Centre on a South African psychotherapy community service*

As if in some way the political divisions that began with The Controversial Discussions continue decades later and on another continent, it is the AFC that has primarily influenced the services provided by Ububele, a psychotherapy resource and training centre situated on the border of Sandton and Alexandra Township in Johannesburg. Ububele in part focuses on infants and children (under seven years old) and their caregivers and has become an important service provider in the parent-infant psychotherapy field. Unlike the indirect relationship between the U5 Group and the Tavistock, the collaboration between Ububele and the AFC has been clearer. (Ububele also hosted the 2001 *Widening Horizons* psychoanalytic conference[26] at which Berg (2001b) first presented her parent-infant work.)

[26] This conference was dedicated to Sheila Miller in recognition of her contributions to the local psychoanalytic community.

In 1950, Anna Freud founded The Hampstead Child Therapy Clinic. The Well-Baby Clinic was established as part of this and the clinic was later renamed the Anna Freud Centre. In 1997, the Parent-Infant Project (PIP) was launched at the AFC. This new project, founded and headed by ex-South African Tessa Baradon, integrated clinical services with training and research. The project has been manualised since 2003 and a book co-authored by Baradon (Baradon, et al., 2005) describes the PIP approach and the theoretical influences that inform the project. The 'patient' in this model is clearly identified as the infant[27]-parent *relationship,* although this relationship can be addressed via each of the participants. Both brief and open-ended treatment interventions may be considered.

Baradon has directly and indirectly played a supportive role in the establishment of parent-infant interventions at Ububele. In 2006, a parent infant reading group was started at Ububele by co-founder Tony Hamburger. Texts by Acquarone (2004) and Baradon et al. (2005) were used as introductory readers. Baradon herself was invited to run an introduction to parent-infant psychotherapy training for the reading group in 2007. Simultaneously, new funding allowed for the creation of the Ububele Umdlezane Parent-Infant Project (UUPIP) which aimed to support hospitals and clinics by providing them with parent-infant counselling services. Katharine Frost, who is the Director of UUPIP, has subsequently completed a five-day PIP training course at the AFC and facilitated similar training courses at Ububele. At the time of writing, a cumulative total of 40 professionals and lay counsellors have completed the Ububele courses. Ububele staff discussions in collaboration with Baradon representing the AFC led to the establishment of The Baby Mat Project (described by Frost & Van Der Walt, 2009) at primary health clinics in Alexandra Township. The intervention is an adaptation of an AFC community intervention that addresses the needs of refugee populations. Mother-infant groups, part of the "New Beginnings Group Programme" developed by the AFC, were facilitated by UUPIP staff at two Johannesburg shelters and the work will be evaluated using pre- and post-test measures during 2011. The UUPIP parent-infant psychotherapy clinics at Alex Clinic, Rahima Moosa Mother and Child Hospital and Ububele itself are also modelled on the AFC PIP service. These projects are staffed by lay counsellors, and intern and qualified psychologists who have completed the UUPIP training.

[27] Babies up to two years (Baradon, et al., 2005).

### *Parent-infant psychotherapy in public and community health settings in South Africa*

Although a split along the lines of The Controversial Discussions is suggested by the AFC and Tavistock support for the UUPIP and U5 Group respectively, the collaboration and cooperation between members of the two groups on various projects indicates that locally these divisions are more superficial. Primarily this might be understood in terms of an absence of any intensive local training programmes/institutions with clear theoretical orientations in the parent-infant field. Practitioners draw on whatever is available in terms of training and professional support.

For example, Clare Harvey, the previous head of the Parent-Infant-Psychotherapy Clinic at Rahima Moosa Mother and Child Hospital in Johannesburg, is UUPIP-trained and is also a member of the U5 Group. The Rahima Moosa PIP clinic started informally in 2005 with referrals of mothers-with-infants by nurses in the maternal post-natal clinic and nurses/dieticians in the paediatric clinic. The clinic is gradually extending its services. A much smaller public health service has recently been set up at Dr George Mukhari Hospital in Ga-Rankuwu in North West Province. Clinical psychologist Michael Theron, after joining the U5 Group and in collaboration with the hospital's Speech Department and Kangaroo Mother Care Ward, initiated the parent-infant/child psychotherapy service.
The author and Nicole Canin recently founded a caregiver-child counselling service in central Johannesburg called Lefika Caregiver-Child Centre. Lefika La Phodiso Art Therapy Centre, under which the counselling service falls, is affiliated to the IPCP. The clinic service is an adaptation of parent-child psychotherapy to caregiver-child clients who are referred by child-centred NGOs and Johannesburg Child Welfare. The project represents a useful pooling of resources and expertise from different theoretical and clinical perspectives; Canin ran training groups at Ububele and attended the 2009 Tavistock short course in Under Five Counselling.

The Parent Intervention Programme established in Khayelitsha as part of the epidemiological project (described above) conducted by Cooper and collaborators has continued, beyond the limits of the study, as one of several Parent-Intervention Programmes operating in township and other communities in Cape Town. Landman now acts as consultant to the coordinator of the parent-infant project at the Parent Centre.

The parent-infant counsellors (PICs) continue to be selected, trained and supervised through the Centre. They counsel mothers from economically deprived communities in the mother's home from mid-pregnancy to six months post-partum. In Landman's words (interview 2 March 2010), the work is "to the child through the parent". There is a vision to extend this work nationally. This will require funding and government support, two major obstacles to the development of the field in South Africa.

The other three impediments to the firm establishment of parent-infant/child psychotherapy as a valuable and necessary service across all sites (private, public health and community settings) are the absence of adequate and accessible training and a lack of public and professional awareness, as well as the challenge of working in communities where there is diversity of language and culture.

## The future of the field

The South African field has emerged from infancy and toddles forwards towards a hopefully more mature future. From this perspective, several key issues emerge. Of these, the debate around the use of lay counsellors — which is not exclusive to the parent-infant/child psychotherapy field — warrants three particular comments.

Across the globe, as can be inferred in this historical account, parent-infant/child psychotherapy sites have been developed in association with and offered through the clinics of state-funded health services. This has significant and positive implications for the reach of such services and the training of the service providers. The South African field has developed without public health support, rather than because of it. Here, the majority of services have been offered either through outreach projects in association with non-governmental organisations or by practitioners in private practice. Those services that are offered in public health settings are not (yet) part of a broader national, state-supported strategy. Rather, the viability of the projects depends on the involvement of a handful of passionate individuals.

The second comment is that outreach projects have largely relied on lay counsellors to deliver services into communities. This raises the issue of what can be considered parent-

infant/child *psychotherapy*, particularly when using a Western determined definition of psychotherapy (and psychotherapist). While recognising the importance of highlighting this polemic, it is beyond the scope of this paper to explore the matter further. Resolving the debate is not a precondition for recognising that psychoanalytically oriented community projects, even those that employ lay counsellors, do at this stage represent important therapeutics projects in the contemporary South African parent-infant field.

The related issue of training and supervising lay professionals, integral to the work done through the Cape-based Parent-Intervention Programme and the Ububele projects, is another aspect of the lay counsellor debate in need of engagement, particularly if expansion of parent-infant/child psychotherapy services into the communities that arguably need them most is to be facilitated. The third comment is that using a psychoanalytic supervision model when working with lay counsellors might provide some path out of the impasse.[28]

In terms of available professional training, the key challenge is the current paucity of opportunities. *Intimate Encounters: an Introduction to Parent-Child Psychotherapy* is a new short course, facilitated by Canin in association with the IPCP. This course, together with those offered by Ububele and the seminars/workshops led by Davies, represent the only available parent-infant/ child training for local professionals. Unlike the diplomas in infant mental health and psychotherapy offered internationally, the local courses are brief and serve a basic introductory purpose. None of them are accredited, although continuing professional development (CPD) points are offered.

Self-reading and supervision provide further opportunities for individual professional growth in the field. Peer support through membership of reading groups and the local affiliations to the WAIMH is necessary to supplement these courses. Ongoing exposure to international developments is needed if South Africa is to remain abreast of advancements in the field. To this end, attending the 13th World Congress of the

[28] This and other important issues arose out the extensive interviews I conducted in researching this historical account. The interview data warrant more detailed discussion and are the subject of a second paper. Concerns and ideas surrounding selection, training and supervision of lay community counsellors within a psychoanalytic frame of understanding that arose as central issues in Landman's doctoral thesis (Landman, 2009) will be the subject of future journal articles.

WAIMH, which will be held in Cape Town in April 2012, should be crucial for current and future practitioners.

These efforts to address the dearth of training in South Africa, however, meet only one half of the supply-demand equation. In a counter-intuitive sense, parent-infant psychotherapy services become meaningful by virtue of their supply first, and then awareness-raising of the need in order to create demand second. Available services need to be promoted to the local parent population and referral agencies (paediatricians, midwives, gynaecologists, early childhood educators etc.) if the number of referrals to such services is better going to reflect the need for such services. Locally, a self-help book by clinical psychologist Jenny Perkel (Perkel, 2007) has facilitated the public awareness task. In her book, Perkel introduces to the South African parent population the idea that parent-infant psychotherapy exists as a treatment option for parents/infants experiencing difficulties.

## Conclusion

As described above, the idea of effecting healthy change in child-parent relationships through psychoanalytically-oriented, early parent-infant/child interventions has become an international trend. A review of the literature suggests that parent-infant/child psychotherapy, in one or other manifestation, appears to be practised on every continent. In South Africa, parent-infant/ child psychotherapy services are currently offered in the private and public health sectors, and in community settings.

This account of the emergent history to current status of the South African field raises several key issues, which warrant further exploration and debate. Increased awareness of the field needs to manifest at all levels of society. There is an existing gap at the educational level in terms of parent-infant/child psychotherapy training. At the political level, government support and funding are necessary to extend services. Infant mental health will need to be recognised in terms of national health policy. At the professional and lay public levels, a dissemination of information is required in order to identify and refer parent-infant/child cases where emotional, behavioural and relational difficulties are

evident. The promotion of the field will depend on increased research and published reports by South Africans.

The absence of strict allegiances to international centres associated with either the Kleinians or Contemporary Freudians, suggests that in South Africa something of the international split that has existed since the Controversial Discussions might be integrated or bridged. Certainly the advantages of pooling resources and sharing ideas in this field are clearly apparent, and these might be more possible in a climate that is theoretically inclusive rather than exclusive. Indications are that given an historical lack of teachers and training in South Africa, it has been diverse texts from across the psychoanalytic spectrum that have driven acquisition of theory and clinical skills in the field, and rendered local theory and practice arguably eclectic as a result.

There is unexplored terrain between research/practice internationally and endeavours to provide services within the South African field. The work in community sectors by stakeholders such as Berg, Landman and Frost (described earlier) and the engagement by such practitioners with cultural and socio-economic issues represent a significant current and potential contribution to international literature. The adaptation of more widely-described international approaches for application to local settings is possible in this country because of differentiating factors in the South African supply-demand relationship, as compared to those countries where services are provided through the public health system. For example, one area of emerging local practice that may contribute to the international literature is that of parent-infant/child *group* psychotherapy; an area worthy of development in South Africa. The use of lay community counsellors has also been mentioned.

This paper charts the developmental path of the South African parent-infant/child psychotherapy field within the context of the international history of the territory. Current services and projects in this country have been briefly described. With greater public, professional and political support it will be possible for parent-infant/child psychotherapy to make a meaningful contribution to the promotion of positive infant, child and parental mental health and healing in South Africa. Since 1995 this has been increasingly on the professional agenda.

# CHAPTER FIVE

## Parent-infant psychotherapy in South Africa: Contextual challenges and adaptive responses

Researching the history and the development of parent-infant psychotherapy in South Africa, reported on in the previous chapter, resulted in the collection of data pertaining both to the current status of the field and to the consequences of importing ideas of parent-infant psychotherapy practice into South African contexts. As discussed in the introductory section to Chapter Four, impoverished opportunities compromise the provision of parent-infant services. There are limited opportunities for skills acquisition by professionals, mental health services are not prioritised by the health department and there is insufficient awareness and funding in both the governmental and non-governmental sectors of health care.

Further exploration of these and other issues was identified as an important aspect of the primary research question, particularly given the significance (as reported in the international published literature and mentioned in Chapter Two) of early parent-infant interventions. The interview based data gathered during the semi-structured interviews with stakeholders and practitioners in the South African parent-infant field (see Chapter Three) provided rich material for analysis. The interviewees had all been invited to respond to questions that addressed: the nature of projects they were involved in; the challenges/limitations/obstacles identified; their perceptions of relative successes and failures; and their visions/hopes for the future. The stand-alone section[29] of this chapter, which is in many ways an extension of the previous chapter/journal article, is the result of a thematic analysis of these interview-based data. The data analysis constitutes the basis for a discussion of parent-infant psychotherapy in South Africa across three sectors: private, public and community (non-governmental). The

[29] This manuscript was published by *Journal of Child and Adolescent Mental Health* and content accords with the requirements of the editor and the recommendations of the anonymous reviewers. This manuscript was submitted for review in 2011 and content may not accurately reflect the status of parent-infant psychotherapy in South Africa as of 2012. The manuscript as included in this chapter has been formatted in accordance with the style of this thesis and this may differ from that of the journal article (Dugmore, 2012a).

results have been organised as reported contextual challenges and then described as adaptations to practice. The focus is on the indigenisation of practice. The voices of the interviewees are foregrounded in the write-up.

The overarching research question of this thesis concerns the opening of ports of entry and the impact this has on the psychoanalytic frame. Stern (1995) identifies five ports of entry that relate to accessing the theoretical target as it is located within the parent-infant system. However, as the following discussion of indigenisation will suggest, the contexts of treatment (public, private or non-governmental) and the environment within which the clinical parent-infant system is located (socio-economic, cultural, language, supervisory etc.) need to be acknowledged if the field is to develop. We can understand context as being the milieu *in* which a practitioner works with the parent-infant system, but if we rethink it as a port of entry then it becomes the milieu *through* which a practitioner works. This will have interesting implications for how parent-infant psychotherapy is practised and for how the psychoanalytic frame that circumscribes parent-infant psychotherapy is defined.

It is argued that thinking of the challenges and adaptations discussed in this chapter not as contextual factors, but rather as ports of entry, offers an advantageous and novel viewpoint. From this perspective, an extended list of ports of entry is necessitated and I would propose opening a 'secondary' level of ports of entry. Seven secondary ports of entry are put forward and discussed in Chapter Eight. This list includes: the use of observation, which has been described in terms of its influence on and role in parent-infant psychotherapy in Chapter Two; the use of group dynamics and group culture (two recent journal articles offer some commentary on this, see Bain, et al., 2012; Rosenbaum, et al., 2012); the use of developmental guidance for parents; the role of supervision for the therapist; the role of the socio-economic environment within which the parent-infant system is located; similarly the socio-cultural environment that requires translation/mediation of language/culture (two recent WAIMH Congress presentations addressed this issue, see Berg (2012d) and Frost and Esterhuizen (2012)); and the educational environment that offers an additional portal to the parent-young/child system via the young child.

In South Africa, where primary ports of entry are not easily accessed because of inadequate and insufficient social service and primary health structures (see introduction to the previous chapter), these identified secondary ports of entry may represent an initial portal for reaching

parents and infants at risk for mental health difficulties. Arguably, once these portals have been opened, practitioners are better positioned to employ the five 'primary' ports of entry as named and described by Stern (1995). This proposal — of primary and secondary level of ports of entry — emerged in the write-up of the Discussion chapter but it is an important distinction, hence its emphasis here. In terms of this chapter, what is stressed is that the secondary level of ports of entry may be unique to the South African situation, or at least to developing countries that compare to South Africa, and that opening them represents a facilitated access to the parent-infant clinical system.

The impact of utilising multiple secondary and primary ports of entry on the psychoanalytic frame is significant and does raise critical questions about whether and how parent-infant psychotherapy (as implemented in South Africa and reported in this chapter) can be considered psychoanalytic. This has been raised in the previous chapter in relation to the Parent Intervention Programme in Cape Town. The issue will be taken up again in the Discussion chapter where the notion of psychoanalytic mindfulness, introduced in this chapter, will be linked to a proposed flexing of the frame.

# The development of psychoanalytic parent-infant/child psychotherapy in South Africa: Adaptive responses to contextual challenges[30]

Abstract:

*South African authored writings on psychoanalytically-informed parent-infant/child psychotherapy are rare, but this dearth does not accurately reflect the extent of practice in the country at the community, public and private levels. Interviews with a sample of key stakeholders and practitioners provided information on different services currently offered in the South African parent-infant/child psychotherapy field. Three major themes were identified during an analysis of interview material: the role of language and culture; the issue of training; and the challenge of working outside of a national health system. Interviewees also described adaptive responses to these contextual challenges. These responses are discussed as evidence of the usefulness of theoretical and technical eclecticism, when applied with psychoanalytic mindfulness, in developing the South African parent-infant/child psychotherapy field.*

## Introduction

In the international domain, psychoanalytic parent-child psychotherapy is widely practised and well described (for example Baradon, 2009; Baradon, et al., 2005; Cohen & Muir, 2002; Emanuel & Bradley, 2008; Lieberman, 2004a; Pozzi-Monzo & Tydeman, 2007; Pozzi, 2003). Although less well reported, parent-infant/child psychotherapy, as practised in South Africa, has also been described (Berg, 2001a, 2002b, 2003, 2007; Dugmore, 2009). Dugmore (2011) has mapped out an historical account of the increasing breadth of local practice in parent-infant/child psychotherapy field in South Africa. This paper

[30] Copyright for this manuscript resides with the publisher: *Journal of Child and Adolescent Mental Health*. Citation: Dugmore, N. (2011).The development of psychoanalytic parent–infant/child psychotherapy in South Africa: Adaptive responses to contextual challenges. *Journal of Child and Adolescent Mental Health*, 24 (1), 73-88.

offers a more in-depth discussion of current local practices and approaches based on interviews with key stakeholders and practitioners. Three major challenges linked to importing a predominantly western tradition of practice into the South African context were identified and adaptive strategies and possibly uniquely South African forms of practice reported. These will be discussed in terms of the impact on the future development of the field.

Psychoanalytically-oriented parent-infant/child psychotherapy may be variously named elsewhere — Watch Wait and Wonder (Cohen, et al., 1999), child–parent psychotherapy (Lieberman, 2004a), parent-infant psychotherapy (Baradon, et al., 2005), tripartite psychotherapy (Berlin, 2008), under fives counselling (Emanuel & Bradley, 2008) — but key to all approaches (as indicated by the author's preferred term 'parent-infant/child psychotherapy') is targeting parent(s) *together with* child. Interventions may shift from orienting treatment towards the child or towards the parent; invariably, however, the parent(s) and infant/child attend sessions together.

This is the first of three fundamental features that define the parent-infant/child psychotherapy field for this study. The second defining feature is the location of parent-infant/child psychotherapy within the spectrum of infant mental health. This study presumes that infant and young child mental health and ill-health, can be identified, described and treated. Thirdly, parent-infant/child psychotherapy is firmly underpinned by psychoanalytic and attachment theory.

## A brief description of parent-infant/child psychotherapy in the international field

Parent-infant/child psychotherapy, as it is practised across the world, is largely grounded in a western tradition of psychotherapy. Although there is divergence across various approaches, a review of the international literature allows for extrapolation of key ingredients, both in terms of theory and technique.

The traditional, western psychoanalytic approach to parent-infant/child psychotherapy identifies the parent-infant/child relationship as the 'patient'. The centrality accorded this

dyadic relationship can be traced in origin back to Winnicott's idea that "… whenever one finds an infant one finds maternal care, and without maternal care there would be no infant" (Winnicott, 1960, footnote 1:39). A range of "ports of entry" (Stern, 1995) may be used to address and access the parent-infant/ child relationship. Unconscious processes are implicated and explored in an attempt to understand a presenting difficulty. Symptoms, as in classical psychoanalysis, are presumed to have meaning (Sorensen, 2003). Psychotherapists observe and interpret non-verbal and verbal communications and attend to the transferences and their own countertransference. Specially selected toys are provided to elicit symbolic play. The preferred setting is a consulting room in which provision is made for comfortable seating and the analytic frame can be maintained, although interventions may take the form of home visits (Lieberman, 2004) or be site-specific, for example the Anna Freud Centre's work with mothers of infants in prison (Baradon, 2009). At the Tavistock Clinic, a five-session model was developed to be able to provide a rapid response to families in distress (Emanuel & Bradley, 2008; Pozzi, 1999) and most authors reporting on parent-infant/child psychotherapy describe effective brief interventions (Baradon, et al., 2005; Cohen, et al., 2002; Cohen, et al., 1999; Cramer & Stern, 1988; Lieberman, et al., 1991; Robert-Tissot, et al., 1996; Thomson-Salo, et al., 1999).

## Research method

South African endeavours into the parent-infant/child psychotherapy field have had limited representation in the literature. To document the history (Dugmore, 2011) and current status of the field, the author interviewed 15 key stakeholders, practitioners and proponents of parent-infant/child psychotherapy in South Africa. While there may be other well known stakeholders in the broader infant mental health field, those interviewed in this study were selected as a sample of key stakeholders within the psychoanalytically-oriented parent-infant/child field. Research participants were identified from the lists of local presenters at the 1995 Congress of Infant Mental Health, the 2001 Widening Horizons Psychoanalytic Conference, the 2002 Infant Mental Health Conference and the 2009 Johannesburg Association of Psychoanalytic Psychotherapy Study Groups Conference. Research participants were also selected from the projects and sectors mentioned below,[31]

[31] Several participants are employed in more than one sector.

and by following leads from interviewees and colleagues. Research material was gathered through open-ended, face-to-face and email interviews between November 2009 and April 2010, and follow-up correspondence in early 2011.

An interview schedule of 17 questions guided the interviews. Questions were designed to elicit commentary related to the participant's theoretical orientation and perceived influences on practice and his/her personal history of involvement in the field. A description of the site and information on the services offered was requested. Participants were also asked to describe difficulties they had experienced in applying clinical principles to particular intervention sites and their responses to such difficulties. Opinions on the relevance of the work and the future of the field were invited. The history of the field emerged through these interviews, as did an account of the contextual challenges practitioners face and their adaptive responses.

Thematisation of participants' responses, in relation to the application of parent-infant/child psychotherapy in South Africa, provides the impetus for the discussion section of this paper. While the ideas expressed in the discussion are largely those of the author, hypotheses have arisen out of an interpretive analysis of the challenges and adaptive responses reported, and to some extent dialogically engaged with, during the participant interviews. The intention is to illuminate participants' subjective experiences and actions and open up the debate about implications for the future.

The author is grateful to her colleagues for allowing her to interview them. Permission to name stakeholders was obtained and all interviewees have had an opportunity to review this paper before submission. Their corrections and comments have been incorporated.

## Key parent-infant/child services in the current South African field

Interviews with research participants served as the primary source of information in the identification and description of the key parent-infant child/services operative in the current South African field and selected for inclusion here. In summary, these services fall into three sectors: the private sector where parent-infant/child psychotherapy is offered by psychotherapists in private practice settings; the community sector where practitioners

working through non-governmental organisations (NGOs) provide various parent-infant/child services; and the public sector where parent-infant/child psychotherapy is offered at clinics/hospitals within the South African public health system. A brief description of the services within these three sectors is necessary to contextualise the challenges raised by participants in this study.

### *The private sector*

Private sector cases present primarily as word-of-mouth self-referrals, although increasingly clients are referred by other psychotherapists and the handful of professionals who are aware of early parent-child interventions. Typical referral problems include regulatory difficulties, social and behavioural problems, separation anxiety and other attachment disturbances. Practitioners work in a play therapy room or with access to appropriate toys in a multi-purpose (adult and children) setting, and sessions are usually a traditional 50-minutes in length (Davies, Joffe, Wirz and Johannesburg Under Five Focus Group interviews).

### *Public (State) sector*

This research identified three public sector sites. Of these, the biggest is the Division of Child and Adolescent Psychiatry at the Red Cross War Memorial Children's Hospital, located in the suburbs of Cape Town, the legislative capital of South Africa. At this site a parent-infant service is accessed by families from across the Cape Peninsula, and from across the socio-economic spectrum. Referral problems described by Associate Professor Astrid Berg, Senior Consultant in Child and Adolescent Psychiatry (Berg interview) accord with those reported elsewhere in the literature (Pozzi, 2003; Emanuel and Bradley, 2008) and by private practitioners (see above).

Ten thousand babies[32] are delivered at Rahima Moosa Mother and Child Hospital annually. Located in Johannesburg, South Africa's economic centre and capital of Gauteng Province, the hospital boasts a small Parent Infant Psychotherapy Clinic. The clinic was started by Dr Katherine Bain (Head of Department (HOD) 2005–2008) in response to a need she

[32] www.witspaediatricfund.org.za [accessed 3 April 2011].

identified for earlier interventions linked to the high prevalence of attachment disorders and emotional difficulties diagnosed in older children (Bain interview). The population served by the hospital clinic is primarily the surrounding community.

A smaller parent-infant/child psychotherapy service has been set up at Dr George Mukhari Hospital in Ga-Rankuwu in North West Province. The patient population is drawn largely from the surrounding formal and informal settlements, many of whose inhabitants live below the poverty line. Michael Theron, Clinical Psychologist, works closely with the Speech Department seeing children (with their mothers) who present with developmental language delay and autism. Most referrals have already received a medical diagnosis, but "once they are with me I have [additionally] identified psychologically orientated explanations for the presenting problem" (Theron interview and correspondence). A group parent-infant service has also been requested by the Kangaroo Care Ward at the hospital.

### *Community (Non-Government sector)*

This research identified several NGOs working with parents and their infants/children. However, these services are restricted to a few communities in and around Cape Town and Johannesburg.

The Parent-Intervention Programme operates in several township communities in Cape Town. It is an outreach project of the Cape Town-based Parent Centre and was integrally involved in a large epidemiological study on the impact of post-natal depression on infant development (Cooper *et al.*, 2002; Cooper *et al*. 2009). Dr Mireille Landman, a collaborator on this study, is a consultant to the Parent Infant Project and the Parent Centre and has been involved in the training and supervision of counsellors. The parent-infant counsellors (PICS) are all members of the community who have been carefully selected and trained; level of education is not a requirement for selection.[33] Mothers considered at risk are identified by municipal and state clinic personnel or self-present through word-of-mouth in the communities. The PICS conduct a peri-natal intervention through 5 ante-natal,

[33] Landman explains that although candidates with school-leaving certificates are preferred "because they are better able to grasp the more complicated concepts addressed in the training and supervision", initially it was not always possible and "it was evident that counsellors' capacity for containment did not seem to depend on this achievement" (Landman correspondence).

followed by 15 post-natal, hour-long, semi-structured home visits for 6 months following birth. During these visits, mothers are offered the opportunity to express their own feelings and concerns and parents and counsellors spend time watching and reflecting on the infant's unique behaviour as an expression of individual identity and communication of needs. Counsellors encourage healthy attachment behaviour and provide information and support intended to enhance parental confidence and self-esteem (Landman correspondence). Landman gives an example of how the intervention works:

> *[It is] to the child through the parent … The mothers talk about having been heard, having someone hear how angry they were last night because their baby was screaming and how they wanted to throw the baby against the wall. And of course the [PIC] will listen to that, and then help them to think what they could do alternatively. But the fact that she has been heard helps her to hear her own baby.* (Landman interview)

Berg and her co-worker Nosisana Nama, see mothers with their infants at a Khayelitsha Well Baby Clinic for a few hours a week. This service acts as a second pillar to the work done at the Red Cross War Memorial Children's Hospital (described above). Clinic nurses make the referrals, many of which are cases of failure-to-thrive infants. The 20 to 40 minute consultation is based on a medical consultation. The service is a drop-in service and appointments are only made for a follow-up session.

Ububele, an NGO with a strong psychoanalytic orientation, offers several Ububele Umdlezane Parent-Infant Project (UUPIP) services. These were initially introduced at Alexandra Clinic, the major municipal health setting in Alexandra Township, located on the outskirts of Johannesburg. A Baby Mat Project now rotates to various other clinics in the area. Baby Mat practitioners position themselves on a 'mat' in busy Well Baby Clinics and mothers can approach the therapist themselves or may be referred by clinic nurses. Consultations last from 15 to 25 minutes and more serious cases are referred to the parent-infant services where 45–50 minute consultations are offered. A recently established group project was run as a trial for 16 weeks at 2 initial sites in Gauteng Province: Nkosi's Haven and a shelter in Johannesburg City.

Lefika Caregiver-Child Centre (Lefika CCC), based at Children's Memorial Institute (CMI) in Braamfontein, in central Johannesburg, provides a small counselling service to primary caregivers (which may include parents, but not always) and the children in their care. The centre is staffed by qualified psychologists, a social worker and an occupational therapist who volunteer their services as caregiver-child counsellors. Booked appointments last up to 90 minutes. Many cases are referred by child welfare services.

## Thematisation of interview material

### *Identification of contextual challenges*

Three main challenges confronting South African practitioners were described by interviewees.

#### *The challenge of language and cultural differences*

Although a question related to the role of cultural and language differences was posed in all interviews, it is perhaps not surprising that it was only answered in any detail by those practitioners working in the public and community sectors. All of these interviewees identified language differences as an obstacle to working. Both Berg (interview) and Katharine Frost, Programme Director of Ububele Umdlezane Parent-Infant Project (Frost interview), cited difficulties in finding skilled interpreters as a major factor contributing to the delay in the rollout of further services. Employing interpreters introduces further challenges, for example, material gets lost in translation — in both directions — and "[t]he use of an interpreter creates a complicated matrix of people each with their own histories and relationships. Interpretation is a subtle art and the interpreter also needs to take up a therapist role." (Frost interview).

Cultural ideas about what constitutes help might explain the tension between perceived need on the part of clients, and need as defined by service providers. Clare Harvey (Parent Infant Psychotherapy Clinic, Rahima Moosa Mother and Child Hospital, Johannesburg, HOD 2008–2010) comments:

> *[M]any patients referred do not understand that the relationship with their infant is where the therapy takes place …. Mothers also want concrete help, such as tablets, and take some time to understand the notion of therapy as a 'talking cure' so to speak.* (Harvey interview)

Frost addresses the cultural meaning of symptoms:

> *Primary difficulties are concrete ... rashes, or constipation. But there is a hidden concern, which is very much about HIV. Which is very much about dislocation. Which is very much about being a young mother … There is a lot about domestic violence. There is a lot about the difficulties of poverty … once we are able to go past the concrete presenting problem …. We've increasingly had cultural complaints ... A lot of newborn babies have a red birthmark at the base of the neck and it is called an ibhala, and if the ibhala moves to the fontanelle, [it is believed that] the baby could die.* (Frost interview)

### *The difficulties of working without formal training in parent-infant/child psychotherapy*

All interviewees commented on the implications of developing the field without ready access to formal training.

Training opportunities at local tertiary level[34] are extremely limited. At the University of Cape Town, doctors doing sub-specialist training in child and adolescent psychiatry gain some experience in parent-infant psychotherapy as part of the M Phil course in Child and Adolescent Psychiatry (Berg correspondence). At the universities of the Witwatersrand, Stellenbosch and the Western Cape, some Psychology Masters students have had brief exposure to the field (interviews with Dr Katherine Bain, Lecturer at the University of the Witwatersrand; Dr Mark Tomlinson, Associate Professor University of Stellenbosch; and Jenny Perkel, past Lecturer at the University of the Western Cape), but only those few psychologists doing their internships at Ububele and Rahima Moosa Hospital gain any clinical experience (Bain and Frost interviews). This is unlikely to change in the future,

[34] Only those tertiary institutions represented by participants in this study are included.

particularly given the existing pressures during the Masters degree programme (Tomlinson interview).

Those few service providers who have had formal training in parent-infant/child work have received it through international institutions. For example, Judith Davies is a Tavistock-trained child psychotherapist now practising in Cape Town; Nicole Canin and the author (psychologists in private practice and co-founding members of the Lefika Caregiver-Child Centre) have done the Tavistock Short Course on Working with Under Fives (Dugmore, 2007); and Frost and Bain have had some training in parent-infant psychotherapy at the Anna Freud Centre. The difficulty of acquiring qualifications in the field is exacerbated by the expense of pursuing such training opportunities overseas (Bain interview). At the non-accredited level, Tessa Baradon from the Anna Freud Centre facilitated two PIP courses at Ububele and Frost continues as facilitator of this training initiative. In 2010 Canin offered for the first time a 16-week course introductory course on parent-child psychotherapy. Davies has run infant–parent workshops in Cape Town, Durban, KwaZulu-Natal Province and in Harare in neighbouring Zimbabwe.

The necessity and difficulty of juggling several roles simultaneously (adult and child psychotherapist, couple counsellor, assessor of risk etc.) and negotiating the matrix of transferential complexities that develops as a result, together with the very primitive anxieties that belong to early childhood and parenthood, are challenging and in many ways unique to the field of parent-infant/ child psychotherapy. For the practitioner (and the private practitioner in particular) who does not work as part of a therapeutic team within which these different roles may be delegated, the lack of training poses a particular challenge (Under Five Focus Group interview). Nasreen Malek works in private practice in Durban where the field is still relatively undeveloped. She describes her work in this field as a “lonely journey” and laments the absence of colleagues in the field, both at the peer and supervisory levels (Malek interview).

Inadequate training directly affects the quantity and quality of therapists who might be able to provide parent-infant/child services across sectors (Landman and Tomlinson interviews). However, service provision is further hampered by a broad lack of support and awareness of parent-infant/ child interventions.

*The challenge of working within a health system that does not acknowledge infant mental health or the need for parent-infant/child services*

Tomlinson would like to see the broader concept of infant mental health on the agenda for politicians in South Africa, but points out it is not yet recognised internationally:

> *At the moment in DSM there is nothing on infant mental health. There is a zero to three … but it is a diagnostic system. The ex-president of WAIMH was asked by the World Health Organisation to consult on the ICD-11, which is coming out with DSM V, and she was pushing hard for infant mental health and all the time she got back "What do you mean? Where is the evidence? The epidemiological data?" There is some on attachment disorder, but not sleeping, feeding disorders. Mental health professionals don't get it. So it is a battle, and not just here.* (Tomlinson interview)

Lauren Gower, co-founding member of the Goodstart Programme operating in Johannesburg from 1994 to 1999, makes this proposal:

> *I think infant mental health needs to be developed in South Africa, but it needs to be part of a broader initiative … Clinics need to be walk-in. There isn't that kind of support for people and I think it needs to become part of the culture … it needs to be okay to ask for help with raising your children.* (Gower interview)

Most interviewees echoed that many *parents* do not recognise their need for help and hence do not seek it. This means that supply may exceed demand, particularly in the private sector. Jenny Perkel, author of *Babies in Mind* (Perkel 2007) comments:

> *It's about educating the public … generally people don't think to go and see a psychologist when they have problems with their baby. And a lot of people will say, "but the baby is so young, they can't have problems"*. (Perkel interview)

A lack of awareness has a negative impact on funding, jeopardising both current community projects and future plans to expand services. Berg (interview) says that provinces need to own the mental health of infants and warns that the service must not be outsourced with

some huge project which dies when the project leader leaves. It emerged during correspondence with interviewees that two of the three current public services appear to be in jeopardy, as they are primarily driven by individuals who, if they choose to resign their posts, may not be replaced swiftly enough for the projects to endure.

### *Responses to challenges*

Whenever a practice that arises in a particular context is transferred into a different context, the indigenisation question has to be confronted. Parent-infant/child psychotherapy developed primarily in the national health system clinics of Europe and North America. In translating such practice into the South African context, the above mentioned challenges have had to be addressed. Several responses to these identified challenges represent interesting adaptations of the more mainstream parent-infant/child psychotherapy approach described in the international literature.

• Tackling differences in language and culture

Frost (interview) attributed early resistance to the Baby Mat project to the community's perception of her as foreign in terms of race and culture; she was largely ignored for the first few months. However, once she was joined by an interpreter (auxiliary social worker) from the community who also gave an introductory talk to the staff and mothers present, mothers began approaching the mat more steadily. Frost identifies her interpreter, Brenda Sephuma, as a necessary member of the therapy team and elaborates that, as the Baby Mat service has grown and necessitated the recruitment of new therapists, Sephuma's role and function seem to have extended in these new settings to include adjunct practitioner, as well as interpreter (Frost correspondence).

Berg elaborates her dependence on Nama, whom she refers to as a cultural counsellor:

> *Initially she was there for interpretation, but I soon learnt that I had to listen very carefully to her. She is very politically-minded and she knows exactly how*

> *the community runs and how careful one must be. And over the years I've realised that it is much more difficult to get something going in the community … and she was integral and I listened to her advice every step of the way.* (Berg interview)

Arguably, such collaboration has facilitated for Berg a revised way of thinking about what we construe as culture. She draws a distinction between matters of culture and those of custom including, as an example of the latter, the practice by some mothers of sending infants away to be reared by grandmothers. Such behaviour, "habits", she argues, can be seen as "repetition compulsion" rather than as cultural.

> *I would respect culture, the deep cultural things all the way, but when it comes to habits then I think they can be changed. And there is actually an indigenous term for it. The isiko, the amasiko are the deep things, that is, the ancestor reverence, the ubuntu, that you don't challenge. But the isithete are customs, like force-feeding. Grandmothers might force-feed but child development-wise that may not be a good thing. And that can change. You are not questioning the culture. There is a fine distinction there … Because to say it is all culture, that is how they do it, is a form of racism. It is abdicating.* (Berg interview)

Tomlinson also takes critical issue with how we define a child-rearing practice as specific to a culture. He, however, emphasises the need to locate so-called cultural practice within the temporal context, and makes the point that careful exploring is needed rather than superficial jumping to conclusions. He gives the following example:

> *I interviewed this mother on why, what happens, when an infant cries. And she said … "I tell my son that he must hug his son when he cries." And I asked her if she did that, when her son was a small boy — and this was after a long interview and we'd gone through all the surface stuff — and she said, "No, we were living in apartheid and the only job for him was to leave the country and join Umkhonto we Sizwe*[35] *and that meant I needed to make him as strong*

[35] Umkhonto we Sizwe was the military wing of the African National Congress in the fight against apartheid.

> *as possible". And I said, "Now, in the new government, you'd do things differently? You would have held him?" And she said, "Of course".* (Tomlinson interview)

• Compensating for the absence of training and the related issue of employing community counsellors

To address the demand for practitioners in the community sector, the Parent Infant Programme and some of the UUPIP services rely on lay counsellors for service delivery. At Ububele this is not described as a last resort, but rather as one of the organisation's founding principles, formulated to address the inequalities in terms of training of mental health practitioners that is the legacy of our apartheid past (Frost interview).

Landman suggests that using workers from the community does away with some of the difficulties that might otherwise be presented by language and culture. An anticipated rejection of Western ideas can be allayed and this is again seen as a benefit of using community members who are able to:

> *... straddle the traditional with new ideas ... But we can go into communities because we train people from that community... They've been accepted. We were very worried that people would see us as the westernised ideas but actually, it all is okay.* (Landman interview)

She attributes low treatment attrition to being able to use PICs who have access to mothers in their homes:

> *They [the PICs] go to the mom and [they] make jolly sure [they] get them. And if they're not at home they wait for them. It is a whole different model. There are no appointments. [Mothers] leave a note saying "wait for me, I'll be back". Or the [counsellor] will leave a note or tell the neighbour to tell the mother to phone. The difficulty and the advantage are that the community workers live in the same community, so they could be neighbours ...* (Landman interview)

Landman describes the work done by the lay counsellors as more "cognitive-behavioural" than psychoanalytic, but she cites Bion (1962) when she describes psychoanalytically-oriented supervision that may spill over to the intervention level. She says of her supervisory function: "I'm doing the reverie for the counsellor and the counsellors are doing it for the mothers." (Landman interview).

Practitioners in all sectors lament their own insufficient training. In describing the birth of the Khayelitsha service, Berg recounts suggesting the idea of a parent infant service at the Red Cross Hospital to the then head of psychiatry.

> *[Prof Robertson] was very happy for me to start but he gave me this advice: "You must go into the community setting as well". And I was terrified and said 'how can I go into a community setting if I don't know enough in [the Red Cross] setting. And he said, "well you are interested, and that is enough".* (Berg interview)

Proposed solutions to the unavailability of training reflect diversity of response. Most interviewees cite reading published texts as critical to their own personal acquisition of both theoretical and clinical knowledge. Some stress the importance of reading and work discussion groups as sources of information and inspiration and as providing a check-and-balance function. The Goodstart Programme goal to train psychologists to deliver an under fives counselling service to mothers and children in South African communities was derailed by funding difficulties, but the intention had been to use a monthly reading and supervision group as a training forum (Lesley Caplan, co-founding member of the Goodstart Programme, personal correspondence). Lefika Caregiver-Child Centre is building on this idea. Bain (interview) proposes some sort of university certificated, post-Masters course in parent-infant/child psychotherapy. Defending the non-accredited training offered at Ububele, Frost (interview) says: "It is very nice that we don't have to go through the whole rigmarole training as in the UK, where I certainly wouldn't be able to do the work I'm doing now." Berg (interview) would like to train child psychiatrists and psychiatric nurses to replicate the work she does in other communities, while Tomlinson (interview) makes the claim that it would be preferable to train more community-based therapists. Arlene Joffe, psychotherapist in private practice, is wary of suggesting the use of lay counsellors in this

field. She proposes that psychoanalytically-oriented child psychotherapists need encouragement to begin doing parent-infant/child work and that the field will grow from that.

Practitioners who have done an infant observation argue that as a training opportunity, infant observation[36] has much to offer. Interviewees described it as: "an essential aspect" (Landman and Davies interviews); "the basis" (Berg interview), "pivotal" and "the cornerstone" of training in the field (Wirz interview) and "hugely beneficial for psychotherapy" (Tomlinson interview).

• Adapting the clinical setting and techniques used within it

Interview responses by practitioners working across sectors suggest that in the South African context adaptations to the clinical setting and to techniques used at the level of practice are both necessary and possible. Private practitioners report offering more than the traditional five sessions (Wirz and Johannesburg Under Five Focus Group interviews); this was made possible by the access most of their clients have to private medical cover. In the community sector, transport difficulties, both in terms of cost and getting time off work, mean that many clients can often only attend an initial appointment. For this reason a single-session approach based on the description of "therapeutic consultations" by Winnicott (1971b) is being developed at Lefika CCC.

Indeed it is really at the community level, that creative adaptations of the clinical setting are most evident. As Berg reflects in her writings: "When I entered the community of Khayelitsha … I soon realised that the model that I knew and had been trained in [Anna Freud Centre model of parent infant psychotherapy] would have to be revised" (Berg, 2007, p. 217). Berg (interview) lists keeping time and boundaries, avoiding acting-out and focussing on the individual — aspects of a more western approach to psychotherapy — as assumptions about the analytic frame that required rethinking.

Landman (interview) describes how the Parent Centre initiative (in Hanover Park in Cape Town) that became the forerunner of the current Parent Intervention Project was an

[36] For a description of infant observation and its use in training see, for example, Bick (1964) and Coll (2000).

adaptation of the American Healthy Start (now Healthy Families America)[37] model. Landman (1995) gives an example of an adaptation: visit times were often disrupted because mothers had returned to work or were seeking work and so it was decided that the (then-called) Family Support Worker would split visit time between *mother*-and-baby and *childminder*-and-baby. This decision also acknowledged the central and influential role played by childminders. (A similar idea underlies the founding of the Lefika *Caregiver*-Child Counselling Centre, so named because it is recognised that many children in South Africa are cared for by a caregiver that may not be the parent).

Frost (interview) adapted the Baby Mat technique — from an Anna Freud Centre intervention — to accommodate the particularities of local clinic settings. She describes how the idea of a 'mat' was devised to create a safe, contained space in a busy baby clinic that has no separate room available.

Symbolic play is a key ingredient in parent-child psychotherapy but, Berg (interview) argues, sharing toys is an unrealistic expectation for deprived children. Instead she offers a toy with the understanding that it can be taken home. Berg also makes available a biscuit; the use of which she claims has diagnostic value. She draws a similarity between her "biscuit game" and Winnicott's spatula game[38] (Winnicott, 1941), although she suggests that this was not her original intention (Berg interview).

None of the interviewees working in the community sector refer to a manualised or rigid model that might determine a technical approach. In reflecting on her work, Berg says:

> *Of the two pillars [Red Cross and Khayelitsha]… I must say I've learnt the most being in the community … My conviction is that mothers matter, even if they are poor and are not educated … or may not speak English. They have as much right to an individual session, confidentiality, a listening ear and an analytic attitude as anyone from [upper middle class Cape Town suburb]. And because of that I have not said*

[37] A nationalised home visiting programme model designed to work with families who are identified as at-risk for child abuse, neglect and other adverse childhood experiences. Services are offered voluntarily, intensively and over the long-term http://www.healthyfamiliesamerica.org.

[38] In his paper on the "set situation", Winnicott (1941) described how presenting a baby on its mother's knee with a shining tongue depressor (spatula) and paying attention to mother's and baby's responses to this presentation allowed him to observe and reflect on the mother-infant interaction.

*that in the community they must all be in groups or in a manualised approach, because I don't do that with my private patients. (Berg interview)*

In terms of community sector work, another comment by Berg (2007) serves as a guiding principle: "[I]t is the task of the person entering the community to adapt and accommodate to its context" (p 217).

• Raising public awareness across the different sectors

With current research (being undertaken by the University of the Witwatersrand) hypothesized to support the efficacy of the UUPIP services, Frost (interview) is hoping to have the Baby Mat and group projects represented nationally in baby wellness clinics. Landman (interview) would also like to see the Parent Intervention Project taken up at national level, since it was shown in the epidemiological study to be an effective intervention (Cooper, et al., 2009). All interviewees would like to see the field grow and many recognise that this requires networking with and educating various stakeholders.

## Discussion

The interface between psychoanalytic theory and practice in the South African psychotherapy field and in local community work has been reflected on in the literature (Lazarus & Kruger, 2004; L. Swartz, Gibson, & Gelman, 2002; S. Swartz, 2007). Certainly, the issue of indigenisation is not unique to transplanting parent-infant/child psychotherapy, with its roots in a Western tradition of child psychotherapy and social work, into a South African field. It is argued, however, that certain aspects, particular to the field that is the object of enquiry in this paper, warrant further discussion.

What struck the author during the interviews, and what hopefully is evident to the reader from the given quotes, is the self-reflexive attitude with which indigenisation of practice is engaged. Sterling (2002) has written about changes to her own thinking when facing a task for which the body of psychological knowledge she possessed seemed inadequate. She comments that "the development of any true capacity to think…involves a more

fundamental emotional engagement with the anxieties of 'not knowing' " (Sterling, 2002, p. 23) and she describes this as a profoundly frightening experience. Although not a parent-infant/child psychotherapist, her reflections capture something this research reveals: psychoanalytic mindfulness seems to typify the kind of thinking interviewees demonstrated when describing their experiences in this field. Reverie, containment and the transforming of emotional experience into alpha-elements are associated with the mother-infant relationship (Bion, 1962a) and parent-infant/child psychotherapy (Barrows, 1997). This author's sense is that a capacity for reverie has also allowed practitioners in this field to convert potentially overwhelming contextual challenges into alpha-elements that are represented as adaptive responses. As Berg writes: "If we know that we do not know it all, then helping and learning from the other becomes truly possible" (Berg, 2001a, p. 39).

Indigenisation also anticipates the need to address the issue of cultural universality and differences. The perception of vulnerability in infancy is universal, as is the importance accorded caregiving tasks aimed at strengthening infants (Richter, 2002b). Following Richter (2002), it is at the level of child-care practices, aimed at protecting children and building their resilience, that cultural differences manifest and need to be addressed. In a country as multicultural and diverse as South Africa, classifying such differences according to language, race and ethnicity may be an oversimplification of a complex and sensitive issue. Efforts to deliver culturally sensitive infant mental health services may be further impeded by what Tomlinson (2001) reports to be a paucity of cross-cultural studies investigating attachment.

For participants in this study, it is primarily the translation of language that signals the need to translate so-called cultural norms and customary practices. This is true, too, of infancy research (Tomlinson, 2002, 2003).

In the parent-infant/child psychotherapy field, Berg (2001, 2002, 2003, 2007) has highlighted and addressed particular difficulties in some detail. She suggests that it is "awareness of the relativity of one's own culture, and the reality of another culture" (Berg, 2007, p. 217) that needs to be kept in mind in order to formulate principles of intervention for a different cultural context. In a moving account of what she calls a "failed" case of parent-infant psychotherapy, Berg (2001) analyses what happens when culture is neglected. By empowering her translator as "cultural counsellor" (Berg interview), Berg demonstrates a creative response to a complex contextual challenge. Her insightfulness and mindfulness

have contributed to an understanding of the importance of addressing cultural issues locally, and have been recognised internationally (Baradon, et al., 2005). Perhaps most crucially, Berg's comments above, supported by those of Landman (interview) and Frost (interview), point to the critical importance of dialogic and co-operative interactions between multi-disciplinary practitioners from multicultural backgrounds as one way of facilitating the design of culturally sensitive projects.

The absence of formal training in infant mental health and parent-infant/child psychotherapy is problematic for both lay counsellors and those practitioners with a professional degree. The training of parent-infant/child psychotherapists in countries economically or demographically (or both) similar to South Africa has received scant attention in the international literature, which means that local practitioners cannot draw on models from other emerging/developing countries to inform their own adaptive responses. Melega and Almeida (2007) and Bharucha and Bharucha (2009) describe infant mental health projects in Sao Paulo, Brazil, and Mumbai, India respectively.[39] These articles underscore the importance of psychoanalytic infant observation, which they have adopted and adapted, as pivotal to the training of infant mental health professionals in their countries. Similarly, observing an infant originally inspired many South African practitioners to contemplate extending their clinical practice to include work with infants/young children in tandem with their parents. As an infant observation seminar leader, the author endorses the centrality this mode of learning enjoys in the field, particularly in the absence of exposure to infant mental health and parent-infant/child psychotherapy during formal training. Melega and Almeida (2007) and Bharucha and Bharucha (2009), like many of their counterparts in South Africa, have also received input from the Tavistock Clinic in London.

For all professional practitioners interviewed, entry into the field has been driven primarily by interest. As Berg's earlier quote suggests, this has frequently had to be sufficient. This paper postulates that interest, coupled with a psychoanalytically-oriented training that arguably produces a "psychoanalytic mind", and then nurturing and growing that mind through reading in the field, seeking supervision and thinking about the interface between theory and practice (see S. Miller, 1999 for a related discussion), have developed "good enough" parent-infant/child psychotherapists.

[39] Both Brazil and India have International Psychoanalytical Association (IPA)-accredited psychoanalytic societies. South Africa, as of 2010 has joined this rank.

Accessing published texts in the parent-infant/child psychotherapy field will have exposed practitioners to a range of psychoanalytically-oriented theorists and technical approaches, which may or may not be commensurate with the original orientation of their trainings. For example: the author asked Berg (interview), "I know your background is Jungian, but where are all your theoretical roots?" She responded, "Very much the infant research, the current research. Stern. The intersubjective field. And also very much informed by Kleinian theory, Michael Fordham and the object relationists. And Winnicott." Berg credits Jungian theory as useful in "building a cultural bridge". Tomlinson (interview) stated, "I like attachment theory because it is the only one that is evidence based". Both Berg (interview) and Frost (interview) claimed to have taken inspiration in setting up their community initiatives from the paper by Daws (1985) on work at baby clinics. The emphasis on acquiring knowledge and skills through reading texts in the broader parent-infant/child psychotherapy field appears to have led to a technical flexibility that is rooted in a kind of theoretical eclecticism.

It is interesting to contemplate the shape of the future South African field if its origins are embedded in eclectic knowledge acquisition. The author argues that creative techniques will be developed in response to identified challenges, but that this does not necessarily imply a compromise of theory. Perhaps this is best illustrated through an engagement with the debate that surrounds the employment of lay counsellors. The polemic of using non-professional practitioners is not raised for discussion elsewhere in the international parent-child psychotherapy literature. It may be that exploring the issue in the South African context will inform the development of both the local and international field, that is, contemplating the role of lay counsellors may be meaningful in all communities where economies of scale affect service provision.

Tomlinson (interview and personal correspondence) suggests that the use of lay community counsellors highlights the issue of what is and what is not parent-infant/child *psychotherapy*. Certainly by 'Western' standards, the work done by the PICs employed on the Parent Intervention Project would not be recognised as psychotherapy. Compounding the controversy in employing lay counsellors to deliver such a service are the pathological presenting problems (child abuse and neglect, the impacts of HIV/AIDS on attachment, failure to thrive) that form the bulk of referrals to community sector services in the field, and

the absence of skilled resources in these services.[40] And yet several community initiatives in the field depend on lay counsellors to be sustainable.

Perhaps the critical question is not *who* qualifies to do parent-infant/child psychotherapy, but rather *how* we deliver a meaningful, psychoanalytically informed service. It is in addressing this question that Landman has demonstrated psychoanalytic thoughtfulness. She reports an emphasis on selecting people to work as PICs who can empathise, think and reflect and who demonstrate willingness and interest. The training is important, she says, and she describes a psychoanalytically-informed supervision with containment offered in tiers from herself to supervisors and then via the counsellors to the mothers. This objective, to provide skilled psychodynamic supervision, might be the crux of the development of future projects.

A psychoanalytic mind may compensate for lack of training in the field and may generate adaptive responses to contextual challenges. Holding on to psychoanalytic values helps orientate ourselves when facing what we do not know. Rather than getting mired in theoretical dogma or seeing technique as colliding with theory, South African parent-infant child psychotherapists seem to have been able to create a thinking space that allows for movement between approaches, adapting and integrating aspects of traditional applications into new forms of practice. For Richter, "consciousness of ourselves and our reflection in our work ... [are] an important source of information" (L. Swartz, et al., 2002, p. vii).

In terms of theoretical background, it may have become clear to the reader of this paper that psychotherapists representing many different psychodynamic orientations have been drawn to work in the parent-infant/child field. In South Africa, where the psychoanalytic political lines are less clearly drawn than they are, for example, in England (Dugmore, 2011) this may be considered a source of great creativity and part of the explanation for what appears to be a more technically eclectic practice. The theoretical and technical emphases in all settings appear to be on flexibility in terms of approach. Arguably, this allows for maximum adaptation of service to needs.

A big challenge to developing the field in South Africa is that presented by having to work within a national health system that does not acknowledge or prioritise infant (and parent)

[40] In an ironic counterpoint, professional practitioners are more widely represented in the private sector of the field where the majority of (currently) presented problems fall on the neurotic spectrum.

mental health. The country has no specific budget for mental health either at national or provincial level and therefore mental health services are funded out of general health budgets where they inevitably end up at the bottom of a list of pressing needs (Burns, 2011). However, the situation may improve since infant and maternal life expectancy was identified as one of four key areas adopted as an of the 10-point strategic plan of 2009–2014 (Motsoaledi, 2010), but there is also an anticipated decline in national budget allocation to the health sector over the next 3 years (Mukotsanjera-Kowayi & Godknows, 2011).

Berg (2007), commenting on her initial venture into the Khayelitsha community, asks a fundamental question that goes to the heart of the issue: "[C]an infant mental health have a place in the minds of the mothers and clinic nursing staff when the main task is the physical welfare of the child?" (2007, p. 215). In answering, she suggests that the yearly average of 300 infants with their parents that have been seen, half being repeat visits, indicates the importance of addressing mental health issues. This is not necessarily a simple task, particularly when the Cartesian model of understanding physical and psychological matters applies (Berg, 2007). What presents as a medical problem is not easily reframed (either for the medical or lay population), as possibly being located in the mental domain.

Raised awareness of infant mental health needs to manifest at all levels of society: at the educational level in terms of training; at the political level in terms of government support and funding; and at the professional and public levels in terms of referrals and financial support. The lack of awareness of the existence of services, both on the part of referring agents (doctors, teachers and psychologists) and the early parent population, hampers efforts to meet the need for early childhood and parenthood interventions. How we visualise a future relates to the conclusions we can draw, particularly in relation to the relevance of parent-infant/child psychotherapy in South Africa.

## Limitations

This study has limited itself to interviewing a selection of key stakeholders affiliated to psychoanalytically-informed parent-infant/child services. This, by definition, excludes[41]

[41] Subsequent to the submission of this paper, the author learnt of a mother-child service at Tygerberg Hospital in the Western Cape. Regrettably, this service was omitted in this study. The author would be grateful to

other important infant mental health services, both those not located within a psychoanalytic orientation, and those not accessed by the author. The methodology of participant selection and the related issue of identifying of service sites (and training institutions) are acknowledged as limitations of this study. Related to this, the broader field of infant mental health and the current and future roles of government, training institutions and regulatory bodies require further investigation and discussion. A further limiting factor of the study relates to matters of culture and the extent to which cross-cultural and culturally-sensitive practices were investigated in the interviews and addressed in the discussion. Cultural concerns in the infant mental health field warrant greater attention.

## Conclusion

Parent-infant/child psychotherapy initiatives for addressing the emotional and relational health of infants and very young children and their parents must be developed across all health sectors in South Africa. However the relevance of parent-infant/child psychotherapy is intricately linked to the potential for reaching vulnerable and at-risk parents and infants/children. For stakeholders working in the state health and community sectors, this population is described as both economically and geographically disadvantaged in terms of access to parent-infant/child resources. Many things further hamper delivery of services, not least of which is insufficient and inadequate professional practitioners. The inequalities of the past have had a negative impact on educational and professional training opportunities for many South Africans, and while employing lay community counsellors addresses some challenges it creates others, raising a polemic that requires debate. Training is recognised as important, but it may need to be viewed as developmental.

From their responses, interviewees appear to have applied a ‘psychoanalytic mind’ to the challenges encountered. It is possible that adaptive strategies, particularly in the community sector, may represent pioneering endeavours. The growth of the local field will continue to demand the development of such projects. While existing service providers deserve applause, there may be much to gain from increasing dialogue between the agents and

---

receive information on psychoanalytically oriented services/sites known to readers of this journal to help update future reports on services in the field.

agencies driving current, largely isolated, projects. The 13th World Association for Infant Mental Health Congress (held in Cape Town in April 2012) served as an important forum for dialogue between key stakeholders and as a significant opportunity to showcase South African initiatives in the field of infant mental health. Nearly 700 local and international delegates attended the 5-day congress; regrettably the South African Health Ministry was not represented. Certainly it represents a platform for local practitioners to showcase for the world the relevant applications of parent-infant/child psychotherapy in this country.

*Acknowledgements: A special acknowledgement goes to the parent-infant/child psychotherapy practitioners and stakeholders who participated in this research:*

Dr Katherine Bain, Head of the Parent Infant Psychotherapy Clinic at Coronation Hospital (now Rahima Moosa Mother and Child Hospital) 2005–2008, Johannesburg, lecturer at the University of the Witwatersrand

Assoc. Prof Astrid Berg, Senior Consultant in Child and Adolescent Psychiatry, Red Cross Children's Hospital, Cape Town.

Lesley Caplan, Clinical Psychologist in private practice, Johannesburg, co-founding member of the Goodstart Programme operative in Johannesburg 1994–1999.

Nicole Canin, Counselling Psychologist in private practice, Johannesburg, co-founding member of Lefika Caregiver-Child Centre, Johannesburg.

Judith Davies, Child and Adolescent Psychotherapist in private practice, Cape Town.

Katharine Frost, Programme Director of Ububele Umdlezane Parent-Infant Project, Johannesburg.

Lauren Gower, Clinical Psychologist in private practice, Johannesburg, co-founding member of the Goodstart Programme operative in Johannesburg 1994–1999.

Clare Harvey, Head of the Parent Infant Psychotherapy Clinic at Rahima Moosa Mother and Child Hospital from 2009–2010, Johannesburg.

Dr Arlene Joffe, Psychotherapist in private practice, Pretoria.

Nasreen Malek, Clinical Psychologist in private practice, Durban.

Dr Mireille Landman, Clinical Psychologist in private practice, Consultant to the Parent Infant Project, Parent Centre, Cape Town.

Jenny Perkel, Clinical Psychologist in private practice, Cape Town, freelance writer and author of *Babies in Mind* (Perkel, 2007).

Michael Theron, Clinical Psychologist, Ga-Rankuwu Hospital, Northern Province.

Dr Mark Tomlinson, Associate Professor Psychology Department, Stellenbosch University, Clinical and Research Psychologist.

Bea Wirz, Psychotherapist in private practice, Cape Town.

And a focus group of 15 members of the Johannesburg Under Five Reading and Work Discussion Group.

# CHAPTER SIX

## Parent-infant psychotherapy described

Although parent-infant psychotherapy is well-established and widely practised internationally, it is a relatively new and under-developed treatment intervention in this country. Following the introductory sections to the previous chapters, it is partly as a consequence of the two-tiered delineation of the South African health system and the absence of both training and intervention opportunities within public structures that so many parent-infant psychotherapists have sought to acquire and develop their clinical skills within the private sector.

As has been addressed in the previous chapter (Chapter Five), working in the South African private sector raises particular contextual opportunities and challenges for the parent-infant psychotherapist. The physical setting more closely matches that described in the international literature; a private consulting room set up to include various seating options and age-appropriate toys and drawing materials. The fees that are charged commonly accord with recommended national pricing guidelines for health service providers and many families are able to claim these fees back from the private medical aids to which they belong. The demand for parent-infant psychotherapy in the private sector has not yet reached a threshold that would put pressure on practitioners and supply of services currently outweighs demand. A consequence of this affordability and availability of treatment is that families seen in private practice frequently elect to be seen on a longer term basis than is described in the international literature. It is also not uncommon for families to return with requests for further treatment, as has been referred to and described as serial brief treatment by Stern (1995). This introduces an interesting aspect of an important debate concerning what it means to maintain a rigid frame for treatment. This is discussed later (Chapter Eight).

In contrast to their overseas counterparts working in well-resourced and networked clinic systems, South African parent-infant psychotherapists in private practice typically work

alone. This impacts on opportunities for referral to colleagues and increases the burden of responsibility in that screening and treating are invariably done by the same person. Private practitioners may also have to attend to multiple aspects of case management (referrals, administrative issues, liaising with other authorities) and not infrequently may find themselves consulting to more than one sub-system in a family (the couple, the parents, parent-with-infant, individual adults etc.).

It may have been possible to limit this research study to that of theory-development (Edwards, 1998) if South African generated descriptive research could be cited and reviewed. However, given the paucity of literature that would meet such criteria, it was deemed necessary to include a descriptive phase. This descriptive phase entails two aspects. Firstly, interview based data were collected and analysed in order to describe the context of the object of study; that is parent-infant psychotherapy as practised in South Africa. The results of this aspect of the research enquiry were reported in the journal articles included in the previous two chapters. The second aspect is psychotherapy case based and analysis of case study data informs the contents of the stand-alone manuscripts that essentially constitute this and the following chapter.

The previous two chapters focused on the history, the development and the current status of parent-infant psychotherapy in South Africa. This chapter is towards a descriptive research aim and the narrower focus is on parent-infant psychotherapy as offered in a private practice setting in South Africa. Like many of my colleagues, I work primarily in private practice and hence the two cases I have selected for illustration and discussion here are contextualised as belonging to the private sector.

The particular research sub-question addressed in this chapter is concerned with an understanding of a symptom as having meaning within a clinical model that allows for different ports of entry. In the parent-infant psychotherapy literature, typically described referral and presenting problems include regulatory disorders (sleeping, feeding, weaning and toilet training), excessive crying, failure-to-thrive, tantrums and aggressive or disruptive behaviour, psychosomatic difficulties, developmental delay, attachment problems, maternal depression, trauma, sibling rivalry, accident-proneness, hyperactivity (Acquarone, 2004; Baradon et al., 2005; Emanuel & Bradley, 2008; Pozzi & Tydeman, 2005), all of which are referenced in the period of infancy, early childhood and/or early parenthood.

Of these, the symptom I have chosen to focus on is that of a sleep difficulty attributed by the parent in the presenting concern to the infant. The rationale for identifying sleep as the selected symptom is given in the manuscript that follows this preliminary introduction; essentially sleep has been described as a common difficulty in a paediatric population (Mindell, et al., 1999). Sleep difficulties and the understanding and treatment thereof are also the subject of an early book written by Daws (1989) — *Through the Night: Helping Parents and Sleepless Infants* — published in the parent-infant field. The book has become a classic text for both professionals and parents who have encountered disturbed sleep behaviour in infants and young children. Its focus on a particular symptom, unlike all other books published in the psychoanalytic parent-infant field, supports the significance of sleeplessness as a frequently encountered difficulty in infancy and parenthood. The significance and meaning of such a symptom for the parent-infant clinical system is illustrated, explored and discussed.

As will be suggested, multiple ports of entry may be accessed, often simultaneously, in parent-infant psychotherapy; particularly as practised in a private practice setting. While not made clear in the remainder of this chapter, the reader's attention is drawn to the footnoted idea (p. 141) that containment (and hence ports of entry) may be understood as hierarchical. This will be explored further in the introduction to the next chapter. Regardless of any hierarchy, it can be anticipated that the multiplicity of ports accessed in parent-infant psychotherapy will impact the psychoanalytic frame in unique ways. This chapter will draw attention to this tension, which represents an aspect of the overarching research enquiry, but a fuller discussion will be deferred until Chapter Eight.

This chapter serves to reference parent-infant psychotherapy, as I practise it, for the reader of this thesis. The publication requirement of this thesis equally affords an opportunity for introducing parent-infant psychotherapy to the broader community of psychoanalytic psychotherapists in South Africa. It was with this educative goal in mind that the original manuscript was submitted to the local journal *Psycho-Analytic Psychotherapy in South Africa*. It was accepted for publication in 2009 (Dugmore, 2009). An identical version of the journal article, formatted in accordance with the style dictates of this thesis, constitutes the balance of this chapter.

# Ghosts, aliens and things that go bump in the night: an illustration and discussion of parent-child psychotherapy in relation to childhood sleep difficulties[42]

Abstract:

*This paper suggests that parent-child psychotherapy may be considered a relevant extension of psychoanalytic psychotherapy in conceptualising and addressing the more psychological aspects of a presenting symptom. Two short-term cases where the presenting problem was a sleep difficulty are used as illustrations of parent-child psychotherapy. The underlying theory and key aspects of the therapeutic intervention are briefly described. In the first case, the link between maternal bereavement/loss and a child's sleep difficulty is explored. In the second case it is shown how alerting a child and his parents to the meaning of a symptom originating in the child's internal world may provide relief. Parent-child psychotherapy may be an effective and relatively short-term choice of treatment. This has positive implications for health and education professionals working with young children and their parents.*

## Introduction

This paper suggests that parent-child psychotherapy may contribute to the relief of anxiety located somewhere within or between a child and his parents and manifesting as a behavioural symptom. I have chosen to address the question through a consideration of two cases where the symptom was a sleep difficulty (defined in this paper as a disturbance in a child's sleep behaviour severe enough to cause the parents to seek help). Sleep difficulties are worthy of exploration, partly because they represent a common problem in the paediatric population (Mindell, et al., 1999) partly because, as will be illustrated, they can be considered symptoms

[42] The copyright for this manuscript resides with the publisher *Psycho-Analytic Psychotherapy in South Africa*.
Citation: Dugmore, N. (2009). Ghosts, aliens and things that go bump in the night: an illustration and discussion of parent-child psychotherapy in relation to childhood sleep difficulties. *Psycho-Analytic Psychotherapy in South Africa*, 17 (1), 36-58.

with meaning. In the first case an unresolved bereavement/loss (a 'ghost') in the mother's life interfered with putting the child to sleep and in the second case the difficulty originated in the child's internal world as nightmares ('aliens').

Before describing the two cases of 'bumps in the night', I will begin with a brief discussion of both parent-child psychotherapy and paediatric sleep difficulties. Parent-child psychotherapy[43], as described in this paper, takes place in the presence of both the child and parent(s). The 'child' may be an infant, toddler, pre-schooler or latency-aged and 'parent' may include either or both parent/s, or even a caregiver in a parenting role.

## Parent-child psychotherapy

The origin of child-parent psychotherapy is attributed to Freud's work with "Little Hans", locating it in the psychoanalytic tradition. In 1941 Winnicott wrote about relieving a baby of her asthmatic wheezing by freeing the baby from maternal anxieties (Winnicott, 1941). In America, during the 1970s, Fraiberg and colleagues (Fraiberg, et al., 1975) formalised an intervention aimed at understanding the "ghosts" from the past that haunt the nursery and impair mother-infant relationships. Since the 1980s, the Tavistock Clinic has had a dedicated Under Five Counselling Service offering short-term work to parents and their young children (see Emanuel & Bradley, 2008). A similar service, called the Parent-Infant Project, was started at the Anna Freud Centre in 1997 (see Baradon, et al., 2005). In Switzerland, Daniel Stern and colleagues practice parent-infant interventions based on understanding the unresolved parental attachments that are reproduced in the present relationship with the child (Cramer & Stern, 1988; Robert-Tissot, et al., 1996; D. Stern, 1995) and in Canada an intervention called Watch, Wait and Wonder has had much success (Cohen, et al., 1999). Increasing attention is being paid to the role of fathers and the couple relationship (Barrows, 1999b, 2008) in child-parent interventions. The idea of effecting healthy change in child-parent relationships through psychodynamically-oriented early child-parent interventions has become an international trend in the last 16 years and is currently practised on all five continents (Pozzi-Monzo & Tydeman, 2007).

[43] Elsewhere this type of intervention may be referred to as infant-parent psychotherapy, mother-infant therapy or under-five counselling but my preferred term is parent-child psychotherapy.

In South Africa there is an emerging interest in child-parent psychotherapy among child psychologists but limited awareness in terms of referring agents (medical practitioners, teachers, nursing sisters, social workers). Most of the parent-child[44] cases I see in my private practice are self-referrals. Likely presenting problems include excessive crying, attachment problems and separation anxieties, maternal depression, anxieties caused by traumatic experiences and physical illness, excessive aggression towards other children or adults, sibling rivalry, hyperactivity, and feeding, weaning, sleeping and toilet training difficulties.

The aim of child-parent psychotherapy is to apply psychodynamic thinking and observational skills to addressing such problems in the context of therapeutic work. Underlying the aim is the assumption that "in becoming a parent, past childhood experiences and unresolved conflicts and traumas are activated and re-enacted with the actual child, in the present" (Pozzi & Tydeman, 2005, p. 294). "Plasticity" is attributed to the early years of childhood and parenthood (Pozzi & Tydeman, 2005), which arguably makes such parents and children very responsive to therapeutic interventions. In both observing and thinking about what is displayed in the sessions by and between the family members, child and parents are helped to understand symptoms as meaningful communications. This facilitates the expression and processing of overwhelming anxiety in more healthy ways.

Parent-child psychotherapy takes place in a playroom setting equipped with age-appropriate toys. I include various seating options: large and small chairs and cushions. The therapy is non-directive and the family's story is gathered up over the course of therapy, largely as the family members present reveal it. There are aspects of the paternal and maternal history, as well as the child's early history, that I may enquire after directly. Parents are asked to allow the child to self-initiate play but to participate if invited to do so. I take up a similar position. I do not follow a particular model in terms of my addressing the child, the parent or the relationship but rather, in a more intuitive and eclectic way, allow myself to shift between these different "ports of entry" into the system (to use a term coined by Stern, 1995) as the session and the dynamics dictate. In the words of Salzberger-Wittenberg, speaking about her

[44] Child-parent psychotherapy is used both generically in the general literature to refer to a field of work and specifically by Lieberman (1991)to refer to a particular model (CPP). My preferred term, parent-child psychotherapy, is differentiated from both the specific CPP and the more general usage and implies the priority of the parents in that although in my approach the parents may be seen alone, the child is never seen without at least one parent.

own work in this field, “I set out with no rigid technique in mind and [find] myself working a little differently with every case” (Salzberger-Wittenberg, 1991, p. 104).

## Sleep difficulties

Sleep difficulties account for up to 30 percent of reported paediatric problems (Martin, et al., 2007; Rosen, 1997). Both those types defined as ‘disorders’ (e.g. apneas) as well as those described as behavioural difficulties (e.g. resisting going to sleep, nightmares, repeated night wakings) are addressed in the paediatric literature. Links between sleep difficulties and later hyperactivity, conduct problems and learning difficulties have been explored (Anstead, 2000; Dahl, 1998; Wolke, Rizzo, & Woods, 2002).

From a psychological perspective, sleep disturbances are strongly associated with difficulties in the parent-child relationship. Such difficulties include: poor attachment and separation issues; feeding problems; absent or inconsistent limit-setting; and poor maternal mental health, particularly depression. In my experience, and much of this is supported in the psychological literature (see particularly Acquarone, 2004; Daws, 1989), other factors that may contribute to sleep disturbances include trauma experienced in relation to the pregnancy, a history of miscarriage or stillbirth, complicated labour, maternal bereavement during pregnancy or the first year of the child’s life or unresolved grief from an earlier bereavement, marital conflict and/or a lack of emotional support for the mother.

Paediatric research shows that medications have not been effective in long-term management of most sleep problems, which leaves professionals having to consider that “the agent of change [might need to be] the parent, not the prescription pad” (Adair & Bauchner, 1993, p. 165). Sleep modification schemes, variously described as controlled crying or sleep training, are popular solutions, but as with medication embody an idea that symptom removal solves the problem. I hope to show that parent-child psychotherapy presents a preferable alternative to medication and to behaviour modification interventions.

In the two cases described below, the parents and the child were invited to the first session. The picture that emerged was drawn from listening to the verbal communications as well as from observing non-verbal interactions between the family members present (and references

to those absent), attending to the child's play and reflecting on my countertransference. In both cases the mother was told, at the first point of telephonic contact, that therapy usually takes the form of five sessions, with more if necessary. This short-term approach is consistent with models of under-five counselling (Pozzi & Tydeman, 2005). Although brief encounters of such work have been shown to be successful (Weltner, 1982), it has become clear to me that longer-term work or further sessions at a later stage ("serial brief therapy" as described by Stern, 1995) may be helpful[45]. I will suggest that the two interventions described below were effective but perhaps incomplete.

## Things that go bump in the night

### *Case One – Ghosts*

*In our initial telephone conversation, Mrs Z told me that three and-a-half-year-old Zach wouldn't sleep and that she and her husband were at their wits' end. Mother and son attended all five sessions, spread over six weeks, with the father present at the first two and the final one.*

*On the way up the passage to the playroom, I overheard Zach mention "doctor" to his mother. In the room I reflected that Zach thought he was coming to a doctor person and I was told that he doesn't like injections. Indeed Zach didn't seem at all pleased to be at this consultation; he sat on his father's lap for the full 45-minutes, repeatedly asking to go home and refusing to look at either the toys or me.*

*The parents presented the problem as one of power struggles, particularly around bedtime, and repeated nightwakings. They had tried sleep training, which involved leaving Zach to cry himself to sleep, but had felt it was too cruel. Medication prescribed by a paediatrician had worked for a few nights only and putting him on a mattress in their bedroom felt unsuitable as a long-term solution. Zach was back in his bedroom when they came to see me but would repeatedly get out of bed at bedtime and cry for them during the night. "Would bolting the door be a bad idea?" a desperate-sounding Mr Z asked me,*

[45] The multiple difficulties faced by many of the families seen in the Under Five Service at the Tavistock Clinic has led to a reconsideration of the initial five-session model in more complex cases (Emanuel, 2009).

*before admitting to having put a lock on the door that was making Zach "hysterical" and clearly causing the parents much guilt.*

*Mrs Z suspected a separation anxiety was at the root of the problem. Her husband felt that she was contributing to the difficulty but could not explain why that would be so. The onset of the sleep problem coincided with being on a family holiday that involved staying with the paternal grandparents. Mrs Z described being worried that 22-month old Zach's cries would disturb her in-laws and so she sat with him at night when he woke. Zach was described by his mother as needing structure and routines, which the holiday had disrupted.*

*In response to a general question about the parents' own families, Mrs Z told me that during the ninth month of her pregnancy she was woken by a 10 pm phone call in which she was told her father had collapsed. He was rushed to hospital and cancer was diagnosed. When Zach was six weeks old, her father took a turn for the worse and she was again called out in the middle of the night. Mrs Z's father died a few days later and she became tearful during the narration of this sad and anxious time, which surprised her. She said she thought she'd dealt with her father's death. I suggested to her that it is difficult to mourn someone when you are so busy with caring for a new life. A second loss was reported: Mrs Z's divorced mother left the country for a round-the-world trip shortly after Zach was born. An only child, this left Mrs Z both bereaved and unsupported. By contrast, Mr Z described a close relationship with his own family and supportive parents who helped with caregiving on a regular basis.*

*In the second session, Zach sat on his mother's and then father's lap and resisted all encouragements from his parents to get off and play. The parents reported an improvement, although "he still wakes at 10 pm", Mrs Z said. They described feeling less anxious themselves about the sleeping problem and felt that they would find a way of solving it that didn't cause them stress. They told me they'd come up with a plan that one of them would sit on a chair outside his open bedroom door, reassuring him verbally of their presence. They planned to move the chair further and further down the passage. The parents said they felt more able to refuse "manipulative" demands, particularly for water or biscuits at bedtime. Mrs Z said she and Zach were arguing less during the day.*

*I drew Mrs Z's attention to her comment that Zach "still wakes at 10 pm", reminding her that in our first session she had told me that that was the time the call came about her father. She became very still and started weeping quietly. Zach watched his mother. I said that perhaps Zach's 10 pm call evokes the feelings of her father's collapse, or perhaps it serves the purpose of reassuring her that Zach himself hasn't collapsed.*

*Later I described separation at sleeptime as a kind of weaning and was told about some complications and extreme resistance at what Mrs Z described as a "premature" giving up of breastfeeding. I linked these earlier difficulties to Zach's reluctance to let go of his parents now, saying "perhaps Zach is worried that if he stops being a baby on his mom's lap and climbs off to play with the big boy toys, then he won't be able to get back on later if he needs some cuddling". Zach looked at me but didn't budge. He asked to go home.*

*Mrs Z said she wanted to talk about how Zach seems to prefer his paternal grandmother to her own mother. I invited her to describe her relationship with her mother and this led to her expressing feelings of being dropped and let down, both in her own childhood and since Zach was born. Mrs Z insightfully wondered whether the need for routines might be a reaction to the unpredictable and unreliable mothering she received. I reflected that perhaps it is not Zach but herself who needs a predictable routine. Mr Z said that if his wife was a bit more flexible there might be fewer power struggles with Zach. He referred to the holiday when the problem started and suggested that Mrs Z was worrying too much about how Zach would cope out of his own environment rather than trusting that even though the routine was different, it might be alright.*

*In the third session, Mrs Z arrived with a wailing Zach, distressed because his father had just phoned to say he couldn't make the appointment. For several minutes, Zach sat, crying, on his mother's lap while I reflected his crossness and disappointment. I said perhaps Mrs Z was disappointed too. Zach stopped crying and seemed to be listening as Mrs Z talked about how unsupported by her husband she sometimes feels. Zach started looking around at the toys, particularly the doll's house. He half-slid off his mother's lap but then pulled himself back up when Mrs Z, seemingly unaware of his interest, put her keys in the doll's house.*

*With some encouragement from me, Zach and his mother sat on two floor cushions. Zach played by himself with the train-set, occasionally asking his mother to help him couple the carriages together while she told me that they were enjoying each other's company during the day and that for the last two nights Zach had slept straight through. Mrs Z was also surprised that Zach had asked her to tell him about his maternal grandfather. I said that clearly Zach had been paying attention to our conversations. Mrs Z said she had enjoyed showing Zach photographs, including a special one of him with his grandfather taken in the hospital shortly before her father died. I felt I was witnessing a creative coupling of Zach with his mother and that in some way this was significant for the process of grieving of the maternal grandfather.*

*After a while Zach turned his attention to the animals and then asked his mother to help him join pieces of fence together to make a kind of paddock. Together they used scissors to cut string in order to secure the pieces of fence. Both seemed quite pleased with their joint effort.*

*Mother and son entered the playroom for our fourth session, holding hands. Zach smiled and greeted me and announced that he was going swimming at his granny afterwards. He sat on the third, empty adult chair and I commented on Mr Z not being here; he had a work commitment I was told. Zach got off the chair and asked his mother to play with him on the floor. He immediately took out the farm animals and four fence pieces and spent some time getting quite frustrated in his endeavours to construct a paddock. He got his mother to help him apply sticky tape.*

*Zach also asked his mother to help him build a wall from Lego blocks. The wall became a structure that Zach decided needed a roof and sides, "so that the animals don't get wet," he said. One side initially had a window that Zach later wanted filled up "so the rain doesn't come in". The house was a little uneven and required several attempts at rebuilding. By the end of the session it was still unfinished. During this construction play, Mrs Z told me how huge the improvements had been since they last saw me: apart from the previous night, when she had attended a parent feedback meeting at the school, Zach was sleeping through. In exploring what had happened the previous night, I was told that Mrs Z left her husband to put Zach to sleep but he had not managed to and Mrs Z felt anxious that she would never be able to leave Zach to be put to bed by anyone else.*

*Mrs Z told me that Zach's teacher, who did not know about the sleep difficulties or the therapy, had said in the parent meeting that there had been a recent and dramatic improvement in Zach's curiosity and seeking out of knowledge, and in his social relationships and that his overall behaviour appeared more settled. I pointed out to her that the same thing happened in the room; once Zach got off his mother's lap he could settle down and play.*

*Mrs Z told me about a book Zach has about a mouse that has to cope with a death. She and Mr Z had decided not to read it to Zach at bedtime because of how it might affect his being put to sleep. I pointed out her use of the euphemistic term "put to sleep". This reminded her of something that she became quite excited about reporting. She had told her mother-in-law about the link I had described between bereavement and sleep difficulties and her mother-in-law had found it fascinating because of her four children, only Zach's father had been a terrible sleeper. What was interesting to Mrs Z's mother-in-law was that her own mother had died when Zach's father was a four-week old infant.*

*Zach walked into the playroom for the last time, accompanied by both his parents, and immediately announced to me that he wanted to sleep at his granny tonight. Mr Z said that such a sleepover would be a first. Both parents expressed relief that the sleeping problem was now "a thing of the past". Mr Z told me in a humorous manner how Zach had asked why the unused lock was still on his bedroom door. Mr Z said to me, laughing, "do you think we can take it off?" I reflected that the external bolt had to some extent become an internal firmness (see Pozzi, 2003) but that there might still be a worry about whether the improved situation would last. Mr Z turned to Zach and said, "this weekend we are going to get a screwdriver and you and me will take it off".*

### *Discussion of Case One*

Several aspects of the intervention will be considered in order to attempt an exploration and illustration of the therapeutic process.

Daws (1989) describes how the mother of a case she saw seemed unable to take in her baby's infantile needs and distress because she was herself too full of grief. She suggests that the baby might have been suffering some of her mother's pain. This seems important in thinking about the issue of maternal bereavement/loss and the relation to the symptom. In thinking about the Lego container, I wondered whether it might represent the need for a safe holding space that will keep bad things out (rain which could be seen as a symbol for projections of maternal sadness) and keep good things in (domestic animals which symbolise family relationships). The existing space, be it in terms of holding in the Winnicottian sense (Winnicott, 1960) or more likely containing as described by Bion (1962b), seems to be inadequate, as if mother is too filled up with her own emotional pain. The therapy provides an opportunity for Zach and his mother together to construct a Lego house that symbolically represents a new maternal containing capacity that is neither too full to take in, nor too leaky to hold Zach's projections (see Joffe, 2008).

During the shared play described above, when Zach got frustrated and grumpy, Mrs Z told me that he could sometimes be wilful and stubborn, but in the first session, she had described Zach as "a very nice boy, not naughty at all". This led me to think about the splitting off of more resentful/hateful feelings and about what role this might play in maintaining the symptom and in Mrs Z's inability to set appropriate sleep-related limits. Perhaps the split off feelings had been lodged in the symptomatic behaviour, making Zach initially a "nice boy" and a "bad sleeper". I wondered at the extent to which Mrs Z might compensate for guilt stirred up by more negative thoughts and then, in a kind of vicious cycle, have found herself feeling more resentful towards her demanding child. This might explain the power struggles described in the presenting problem. Over the course of the therapy it seems there was a shift towards a healthier tolerance and acknowledgement of ambivalent feelings towards Zach.

I felt this might be true too of Mrs Z's attitude towards herself as a mother. Stern (1995) argues that the "motherhood constellation", a triad made up of infant-mother-maternal grandmother, more so than the Oedipus Complex, is the central organising principle in the mother's psychic life and hence particular attention can be paid to the mother-infant relationship in the context of the mother's own internal relationship with her mother. I would postulate that Mrs Z's difficult relationship with her mother explains something of the type of maternal object she has internalised and her identification with it. Over the five sessions, Mrs Z reflected on her experience of being mothered, and hence on her mothering of Zach. This

integration of ambivalent feelings about mothering makes it more possible for Mrs Z to think about her role in the sleep problem, which then frees Zach from being identified as the person who has the problem.

Both in terms of the way in which the father's presence should mediate the influence of the maternal grandmother (Stern, 1995) and in the father's role in sustaining and containing the mother (Barrows, 1999), this father might not be sufficiently available, as is evident in his intermittent attendance at sessions.

Zach's overt expression of distress at his father's non-arrival seemed to convey his mother's less acknowledged disappointment at her husband's unavailability and suggests that Zach is carrying some of his mother's pain. Zach seems to take up the place (literally in terms of his claiming the empty chair) of the absent father. For Zach, being coupled in this way with his mother fosters more infantile dependencies, but also prevents him from being able to grow up. For Mrs Z, her son's constant presence allows her to avoid confronting the absence of her husband. This can be seen when she claims the doll's house for herself by putting her keys into it, thereby unconsciously inhibiting Zach's potential exploration of a third space outside of that taken up by the child-on-mother's lap dyad. It was through consciously acknowledging an experience of loss in terms of the absent husband, together with the evocation of the earlier parental loss (deceased father and unreliable mother), that Mrs Z can begin a process of mourning that allows her to let go of her son.

In Fraiberg's paper (Fraiberg, et al., 1975) *Ghosts in the Nursery*, she describes how intruders ("ghosts") from the maternal past take up residence and cause disturbance in the mother-infant relationship ("nursery"). Barrows (1999) suggests that the father's "ghosts" might also be part of an unassimilated intrapsychic conflict that is projected into the child. Initially Mr Z describes his family as supportive and available but Mrs Z's reported conversation with her mother-in-law suggests a different possibility in terms of father's early attachment status. Mr Z denies any role in the presenting problem by attributing the problem to Mrs Z and then not attending sessions. I would argue that not being able directly to address Mr Z's role limited the possibility of freeing Zach from his father's projections, whatever they might have been. The incompleteness of the therapy in this regard is indicated by Mrs Z's complaint that her husband could not put Zach to sleep when she went to the parent meeting. Zach's distress at his father's non-attendance, and to some extent the imperfect house that he builds as well as

his question about the lock, suggest that he has an unconscious need for work to be done in the father-child relationship.

The lessening of separation anxiety that is evident in the improvement of the symptom can be seen in the process of therapy too, particularly if we track Zach over the five sessions. Initially he is resistant to any intervention and makes a negative "doctor" transference. This is not an atypical transference for children in therapy, but I did wonder whether I might represent a third person who would intrude into the mother-child couple and that this might partly explain Zach's resistance. By the second session Zach appears to be allowing, and also following, the adult discussion. He is aware of the emotions experienced by his mother and asks her later that week about his grandfather. In this way he facilitates healing in his mother, as he does when he plays by himself, allowing his mother to talk.

It is during the third session that Zach takes up a more active role in the therapy, primarily through play. The argument for including the child in the parent intervention is supported by the addition of symbolic play to the therapeutic process. Zach is clearly interested in the making of structures and containers. He elicits his mother's help, not in a merged way but in a co-operative way, and in so doing creates a symbolic opportunity for them to co-create something of a container-contained way of relating. The use of scissors to cut and string/tape to join suggests a creative working through of issues of separation and togetherness. From his teacher's comments it would seem too that the development of symbolic play in the therapy coincides with an increased potential for learning at school. Mrs Z seems also to have acquired a new curiosity, in her case about things psychological as evidenced by the conversation she reports having with her mother-in-law. The closed relating of the mother-baby dyad has opened up (as represented by Zach's being able to get off his mother's lap and her allowing him to do so) and this has allowed for creative and symbolic play-thinking to commence. This would seem to support the idea that only in the move from the dyad to a triad, and the creation of a space for a third (in the therapy this occurs transferentially through the mind and presence of the therapist), can the possibility of a space that can be internalised as a thinking-containing function become available[46]. The therapist initially performs this

[46] I am grateful to the comments of an anonymous reviewer of this paper for drawing my attention to the possible links to be drawn between the development of symbolic play and desire for knowledge and the processes that may have facilitated this. It is beyond the scope of this paper to give this observation the consideration it deserves.

external containing function by thinking (see Bion, 1962) about the presented material which in part facilitates Mrs Z's being able to offer such containment to her son.[47]

In our fifth and final session, Zach suggests to his father that the threatening lock might no longer be needed and in so doing seems to have taken some responsibility in separating from his parents. By then he is relating to me as a helpful other, outside of his family triangle; perhaps a benevolent grandmother figure who, like the external granny, has provided him with an opportunity for developing separateness and independence.

### *Case Two — Aliens*

*My clinical work with four-year-old Alex and her parents lasted a total of three sessions.*

*Mr A and a visibly pregnant Mrs A described in the first session how over the past three weeks their daughter would regularly wake screaming at night, complaining about "aliens in her brain". They were very worried about what might be causing the frightening nightwakings. Their response had been to soothe Alex by bringing her back into their bed, which is also where she fell asleep at the beginning of the night, but they didn't feel this really addressed the possible cause. The only other reported significant change in Alex's behaviour was that recently she had started displaying uncharacteristic aggression towards her youngest sibling.*

*Alex shook her head when I asked if there was anything she wanted to say about the alien nightmares. Mrs A said Alex's television exposure had always been restricted but that she might have seen something about aliens on TV. The parents' associations included newspaper reports on UFOs and "crooks" which Alex had asked about in relation to overheard discussions about housebreakings. They told me that they regularly reassured Alex of the family's safety by reminding her of the electric fence and the security doors.*

[47] There appears to be a cascading of the developing process of containment; the containing mind of the therapist is internalised by the mother as a thinking space that in turn functions as an external space/containing mind for another internalisation of a container, this time by the child. This seems to be well represented symbolically by the stacking cups of descending size that are such a favourite in my playroom.

*The marital relationship appeared very good and the family had not suffered any trauma. Alex was described as generally cheerful and well adjusted. She started off the session on her mother's lap, sucking her thumb and playing with her mother's hair, then she moved to her father's lap and finally to the doll's house. Apart from the obvious pregnancy and some renovations at home, nothing in the parents' narrative or in the history-giving suggested itself as a cause of the current difficulty so I turned my attention to Alex's play, wondering if she might give us a clue as to the source of her anxiety.*

*Alex touched and named some of the objects in the doll's house; "toilet", "bath", "underwear" (on a maternal figure) and "beds". She then took a baby figure and played hide-and-seek with it in the house. I said she was interested in finding out where the baby was being hidden and I said that I had noticed there was going to be a new baby in her family. She took a mother figure, balanced her on the roof of the house and let it drop. She repeated this with the baby figures. I reflected some angry feelings towards the mom and the babies. All this time the parents were watching Alex, and watching me. I could sense their curiosity.*

*Alex then pushed two babies into one of the rooms in the house and moved a toy wardrobe so that it partially blocked the room. She used building bricks to cover up the entrance more completely. Then she took a little girl figure and made it climb over the wall into the room. I interpreted that she was struggling with confused and attacking feelings evoked by the baby in mother's abdomen. Mr and Mrs A seemed sceptical of and resistant to hearing my interpretation, saying that Alex doesn't display anything except excitement and love towards the baby and her mother's abdomen. I said that I thought that the aggression "in her brain" was being acted out in the world towards her youngest sibling, rather than the unborn sibling, probably because earlier feelings of aggression at being displaced by the youngest sibling had been re-evoked with this new pregnancy. I said, directing my comments to both Alex and her parents, that it seemed to me that she had built the wall to protect the babies behind it from her getting to them. As if she might both want to, but was also scared of what would happen if she could. Mr A asked, "You mean really she'd like to hurt the baby?" I responded that she seemed to also want to harm her mother but that she probably felt very worried and guilty about these attacking thoughts. I said that her guilt might explain the nightmares, which were likely to be taking the form of punitive fantasies for aggressive thoughts.*

*Alex turned her attention to the train-set, careering the train wildly around the room so that the maternal and paternal figures that she had balanced in a carriage fell out. I interpreted to her that she might be angry with the daddy too, for giving mommy the baby. She finished off the session playing with the dinosaur figures that attacked all the other animals. Alex left happily, laughing and skipping down the passage.*

*We met again ten days later. Alex leant against her mother and then father for a while. Her mother tried to interest her in the paper and crayons but it was the doll's house that again attracted her. Discussion with the parents seemed to be in response to my interpretations in the last session and to Mr A's expressed cynicism "were we not suggesting things talking about her play last week and linking it to the pregnancy?" Her parents reported that Alex was much calmer generally and less terrified at night and on this basis conceded that something helpful had come of the first session, although they were not sure what had really happened. They seemed willing to explore the idea that Alex's experience of this pregnancy was not simply one of joyful anticipation. They also wanted me to talk about appropriate limit setting in terms of where Alex slept.*

*Rather than give advice, which I felt would be colluding with a resistance on their part to exploring unconscious anxieties, I asked them to tell me what they felt about having Alex in their bed. While they were talking, I observed Alex put a mother and father couple in the double bed and a girl and boy figure in the twin beds. She showed her mother how the twin beds can be bunk beds, bumping the one of top of the other. Then she removed the father figure from the bed, closed the doll's house doors and tried to push the father figure through the front door and the too-small windows, banging his head against the frames. I asked Mr and Mrs A whether Alex had expressed any interest in matters of conception. They said not but did say that she had been very curious when shown scans of the baby in utero. Struck by my own recollection of a foetal scan I asked them what they thought of these images. They both seemed to share my association because they laughed, a bit nervously, and then looked at each other. One of them said, "I suppose the picture looks a bit like an alien." They both looked at their daughter with curiosity and amazement. I said, "*In *Alex's mind the baby looks like a very scary alien."*
*Alex stopped playing in the doll's house and went to sit at the small table. She did a sunny drawing of a person that she identified as her youngest sibling. Then she rolled out the playdough and cut a heart shape using a dough-cutter. She drew her parents' attention to*

*this heart and a second bigger one. Her mother said, "That is like the bigger and bigger hearts God gives a mom and dad every time they have a new baby".*

*At the next session, our third, Alex was excited to play with the doll's house again. She commented crossly on the furniture that had been muddled up since the last session and she reorganised it. She drew a picture "for her mother" which I interpreted as a loving gift. Her parents reported a great improvement; she still falls asleep in their bed and then gets carried to her own but there had been no further nightwakings. The family was going away for the holidays and requested that we consider this our last session unless they felt they needed more help in which case they would call me. Alex was angry when I said our time was up and I reflected this to her.*

*I had to contact the family a few weeks later as there had been a duplicate payment on their account and Mrs A told me that they consider it a "miracle" that Alex was "cured" from her nightmares after the second session of therapy.*

### *Discussion of Case Two*

My sense from the parents' initial associations to aliens was that Alex's terror was not related to possible external attacks but more likely to internal persecutory anxieties.

It was through close observation of Alex's play — her choice of objects to touch and name and then her "dramatic enactments" (see Emanuel, 2008) with the mother, father and baby figures — that I was alerted to the possibility that Alex was struggling with something of a primitive sexual nature. The aggression enacted in the play (attacks on the rival baby, its mother and the father) revealed Alex's more murderous fantasies. Alex's symptom, the alien nightmare, appeared to be a defense[48] against the inner conflict these aggressive fantasies were generating. I chose to interpret Alex's play using child-friendly language so that she might have her frightening feelings contained, but I also addressed my comments to her parents so that they could know something of their child's internal world. I would argue that

[48] The following comment by a reviewer of this paper makes a useful addition to an understanding of the symptom: "The foetus, attacked in phantasy as an alien intruder which threatens Alex's safe place with her parents, launches a retaliatory persecutory attack on Alex when she is in a dreaming state. While a dream serves as a container of the child's anxieties, a nightmare suggests the failure of the dream's containing function."

having the child and parents together in the playroom allows the therapist's role in taking up the task of containment to serve as a model for the parents.

Working with a child and her parents together can, however, be daunting. At the end of the first session Alex left happily, perhaps even relieved. I wasn't so sure, however, about her parents. I worried that for them my interpretations might be hard-to-believe psychological nonsense. Although the next session was booked, I wasn't sure the family would come back. One of the inherent difficulties in parent-child work is the anxiety that can be evoked in the therapist as a result of being watched by the parents in interactions with the child. Rivalrous and critical feelings in the parents can feel persecutory for the therapist and anxieties about performance can also get caught up in the transference and countertransference. For me, these anxieties were amplified by the primitive sexual and aggressive feelings expressed in Alex's play and my role in alerting her parents to their existence. In part too, I think, my countertransference was an identification with Alex's split off and projected anxiety about being accepted after revealing her aggression. I was left with worries about being not wanted.

In the second session Alex again enacted some primitive sexual anxiety, this time more specifically related to how daddy gets inside — the bumping of things at night. Without describing primal scene anxiety, I tried to encourage the parents to think about how Alex would be making sense of the notion of conception. This question might not have succeeded in alerting her parents to this possible source of anxiety, which I felt was being fuelled by her being allowed to fall asleep in their bed, but it did lead to a useful insight, the association of the "aliens" of Alex's brain/nightmares with the alien foetus in her mother's abdomen.

That this linking of aliens to foetus provides both Alex and her parents with relief is demonstrated, I felt, in the shift in her play, and her parents' response to the new play. At the end of the second session, there were reconciliatory attempts to reassure each other that Alex could love a new sibling and that her parents could continue to love her. The meaning of the symptom, persecutory fear linked to guilt because of aggression, was uncovered and this led to a lessening of Alex's anxiety and to an attempt at reparation. I thought that the parents' denial of aggression in Alex (and we cannot begin to speculate to what extent within themselves) had probably played a role in maintaining the symptom.

As in the previous case, there appears to be unfinished business in this example of parent-child psychotherapy, which raises questions about the real shortcomings of short-term work.

Alex herself implies this possibility when she complains about the furniture that gets muddled up over the gap between sessions, and more explicitly when she is angry at ending.

A final communication with Mrs A one year after the therapy ended seems to confirm that the underlying anxiety might not have been fully addressed in the three sessions we had together. I contacted the family to get consent to present this case and Mrs A said it was a coincidence I was phoning. She told me that Alex had recently had a few nights of disturbed sleep, the first in a year, and that she had complained about "noises downstairs". Alex had asked her mother if they could "go and see that lady that helped last time." Mrs A understood the current problem to be related to starting a new group at school. Although mother was suggesting an anxiety about separation, which indeed it might partly have been, I had to wonder about the noises in the "downstairs" and whether they might suggest further underlying Oedipal anxieties. Mrs A seemed confident that they would figure things out and I did not hear from the family again.

## Conclusion

I have attempted to describe my observations, thoughts and interventions in these two cases to illustrate how exploring the meaning of a behavioural symptom in the presence of the child *and* parents raises awareness for all present of the unconscious basis for that symptom. Addressing the underlying anxiety is critical if we want to remove the symptom and effect relief that is more than just palliative.

We could easily allow ourselves to be seduced by the apparent "miracle" of the "cure" (as Mrs A described it), but we might then be overlooking the possible shortcomings of brief parent-child psychotherapy. In terms of the efficacy and (in)completeness of parent-child psychotherapy there are two aspects of the work that I believe deserve further consideration; the duration of treatment as well as the different ports of entry into the family system.
A short-term model of working with young children and their parents developed as a result of the pressure in clinics of long waiting lists coupled with the urgent need for attention in what is identified as a vulnerable population. Financial and time constraints add to these pressures. Brief work has obvious appeal with respect to these factors, however, if families can be helped to continue in therapy beyond first magical relief of the symptom, deeper exploration

of the unconscious basis for the symptom will be possible. I believe that those of us working in a private practice setting may be more optimally placed to offer the kind of longer term or serial work needed to further promote the development of healthy object relationships and/or prevent the development of pathological ones.

Having access to different ports of entry in parent-child psychotherapy, irrespective of the length of treatment, increases awareness of the unconscious dynamics that contribute to the formation and maintenance of the symptom and allows these to be thought about in the here-and-now. In the above case of 'aliens', it was because child and parents were seen together that the particular meaning of the presenting symptom was uncovered: both the child's symbolic play and the parents' associations were needed to solve the riddle and effect relief. In the first case presented here, it became apparent that there were some difficulties in the parenting relationship and it may have been more helpful to see the couple on their own for a few sessions, possibly alternating with parent-child sessions. The father's absence from two sessions in this case may also have limited the efficacy of that intervention in terms of addressing issues at both the marital dyadic and father-child dyadic levels and certainly contributed to a sense of incompleteness at termination.

There is a strong argument for early, preventative interventions in the field of infant mental health. My hope is that the work described here might inspire health and education professionals who work with young children and their parents to consider parent-child psychotherapy as a useful and effective choice of treatment, both in its brief and more extended forms. It is the combination of vulnerability and plasticity, both associated with early childhood and early parenthood, that makes parent-child psychotherapy such a critically important and worthwhile endeavour.

# CHAPTER SEVEN

## The grandmaternal transference

This chapter extends the descriptive aim of the research while primarily addressing a theoretical-heuristic aim; that of expanding our understanding of ports of entry to include the concept of a grandmaternal transference. At the end of the discussion of Case One in the previous chapter, I suggested that Zach may have been relating to me as a grandmaternal figure and it is this idea that I wish to elaborate here. In practising as a parent-infant psychotherapist and supervisor of other parent-infant psychotherapists, primarily in the private practice sector and to a lesser extent as supervisor to a small community project, I have repeatedly been struck by the significance of the maternal grandmother in the background history of mothers (as per the case of Mrs Z in Chapter Six) who present or are referred for parent-infant interventions.

It is interesting to review informal data gathered from 76 cases seen by myself[49]. In 15 cases there was insufficient mention of the maternal grandmother for me to classify the mother's relationship to her mother, and in 12 a good relationship was reported. However, in 18 cases (24% of the total), conflict in the mother-maternal grandmother's relationship was described, in 19 (25%) the maternal grandmother was reported to be physically (geographically) unavailable and in seven cases (9%) the maternal grandmother was deceased. In five cases (7%) mothers volunteered that the relationship with their own mothers was poor. This informal data suggest that in almost two-thirds of the cases, the relationship between mother and maternal grandmother is compromised.

It is widely accepted that the mother-daughter relationship is foregrounded during pregnancy and early motherhood (Birksted-Breen, 2000; Breen, 1975; L. Hoffman, 2004; Knowles &

[49] For the most part information was volunteered by the mothers, rather than elicited, and the cases were seen as private cases between 2005 and 2010.

Cole, 1990; Raphael-Leff, 2009). There is support in the literature for the significance of the loss for a mother of her own mother due to geographical separation (Berg, 2003) and death (Daws, 1989; Dowling, 2006). Although unable to draw definite conclusions because of her small sample size, Breen (1975) does suggest that there may be a correlation between the loss of a mother during childhood, or up to one year before the pregnancy, and her being classified in a lesser-adjusted group of mothers. Further, Robbins (1990) argues that the reactivation of grief over mother loss during times of crises and transitions is to be expected.

Although not directly addressed in this research, the function of culture does warrant acknowledgement in the context of a discussion of the maternal grandmother and her relationship to both her daughter, her grandchild and to the mother-infant couple.

Social anthropologist Kitzinger (1978) dedicates an entire chapter in her book *Women as Mothers* to "Grandmothers". In describing what she terms "peasant societies", Kitzinger (1978) reports that in Jamaica, after birth, there is a nine day seclusion ritual during which mother and child are cared for by the maternal grandmother, or the "nana"[50]. Where this caring is provided by a nana, she will be like a grandmother figure in that she is almost invariably a neighbour and represents a secure and familiar figure. Although writing over 30 years ago, Kitzinger's (1978) claim that in industrial societies the role of grandmother has little anticipatory meaning, whereas in pre-industrial societies it frequently has major importance, may still hold water. I would claim that the modern devaluation of grandmothers and the dispersal of communities so prevalent in post-industrial times has left women alienated geographically and socially from their own mothers (and substitute women of their mothers' generations) during the critical transition to motherhood, and that this is a largely unacknowledged loss. Stern has suggested that "new mothers need other, experienced women around them" (Stern, 2004, p. 33) and that they create what he calls a benign grandmother fantasy. Recent sociological and anthropological research in societies such as rural Gambia (Sear, Mace, & McGregor, 2000), Ethiopia (Gibson & Mace, 2005) and South Africa (Duflo, 2003) indicates that this yearning may be based on something more than a fantasy; researchers have found that the presence of maternal grandmothers improves child growth and survival.

[50] Troester (1984 cited in Greene, 1990) calls such women "other-mothers", a term that includes women who are grandmothers, cousins, aunts and connected by kinship to the natural mother.

In terms of South Africa, it is widely assumed that grandmothers play an important role in child-rearing (De Villiers, 2011). De Villiers' (2011) doctoral thesis on this subject raises several issues that I have selected for highlighting: the grandchild provides the grandmother with an opportunity to mother again (this is particularly poignant given that many grandmothers do not mother their own children); for the mothers an opportunity is created for being re-mothered through vicarious sharing in the grandmaternal care; aspects of the mother-daughter relationship can be reworked; paternal involvement may be unconsciously side-lined by the emphasis on grandmaternal care and/or grandmaternal care may substitute for unavailable paternal care; grandmaternal involvement in childcare relieves mothers from feelings of being overwhelmed and lessens maternal anxiety.

South African author and parent-infant psychotherapist Berg (2007) elaborates Stern's motherhood constellation "in African tradition" (p. 220). Berg (2007) stresses the importance of addressing the mother-grandmother relationship — the motherhood constellation — in terms of traditional African values or 'custom' and she implies that neglecting this negatively impacts parent-infant interventions and the reputation of the parent-infant service in the community setting.

This foregrounding of the role of maternal grandmother in terms of her relationship with her daughter (the mother) has implications for parent-infant psychotherapy in all settings. The following quotation: "Motherhood seems to … be a process of birth as much for the mother as for the child" (Knowles & Cole, 1990, p. 6), highlights the importance of the postpartum period in terms of intervening therapeutically as it is in this stage that psychodynamics emerge in relation to mother and her own mother with ramifications for mother-as-mother. Breen's (1975) comments on maternal preoccupation with notions of good and bad motherliness signal likely aspects of the transferential relationship when we have a woman-as-mother in therapy. For example, I was recently asked by the anxious mother of a three-year old boy referred for aggression at nursery school: "You look like you have children, did you smack yours when they misbehaved?"

The role of transference and the issue of transferential interpretations have been somewhat controversial in the parent-infant psychotherapy literature. Piovano (2003) expresses the belief that the transference must be recognized as the source of change and transformation and describes the therapist as a "reactivated transference developmental object" (p. 263) as well as

a new developmental object. Berlin (2008), by contrast, is critical of those interpersonal therapies that see the fulcrum of change as the attachment to the therapist; she argues for a focus that facilitates the attachment between a child and primary mothering figure.

Certainly transference, in terms of how it is described in the literature and reportedly dealt with, could serve as a differentiating or integrating factor across parent-infant psychotherapy approaches. At the level of differentiation, several authors stress the parent's transference to the baby (Barrows, 1997; Cramer & Stern, 1988; England, 1997; Hopkins, 1992; L. Miller, 1992). Harel et al. (2006) claim the unique idea of a dual transference; the child and parents equally project and transfer onto the other in a mutual, two-way process that creates a "projected relationship" (Harel, et al., 2006 citing Seligman, 1999). So, for example, Hopkins (1992) interprets Fraiberg et al. (1975) as stressing that the parents' negative transference to the baby — related to the nature of parental 'ghosts'— was more the focus of the intervention than the parents' transference to the therapist. Salzberger-Wittenberg (1991) cautioned against interpreting the parent's transference to the therapist. Barrows over a decade ago (1997) suggested that more use is made of the countertransference than the transference, but in recent texts (Emanuel, 2009; Emanuel & Bradley, 2008; Piovano, 2003) the role of both transference and countertransference in parent-infant psychotherapy are highlighted.

In this chapter I will propose that the grandmaternal transference plays an intrinsic role in mother-infant psychotherapy. Stern (1995) explored the maternal grandmother's role in terms of what he coined "the motherhood constellation". I will develop Stern's 1995 theory by extending an acknowledgement of the significance of the maternal grandmother in our thinking about the mother-with-infant, to her significance in our thinking about the mother-with-infant in the psychotherapeutic encounter. This invites a greater comparison of the role of parent-infant psychotherapist with the role of maternal grandmother and demands a more thorough engagement with the idea of a grandmaternal transference than was offered by Stern in his 1995 text.

If transferential issues can serve to differentiate or integrate parent-infant psychotherapy approaches, as suggested above, then it may be useful to conceive of the grandmaternal transference as a unifying aspect. Following Stern (1995), mother's mother exists intrapsychically for all new mothers regardless of her presence or absence in the external

world. The triadic composition of parent-infant psychotherapies invites consideration of the role taken up by the therapist. In relation to this idea, the grandmaternal transference may represent an additional port of entry that is hierarchical both in a generational and in a containing sense. Generationally, the therapist as grandmother provides containment for the parent (particularly the mother) and the infant, both dyadically in her respective transferential roles as mother and grandmother, and triadically in her thinking about parent-with-infant. As a container of the mother's projections and hate (see Thomson-Salo & Paul, 2001), the therapist creates an opportunity for the mother to act as container for the infant's anxieties. This cascading, hierarchical function from therapist to mother to infant was highlighted in the previous chapter with reference to stackable container cups (see Chapter Six, Footnote 6, p. 141). In my playroom the Russian nesting dolls are similarly popular with young children and arguable equally representative of this generational-hierarchical process.

The grandmaternal transference concept is elaborated and demonstrated in the remainder of this chapter using psychotherapy case study and case vignette data. The employment of the grandmaternal transference as a port of entry is developed and three different manifestations of the grandmaternal transference are proposed. Data are used to serve both descriptive and heuristic research purposes. The usefulness of the grandmaternal transference in relation to the maintenance of a psychoanalytic frame under pressure from multiplicities of persons and ports of entry will be discussed in Chapter Eight, referencing case study data from this chapter.

This manuscript on the grandmaternal transference was submitted to and accepted for publication by the *Journal of Child Psychotherapy*[51], official journal of the Association of Child Psychotherapists, which is the main professional body for psychoanalytic child and adolescent psychotherapists in the United Kingdom. An identical version of the final manuscript, edited by the *Journal of Child Psychotherapy* (pending publication) but using a style in accordance with this thesis, constitutes the remainder of this chapter.

[51] To be published as Dugmore, N. (2013). The Grandmaternal Transference in Parent-Infant Psychotherapy. *Journal of Child Psychotherapy. 39(1).*

# The grandmaternal transference in parent-infant/child psychotherapy

Abstract:

*The psychic significance of the figure of the grandmother in psychodynamic psychotherapy has received scant attention. This paper develops the concept of the 'grandmaternal transference' in parent-infant psychotherapy and explores its identification, its possible functions and its therapeutic significance. The grandmaternal transference has special relevance to parent-infant psychotherapy since the grandmother often represents both the mother's mother and the child's grandmother and offers a unique third position between mother and child. Three clinical vignettes illustrate how the grandmaternal transference may operate in this third position. In the first vignette, the therapist becomes in the transference a containing grandmother thereby facilitating maternal containment. In the second case, the therapist may be experienced as a differentiating grandmother able to help mother and infant with separation and individuation. In the third one, the therapist is transferentially experienced as a paternal grandmother who acts as a pseudo-father able to embody the paternal function. In each of these positions, the transference and countertransference – whether positive or negative – require that the therapist responds to rather than enact the grandmaternal role. The three configurations of the grandmaternal transference have different clinical manifestations and offer different therapeutic ports of entry.*

## Introduction

*Thandie, a two-year-old girl, walked up to me in our first session and stood looking at me for a few seconds before reaching for my reading glasses on the table next to my chair. She put them on her nose and looked at her mother and smiled. Mother smiled too and said to her daughter, "Yes, they are just like Nana's", and to me, "Thandie loves trying on her grandmother's glasses."*

Parent-infant/child psychotherapy presupposes the presence of, at least, three people in the clinical setting: the parent (most frequently the mother[52]), the child, and the psychotherapist. As a parent-infant/child psychotherapist, I have often had cause to consider what roles and functions I may be representing as the third person to the mother-infant dyad. While the paternal role (Daws, 1999) would seem an obvious conclusion; the above vignette from a case in the early months of my commencing work as a parent-infant/child psychotherapist, was one of several that alerted me to the presence of a grandmother that mattered to a young child and to that child's mother. In subsequent cases, recurring references to mother's mother in the context of her as the child's grandmother led me to increased contemplations on the significance of grandmothers in both the internal and external worlds of my young patients and their parents. Later, I began to use the figure of the grandmother in the here-and-now. This paper addresses the idea that the representation of therapist as grandmother, and particularly maternal grandmother, warrants consideration.

Daniel Stern's notion of the 'motherhood constellation' (Stern, 1995) highlights the role of the maternal grandmother both at the developmental level in terms of the woman's transition to motherhood, and at the therapeutic level in terms of what he named 'the good grandmother transference'. Notwithstanding, and seemingly despite Stern's theoretical and clinical contributions to our understanding of the role and representation of the maternal grandmother, a search for the word 'grandmother'[53] in the psychoanalytic parent-infant/child literature retrieves a relatively small number of texts in which she is given any identified role. Within the library of parent-infant/child psychotherapy books, where one would expect her role to loom larger, 'grandmother' has been largely side-lined. She is either not indexed at all (for example Baradon, 2009; Baradon, et al., 2005; Lieberman & Van Horn, 2008; Pozzi, 2003; Sameroff, et al., 2004) or discussed simply in relation to a particular parent-infant/child case (for example Acquarone, 2004; Raphael-Leff, 2003), in terms of her (un)helpfulness as an alternative caregiver (Emanuel & Bradley, 2008; Raphael-Leff, 2003) or in the context of her absence/non-supportive presence (Daws, 1989). Even less well explored in the literature is the manifestation of a possible grandmaternal transference, both within the parent-infant/child psychotherapy field, which is the domain of my discussion, and beyond.

[52] While the father's presence is strongly encouraged (Barrows, 1999b, 2004) in parent-infant child work, it is widely acknowledged that the mother-infant/child dyad presents more frequently for treatment than any other configuration of family members.
[53] Including 'grandparent(s)', 'grandparental' and 'grandmaternal'.

In my clinical encounters with mothers and children, I have regularly found myself confronting the role of the maternal grandmother as she is referenced by mother and/or child in terms of her presence in their near-past and current lives, as she surfaces in the transference both as a positive and negative psychic figure, and as she appears in my countertransferential contemplations and — when unchecked — in my countertransferential enactments. Informal correspondence and discussion with colleagues in the field have supported my speculations that the grandmother looms larger than is generally acknowledged. This paper will touch briefly on the role of grandmother in parent-child development, recognising that this requires further exploration, which is beyond the scope of this paper. It is the grandmaternal transference in parent-child psychotherapy that will be here highlighted, illustrated, and discussed in terms of implications for clinical practice.

Before I commence my argument for the existence and the useful recognition of a grandmaternal transference, I will attempt to define my use of 'transference'. As suggested by Laplanche and Pontalis (1950), transference is frequently used in a more extended meaning than that originally proposed by Freud. In respect of the argument put forward in this paper, two extensions of its meaning are used. Firstly, for Freud the transference may be connected with imagos other than those of the father and mother (Laplanche and Pontalis, (1950) and similarly for Klein (1946) the transference situation may represent "mother, father, or other people" (1946, p. 436). The grandmother imago, particularly in cultures where grandmothers are more prominent in the lives of mothers and their children, may manifest in the transference. Secondly, although transfer from the *past* to the present, or the replacement of "some *earlier* person by the person of the physician" (my emphasis) (Heimann, 1950, p. 456) is always implied in definitions of transference, given the primary timing of parent-infant interventions that address an infant/young child (in the context of his/her parent), the "earlier person" may well still be psychically active in the present and/or the very *near-past.* Hence; I propose here an extended use of 'transference', legitimated by the significant role the maternal grandmother plays in the lives of many infants, young children and their mothers.

It is as mother's mother that grandmother is most often profiled in psychoanalytic feminist and maternal studies, particularly in relation to the new mother's developmental shift from daughter to mother-herself, and thereby her own mother's implicit transition to grandmotherhood (Birksted-Breen, 2000; Breen, 1975; Knowles & Cole, 1990; Raphael-Leff, 2009). The new mother needs to identify with her own mother and remain in touch with

herself-as-child in order to be an understanding and loving mother to her infant. This is a complex process in that internalised identifications across the tri-generational matrix can be both positive and negative. If the pregnant woman gives psychic birth to three generations — the infant, herself-as-mother and her-mother-as-grandmother (Merbaum, 1999) — then we should anticipate that engaging with the new mother's psychic world is likely to lead to encounters with all three generations, or their representations, both positive and negative.

In terms of the child-mother-grandmother triangle constituted with the birth of an infant, the child's relationship with his/her maternal grandmother receives substantially less attention in the psychoanalytic literature than the relationship between mother and mother's mother. Early psychoanalytic theorists (Abraham, 1913; Ferenzi, 1913; E. Jones, 1913) have, however, highlighted the significance of the grandparental relationship (subsuming grandmother under the term grandparent) for a child's character formation. Citing these authors, Rappaport (1958) coined the term "grandparent syndrome" to describe the development of negative personality traits via an identification with a grandparent. LaBarre et al. (1960), differentiating grand*mothers*, suggested that they in particular may be considered directly influential in terms of childhood psychopathology. LaBarre and collaborators proposed that the positive role of the grandmother was evidenced in the provision of stability and nurturance, but that her presence could lead to confused identification for the child and the resultant splitting of good and bad parent images. Klein (1952a) had earlier illustrated such splitting in her description of an instance where a ten-month old boy was held up to the window by his grandmother. When he turned his vision back to the room, he saw standing close to him the unfamiliar face of an elderly woman visitor. He is reported as having an anxiety attack, with Klein concluding that:

> … at this moment the child felt that the 'good' grandmother had disappeared and that the stranger represented the 'bad' grandmother (a division based on the splitting of the mother into a good and bad object). (Klein, 1952a, p. 103)

Klein's description suggests the possibility of the introjections of the grandmother as an object into the child's internal world; which together with the importance of the grandmother as an object in the mother's internal world, also suggests the possibility of the activation of the grandmaternal object in the transference.

Stern (1995), arguably more than any other author, highlights the psychic role of the maternal grandmother in the mother's internal world. Readers familiar with Stern's dissertation will know that he proposes that when a woman becomes a mother, she undergoes a unique developmental shift characterised by a new intrapsychic organisation – the 'motherhood constellation' – made up of the infant-mother-maternal grandmother. Stern's discussion of the motherhood constellation normalises this developmental period in a woman's life as well as:

> the mother's discourse with her own mother, especially with her own mother-as-mother-to-her-as-a-child; her discourse with herself, especially with herself-as-mother; and her discourse with her baby. (Stern, 1995, p. 177)

Importantly, Stern argues that during the peri-natal period, the motherhood constellation is more powerful in informing the mother's inner world of representations than is the Oedipal constellation. It is surprising and, I would argue, regrettable that Stern's motherhood constellation is largely under-referenced in the parent-infant/child literature. Berg (2007), a key author in the field, can be singled out for her foregrounding of the motherhood constellation and in particular for her application of Stern's thesis to discussion of the cultural roles of grandmothers in the South African context in which she works.

## The grandmaternal transference

That the therapist as grandparent, and hence the discussion of grandparental transferences, has received scant attention in the literature (Imber, 2010) should come as no surprise. There are a few exceptions (Balsam, 2000; Merbaum, 1999; Tucker, 2006) outside of the realm of parent-infant psychotherapy that indicate something of the therapist/analyst's understanding, experience and use of the grandparental transference/ countertransference. Balsam (2000), for example, acknowledges what she describes as the reactive and proud feelings of being an 'analytic grandmother' and Imber (2010) explores the analyst's own identification with a good mothering figure, derived from the analyst's motivational system and enlisted by patients who are parents[54]. The idea of institutional representation of the grandparent and the implied, if not named, grandparental transference, is humorously indicated in a clinical

[54] Imber wonders whether Freud himself, in his treatment of Little Hans, might have fancied himself a "kind of good grandfather" (2010, p. 491) .

anecdote given by Elmhirst (1990). She reports that a child receiving a home visit from a worker from the Paddington Green clinic asked the health worker, "May I sit on your lap, Paddington Green?" (Elmhirst, 1990, p. 13), as though the health worker and clinic represented a combined object offering a type of (good) grandparental care.

Although the maternal grandmother does not receive recognition at the level of indexed entries in published parent-infant/child texts, there are some parent-child psychotherapy commentators (Daws, 1985; Hopkins, 1992) who seem to imply, if not name, a possible grandmaternal transference. Other authors (Baradon, 2005; Belt & Punamäki, 2007; L. Hoffman, 2004) pay, in varying degrees, somewhat more attention to the concept. Again, however, it was Stern (1995) who, in emphasising how the mother yearns for a positive response from a maternal figure, anticipated and then named 'the good grandmother transference'. He elucidates the concept under the sub-heading "Clinical Implications of the Motherhood Constellation" (Stern, 1995).

It is this link, between the role of the maternal grandmother in the intrapsychic triad of infant-mother-mother's mother and the aspect of the therapist in infant-parent psychotherapy, that I wish to expound. I will argue that the therapist-as-grandmother is able to make sense of the three-ness in the clinical setting and is able to see the relationship between mother and child from a privileged triangulated position that is not only outside of the mother-infant/child dyad, but also related to each member of that dyad. While defending the significance of Stern's interrelated notions of the grandmaternal transference and the motherhood constellation for parent-infant/child psychotherapy, I submit that these concepts can be elaborated upon in order to do justice to the complexity and variety of grandmaternal transferences that may manifest in parent-infant/child psychotherapies.

Stern (1995) suggests that the motherhood constellation supersedes existing mental organisations, taking centre stage during the peri- and post-natal period before exiting and leaving behind the old constellations, particularly the Oedipal one. In terms of the clinical implications, he suggests that some of the basic concerns of the motherhood constellation remain throughout parenthood. I will propose that because the child often has a relationship with a grandmother in the real world as does the mother with her mother-as-grandmother; the

motherhood constellation remains psychically active, if not dominant, beyond the early post-natal period into later childhood/parenthood.

Esman (1996) suggests that the good grandmother transference is "supplied by the therapist rather than created by the patient" (1996, p. 415). While I do not agree with this interpretation of Stern's argument, I do think that Esman anticipates an important point that has been neglected by Stern, namely that of 'the grandmaternal countertransference'. In the same way that a maternal countertransference does not presume that the therapist is also a mother, a grandmaternal countertransference is not conditional upon the therapist being a grandmother.

While Stern's concept locates the significance of the maternal grandmother at an intrapsychic level, there seems to be a tension between the internal constellating role of the maternal grandmother and her actual role in the real world. Disturbances are likely to occur when the mother's relationship with her mother in the external world is compromised, for example, through enmeshment, unavailability, bereavement or conflict. Depending on the nature of the triadic relationships, the constellation may manifest as disorganised. It has been through those cases where both the roles of the environment-grandmother and object-grandmother — to borrow from Winnicott (1963a)[55] — have been brought into the therapy that I have become aware of the importance not only of acknowledging, but also of using, the grandmaternal transference. My preferred term takes account of both positive and negative experiences of such and represents a significant departure from Stern's description of a good grandmother transference. The following case vignette illustrates the complexity of a grandmaternal transference that manifests as mixed.

### *Case — Ms C and Connor*

*Ms C, mother of three-year-old Connor, left several voicemail messages for me requesting an urgent appointment. The referring school principal had reportedly warned Ms C that I was busy and in her messages she implored me to find her a slot, suggesting that she would not take a referral to anyone else but wanted to see me because "you are*

[55] "The environment-mother is human, and the object-mother is a thing, although it is also the mother or part of her" (Winnicott, 1963a, p. 182). The similarities between the object- and environment-mother and what could be termed the object- and environment-grandmother require further elucidation.

*the best". She said she would have to ask the principal to call me if I couldn't give her a session. When we finally made contact, I was able to offer her an appointment for a few weeks hence, which she complained was "somewhat inconvenient". I was aware of being flattered by her high regard for me, but also feeling commandeered into meeting mother's need and guilty at not being able to accommodate her sooner.*

*In the first session, Ms C spoke of being called in by Connor's nursery teacher as he was not adhering to school rules or following instructions, and furthermore he was cheeky to adult staff and bossy with his playmates. Ms C described herself as a mother who believed in bringing up children to self-regulate and "stand up for themselves". Connor, meanwhile, had emptied every container of toys onto the playroom floor, asked me persistent questions about what was on the other side of the door that led from my office into my house, and repeatedly tried to climb onto a table and lean towards the wall clock. Initially I found myself overlooking Connor's attacking and potentially self-injurious behaviour, but then I became anxious that Connor would fall and injure himself, barge through the door into my personal space or destroy the contents of the room. I started worrying that I was being a pushover. My consequent attempts at taking a firmer stance by setting clearer limits were met with open defiance and challenge by Connor and were unsupported by Ms C. Ms C, a single parent and CEO of a big corporation, told me that she relied heavily on her own mother, who was a "godsend", to take care of her only child during the day. Connor interrupted his mother to tell me that she was a "strict granny". Ms C then mentioned that her mother was frequently unavailable as she was also involved in the care of Connor's older cousins and added that her mother's "spoiling" of Connor, for example not stopping him from watching television all afternoon, upset her.*

Negative and positive transferences may simultaneously come to bear on the therapy process and, as illustrated, may arise from either mother or child, or both. Stern (1995) suggests that "the greatest danger to effective treatment is a negative transference or countertransference" (Stern, 1995, p. 161), but I would suggest that both a negative (conflictual) transference and too-positive (idealised) transference represent a derailment threat. Even when a mother commences with a positive pre-transference, as does Ms C above, the idealisation of therapist as good-grandmother may, "sooner or later, succumb to de-idealization with resultant

aggression" (L. Hoffman, 2004, p. 652). Left unaddressed, both a negative and too-positive grandmaternal transference, may result in a devaluing of the intervention.

While transference interpretations may not be encouraged in this field (Barrows, 1997; L. Hoffman, 2004; Hopkins, 1992), this does not imply that they are not reflected upon. A mother needs to believe that psychotherapeutic help will be wise and kind, and not rivalrous or withheld, in order to make use of it. If pre- or early transference indications are to the contrary, they need to be understood and addressed. Imber (2010), albeit not referencing parent-child psychotherapy, maintains that it is easier *to talk* about tolerating being both the good and bad object, than it is *to do* so without privileging one position over the other.

It became clear to me that Ms C's and Connor's transferences to me as a bad grandmother figure (unavailable and strict) would need to be taken up if I was to be able to help both of them think about what regulation and self-regulation might mean. I interpreted Ms C's wish for me to be unlike her own mother; that is for me to be available and firm, and C's worry that I would be either "too strict", or else not strict enough, to help him feel safe. My acknowledging both mother's and son's hostility (and the disappointment and anxiety that the hostilities concealed) by addressing the delay in getting the appointment and the need to follow rules that prohibited hurtful behaviour in the playroom to self and others, allowed Ms C to consider her mother from a more depressive position and Connor to approach me as helpful rather than persecutory. Thus the possibility of establishing and then maintaining a positive therapeutic alliance was tentatively fostered, and the work on addressing Connor's feelings of abandonment by his hard-working mother, and Ms C's guilt at not always being available to her son, could begin.

In introducing the idea of the good grandmother transference, Stern describes and evidences the new mother's desire for a maternal figure. He implies that it is the new *mother's* wish or need, determined by the governance of her psyche by the motherhood constellation that ushers into the therapy setting the grandmaternal transference. While the transference from the mother onto the therapist is a maternal one, it is "grand"[56]maternal in simultaneously evoking the therapist as grandmother-to-mother's child. The case vignette below (together with the earlier vignette of Thandie with which this paper began) clearly illustrates the role

[56]Abraham (1913) posited that children understand the prefix "grand" at a literal level, that is "grander".

played by the *child* in establishing the grandmaternal transference. Tim, in identifying me with his grandmother, allows his mother to retain her position unchallenged.

*Tim, a five year old boy presenting with autistic features, asked me if my car was "an 'en' and a 'dee' or a one and a two?" Not sure what he meant, I asked him what he thought it was. He said "a one and a two like my granny's". Tim's mother explained that her car's transmission was automatic (N and a D) and her mother's was manual!*

Evidently, the triad that includes grandmother can also be introduced by the child patient. Arguably this is facilitated because the child is no longer a pre-verbal infant, which may contribute to understanding how the motherhood constellation is maintained as an important psychic constellation beyond infancy, that is, through the child's relationship with his mother's mother.

The grandmother-as-therapist and the grandmaternal transference can be configured in different ways. I will describe three possible configurations of the infant/child-mother-therapist triangulation that manifest transferentially or may be enacted countertransferentially. These representations are 'the therapist as a containing grandmother', 'the therapist as a differentiating grandmother', and 'the therapist as a paternal grandmother'. The different therapeutic ports of entry (Stern, 1995) they offer are discussed for "by understanding the transference, we can maximize our supportive interventions" (L. Hoffman, 2004, p. 643).

## The therapist as a containing grandmother

### *Case — Mrs S and Sindy*

*Mrs S was referred to me by her family doctor whom she had consulted because she didn't feel she had a relationship with her 12-month old daughter Sindy. I quote from my process notes after the first session with both parents and Sindy:*

> *"Mother tells me that she doesn't have a good bond with Sindy and that this started when Sindy was looked after by her maternal grandmother when Mrs S returned to work (Sindy was four months old). By the Christmas holiday, three*

*months later, a very strong bond had developed between Sindy and grandmother. Recently Mr and Mrs S have employed a nanny to look after Sindy, but when granny comes to visit, Sindy will have nothing to do with her mother or the childminder. Mrs S has tried to ask her mother to 'back off', but says maternal grandmother doesn't understand, or 'won't listen'. Mrs S describes maternal grandmother as 'nosy, intrusive, undermining, not respectful of separateness'. Mr S was mostly silent in the session, but did say that he is worried that when his daughter starts talking she will call granny 'mama'. Sindy sat in the middle of the carpet, back to her parents, facing me, watching me intently. Of the toys I put out she was particularly drawn to the blue ball [with little rubber protrusions] which she mouths and bites."*

*Mr S does not arrive for the second session, claiming work commitments. (He does not return for the remaining sessions either, reportedly telling his wife that "it seems the problem has to do with you and your mother"). While Mrs S narrates, in a "babyish voice" (as described in my notes), the story of her difficult week, Sindy rolls the blue ball to me and I return it, eventually lowering myself to a cushion on the floor to make the ball rolling easier on my back. Mrs S tells me of a recent unannounced visit by her mother and her mother's giving of ice-cream to Sindy before dinner. It is while she is describing her own retreat in anger and frustration to her bedroom, that I become aware of the exclusionary quality of the ball game Sindy and I are involved in. I observe the lonely figure Mrs S cuts, huddled in the adult chair, and I suggest that Mrs S take a seat on the floor too. I initiate a game that requires the ball being passed between the three of us. Eventually, consciously, I return to my chair and watch as Sindy and Mrs S enjoy a game that now involves the rolling, throwing and hand-to-hand passing of several different sized balls Sindy has selected. Sindy looks up at me whenever stray balls bounce towards me. I roll them back towards the mother-infant couple.*

While this vignette seems hopeful, the resolution of the therapy itself was more complicated. Mrs S in later sessions described a very dependent relationship on a rivalrous mother, both as an adolescent when, for example, her mother joined her during her gap year overseas, and as an adult when her mother contrived to be, in her words, 'Sindy's mother':

*Mrs S told me in the third session that she had "needed" to ask her mother to fetch and drop Sindy from playschool the previous day and had been very angry when she returned from work to discover Sindy was not at home. Grandmother had taken Sindy to her own home after school and bathed and fed her early, herself.*

I felt that much of my work in terms of using the grandmaternal transference creatively was about acknowledging rivalrous moments in the countertransference and in those moments helping Sindy and Mrs S to turn towards each other. It was Sindy's and my own "dramatic enactment", to use Watillon's 1994 concept as developed by Emanuel (2008), with the ball play in the second session that allowed something to be understood by me through attending to the transference-countertransference. Sindy could not use her mother as a containing object and Mrs S was not able to take up the containment of her own child. In the external world it would seem the maternal grandmother positioned herself in competition with her daughter rather than as a containing figure for mother-with-infant. Colluding with Sindy's recruitment of me into an alternative maternal role would only serve to disempower Mrs S further. Rather, my task as therapist was to take on the function of the therapist as containing grandmother (see Figure 1), thereby facilitating the internalising of a container by a mother who takes on such a function for her infant/child. In this endeavour, Daws' (1985) comment on the complexity of being a parent-infant consultant is recalled:

> Like good grandparents, they do not use their own experience to take over parenting from the parents: perhaps they provide a model of availability and receptivity to the parents' anxieties, which enables the parents to do the same for their babies. (Daws, 1985, p. 84)

While in the above vignette the maternal grandmother's failure to provide containment for the mother-infant dyad results from her apparent locus as rival mother rather than grandmother, other cases I have seen suggest that perceived grandmaternal unavailability (possibly a repetition of a disturbed early attachment between mother-as-infant and her mother) may usher in a similar transference. What is key is not the particular manifestation of the mother-grandmother relationship (in the above illustration highly competitive), but rather the absence of maternal (and grandmaternal) containment and the poor attachment status of the mother-infant dyad. At the external and intrapsychic levels, the motherhood constellation is not healthily functional and so the tri-generational aspect to containment is absent.

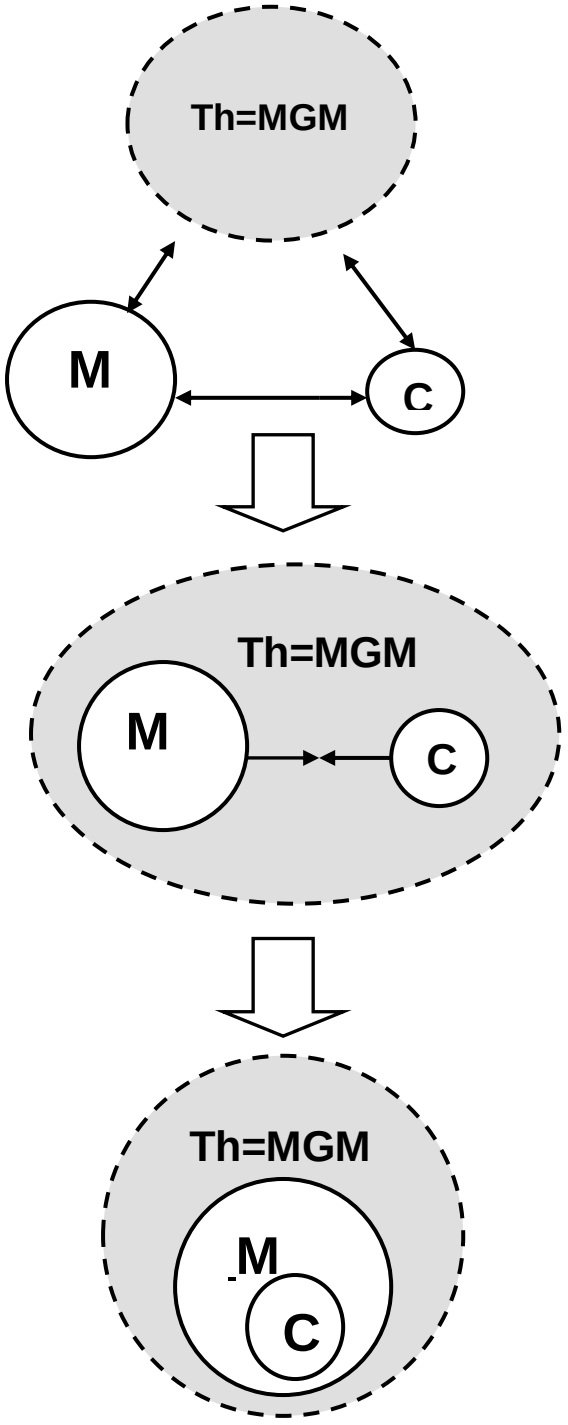



**FIGURE 1: THERAPIST AS CONTAINING GRANDMOTHER IN THE TRANSFERENCE**

THE THERAPIST (TH= MGM) IN THE TRANSFERENCE-COUNTERTRANSFERENCE AS A CONTAINING GRANDMOTHER WHO RECONCILES WHERE THE RELATIONSHIP BETWEEN MOTHER (M) AND INFANT/CHILD (C) SUGGESTS FAILURE IN CONTAINMENT AND POOR ATTACHMENT.

## The therapist as a differentiating grandmother

### *Case — Mrs Z and Zach*

*Three-year-old Zach was seen for parent-infant psychotherapy to treat a sleep disturbance. Zach and his mother attended five sessions, with Mr Z present at the first and penultimate sessions. In terms of the case's illustrative usefulness here, power struggles around bedtime and Zach's repeated night waking and needing his mother to lie next to him comprised the presenting problem. Mr and Mrs Z had unsuccessfully tried sleep training and medicating Zach and were reluctant to encourage his sleeping in their bedroom. Zach's parents seemed to understand his sleep difficulty as evidence of a "separation anxiety" but were at a loss to explain further. Over the six-week treatment span, it became clear that "loss", or rather the avoidance of any experience of separation which would invoke loss, did indeed underlie the symptom. The distress, primarily between Zach and his mother, appeared related in terms of a precipitating event to the death when Zach was nine months old of Mrs Z's father, concurrent with the extended absence of her divorced mother. At home, at night, Zach tenaciously clung to his mother who for her part could not disentangle herself from him.*

*In the first two therapy sessions, Zach could not be persuaded by his mother to leave the parental lap and he refused to acknowledge me other than to stare at me from the safety of his mother's ambit. In the third session, with my encouragement, Zach and his mother sat on two cushions I had placed on the floor and he began playing. In a Zach-initiated project, mother and son cut string and tape to tie paddock fence pieces together. At the beginning of the fourth session, Zach spoke to me directly for the first time. He told me that he was going to swim at his grandmother's*[57] *home that afternoon. In the fifth and final session, Zach addressed me for the second time, announcing that he wished to sleep at his grandmother that night.*

For Zach, the figure of his therapist came to represent a grandmother who could help him to separate from his mother and explore the world beyond the mother-child dyad (Dugmore, 2009). Elmhirst (1990) notes that grandparents can help young children "discover that time

[57] In this case the grandmother referred to was a paternal grandmother, but as a substitute for the poor relationship with her own mother, Mrs Z called her mother-in-law "mom" and related to her as such.

away from home, even nights away from home, can be safe, interesting and enjoyable" (p. 16). Her observation is supported by feedback from Zach's nursery teacher who reported that he had become more curious and eager to seek out knowledge and that his social relationships had improved over the course of therapy.

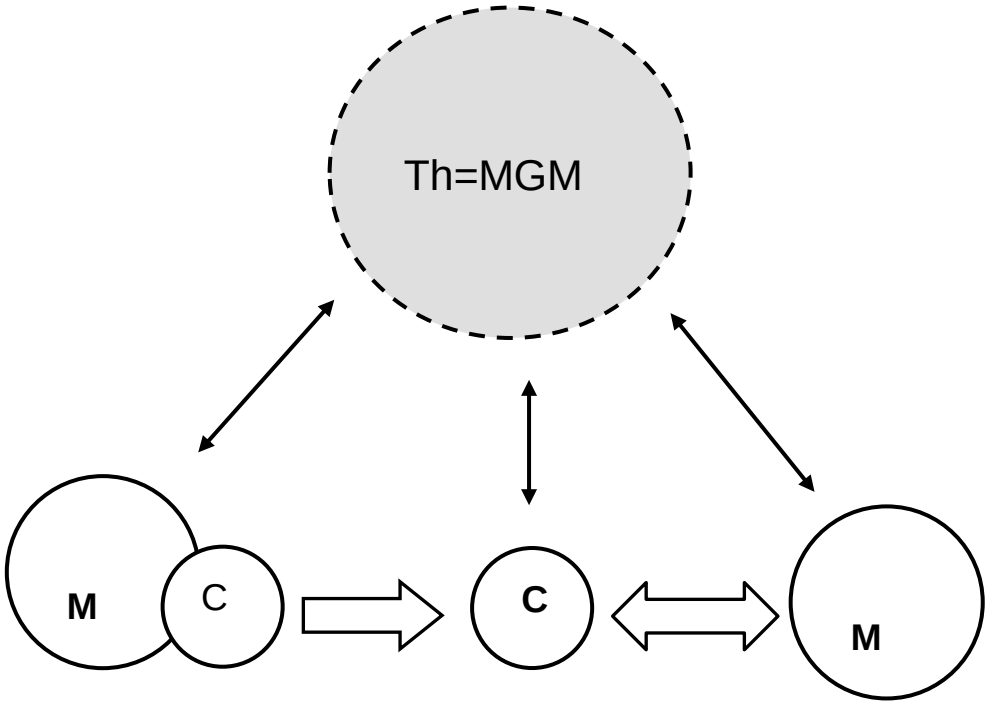



**FIGURE 2: THERAPIST AS DIFFERENTIATING GRANDMOTHER**

THE DIFFERENTIATING FUNCTION IS TAKEN UP BY THE THERAPIST-AS-GRANDMOTHER IN THE TRANSFERENCE. THIS ALLOWS FOR SEPARATION BETWEEN MOTHER-INFANT/CHILD AND THE INTRODUCTION OF TRIANGULAR SPACE.

Dowling (2006), drawing on Winnicottian ideas, implies an emphasis on the mother-grandmother/therapist relationship when she remarks that there needs first to be a reflective space between mother and therapist before mother can explore her relationship with her infant. In the absence of being able to make contact with Zach, I had spent the first two sessions helping Mrs Z to reflect on her experiences of loss. Zach had listened to our conversation and reportedly asked his mother about his deceased grandfather when they got home. In the third session, Zach allowed me to both facilitate (pass him items) and observe

his play and I directed many of my interpretations to him. I would argue that it is by establishing a relationship with infant/child *and* mother that separation of the merged dyadic unit is facilitated. As Trotman (2002) suggests, the paradoxical function of joining mother and child by separating them belongs to the maternal grandmother (Trotman, 2002). The maternal grandmother offers "a more objective, less personalized stance than they [mother and daughter] can offer on their own" (2002, p. 86). By fostering the connection between the child and therapist represented transferentially and indeed countertransferentially via the grandmother, the three generations are reconfigured as a triangulation which allows for separation and differentiation (see Figure 2).

## The therapist as a paternal grandmother

### *Case — Mrs B and Ben*

*Mrs B, a divorced mother of boys aged four and two, came to see me because of sleep difficulties manifesting in both sons, but particularly her youngest who she brought to the parent-child psychotherapy sessions. Ben's initial response to me was to arch backwards in his mother's arms as if he could only bear to look at me from some distance. In contrast to his expressed wariness of me, Ben engaged his mother lovingly in play, passing her toys, asking her to open containers and maintaining bodily contact with her at all times. While most of his play centred on his mother — on her lap or between her feet — at one point some coloured rings he and his mother were stacking rolled close to my chair. He stared fixedly at them with glances up to my face, but despite my gentle encouragements he refused to fetch the rings, turned his back on me and clutched his mother's legs. I felt excluded and rejected and understood myself to be perceived by him as an unwanted third that threatened to intrude upon the coupling he created with his mother.*

*While my initial thoughts were about the possibility of an Oedipal transference, with me as the father, Mrs B's concurrent narrative about the complicated relationship with her own mother made it seem more likely that Ben's negative transference to me was compounded by the role maternal grandmother played in his and his mother's lives. Mrs B had presented as very anxious and insecure about her mothering and overwhelmed by the conflict with her sons over sleeping. Earlier in this first session, she told me how*

*much she wished to be a good mother who knew and did the right things. She kept asking if she should "sleep train" the boys, or if she should let them sleep in her bed, which seemed to be what she understood them to be longing for and which, by her own admission, she enjoyed. "What would you do?" she repeatedly implored. When I interpreted her wish to be given guidance by me, she responded that she needed my reassurance, as she felt muddled about what was wrong and what was right. I suggested that her confusion might be linked to conflicting advice she was receiving elsewhere.*

*Mrs B told me that her ex-husband had withdrawn as a co-parent, relocating to the coast and only seeing the boys for a few hours, largely unannounced, when he was in town for business. Mrs B, alone and unsupported, had turned to her mother for parenting advice. However, her experience of her mother, she told me, was as a confrontational "What are you doing?" inside voice. Mrs B and her mother reside in the same housing complex and according to Mrs B her mother is very involved with the boys' childrearing, regularly commenting on what grandmother pronounces to be Mrs B's "spoiling" mothering. Mrs B described feeling torn between her own maternal responses — for example wishing to comfort her sons by allowing them into her bed — and her mother's notions of mothering which emphasise the importance of routine and a child's independence and which manifest as advice that her grandsons sleep in their own beds and give up their dummies. Mrs B told me very tearfully that she had been persuaded by her mother to stop breastfeeding her firstborn at two months so that he would "get used to a bottle" before her maternity leave ended one month later. Her mother's "guidance", which she believed "right", had conflicted with her own perceived "wrong" wish to continue breastfeeding at night once she returned to work.*

Klein's (1952a) idea of the bad grandmother projection deriving from a split of the mother object would make sense in terms of Ben's projection onto me; however, his mother's narrative makes it impossible to ignore the external grandmother, arguably internalised by Ben as a paternal-oedipal object. Ben's perception of me as a bad grandmother-father who would try to come between him and his mother I understood to be the situation of his negative transference. By contrast, Mrs B's transference was initially and primarily of an idealised mother/grandmother whom she perceived as omniscient and omnipresent, but also, as became clearer, of a mother/grandmother and husband/father who were unavailable.

*Mrs B's transference was enacted in two desperate, pleading messages left on my voicemail: "What should I do, I wish you were here to sort this out … listen, can you hear them screaming… don't you have an earlier appointment for us?" In the next session, I was able to interpret the wish for a good mother/grandmother who would be constantly available, and we linked this back to her own early experiences of being mothered, as well as to her repetition in the present in terms of allowing her mother unbidden access to her home.*

Of course the pleas could also be addressed, much more unconsciously, to the absent father/co-parent. Over the course of parent-child psychotherapy sessions, something shifted for Mrs B. She was able to use my comments, which were intended to empower her in terms of her mothering, to limit her own mother's critical injunctions, perceived and actual.

*In a follow-up telephone call, after termination, she thanked me for what she considered a very helpful intervention, saying "I have your voice inside me now and that helps me to listen to my own". Much of Ben's play during the early sessions had involved passing two baby dolls between himself and his mother, with each alternately having to hold one. In our last session, Ben allowed me to wrap a blanket around his baby doll, and on his mother's encouragement he gave me a small wave and smile goodbye when they left. Perhaps for Ben too, his experience of me as a daddy-granny in the therapy had made possible the beginnings of an internalisation of a helpful grandmother (and father) object.*

Barrows (1997) argues that the motherhood constellation is determined by the way in which the Oedipal complex has been negotiated, and that the father's role is crucial in negotiating the distance between mother and grandmother as well as mother and infant. In a similar argument, Arnold (1997) raises the suggestion that Stern's concept should be extended to that of the "parenthood constellation". While acknowledging that fathers are an important omission both in terms of Stern's thesis and within the parent-infant field (Barrows, 1999b, 2004), I do speculate that the longevity of the motherhood constellation beyond the child-as-infant might be commensurate with the absence of a father-in-the-environment, or the absence, in terms of not being foregrounded consciously, of the father-in-the-mother's-mind (Britton, 1989). In terms of the latter, for example, it would appear that at times the intensity of primary maternal preoccupation is such that a powerfully enmeshed mother-infant dyad keeps the father out. In such instances, the prolonged prominence of the motherhood

constellation may only allow for the emergence of interpersonal triangulation when the external and/or intrapsychic grandmother, or the therapist-as-grandmother, is configured as a paternal representation (see Figure 3). Arguably this may assist in heralding the entry of the Oedipal constellation. Benjamin (2004) suggests that the person who takes up the third role in relation to the mother and child will only function as a true third if s/he is 'dyadically connected' to the child; someone who is loved and shared by both mother and child. The grandmother is arguably well positioned to represent this symbolic function.

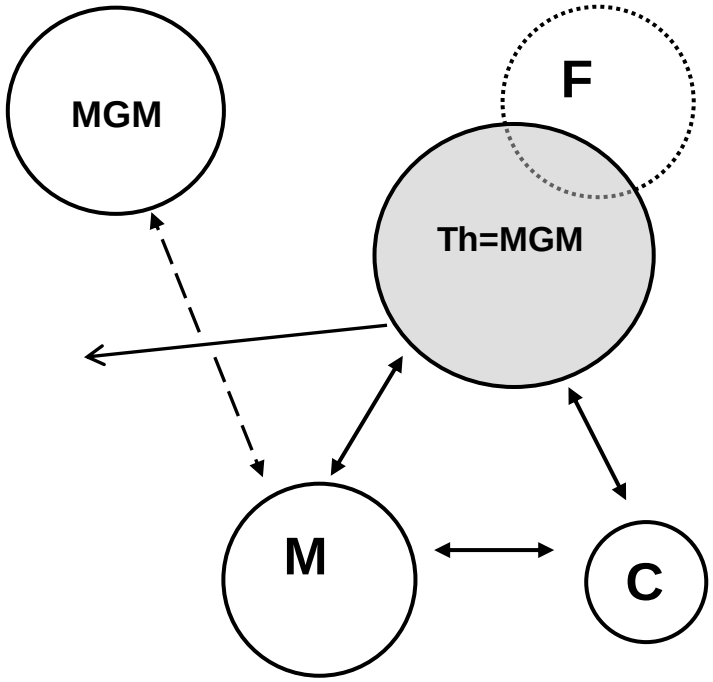



**FIGURE 3: THERAPIST AS PATERNAL GRANDMOTHER IN THE TRANSFERENCE**

HERE THE THERAPIST REPRESENTS, IN THE GRANDMATERNAL TRANSFERENCE, THE FATHER WHOSE FUNCTION IT IS, AS THE PATERNAL THIRD, TO INTRODUCE TRIADIC AND TRIANGULATED INTERPERSONAL RELATIONS FOR THE CHILD. FURTHER, IN THIS PATERNAL FUNCTION, THE THERAPIST CHALLENGES THE PROPINQUITY OF THE MOTHER-MOTHER'S MOTHER DYAD, THEREBY ALLOWING FOR THE EMERGENCE OF THE OEDIPAL CONSTELLATION.

## Discussion

When mother and infant/child are in the psychotherapy room together, at least two generations are present and a third one[58], the grandmaternal, is presumed. The importation of the role of grandmother into the parent-child clinical setting, via the transference, would seem likely, if not inevitable. This paper has addressed Stern's (1995) discussion of the "good grandmother transference", arguing that his original thesis warrants review and elaboration, and three possible configurations of the grandmaternal transference have been described and illustrated. Firstly, where the grandmaternal transference suggests that the mother-child dyadic relationship is compromised in terms of attachment and/or containment — whether this originates from the child and/or mother, or is experienced in the countertransference — the therapist may represent the containing grandmother who facilitates maternal containment of the infant/child. Secondly, the therapist as differentiating grandmother emerges in the transference when there is an unrealised drive towards separation from the mother and individuation by the child. Frequently, the grandmaternal transference in such situations will arise from the child and the port of entry (Stern, 1995) may well be the child's communications, through play and verbally, that are interpreted for the mother. Finally, the grandmaternal transference can be responded to in such a way that paternal functioning and Oedipal triangulation are allowed entry to the mother-infant/child's psychic world. These three positions allow for three further ports of entry that the parent-infant psychotherapist can employ in the parent-child setting.

I wish briefly to address a recurring concern usually framed as a question articulated by supervisees and colleagues working in the field: "Who should I focus on in the session, the mother or the infant/child, particularly when the child is old enough to play?" Identifying with the maternal grandmother as she is psychically represented in the motherhood constellation facilitates the co-existence of dyadic relationships between each of the three members present. As witness to the relationship between mother and infant/child, the therapist as grandmother is also afforded a particular vantage point in the triadic relationship.

[58] It needs to be stressed here that it is not simply the flesh-and-blood presence of the maternal grandmother but rather her psychic manifestation that is key. In the external world, a grandmother substitute may take up the grandmaternal role. Such proxy figures may hold and contain mother-with-child, may represent an alternative maternal role model or be considered a source of advice and wisdom. In terms of this paper, such proxy figures may also, in their psychic manifestation, anticipate the transference of grandmother onto the figure of the psychotherapist.

> The specific port of entry is less important for the treatment outcome than the match between the therapist's chosen port of entry and the child's or parent's receptiveness to the intervention. (Lieberman, 2004a, p. 112)

To recognise the grandmaternal transference allows for the prioritising (and shifting) of a preferred port of entry in healing or strengthening the mother-child relationship: accessing the mother-infant/child couple via the mother-therapist relationship; focusing on the child's communications (particularly play) as meaningful via the child-therapist relationship; or working with the mother-infant/child interaction via the mother-child-therapist relationship.

In conclusion, I would suggest that many psychotherapists, without necessarily articulating it, already attend to the grandmaternal transference and countertransference in parent-child interventions. To quote Stern: "In a sense, our theories have not yet caught up to our practices" (1995, p. 187).

# CHAPTER EIGHT

## Discussion

## Introduction

The practice of parent-infant psychotherapy has at its heart a mother-infant dyad, or parent-infant triad, and it has been widely practised and applied across the globe and across contexts. Given the presence of at least three people (including psychotherapist) in the clinical setting, parent-infant psychotherapy is "simultaneously an individual psychotherapy (with the primary caregiver), a couples therapy (with the husband and wife), and a family therapy (with the triad [and possibly, siblings]), either all at the same time or in sequence" (Stern, 1995, p.16). Clearly such an intervention breaks with more traditional psychoanalytic psychotherapies that have been individually oriented; adult since Freud and then child following Klein and Anna Freud.

Daniel Stern (1995) maintains that one element of the parent-child system is always theoretically privileged in parent-infant psychotherapy and that this counters what he refers to as the "inevitable impurities" (p. 16) of the practice with its accommodation of competing and intersecting ports of entry. In the preceding chapters it has been shown that one element is not necessarily targeted over others; the theoretical and clinical focus on the relationship between and within the elements of the system, including the element that is the therapist, may fluctuate and overlap. More exactly, privileging one or more elements simultaneously or shifting rapidly between them will place particular strains on the 'purity' of the psychoanalytic frame. Furthermore, sites of intervention that have been identified in this research include township clinics, home visits, mother-infant groups as well as the more traditional although differently populated playroom. These settings impact the frame too.

These different contexts allow for further access points to the parent-child system and impact on the form of intervention. In this chapter, the points of access employed by parent-infant

psychotherapists will be elaborated, and the question of what does or does not constitute a *psychoanalytic* intervention broached. Daniel Stern's (1995, 2004) important concept of ports of entry frames the argument; namely that greater flexibility of the psychoanalytic frame is necessitated in order to allow for the use of multiple ports of entry. Furthermore, the application of a treatment — psychoanalytic psychotherapy — originally developed to meet individual needs within a clinical setting to a treatment that addresses persons within a family and possibly in a non-traditional psychotherapeutic context, invites some ethical examination. Possible ethical issues will be described and reflected upon briefly with reference to the South African Psychoanalytic Confederation's Code of Ethics (Silove, et al., 2011).

## Opening ports of entry

Stern coined the term "ports of entry" in his 1995 book, *The Motherhood Constellation: A Unified View of Parent-Infant Psychotherapy*, thereby introducing the term and concept into the parent-infant literature. Stern identifies several ports of entry that can be used to access what he refers to as the 'theoretical target', defined as the element of the system that the therapist wants ultimately to be changed. The ports of entry are ways of reaching the theoretical target; that is they are the elements through which the clinical system is entered. Crucially for this discussion; although determined theoretically, the theoretical may not correspond to the clinical focus — that is the port of entry. I would propose that the theoretical target is revealed by a psychodynamic exploration of the symptom. For example, Zach (Chapter Six) presented with a sleep difficulty and elaboration of the symptom in the sessions revealed a significant bereavement in Mrs Z's life. Her unresolved mourning informed her representations of a sleeping infant, which became the theoretical target. The clinical focus, however, was on the relationship between mother and child. One of several ports of entry that was used was play and the therapeutic process, through the play, focused on Mrs Z's capacity to contain Zach's need for separateness and the associated anxieties.

In his assertion that psychoanalytic parent-infant psychotherapy implicates the parents' representations as both theoretical target and the principle port of entry, Stern seems to be referencing traditional psychoanalysis and the use of interpretation to bring the unconscious (the parent's representations) to conscious (the parent's interactions with the infant). Stern (1995) excludes from his discussion of psychoanalytic parent-infant psychotherapy aspects of

treatment rooted in object relations theory (which is ignored in his text). Incorporating the notions of an earlier Oedipus, projective identification and containment, emotional holding, mirroring and the role of corrective emotional experience, for example, open up further ports of entry, particularly in terms of transferences.

Stern's ports of entry concept is technically useful, but his application of the concept is limited. I would contest Stern's claim for the primacy of one port — parental representations — in psychoanalytically oriented parent-infant psychotherapy and I would argue that multiple ports of entry — beyond the five originally described by Stern — may of necessity be opened to access the multiple elements of the clinical system. Furthermore, I am suggesting that these multiplicities may impact on the psychoanalytic frame and require of it some flexing.

Stern (1995) addressed his thesis to mother-infant interactions — only later (Stern, 2004) including the father more specifically — thereby neglecting a protraction of the work to include older children and other sub-systems within the family such as the couple and sibling relationships. Lieberman (2004a), in describing work with preschool children, has suggested that play, action and language provide further contexts for choosing ports of entry. She includes the child's behaviour (including play), the parent's behaviour, the child's and parent's self-representations and their representations of each other, the parent-therapist and child-therapist interactions (what I would describe as the transference/countertransference relationships) as well as the triadic relationships between the child-mother-father and those between the child-parent-therapist. The couple relationship has been foregrounded as a port of entry by Barrows (2003, 2008). I have introduced through this thesis a further port of entry, the grandmaternal transference (and countertransference), by elaborating Stern's (1995, 2004) idea of a good grandmother transference and benign grandmother fantasy.

The role of infant observation in the development of the parent-infant psychotherapy field and the importance of observation skills have been highlighted, hence the identification of infant observation as a crucial aspect of the training of parent-infant psychotherapists across the globe. While not clearly labelling it a port of entry, Stern (1995) in his discussion of the therapist's representations as a port of entry does acknowledge the contribution of Bick's (1964) method of observation. Sossin (2002), emphasising the observation of nonverbal behaviours in parent-infant psychotherapy, recognises observation as a potentiation of change. I would emphasise that in and of itself observation may represent a port of entry into the

parent-infant system and that it may be useful not only at the diagnostic level, but also at the therapeutic level. For example, Winnicott's (1941) reports of observation in the set situation indicated something of the therapeutic effectiveness of observation — evidenced in his discussion of the asthmatic baby. Earlier I quoted Harris (1966) who described symptom relief in a toddler as a result of her clinical observation of him. In a more elaborated way, the Watch, Wait and Wonder approach. (Cohen & Muir, 2002; Muir, Lojkasek, & Cohen, 1999) encourages parental participation in the act of observation ('Watch') in order to facilitate access to internal representations and to encourage reflective thinking.

Group relational dynamics operant during group parent-infant psychotherapy sessions have not been elaborated in this study, although they are discussed in the literature (James, 2002; Paul & Thomson-Salo, 2007; Reynolds, 2003). Two recent South African journal articles (Bain, et al., 2012; Rosenbaum, et al., 2012) on group parent-infant psychotherapy introduce ideas that implicate the 'group' factor in change to the clinical system. Such research suggests an additional port of entry that may be particularly useful in South Africa where group interventions represent a more economic use of treatment resources.

The fact that families and their members do not exist in a vacuum invites further expansion of the list of possible ports of entry. Following comments by Stern (1995), factors considered highly influential in terms of the growing child's mental health include: primary socioeconomic status; quality of social support; the involvement of the mental health care system; parental culture; minority status and educational level. While not defined as ports of entry by Stern (1995, 2004), they may represent further access points by which the caregiving system may be positively transformed. Thoughtful attention has been given to the idea of such "practical" ports of entry by American author Renschler (2009). He examines the long-standing association of social work (Fraiberg, et al., 1975) — with its emphasis on concrete action — and parent-infant psychotherapy — with its roots in psychoanalytic practice that refrains from action. Renschler's (2009) discussion highlights issues that emerge in home visitations but his broad address and appeal to psychoanalytically-oriented clinicians is to think about increasing their involvement in impoverished communities. In the broader South African community where HIV/AIDS (Long, 2009), poverty, lack of education, high levels of violence and breakdown of family support structures threaten mother-infant attachment, Renschler's (2009) appeal is a relevant one. Contextual ports of entry represent pre-emptors for the more traditionally defined ports of entry that lead to therapeutic shifts and change.

Stern's original definition of a port of entry may require some expansion, particularly in terms of the South African field. To this end I would propose a set of 'secondary ports of entry' that may represent an initial or conjunctive clinical focus at a separate register.

As has been suggested, certain sites of parent-infant psychotherapy intervention in South Africa are beset by challenges that prohibit access to the primary level of the parent-infant system; that is the family-with-infant in encounter with a psychotherapist. Impediments may include socio-cultural obstacles, educational deprivations and economic preclusions. It is at this contextual level that the secondary ports of entry may allow the clinician initial access to the attachment system (made up of both the caregiving and therapeutic relationships). More particularly, in terms of parent-infant psychotherapy in the broader South African field, opening up such ports of entry may be a necessary precursor to utilising what I would refer to as the *primary* ports of entry. (These primary ports of entry reference Stern's original definition and include those suggested by later authors, for example Lieberman (2004a)).

Berg's (see Chapter Five) description of the crucial presence of a cultural mediator/translator in terms of accessing of maternal culture serves as one example of how treating the parent-infant system necessitates the opening of a secondary port of entry. (Berg (2007, 2012a) illustrates this principle with reference to a primary health care clinic case.) Cultural and language mediation would seem crucial in establishing the socio-cultural context within which attachment occurs, and absolutely essential in facilitating and mediating entry to maternal representations. A second, related example of a secondary port of entry concerns the role of education. Frost (see Chapter Five) describes how incorporating a 'talk', given by her co-practitioner and translator Sephuma, to nurses and mothers has been critical in establishing a positive expectation of help and in facilitating the resultant approach of the Baby Mat practitioners by mothers-with-infants. Across contexts, developmental guidance — when given as a mindful response to requests for advice or an intervention in its own right — can serve as a further secondary port of entry into thinking about behaviour and the meaning of a symptom. Sensitively offered developmental guidance may open primary ports of entry thereby facilitating direct address to parental representations. Woodhead (2004) provides an example when she describes how the mother-infant feeding experience, which was the central port of entry to the relational difficulties in the case she presents, required that she give:

> … a kind of 'developmental guidance' (Fraiberg et al. 1975) that [the baby] needed to be fed in arms. I did this because of my impression that both mother and baby were dissociated in the process of feeding and needed help to establish attunement. (Woodhead, 2004, p. 151)

A comprehensive (but not necessarily exhaustive) lists of possible primary ports of entry (see Table I) and secondary ports of entry (see Table II) are given. Listed in the tables are the possible ports of entry as identified in this research, with abridged examples and references to cases and content from earlier chapters.

With reference to Table I (below) this research has in part been descriptive and Stern's (1995, 2004) ports of entry together with additional ports of entry proposed, for example, by Lieberman (2004a) have been illustrated in the earlier case study based chapters. Novel in the list of primary ports of entry is that portal referred to as the grandmaternal transference/countertransference. Case study evidence in support of this elaboration of ideas raised in Stern's (1995) thesis on the motherhood constellation has been presented in Chapter Seven. The notion of a grandmaternal transference has been shown to bear on both the theory and practice of parent-infant psychotherapy. This addition of a primary port of entry that refers to the representation of therapist as (maternal) grandmother allows for clarification of triangulation as determined by the intrapsychic influence of the motherhood constellation (as compared to the influence of Oedipus). In Chapter Seven, three different configurations of the grandmaternal transference were proposed; each may represent a variable port of entry.

In researching parent-infant psychotherapy in South Africa, multiple contextual challenges were identified. Interview participants were also able to describe adaptive responses to these challenges that indicate the importance of identifying and redefining these contextual challenges as contextual opportunities. It is in thinking about the 'context' as something *through* which a practitioner works rather than *in* which a practitioner works that the reframing of contextual challenges/adaptations as ports of entry makes sense. I have subsumed these contextual ports of entry under the descriptor 'secondary' and in so doing introduced the notion of a hierarchy of ports of entry.

The various *primary* ports of entry remain the preferred routes of access in order to effect change in the parent-infant system. Stern's (1995) association of the altering of parental

representations with the theoretical target of psychodynamically-oriented parent-infant psychotherapies appears to be largely true, however the parent's representations are not exclusively utilised as the port of entry by such practitioners. For example, Thomson-Salo and colleagues (Thomson-Salo, 2007; Thomson-Salo & Paul, 2001, 2004; Thomson-Salo, et al., 1999) make a compelling case for the primacy of the infant as the port of entry, particularly when the infant is at risk of failing to thrive. Parent-child and parent-infant psychotherapists who work with older infants (Emanuel, 2007, 2008; Lieberman, 2004a; Pozzi, 1999, 2003) frequently describe the use of the infant/child's play as a port of entry, again suggesting that there may be occasions when the shift is towards the infant/child as the active agent in the psychotherapy. Barrows (2003, 2008) has stressed the importance of the parental couple as the preferred port of entry in cases where marital strife shapes or interferes with the parental-child relationship. The grandmaternal transference, as described in this study, may be indicated as an initial port of entry that facilitates tiered containment; containment of the infant's anxiety by the mother being the ultimate goal. Earlier I have linked this symbolically to the stackable plastic cups and the Russian nesting dolls that are such favourite play items with young children in my playroom.

There is an absence in South Africa of broad-reaching social service and primary health structures that may offer parent-infant services during the peri-natal period and/or identify mother-infant dyads that may be at risk for mental health difficulties. As a result, secondary ports of entry (see Table II, below) are not presumed 'built-in' as they may be, for example, in the United Kingdom with the reach of Health Visitors into the homes of mothers-with-infants, or in the United States of America where parent-infant clinic services are relatively well supported by social services. In terms of early intervention, secondary ports of entry need to be recognised, established and exploited in the South African infant mental health field if vulnerable and at-risk parent-infant families are to be reached and helped. Possible secondary ports of entry emerged for consideration, in part, through interviews with stakeholders and practitioners who are creatively adapting to the challenges they face in their various sites of practice. These include: the socio-cultural environment (through the translation and mediation of language and culture); the socio-economic environment; the educational environment; group dynamics and group culture (in group parent-infant psychotherapy); observation; developmental guidance and supervision.

## TABLE I: PRIMARY PORTS OF ENTRY

THESE REPRESENT THE CLINICAL FOCI AND THE PORTS OF ENTRY INTO THE PARENT-INFANT SYSTEM WHEREBY THE THEORETICAL TARGET IS REACHED.

| PRIMARY PORT OF ENTRY | EXAMPLE |
|---|---|
| **Parents' representations** | Mr and Mrs Z represent Zach as hysterical, manipulative, wilful and stubborn and represent the sleeping difficulty as a power struggle. (Ch. 6) |
| **Infant's/young child's representations** | Alex represented her unborn sibling as vulnerable to attack by play that described two infant figures barricaded behind a wall that was under assault. (Ch. 6) Connor described his grandmother as "strict". (Ch. 7) |
| **Parent-child relationship/interactions** | Zach and his mother co-constructing a secured paddock fence with string and tape. (Ch. 6) |
| **Therapist's representations = Countertransference** | I worried that Mr and Mrs A would not return for the second session, that they would dismiss my interpretations as nonsense. These anxieties were in all likelihood linked to the primitive sexual and aggressive feelings expressed in Alex's play and my role in alerting her parents to their existence. (Ch. 6) |
| **Infant's overt, primarily non-verbal, behaviour** | Initially Ben remained in his mother's arms and on her lap, later playing in close proximity to her and maintaining physical contact. (Ch. 7) |
| **Young child's overt (non-verbal and verbal) behaviour, particularly play** | Zach asked his mother to help him build a wall from Lego blocks. The wall became a structure that needed a roof and sides "so that the animals don't get wet," Zach said. One side initially had a window that Zach later wanted filled up "so the rain doesn't come in". (Ch. 6) |

| | |
|---|---|
| **Parents' behaviour** | Mr S did not attend sessions subsequent to the first having said that he saw the problem as being between his wife and her mother. (Ch. 7) |
| **Young child's self representations** | Four-year old Alex represented her self as an infant; sitting on her mother's lap, sucking her thumb and playing with her mother's hair. (Ch. 6) |
| **Parent's self representations** | Mrs B described herself as unsure whether she was a too-strict or too-indulgent parent (Ch. 7) |
| **Parent-therapist relationship/interactions = Transference** | Ms C reacted desperately and angrily to experiences of the therapist as unavailable and accommodating, while at the same time appealing to the therapist as an idealised expert (Ch. 7) |
| **Infant-therapist relationship/interactions = Transference** | Zach appeared mistrustful of the therapist and avoidant in making contact. He spoke to his parents about visiting the doctor and a fear of injections. (Ch. 6)<br>The therapist directs interpretations to Alex that she might be angry with daddy for giving mommy the baby — this informed by an idea that the child can take such an interpretation more easily than the parents. (Ch. 6) |
| **The couple (parent) relationship/interactions** | Mr S blames his wife for difficulties in the parent-child relationship and then removes himself (literally and figuratively) from the situation indicating difficulties in the couple and/or parent relationship. This was evidenced by a later breakdown in the marital relationship. (Ch. 7) |
| **The sibling interactions** | Alex is reportedly aggressive to her younger sibling. If the sibling had attended a session the interaction may have served as a port of entry to Alex's representation of siblings as rivals and persecutors. (Ch. 6) |

| | |
|---|---|
| **The mother-father-child relationship/interactions (Oedipal interactions)** | Zach's distress at his father's non-arrival at a session echoes Mrs Z's disappointment at her husband's unavailability. In a later session Zach takes up the second adult chair, vacated by (absent) father. These interactions suggest something compromised in Oedipal relating. (Ch. 5) |
| **The therapist-parent-child relationship/interactions (Oedipal transferential interactions)** | Zach's (Ch. 5) and Ben's (Ch. 6) reluctance to talk to the therapist or disengage from interactions with their mother, as though the therapist was experienced as an intruder on the mother-child coupling |
| **The therapist-mother-child relationship/interactions (Motherhood Constellation) = Grandmaternal transference/ Countertransference**<br><br>• **Therapist as containing grandmother**<br><br>• **Therapist as differentiating grandmother**<br><br>• **Therapist as paternal grandmother** | Sindy engages me in ball play. I become aware of the exclusionary nature of the play; my privileged inclusion and Mrs S's physical withdrawal concurrent with Mrs S's narration of anger at her own rivalrous mother. (Ch. 7)<br>In extricating myself from the dyadic play with Sindy and encouraging Mrs S to join in, while simultaneously taking in both the projections and narrative that suggest a rivalrous relationship between Mrs S and her mother, containment of Sindy's anxiety by Mrs S, via containment of Mrs S' anxiety by therapist, is facilitated. (Ch. 7)<br>Zach (Ch. 6 and 7) relates to the therapist as a third who allows him safely to separate from his mother and begin to explore the world.<br>For Ben (Ch. 7), the therapist represents a father-like grandmother who offers structure and differentiation and allows for an ushering in of more oedipal relating. |

In many instances, the secondary port of entry may be the only port of entry and this anticipates a related question of what does or does not, in terms of the South African field,

constitute parent-infant *psychotherapy* and/or *psychoanalytic* psychotherapy? Of the intervention sites reported on in this study, the parent infant programme associated originally with the epidemiological study (Cooper, et al., 2009) in Khayelitsha township most clearly highlights this question and it is discussed here with reference to ports of entry. Parent Infant Counsellors (PICs) working in the Khayelitsha Parent Infant Project, who for example show mothers how to play with their infants, are really only using the secondary port of entry referred to in Table II (below) as 'developmental guidance'. They are neither psychotherapists in terms of training, nor is the service they offer psychoanalytically defined, but they are supervised by a psychoanalytically-oriented supervisor and in this respect psychoanalytically-oriented supervision is identified as a secondary port of entry in terms of access to the parent-infant system. Landman (see Chapter Five) is quoted in explaining how anxieties originating in the mother-infant dyad are contained by the PICs who are then supported in psychoanalytically-oriented supervision. Landman, a parent-infant psychotherapist herself, devised the PIC training and continues to consult to the programme thereby bringing a further level of psychoanalytic thinking to bear on the process.

In South African community settings there may be insufficient resources to offer a parent-infant psychotherapy that utilises a primary port of entry to at-risk mothers-with-infants; hence secondary ports of entry may have to suffice. Arguably, creative and adaptive responses can allow for psychoanalytic thinking to trickle down to the parent-infant system. In Chapter Five I have suggested that it is the employment of psychoanalytic mindfulness that characterises the adaptive responses described by South African practitioners to the challenges they face in their endeavours to bring parent-infant mental health treatments to parents-with-infants in need.

To conclude this aspect of the discussion; I have found in this research that ports of entry are less discrete in both definition and application than Stern (1995) originally purported. If, as has been reported and described, psychoanalytic parent-infant psychotherapists utilise multiple ports of entry and often in conflation, then an interrogation of the impact such multiplicity in clinical focus will have on the psychoanalytic frame is necessitated. This represents a final research sub-question investigated in this study and has not directly been addressed elsewhere. It is the presence of multiple family members in the psychotherapy encounter that sanctions the employment of multiple ports of entry. Consequently, it is the

utilisation of several ports of entry, often simultaneously, that strains the psychoanalytic frame and impacts the psychotherapist's efforts to maintain that frame.

## The psychoanalytic frame

The frame is frequently defined in the literature in ways that imply a circumscribing of psychoanalytic space (Bass, 2007; J. Hoffman, 1997; Künstlicher, 1996; S. Stern, 2009). Künstlicher (1996) refers in this regard to the differentiation between the internal and external worlds, while Hoffman (1997) addresses more tangible matters such as session scheduling, fees, breaks, and the rules of encounter in the room, including the seating. Quinodoz (1992), in equating the psychoanaltyic frame with the setting, defines it as the instrument of the active container function. In addition to the spatial, temporal and financial facets of the setting, Quinodoz (1992) elaborates the importance of refraining from action as a fourth facet. In my own conclusion then, it would seem that the frame serves to contain the transferences. The contract around the frame allows for transgressions to become apparent, and for these to be interpreted as transferential enactments. The frame is thus critical to the endeavour of psychoanalysis. It can be considered the rules of the game (Bass, 2007) that structure the psychoanalytic process and may distinguish psychoanalysis from psychotherapy (Eisold, 2005; Quinodoz, 1992). I will elaborate these ideas in suggesting that a more flexible definition of the psychoanalytic frame best serves parent-infant psychotherapy.

The frame's potential for flexibility has been variously referred to in the literature: as something that can be creatively managed (Bass, 2008); as a product of negotiation between patient and analyst (Greenberg, 1995; S. Stern, 2009) that can be preserved or bent (Bromberg, 2007); as something that can be widened and made more supple, particularly in terms of multiple transferences when working with couples/families (Gerson, 1998); and as necessary to accommodate a widening scope of practice (S. Stern, 2009). To elaborate this latter claim, S. Stern (2009) suggests that intersubjective dialogue depends on safety, emotional attunement and communicative responsiveness. Such intersubjective sensibility demands the kind of freedom — as practised by Winnicott (1941, 1947, 1971b, 1978) — that allows for adaptations to the setting (frame) so that the patient's needs may be met and the analytic process better facilitated.

## TABLE II: SECONDARY PORTS OF ENTRY

THESE REPRESENT CONTEXTUAL PORTS OF ENTRY TO THE ATTACHMENT SYSTEM WHICH IS MADE UP OF THE CAREGIVING AND THERAPEUTIC RELATIONSHIPS. OPENING THE SECONDARY PORTS OF ENTRY MAY BE A PRELIMINARY NECESSITY TO ACCESSING THE PRIMARY PORTS OF ENTRY.

| SECONDARY PORT OF ENTRY | EXAMPLE |
|---|---|
| **Socio-cultural environment and language/culture translation** | Mothers in townships frequently send their weaned infants home to grandmothers living in the rural areas to be raised — this is a cultural habit that could be challenged rather than custom. (Berg interview, Ch. 7)<br>Berg describes the importance of working with a translator who is also a cultural mediator. (Ch. 7) |
| **Socio-economic environment** | Home visits by social workers may foster social support e.g. facilitate applications for social grants. |
| **Educational environment** | Educational books that offer advice and encourage reflective parenting, e.g. Perkel's (2007) book.<br>Working at the intersection between external worlds — including the school and teachers — and the internal world of the child is described by Edwards and Maltby (1998). |
| **Developmental guidance** | Therapist equates learning to sleep alone with the process of weaning, thereby suggesting a gradual process of letting go at night. Parents take this up concretely, reporting literal steps of increased distance at bedtime. (Ch. 6)<br>Home visits where PICs dispense advice as in the Khayelitsha Parent Infant Project. (Ch. 5)<br>The 'talk' initiated to inform nurses and facilitate mothers to approach Baby Mat practitioners. (Ch. 5) |

| | |
|---|---|
| **Observation** | Winnicott's Set Situation and the Canadian Watch, Wait and Wonder approach. (See Ch. 2 and Ch. 4) |
| **Group dynamics/culture** | New Beginnings groups of mothers and toddlers in community settings. (Ch. 7) |
| **Supervision** | Landman (Ch. 5) describes psychoanalytic supervision that is offered via a tiered structure to the lay counsellors working with mothers and infants in the township. |

## Multiple ports of entry and the psychoanalytic frame

Certainly the therapeutic frame might require a novel demarcation in the context of an intervention that involves several different ports of entry into a dynamic system made up of parent(s) and child(ren). The critical question of whether such demarcation can be constituted psychoanalytically demands engagement. This is particularly important given that many of the traditional conventions and assumptions regarding the psychoanalytic frame are intentionally or unavoidably over-ridden in parent-infant psychotherapy. Several of these contraventions have been implied or illustrated in preceding chapters. For example, the reader is reminded of the brief and often serial duration of treatment (Stern, 1995) particularly as reported on in the clinic and community settings described in Chapter Five. The occasion of psychotherapy is also foregrounded, not only in terms of uncommon seating arrangements in a more traditional consultation room but also on the floor in a municipal clinic (see the Baby Mat Project, Chapter Five) or in the kitchen of a home (see Fraiberg, et al., 1975). Therapeutic neutrality, which as a concept comes under scrutiny in any intersubjective process (of which parent-infant psychotherapy is arguably an example), may be revoked. For example, the psychotherapist's neutrality is undermined whenever s/he responds to requests by parents for advice or developmental guidance, and similarly during physical interactions with infants and young children through play and touch. Infants and young children can subvert the narrative spoken process by initiating play (this from a drive towards curiosity). Direct engagement of the therapist by the infant/young child and vice-versa may challenge the frame. Such

engagements do not represent an abandoning of the analytic framework but rather a furtherance of the therapeutic aim (Thomson-Salo, et al., 1999). Further complexities are introduced by the presence of multiple family members in varying combinations; either on request of the therapist and/or determined by the family and only apparent on arrival at a session. The inclusion of a translator (see Berg and Frost interviews, Chapter Five) will add to the intricacies of the clinical encounter and the strain on the frame, as do the manifold transferences and countertransferences determined by the matrix of relationships inherent in a multi-person interaction.

In referencing Daniel Stern's intersubjective clinical system, relational psychoanalyst Altman (2002) makes a claim for more flexibility for child psychoanalysts "while retaining a psychoanalytic frame of reference as guide" (Altman, 2002, p. 37). This statement may be applied equally to parent-infant psychotherapists for whom theoretical and practical challenges abound, but who may want to work in such a way as to maintain a psychoanalytic frame. As Cudmore (2009) stresses, "the establishment of a containing structure or framework, a reliable setting, [is] vital in order to allow the emergence of the family's worries" (p.1). In addressing the tension between the need for therapeutic boundaries and the need for concrete assistance when offering parent-infant psychotherapy in community health settings, Renschler (2009) argues for flexibility. Such requirements of flexibility are echoed in the argument I am proposing for a flexing of the frame, but it is the impact of utilising multiple ports of entry on the parent-infant psychotherapeutic frame that is underscored here.

Quinodoz's (1992) four facets of the psychoanalytic setting[59] — temporal, spatial, financial, refraining from doing — are used here to organise a discussion of the impact on the psychoanalytic frame of multiple ports of entry. In this discussion I am also endeavouring to build a defence of parent-infant psychotherapy as psychoanalytic.

In terms of the temporal factor, deviations from a more traditional treatment setting include: the duration of a session; the pacing of sessions which may vary from weekly to less

[59] Quinodoz's facets reference traditional, individual psychoanalytic encounters and hence require elaboration from the perspective of parent-infant/young child psychotherapy.

frequently[60]; and the length of treatment. In terms of session duration, the Lefika Caregiver-Child Counselling Centre (see Chapter Five), for example, offers extended consultations in anticipation of clients only attending once. By contrast, Berg's parent-infant interventions in Khayelitsha are shortened to 15-20 minutes in accordance with a medical consultation (Chapter Five). While brief interventions with infants and their parents developed as a result of the pressure in clinics of long waiting lists coupled with the urgent need for attention in what is identified as a vulnerable population (coupled with financial and resource constraints), longer term interventions beyond first magical symptom relief may promote the development of healthy object relationships and/or prevent the development of pathological ones.

Stern (1995) defends the practice of what he terms brief serial treatment. Following his discussion, serial treatment in parent-infant psychotherapy is considered appropriate and to be expected (rather than an indication of therapeutic failure) given the correspondence of therapeutic change with developmental change during infancy and early childhood. To defend deviations to the temporal factor as described above, the reader is reminded of Winnicott's willingness to bend the analytic rules if the patient's condition or material circumstances suggested such a necessity (Geissman & Geissman, 1992; Lanyado, 2009; Weltner, 1982; Winnicott, 1971b, 1978). What may result, however, from flexibility in terms of duration factors, are shifts in terms of the port of entry. Longer term therapy with some parent-infant couples may, for example, involve individual adult work or marital work (England, 1997).

The spatial factor also requires an extended definition beyond the description of a typical consulting room as implied in Quinodoz's (1992) discussion. Arguably, part of what determines the 'space' is the presence/absence of significant family members. As Stern says: "that the baby is present does not in itself make the therapy a parent-infant psychotherapy" (1995, p. 113). Further to this statement; when the baby is present, how is the space framed for that baby? Frost (Chapter Five) reports on working in a busy municipal baby clinic that has no separate room available and the adaptation of a mat to represent a safe, contained space. In more traditional settings, parent-infant psychotherapists will offer various forms of seating; adult chairs, a soft mat, cushions, children-sized chairs with table, a couch. The position the therapist adopts relative to the parent(s) and children, and indeed the relative seating of family members, may draw attention to which port of entry is being privileged, and

[60] See Von Klitzing (2003) for a description of the pacing of a parent-infant psychotherapy, initially fortnightly, then monthly and then a bigger break of a few months.

shifts in the ports of entry (as seating arrangements alter) over the course of the session(s). Given that presences/absences may vary from session to session in parent-infant psychotherapy, their constancy cannot be used to determine the frame; rather and importantly it is their inconstancies that are considered significant and portent with meaning. Related to this are technical issues to do with addressing absences and acknowledging presences.

The financial facet of the frame is implicated not with respect to the multiplicities of persons present, but rather in terms of the broader contextual (and secondary) ports of entry. In many community services the parents in the clinical encounter aren't expected to pay for their treatment, hence as a containing, framing facet the financial factor is eliminated. Furthermore, in South Africa issues of poverty and deprivation may contaminate the frame. As reported in Chapter Five, Berg does not expect children in the township settings to share toys — rather, if necessary, a toy is given — and this requires a reframing of provision of opportunities for play. Partly in response to this, Berg presents the infant with a biscuit (see Chapter Five).

Finally, in parent-infant psychotherapy the fourth of Quinodoz's facets, that is refraining from doing, is also frequently contravened (see Renschler, 2009). Stern (1995), in his challenge to the view that parent-infant psychotherapy is not psychodynamic, demands that we define whether action is at the theoretical or technical centre of the therapeutic approach. In terms of a psychoanalytic orientation, thoughts about acts rather than overt acts themselves are privileged, but following Stern (1995) and Renschler (2009), this does not deny action. Typical actions (which are differentiated from enactments, see Renschler (2009)) in parent-infant psychotherapy may include physical contact, interactive play, concrete assistance and developmental guidance. With older infants particularly but not exclusively, a more active role is taken up by the youngest member of the parent-infant system. Play becomes a crucial nonverbal communication and verbal interactions are increasingly introduced. Recruitment of the therapist into play interactions (as described for example in the ball play with Sindy, Chapter Seven) challenges the position of abstinence and neutrality. Additionally, breaks with more traditional definitions of the frame in terms of contact with third parties (school authorities, referring health practitioners, social services) are not uncommon in work involving young children and families.

In Chapter Five I discussed the role of psychoanalytic mindfulness in informing parent-infant interventions that take place in non-traditional settings. This concept is not dissimilar to the

idea of interpretation-in-action, originally credited to Ogden (1994) and applied to parent-infant psychotherapy by Renschler (2009). Common to both notions is the emphasis on reflective functioning. As Renschler describes it: "The therapist's thought process or reflective functioning is by far the most important component of interpretive action, and such interpretations are impossible without the therapist engaging in self-reflection before, during and after the action" (Renschler, 2009, p. 149). Although his focus is narrower than that of this study, Renschler's (2009) bridging of concrete assistance as thoughtful action to the importation of psychoanalytic ideas of practice into community health settings is relevant. Without embracing a flexing of the psychoanalytic frame, vulnerable, impoverished and hard-to-reach South African parent-infant populations will be further deprived — this time in terms of receiving psychoanalytically-oriented early interventions[61].

This study offers an additional perspective from which to incorporate thoughtful action entirely abandoning the notion of the psychoanalytic frame. Exploiting the notion of a grandmaternal transference defends a flexing of the frame, without a forfeiting of its psychoanalytic purpose as container of time and space, and of the transferences. For example, home visits, physical contact (holding the baby) and tendering developmental guidance are accommodated within the domain of the motherhood constellation and the grandmaternal transferential role within that. Additionally, emphasising the therapist-as-grandmother enables parent-infant psychotherapists who have not benefitted from dedicated training to take up a useful position in the consultation setting from which both the infant's and the parent's needs, representations, interactions and transferences can be accommodated and considered.

This emphasis on the motherhood constellation and the primitive anxieties with which early mother-infant development is associated, suggests a further possibility in resolving the tension between multiplicities in terms of ports of entry and the maintaining of a frame that preserves a psychoanalytic endeavour. I refer to the therapeutic alliance.

[61] For England (1997), referencing the then new United Kingdom National Health Service, the distinction between early intervention and prevention is important in order to avoid viewing prevention as a luxury. This may be a crucial point in considering the role of parent-infant psychotherapy in South Africa for, as England (1997) stresses, early intervention both treats an existing dysfunctional parent-infant relationship and contributes to the laying down of healthy foundations for future relating.

## The therapeutic alliance

There are commentators for whom the concept of the therapeutic (or working alliance) is seen as heir to Freud's notion of an unobjectionable positive transference (Levy & Inderbitzin, 2000); a freeing from the 'shackles' imposed by Freud's 1915 and 1919 rule of abstinence (Lindon, 1994). Following Shachter (1992), the therapeutic alliance is defined in terms of the analyst's concern for the patient's welfare, and the trust that results in the patient's perception of this. Despite controversy surrounding its technical utility, the concept of the therapeutic alliance has become a cornerstone of research in contemporary psychotherapy (Gabbard et al., 1988) and the most potent predictor of long-term outcome and the stable maintenance of therapeutic gains (Gabbard, et al., 1988; Schachter, 1992).

I would argue that, given the intensely primitive and often persecutory anxieties stirred up in work with parents and their young children, any intervention in this field needs predication on a positive therapeutic alliance. Stern (2004) calls this the "therapeutic holding environment" and suggests in terms of the parent-infant therapeutic population that "[t]his environment must be far more positive, validating, and accompanying than traditional therapeutic alliances (Stern, 2004, p. 41). For example, the case of Ms C — full-time CEO and single mother — and 'cheeky' and defiant three-year old Connor, presented in Chapter Seven in illustration of a negative grandmaternal transference, illuminates the derailment threat posed by an ambivalent therapeutic alliance. Mrs C, while aggressive and demanding, was also anxious, insecure and largely unsupported in her maternal role. Given the brevity and frequent urgency of the intervention, it is arguably not possible or desirable to work through a negative transference over time. Rather, it is incumbent upon the psychotherapist to recruit the parent(s) into a working alliance by addressing negativity immediately and with empathy.

Given the multiplicities of persons present in the clinical encounter, the therapeutic alliance is neither unitary, nor static. Arguably, it is in pursuit of the establishment of a therapeutic alliance that enlists the trust of all parties that the employment of multiple and fluctuating ports of entry is both practical and necessary. This was also foregrounded in the case of Connor referred to above (see Chapter Seven); his destructive feelings threatened to destroy the clinical process. Interestingly, it is through group-based case discussions, where alliances and identifications with different members or sub-systems of the clinical system frequently

emerge, that we are most clearly reminded of the importance of acknowledging and utilising the manifold ports of entry in order to contain and sustain the clinical process. To elaborate, the presentation of a case in the supervision or work discussion groups I facilitate often splits the group as members identify and align themselves with the different members of the family. For example, a mother like Mrs C may be perceived by some as hardworking, unsupported and left to struggle with an oppositional and difficult child, while other group members may empathise with Connor as a neglected and emotionally uncontained child. A therapeutic alliance is quintessential and ultimately justifies both the use of multiple ports of entry in parent-infant psychotherapy and the flexing of the frame that is then necessitated.

## Defending parent-infant psychotherapy as psychoanalytic

This claim anticipates, as indicated above, the question of at what point an intervention that involves multiple ports of entry and a flexible frame ceases to be a *psychoanalytic* psychotherapy. As has been discussed, key defining concepts in parent-infant psychotherapy are embedded in foundations of psychoanalytic theory, and practice. Theoretically and historically it is the close ties in origin with psychoanalytic thought that most clearly locate parent-infant psychotherapy within the psychoanalytic paradigm. Baradon and Joyce (2005) identify the psychoanalytic model as "the frame of reference for understanding experience, activity and development in the parent and infant, their relationship with each other and their relationship with the therapist" (p. 33).

I would argue that it is particularly the symptom, or the presenting concern, that is understood and engaged with from within a psychoanalytic frame of reference. The efforts of the psychotherapist to attribute meaning to the manifestation of the symptom, not only theoretically but particularly technically, qualify parent-infant psychotherapy as psychoanalytic in orientation. Attending to the transferences and countertransferences may further differentiate psychoanalytically oriented parent-infant psychotherapy from its more behavioural or cognitive-behavioural counterparts. This is true, regardless of whether transferences are only recognised and reflected upon, or also actively interpreted[62]. At all

[62] The reported use of transference and countertransference varies across the literature (Barrows, 1997; L. Hoffman, 2004; Hopkins, 1992), but a shift towards a more active use of transference dynamics is evident in more recent publications (see for example Emanuel, 2009 as compared to comments in Emanuel and Bradley, 2008).

times, however, such attendances to transferential and countertransferential phenomena are in the service of relieving the parent-infant dyad from the anxiety that underlies the symptom.

This research set out to explore the question of what parent-infant psychotherapy is, how it works and when it is a preferred intervention. Psychotherapy case studies and case vignettes were used to investigate the question. In all cases, a presenting concern or symptom had been clearly articulated by the parent. The psychotherapies were endeavours to understand and alleviate the symptom using a psychoanalytic model, albeit with a more flexed frame in terms of technique. Across private practice settings in South Africa, similar referrals to those discussed in earlier chapters (sleep and other regulatory difficulties, problems with bonding, behavioural concerns) are made. In community settings, and the kinds of busy clinics described by Berg and Frost (reported in Chapters Four and Five), typical presenting concerns may differ (worries about birthmarks, failure to thrive, maternal depression), but as symptoms, often of attachment difficulties, they are engaged with from a psychoanalytically-informed orientation and as such a parent-infant psychotherapy intervention remains the preferred mode of treatment. The reader is reminded, however, that this research identified contextual adaptations to more typical interventions and these will impact the psychoanalytic frame. For example, Berg (Chapter Five) reported the necessity of a revision of her Euro-centric Anna Freudian training. For her, the keeping of time and boundaries, the avoidance of acting-out and the focus on the individual were assumptions about the analytic frame that required rethinking. Rethinking does not, however, equate to abandoning the psychoanalytic frame. Regardless of context or the particular manifestation of the psychoanalytic frame, it is an expression of clinical curiosity as regards the symptom or the presenting problem in terms of its latent meaning that seems to differentiate psychoanalytic from non-psychoanalytic interventions, across all three clinical settings in South Africa.

More contentious in terms of qualification as a psychoanalytic psychotherapy is the Parent Infant Project that evolved out of the large epidemiological study into maternal depression conducted by Cooper and collaborators (Cooper, et al., 2002; 1995; Cooper, et al., 2009; Cooper, et al., 1999) and commented on by Landman (Chapters Four and Five). Lay counsellors visit mothers/caregivers-infants at home and while they are themselves not qualified, their psychoanalytically-oriented supervisors are. This intervention does not strictly represent a parent-infant *psychotherapy* because the psychoanalytic frame is abandoned and

the engagement with the symptom is not psychodynamic at the level of intervention. (At the levels of supervision as discussed earlier, a psychoanalytic orientation is evidenced).

The issue of training was identified as a contextual challenge to working in the parent-infant mental health field in South Africa across sectors (Chapters Four and Five). In his discussion of flexibility of the psychoanalytic frame, Scharff (2008) suggests that it can only be entrusted to experienced analysts. While commenting within the context of traditional, individual psychoanalysis, it could be argued that Scharff has a point; employing multiple ports of entry and flexing the frame may require a particular level of therapeutic skill. If this is a most conservative viewpoint, how do we engage with the issue of employing lay counsellors? South Africa has a greater need for parent-infant interventions than is currently being met, hence the importance of acknowledging the current lack of training opportunities in infant mental health, even for qualified professionals[63]. Given the extent of need for infant and indeed parental mental health interventions in this country, lay counsellors have been recruited as service providers on various projects. Over and above the issue of supply versus demand, motivations for employing lay counsellors explored in an earlier chapter (see Chapter Five) include: political redress (Ububele's endeavours to address the inequalities of the past); improved accessibility when counsellors work in their own communities (Landman's discussion of the Parent Infant Project); cultural mediation and language translation (see Berg's and Frost's comments in Chapter Five).

The strongest defence for the employment of practitioners who are passionate about, if not trained in, early parent-child interventions is that in South Africa it is such individuals who have established the infant mental health field and continue to drive and develop parent-infant psychotherapy within it. At the recent WAIMH Congress, held in Cape Town 2012, plenary presentations were made by five South Africans (Berg, 2012d; Davies, 2012; Richter, 2012; Solms, 2012; Tomlinson, 2012), and abstracts submitted by several others were accepted for presentation as workshops, symposia and clinical teach-ins (including among others Bain, 2012; Benatar, Sloth-Nielsen, Tomlinson, & Swartz, 2012; Beukes, 2012; Dugmore, 2012b; Frost, 2012; Frost & Esterhuizen, 2012; Koursaris & Maharaj, 2012; Long, 2012) . The

[63] Adaptive responses to the dearth of accredited training, which includes the establishment of non-accredited courses, have been discussed in Chapter Five.

innovative work being done in the infant mental health field in South Africa was of great interest to international colleagues.

Finally, in response to the issue of training, Fonagy (1998) cites research that suggests that the therapist does account for differences in treatment effects, but his/her experience and training contribute only a modest proportion of this. He goes on in this paper to speculate that it is the absence of the conflict between being "friend and helper on the one hand, professional and expert on the other" (Fonagy, 1998, p. 131) — a conflict intrinsic to a psychotherapeutic relationship — that may contribute to the effectiveness of using volunteer helpers. It would seem that it is primarily at the secondary ports of entry register, as used in the more innovative settings and sites of parent-infant interventions, that lay counsellors may be usefully employed as service deliverers. Fonagy's (1998) comment seems to provide a response to the challenge of limited training opportunities; the establishment of a therapeutic alliance can be held as a primary aim. This supports the argument for increased flexibility in the frame in the service of establishing a working alliance.

## Ethics

I want to end this discussion by raising a topic widely neglected in the parent-infant psychotherapy literature; that of ethics. It is pertinent to this discussion because, as I will argue, using multiple ports of entry not only impacts the psychoanalytic frame, it also complicates and potentially compromises ethical psychoanalytic behaviour. This is potentially paradoxical as regards parent-infant psychotherapy as it is the psychoanalytic frame that is frequently referenced in the description and proscription of ethical behaviour. The South African Psychoanalytic Confederation recently developed a Code of Ethics (Silove, et al., 2011) that has been widely acknowledged as a crucial document. There would seem to be several "Ethical Standards" that present areas of potential conflict for the parent-infant psychotherapist working as defined and illustrated in this research

The first principle pertains to respect for human dignity and includes the idea of informed consent. Any work with children is going to invoke discussion of what constitutes informed

consent, and no less work with infants and young children[64]. Of pertinence here, and related to the ethical standard of respect for the welfare of the client, is the controversial issue of including infants/young children in sessions where more difficult aspects of adult experience are openly discussed. Obvious examples include narratives of traumatic experiences, marital discord, illness and death and the disclosure of negative representations and perceptions of the infant/young child and/or other family members. Theoretically, it is the presence of the infant that elicits such disclosures (Fraiberg, et al., 1975) and affords rich clinical opportunities that compensate for complexities that arise given the presence of the child (Lieberman, 1992). I would argue that children are exposed to more complex or negative family matters anyway, sensitive as they are to such dynamics whether they are articulated verbally or not[65]. In the clinical setting, opportunities for mediation and expression of painful feelings are afforded, as well as opportunities for resolution and reparation.[66]

Under the principle "Responsible and Competent Caring" the Code includes the ethical standard "Professional competence" which states the need for working within a range of professional competence and training. As has been discussed above and in Chapter Five, for many practitioners in the infant mental health field in South Africa, training is limited and often acquired "on the job" so to speak. The ethics document makes an allowance for such, indicating that "[t]he practitioner should consult with other suitably qualified practitioners while developing new areas of competence" (p. 113). Read in the context of this discussion, the need for supervision is foregrounded.

A further ethical standard included in the Code's list is that of "Disciplined maintenance of the psychoanalytic frame". The document lists structural features of the analytic frame as "consistent arrangements with regard to place, time, fees and holiday breaks" (p.115), which may be more easily defined and adhered to in private practice settings but clearly do not help define the psychoanalytic frame in the kinds of community/clinic settings reported on in this

[64] At the recent WAIMH Congress held in Cape Town in April, 2012, a pre-congress workshop addressed the question of infant rights and the development of a declaration of infant rights. This remains on the agenda of the association.

[65] I would curtail disclosures and discussions of adult sexual relations in front of infants and young children, preferring to consider such evidence of the need for a couple-only intervention.

[66] This is evidenced in the case of Zach (Chapter Six); Zach had listened to his mother's emotional and detailed account of her own father's death. Reportedly, when he got home he asked his mother about his deceased grandfather and this facilitated the mourning process for Mrs Z, and ultimately the separation process for Zach once he was relieved of the projections he carried for his mother.

research. The ethics of maintaining a psychoanalytic frame that is defined far more flexibly remain unclear, however what can remain true is the purpose of the frame as defined in the document; namely the creation of a safe analytic setting — that is a safe space. As has been discussed earlier, the establishment of a therapeutic alliance implies this.

Parent-infant/young child work with its inherent and manifold alliances evokes a further ethical conflict. "Conflict of interest", included under the principle of "Integrity" in the document, alerts the practitioner to the "implications and dangers of engaging in multiple relationships with clients or with clients' family members" (p. 117). The document acknowledges the necessity of such in citing community counsellors "whose private life intersects with that of the community served" (p. 117). Such counsellors are urged to be conscious of the meaning and impact of having multiple relationships in their work. Multiple relationships are an inevitable consequence of multiple ports of entry and in the field that is the subject of this research, this is not limited to the experience of counsellors working in community settings (as covered in the code of ethics). The wording of the document may warrant future revision, but this does not exempt parent-infant psychotherapists from heeding the inherent dangers as implied in these statements.

I will recall and elaborate some case material to illustrate the need for ethical integrity.

As has been illustrated (Chapter Six), it is through the therapeutic process of holding and/or containing something for the parent that the infant/young child is relieved of the burden of carrying the parental projections. This anticipates a shift in patient register, and possibly theoretical target, once such projections have been withdrawn and reclaimed by the parent; frequently parents request either explicitly or implicitly that they need individual (or couple) therapy. For example, in the case of Sindy, reported in Chapter Seven, Mrs S started presenting herself, literally, without her daughter, claiming she'd run out of time to fetch Sindy from daycare before the scheduled appointment. Recalling the concept of the grandmaternal transference, what is proposed is that a shift in the primary transferential register from grandmaternal to maternal was underway. While in and of itself this may not indicate an ethical issue, the unanticipated consequences do require ethical engagement. I agreed to see Mrs S on her own after she resisted my efforts to refer her to a colleague for individual work. This resistance is frequently encountered and reported by parent-infant psychotherapist colleagues and seems best explained in terms of the powerful grandmaternal

transference that has incorporated a maternal aspect that now comes to the fore[67].) After a period of several months, Mrs S and her husband separated pending a divorce. Mr S then contacted me reporting difficulties in his relationship with Sindy and requesting a father-child intervention. I made a referral to a colleague, a recommendation he angrily refused to take up claiming that he and his estranged wife were equally entitled to my professional services with regards Sindy given that he had been part of the initial parent-infant consultation.

A similar example of a possible dilemma is when dyadic parent-child psychotherapy develops into individual child psychotherapy (as discussed for example in Von Klitzing, 2003). This may not be ethically problematic given the common practice of involving parents in their child's therapeutic process via regular feedback or review sessions (and the young child's expectation that such will happen). However, there are situations when a sibling included in earlier family-constellated sessions later presents as needing individual work. The parent-infant practitioner may have to grapple with an appropriate outside referral and the justification of such to both the parents and the second sibling. Different members of a family can push and assert their needs and demands so that the theoretical target and ports of entry may necessitate reform over the course of treatment, and this may surface ethical dilemmas.

## Conclusion

This research has shown that any attempt to apply psychoanalytic practice to infant mental health will of necessity demand our engagement as psychotherapists with multiplicities. Opening up ports of entry, at both a primary and a secondary level, is helpful if we are to access the multi-levelled clinical system which has at its heart the mother-with-infant. Opening up ports of entry impacts the psychoanalytic frame, necessitates a flexing of that frame. Parent-infant psychotherapy, given the tensions associated with the multiplicities and flexibilities inherent in its practice, demands engagement with ethical issues. It is the highlighting rather than the resolving of tensions around these issues that has been the purpose of this chapter. Further discussion is encouraged.

[67] There are frequent references in the international literature to particular family members or groupings being referred outside of the original parent-infant therapeutic relationship, but what seems particular in such cases and absent in the typical South African situation, is that these original encounters take place within a clinic system. A positive transference to the clinic itself may facilitate referrals to practitioners identified as belonging to it, whereas for South Africans working in private practice the referral gap is possibly perceived as too unfamiliar to feel safe.

# CHAPTER NINE

## Limitations and directions for future research

This short chapter outlines the limitations of this research and points to directions for future research. These two issues are not mutually exclusive; identified limitations have implications for future research.

Methodological limitations have been discussed in Chapter Three. Of these, shortcomings in the data selection process may represent the greatest weakness of the study and are reiterated here.

The selection of key stakeholders relied on reviewing published literature, identifying parent-infant practitioners from lists of presenters and attendees at psychoanalytic conferences and pursuing word-of-mouth recommendations. Subsequent to the journal submission of the manuscript that constitutes Chapter Five, I learnt of a mother-child service at Tygerberg Hospital in the Western Cape. This omission represents a regrettable oversight and raises the possibility of further exclusions of key interviewees and hence related sites of intervention. A similar selection flaw pertains to my failure to contact all university psychology departments in order to ascertain the curricular inclusion or exclusion of infant mental health. This research commenced in 2009 and data collection was completed within 24 months. The interviews fairly comprehensively record activity in the South African field, as defined in this study, as of 2011. Future research may need to update and more rigorously survey parent-infant psychotherapy practices.

Although this research endeavoured to investigate all three sectors of the South African mental health field, there was a stronger emphasis on the private sector. This is the sector with which I am primarily familiar and in which I principally work. It is also the sector that was maximally represented in terms of the research participants' context of work. Twenty-seven interviewees (including the 15 who made up the focus group) have worked or do work as

parent-infant psychotherapists in private practice. This foregrounding of the private sector at the expense of the other two sectors may represent a limitation in and of itself. The case study based aspect of the research has been embedded in my own practice, representing a further shortcoming in terms of transferability. With regards identifying suitable case studies from my own private psychotherapy practice, convenience selection in terms of ethics and feasibility prevailed. This is not incommensurate with published psychotherapy case study literature that invariably draws on the author's own clinical experience. The issue of transferability of case study data results may have been further compromised given the limitations in number and the focus on depth in most of the presented case material. This may not be unusual in psychotherapy case study based research but it is acknowledged as an inherent shortcoming.

In endeavouring to explore a large field, this study employed broader definitions of key concepts. This may have resulted in a less detailed examination of central concepts. For example, this research has limited its field of enquiry to parents-with-infant. 'Infant' has been broadly defined as under four years of age. The similarities and differences between parent-*infant* and parent-*toddler* psychotherapies have not been exhaustively explored. This continues a trend in the literature where parent-infant and parent-*child* psychotherapies are not well differentiated. Identifying particular ports of entry and associated therapeutic and technical approaches for children in different developmental phases of life may represent a useful direction for future research. Parents have also been described homogenously in contradiction of our clinical understanding of the many cultural, personality and mental health variants within that population. This research has not explored the relationship between different ports of entry and diversity within the parent population. Future research may focus on classifying parents before considering preferred ports of entry in order to optimise therapeutic interventions.

An anonymous reviewer of one of the manuscripts drew my attention to the relative neglect of cultural issues in this research. Cross-cultural and culturally-sensitive practices were briefly investigated in the semi-structured interviews and not included in the literature review. Although the primary focus of this research was not on issues of culture, such issues constitute important areas for future possible research, particularly given the importance of acknowledging the role of culture both in terms of parenting practice in South Africa and in respect of mental health interventions.

The more unified definition of parent-infant psychotherapy underpinning this research, that is a definition that embraces multiple psychoanalytic theories of the parent-infant relationship and the psychotherapy encounter, may not be convincing to all readers. This study emphasises similarities rather than examining differences between the various approaches to and practices of parent-infant psychotherapy. In part this has been informed by my own training and supervision which has been eclectically informed and shaped by exposures to several schools of psychoanalytic thought. In part it has been intentional: Stern's (1995) unifying thesis has been elaborated in order to cohere diverse parent-infant interventions in this country. Successful advocacy of psychoanalytically-oriented parent-infant treatments to national health structures will depend on diverse practitioners finding common ground and presenting a unified approach. A deeper examination of how psychoanalytic psychotherapy is defined, given the current constitution and future delineating of the mental health field in South Africa, would be an implication for future research.

Any South African parent-infant intervention that is predicated on a psychoanalytic developmental theory that prioritises the parent-infant attachment relationship was eligible for inclusion in this study. Sites of intervention were not limited to traditional psychoanalytic psychotherapy settings and practitioners interviewed were not all professionally trained as infant mental health specialists. This may limit the transferability of these research findings to practices in other countries. It does, however, open up the possibility of further research into the use of lay counsellors and the training of such in this country.

One of several criticisms of the psychoanalytic case study as a research method is that it is inherently seductive (Tuckett, 1993; Widlöcher, 1994). Given that this research was intended to serve an advocacy goal, this criticism is acknowledged. While no intentional efforts were made to present the case study material in a skewed fashion, I cannot claim complete separation of the multiple roles of researcher, psychotherapist and advocate that I have fulfilled in respect of this doctoral study.

Stern's (1995) concept of the good grandmother transference has been highlighted in this thesis as the grandmaternal transference Future research into the application of this concept and into expanded understandings of the grandmaternal role in the domain of mother-infant relating are warranted. Grandparents and grandmothers are widely neglected as an object of research generally in the psychoanalytic literature. In South Africa specifically, the cultural

or customary role of grandmothers and the impact these have on the mother-infant domain — both in terms of psychological theory and treatment interventions — demand a more thorough investigation.

Similarly, the link between Stern's concept of ports of entry and the context of South African psychoanalytic practice invites deeper examination. Future research may focus broadly on the use of ports of entry and different registers of ports of entry when applying psychoanalytic principles to community based interventions. Narrower research arising out of this study may further interrogate the usefulness of the concept in terms of parent-infant psychotherapy. An under explored area is that of ethics in relation to parent-infant psychotherapy practice.

Historically and currently, national health strategy and planning committees, training institutions and regulatory bodies have neglected to take cognisance of the need for early mental health interventions. The development of the mental health field in South Africa and of governmentally-supported parent-infant treatment services within it is likely to depend on more compelling evidence of the importance of parent-infant psychotherapy than that provided in this study. While this research has argued for an opening of ports of entry and increased flexibility in terms of the frame, future researchers may need to focus more on efficacy and outcome studies if parent-infant psychotherapy as a field is to be afforded further growth.

# CHAPTER TEN

## Conclusion

Although the broad aim of this research was to explore the parent-infant field in South Africa, the specific focus has been on opening ports of entry and flexing the frame in respect of parent-infant psychotherapy practice. Parent-infant psychotherapy has been defined in terms of three factors. Firstly, 'parent-infant' refers to a patient population that involves parents seen in consultations that *include* infants, with the latter defined as being aged under four (zero to three) as per the World Association for Infant Mental Health. Secondly, in terms of 'psychotherapy', a psychoanalytic orientation was assumed. Thirdly, the existence — albeit under-developed — of a field of infant (and parent) *mental* health in South Africa was presumed. Although three sectors of South African practice have been broadly described — public (State), community (non-government) and private — the narrower focus is on the private practice sector.

The research study was broadly qualitative in design, focusing on both descriptive and theory-development processes. The initial of two aspects to the research process was interview based. Interviewees were selected on the basis of their standing as key stakeholders and practitioners in the South African parent-infant psychotherapy field, either currently and/or historically. Interview questions pertaining to the history and the development of parent-infant psychotherapy in South Africa, including an exploration of challenges and adaptive responses, were addressed to interview participants. The thematically analysed results are presented in two of the four central chapters of this thesis. They have also been published as two journal articles in succeeding issues of the *Journal of Child and Adolescent Mental Health*.

In the first article/chapter, the data were used to supplement a review of the South African generated parent-infant psychotherapy literature in order to comprehensively chart and describe both the history and the current status of the field. This was necessary in order to define the object of study and to address a paucity of published, South-African authored

literature. The second article/chapter foregrounds the interviewees' experiences as practitioners in the field. Discussion of the data highlights three perceived challenges — language and culture, the absence of formal training and the inadequate structure of national health services — and identifies several creative responses. Psychoanalytic mindfulness has been identified as playing a critical role in the indigenisation of western-based modes of parent-infant psychotherapy into the South African field.

The second, case study based aspect of research relied on data selected from my own private practice in Johannesburg, South Africa. The case study method represented the tool for gathering and for analysing data. The ways in which parent-infant psychotherapy addresses a symptom as having meaning — given that both the psychotherapy and the symptom are located within a clinical model that allows for different ports of entry— were examined. A sleep difficulty located in the infant was selected as the symptom in relation to which this question was explored. The results of the exploration are presented in the first of the two case study based chapters. This chapter has been published as a journal article in *Psycho-Analytic Psychotherapy in South Africa*.

Two concepts that originate in Stern's (1995) thesis, namely the motherhood constellation and the good grandmother transference, are developed both theoretically and clinically through the introduction of the concept of the grandmaternal transference. While particularly pertinent to the South African field given the traditional role of grandmothers and the cultural role of the motherhood constellation, the grandmaternal transference may be meaningful across many fields of parent-infant psychotherapy practice. Three different configurations of the grandmaternal transference are described and illustrated. The manuscript that constitutes the second of the case study based chapters has been accepted for publication by the *Journal of Child Psychotherapy*.

Integral to this research endeavour has been the employment of Daniel Stern's (1995) concept of ports of entry. Essentially Stern's claim is that the parent-infant clinical system is transformed by action on any one aspect of it; theoretical targets can be reached regardless of port of entry. In this exploration of the South Africa field, an *opening* up of ports of entry has been proposed. This has been signalled both in terms of expanding existing lists of ports of entry, and in introducing the notion of a *secondary* level of ports of entry. The inclusion of secondary ports of entry relies on a protracted working definition of a port of entry that links

to context. In multiple ways, secondary ports of entry reflect adaptive responses to contextual challenges. They represent entry to the broadest level of the parent-infant system — supportive social structures, caregiving culture, parental guidance — without which those elements of the system more directly associated with the psychotherapy encounter (such as representations, interactions and transferences) cannot be accessed. These secondary ports of entry are illustrated, referencing the data, in the Discussion chapter.

This research anticipated that the multiplicities of ports of entry employed in parent-infant psychotherapy would constitute a challenge to current, more rigid definitions of the psychoanalytic frame. That is to say, a traditional definition of the psychoanalytic frame may not suffice when considering the practice of parent-infant psychotherapy. A tension between the pressure exerted by multiple ports of entry and the strictures of psychoanalytically informed practice on the parent-infant psychotherapeutic frame exists. These tensions are illustrated briefly with reference to the interview and case study based data presented in earlier chapters. It is argued in this thesis that opening ports of entry renders as both inevitable and necessary a *flexing* of the frame. Across contexts — private practice, public healthcare and community projects — this flexing will manifest in various ways. A four-faceted working definition of the psychoanalytic frame was used to structure the argument for increased flexibility. It is proposed that the establishment of a therapeutic alliance in parent-infant psychotherapy necessitates the use of multiple ports of entry and a more flexible frame. It is argued that the concept of the therapeutic alliance provides an impasse out of the controversy this provokes.

Opening ports of entry and flexing the psychoanalytic frame brings ethical issues into a new kind of focus. Ethical parent-infant psychotherapy practice, referencing the South African Psychoanalytic Confederation's Code of Ethics, is briefly highlighted. In terms of ethical practice, particularly when the accepted code of ethics does not directly address parent-infant psychotherapy, psychoanalytic mindfulness is proposed as a quintessential ethical tool.

Parent-infant psychotherapy demands engagement with multiplicities in terms of theory — developmental milestones, object relationships, culture — and multiplicities in terms of practice — the meanings of symptoms, identification of patient(s) and points of access. It is in the field of parent-child psychotherapy that the potential for reconciliation of multiplicities seems to exist. For example, it is in this domain that Bowlby and his attachment theory have

finally been embraced by psychoanalysis. Similarly, it is at congresses, conferences and in training courses concerned with infant mental health that psychoanalytic practitioners from historically competitive theoretical camps – Anna Freudians, Kleinians, intersubjectivists, attachment and relational therapists – find common ground and common goals.

When I commenced this doctoral study in 2009, working with parents and young children within a psychoanalytic paradigm was still a largely unexplored, uncharted and undeveloped aspect of the equally neglected field of infant mental health in South Africa. On completion, in 2012, expansion and growth of the psychotherapeutic aspect and the infant mental health field itself is evident. In part this can be attributed to the developmental trajectory the field was already on, encouraged by the passionate, creative and committed practitioners involved in treatment development and delivery. I would like to think that the conference papers and publications that have arisen out of this research have contributed towards further promotion of the practice of parent-infant psychotherapy in South Africa. Investing in the mental health of infants — who represent the future of this country — and their parents who are the custodians of that future, remains an urgent and serious issue.

This research has found that opening multiple ports of entry necessitates and allows a flexing of the psychoanalytic frame. Such flexibility, coupled with psychoanalytic mindfulness, may contribute towards an expanding scope of psychoanalytic practice and a diversification of intervention sites. South Africa faces the challenge of a paucity of mental health services coupled with an endemic need for such. In the furtherance of psychoanalytic practice and its application to South African communities, parent-infant psychotherapy may represent an example of mutual inspiration and a source of hope.

# References


Abraham, K. (1913). Some remarks on the role of the grandparents in the psychopathology of neurosis. In H. C. Abraham (Ed.), *(1955). Clinical Papers and Essays on Psychoanalysis*. (Vol. 2, p.44-47). New York: Basic Books.

Acquarone, S. (1992). What shall I do to stop him crying? Psychoanalytic thinking about the treatment of excessively crying infants and their mothers/parents. *Journal of Child Psychotherapy, 18*(1), 33-56.

Acquarone, S. (1995a). *Mother Infant Psychotherapy: Psychoanalytic Thinking Applied to Parents and Infants in Distress.* Paper presented at the Infant Mental Health Congress. University of Cape Town, Cape Town.

Acquarone, S. (1995b). *What Shall I Do to Stop Him Crying? Psychoanalytic Thinking about the Treatment of Excessively Crying Infants and Their Mothers/Parents.* Paper presented at the Infant Mental Health Congress. University of Cape Town, Cape Town.

Acquarone, S. (2004). *Infant-Parent Psychotherapy: A Handbook*. London: Karnac.

Adair, R. H., & Bauchner, H. (1993). Sleep problems in childhood. *Current Problems in Pediatrics, 23*(4), 147-170.

Altman, N. (2002). Relational horizons in child psychoanalysis. *Journal of Infant, Child, and Adolescent Psychotherapy, 2*(29-38).

Anstead, M. (2000). Pediatric sleep disorders: New developments and evolving understanding. *Current Opinion in Pulmonary Medicine, 6*(6), 501-506.

Bain, K. (2011). Hold my hand, I'm dying': Identification in attachment and melancholia. *Psycho-Analytic Psychotherapy in South Africa, 19*(2), 1-29.

Bain, K. (2012). Paper presented at the 13th World Congress of the World Association for Infant Mental Health: Babies in Mind - the Minds of Babies: a view from Africa. Cape Town, South Africa.

Bain, K., Gericke, R., & Harvey, C. (2010). Bonding experiences in a South African community hospital kangaroo mother care ward. *Attachment: New Directions in Psychotherapy and Relational Psychoanalysis, 4*(3), 235-262.

Bain, K., Rosenbaum, L., Frost, K., & Esterhuizen, M. (2012). 'The mothers have mercy for me': Change in parent-infant relationships through group psychotherapy. *Psycho-Analytic Psychotherapy in South Africa, 20*(1), 33-68.

Balbernie, R. (2001). Circuits and circumstances: The neurobiological consequences of early relationship experiences and how they shape later behaviour. *Journal of Child Psychotherapy, 27*(3), 237-255.

Balbernie, R. (2007). The move to intersubjectivity: A clinical and conceptual shift of perspective. *Journal of Child Psychotherapy, 33,* 308-324.

Balsam, R. H. (2000). The mother with the mother. *Psychoanalytic Quarterly, 69,* 465-492.

Baradon, T. (2005). "What is genuine maternal love?": Clinical considerations and technique in psychoanalytic parent-infant psychotherapy. *The Psychoanalytic Study of the Child, 60,* 47-73.

Baradon, T. (Ed.). (2009). *Relational Trauma in Infancy: Psychoanalytic, Attachment and Neuropsychological Contributions to Parent-Infant Psychotherapy*. London: Routledge.

Baradon, T., Broughton, C., Gibbs, I., James, J., Joyce, A., Woodhead, J., & Parent-Infant Project, T. A. F. C. (Eds.). (2005). *The Practice of Psychoanalytic Parent-Infant Psychotherapy. Claiming the Baby.* London and New York: Routledge.

Baradon, T., & Joyce, A. (2005). The theory of psychoanalytic parent-infant psychotherapy. In T. Baradon, C. Broughton, I. Gibbs, J. James, A. Joyce & J. Woodhead (Eds.), *The Practice of Psychoanalytic Parent-Infant Psychotherapy: Claiming the Baby*. (p. 25-40). London and New York: Routledge.

Barrows, P. (1996). The Motherhood Constellation. By Daniel Stern New York: Basic Books. *Psychoanalytic Psychotherapy, 10*, 175-178.

Barrows, P. (1997). Parent-infant psychotherapy: A review article. *Journal of Child Psychotherapy, 23*(2), 255-264.

Barrows, P. (1999a). Brief work with under-fives: A psychoanalytic approach. *Clinical Child Psychology and Psychiatry, 4*(2), 187-199.

Barrows, P. (1999b). Fathers in parent-infant psychotherapy. *Infant Mental Health Journal, 20*(3), 333-345.

Barrows, P. (2003). Change in parent-infant psychotherapy. *Journal of Child Psychotherapy, 29*(3), 283-300.

Barrows, P. (2004). Fathers and families: Locating the ghost in the nursery. *Infant Mental Health Journal, 25*(5), 408-423.

Barrows, P. (2008). Locating the ghost in the nursery: The importance of the parental couple. In L. Emanuel & E. Bradley (Eds.), *"What can the matter be?": Therapeutic Interventions with Parents, Infants, and Young Children* (p. 171-186). London: Karnac.

Bass, A. (2007). When the frame doesn't fit the picture. *Psychoanalytic Dialogues, 17*, 1-27.

Bass, A. (2008). A few more thoughts on the frame: Forms, functions, and meanings. *Psychoanalytic Dialogues, 18*, 262-268.

Bateman, A., & Holmes, J. (1995). *Introduction to Psychoanalysis: Contemporary Theory and Practice*. London and New York: Routledge.

Beebe, B. (1997). Mother-infant interaction structures and presymbolic self- and object representations. *Psychoanalytic Dialogues, 7*(2), 133-182.

Beebe, B. (2005). Mother-infant research informs mother-infant treatment. *Psychoanalytic Study of the Child, 60*, 7-46.

Beebe, B., Sorter, D., Rustin, J., & Knoblauch, S. (2003). A Comparison of Meltzoff, Trevarthen, and Stern. *Psychoanalytic Dialogues, 15*(6), 777-804.

Belt, R., & Punamäki, R.-L. (2007). Mother-infant group psychotherapy as an intensive treatment in early interaction among mothers with substance abuse problems *Journal of Child Psychotherapy, 33*(202-220).

Benatar, D., Sloth-Nielsen, J., Tomlinson, M., & Swartz, L. (2012). *Infant rights: Development of a Declaration of Infant Rights*. Paper presented at the 13th World Congress of the World Association for Infant Mental Health: Babies in Mind - the Minds of Babies: a view from Africa. Cape Town, South Africa.

Benjamin, J. (2004). Beyond doer and done to: An intersubjective view of thirdness. *Psychoanalytic Quarterly, 73*(5-46).

Berg, A. (2001a). Neglecting culture: A case of failed infant/parent psychotherapy. *Psycho-Analytic Psychotherapy in South Africa, 9*(2), 32-40.

Berg, A. (2001b). *Neglecting Culture: A Case of Failed Parent-Infant Psychotherapy*. Paper presented at the Widening Horizons Conference: The Development of Psychoanalytic Work in South Africa. Ububele, Johannesburg, South Africa.

Berg, A. (2002a). *Programme and Abstracts.* Paper presented at the Conference on Infant Mental Health: Infants in Changing Cultures, University of Cape Town, Cape Town.

Berg, A. (2002b). Talking with infants: A bridge to cross-cultural intervention. *Journal of Child and Adolescent Mental Health, 14*(1), 5-14.

Berg, A. (2003). Beyond the dyad: Parent-infant psychotherapy in a multicultural society - reflections from a South African perspective. *Infant Mental Health Journal, 23*(3), 266-277.

Berg, A. (2007). Ten years of parent-infant psychotherapy in a township in South Africa. What have we learnt? In M. E. Pozzi-Monzo & B. Tydeman (Eds.), *Innovations in Parent-Infant Psychotherapy* (p. 215-230). London: Karnac.

Berg, A. (2011). Infant mental health needs a model of service delivery. *South African Medical Journal, 101*(10),

Berg, A. (2012a). *Connecting with South Africa: Cultural Communication and Understanding*. Texas: Texas A&M University Press College Station.

Berg, A. (2012b). Infant-parent psychotherapy at primary care level: Establishment of a service. *South African Medical Journal, 6*, 582-584.

Berg, A. (2012c). When a little means a lot. *The Signal: Newsletter of the World Association for Infant Mental Health 20*(2), 1-5.

Berg, A. (2012d). *When a Little Means a Lot: Infant-Parent Psychotherapy in South Africa*. Paper presented at the 13th World Congress of the World Association for Infant Mental Health: Babies in Mind - the Minds of Babies: a view from Africa. Cape Town, South Africa.

Bergmann, M. S. (1997). The historical roots of psychoanalytic orthodoxy. *International Journal of Psycho-Analysis, 78*, 69-86.

Berlin, N. (2008). Tripartite therapy with older children: Mutuality in the relationship of a parent-child attachment. *Journal of Child Psychotherapy, 34*(3), 335-363.

Beukes, J. (2012). *Reflections on the Role of the Nanny in South African Society: The "Other Mother" as Symbolised by Help Outside*. Paper presented at the 13th World Congress of the World Association for Infant Mental Health: Babies in Mind - the Minds of Babies: a view from Africa. Cape Town, South Africa.

Bharucha, M., & Bharucha, A. (2009). Baby observation and child psychotherapy training in Mumbai with a brief observational account from one of the students. *International Journal of Infant Observation and its Applications, 12* (2), 240-250.

Bick, E. (1964). Notes on infant observation in psycho-analytic training. *International Journal of Psychoanalysis, 45*, 558-566.

Bick, E. (1968). The experience of the skin in early object relations. In A. Briggs (Ed.), *(2005) Surviving Space: Papers on Infant Observation* (p. 55-59). London and New York: Karnac.

Bick, E. (1986). Further considerations on the function of the skin in early object relations. In A. Briggs (Ed.), *(2005) Surviving Space: Papers on Infant Observation* (p. 60-73). London and New York: Karnac.

Bion, W. R. (1962a). *Learning from Experience*. London: Tavistock.

Bion, W. R. (1962b). The psycho-analytic study of thinking. *International Journal of Psycho-Analysis, 43*, 306-310.

Bion, W. R. (1963). *Eléments de Psychanalyse*. Paris: Presses Universitaires de France. Collection Bibliotheque de Psychanalyse.

Bion, W. R. (1967). *Second Thoughts*. London: Karnac.

Birksted-Breen. (2000). The experience of having a baby: A developmental view. In J. Raphael-Leff (Ed.), *'Spilt Milk': Perinatal Loss and Breakdown*. London: Institute of Psycho-Analysis.

Botkin, D. R. (2000). Family play therapy: A creative approach to including young children in family therapy. *Journal of Systemic Therapies, 19*(3), 31-45.

Bower, M. (1995). Psychodynamic family therapy with parents and under-5s. In J. Trowell & M. Bower (Eds.), *The Emotional Needs of Young Children and Their Families* (p. 74-84). London and New York: Routledge.

Bowlby, J. (1958). The nature of the child's tie to his mother. *International Journal of Psycho-Analysis, 39*, 350-373.

Bowlby, J. (1960). Grief and mourning in infancy and early childhood. *Psychoanalytic Study of the Child, 15*, 9-52.

Bowlby, J. (1969). *Attachment and Loss: Vol. 1. Attachment*. London: Hogarth Press.

Bowlby, J. (1982). *Attachment and Loss; Vol. 1. Attachment*. London: Hogarth Press and the Institute of Psycho-Analysis. (Original work published 1969.).

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*, 77-101.

Breen, D. (1975). *The Birth of a First Child: Towards an Understanding of Femininity*. London: Tavistock.

Brenman Pick, I. (2000). Discussion III. In A.-M. Sandler & R. Davies (Eds.), *Clinical and Observational Psychoanalytic Research: Roots of a Controversy* (p. 108-118). London and New York: Karnac.

Briggs, A. (Ed.). (2002). *Surviving Space: Papers on Infant Observation. Essays on the Centenary of Esther Bick.* London and New York: Karnac.

Briggs, A. (Ed.). (2005). *Surviving Space: Papers on Infant Observation*. London and New York: Karnac.

Britton, R. (1989). The missing link: Parental sexuality in the Oedipus complex. In J. Steiner (Ed.), *The Oedipus Complex Today: Clinical Implications* (p. 83-102). London: Karnac.

Bromberg, P. M. (2007). The analytic moment doesn't fit analytic "technique": Commentary on Tony Bass's "When the frame doesn't fit the picture". *Psychoanalytic Dialogues, 17*, 909-921.

Bromley, D. B. (1986). *The Case Study Method in Psychology and Related Disciplines*. Chichester: John Wiley.

Burns, J. K. (2011). The nental health gap in South Africa – A human rights issue. *The Equal Rights Review,* (6). Retrieved from http://www.equalrightstrust.org

Byng-Hall, J. (1986). Family scripts: A concept which can bridge child psychotherapy and family therapy thinking. *Journal of Child Psychotherapy, 12*(1), 3-13.

Byng-Hall, J. (1988). Scripts and legends in families and family therapy. *Family Process, 27*(2), 167-179.

Byng-Hall, J. (1995). Creating a secure family base: Some implications of attachment theory for family therapy. *Family Process, 34*, 45-58.

Casement, P. (1985). *On Learning from the Patient*. London: Tavistock Publications.

Cirulli, F., Berry, A., & Alleva, E. (2003). Early disruption of the mother-infant relationship: Effects on brain plasticity and implications for psychopathology. *Neuroscience and Behavioural Reviews, 27*, 73-82.

Cohen, N., Lojkasek, M., Muir, E., Muir, R., & Parker, C., J. (2002). Six-month follow-up of two mother-infant psychotherapies: Convergence of therapeutic outcomes. *Infant Mental Health Journal, 23*(4), 361-380.

Cohen, N., & Muir, E. (2002). Watch, Wait and Wonder: An infant-led approach to infant-parent psychotherapy. *Newsletter of the Infant Mental Health Promotion Project, Imprint 35*, 1-4. Retrieved from http://www.psybernet.co.nz/files/watch-wait-wonder-Cohen_Lojkasek_Muir.pdf

Cohen, N., Muir, E., Lojkasek, M., Muir, R., Parker, C., J, Barwick, M., & Brown, M. (1999). Watch, Wait and Wonder: Testing the effectiveness of a new approach to mother-infant psychotherapy. *Infant Mental Health Journal, 20*(4), 429-451.

Coll, X. (2000). Who needs to observe infants?: Infant observation in the training of child and adolescent mental health workers. *Child Psychology and Psychiatry Review, 5*(1), 25-29.

Cooper, P. J. (1995). *Opening Address.* Paper presented at the Congress on Infant Mental Health. University of Cape Town, Cape Town.

Cooper, P. J., Landman, M., Tomlinson, M., Molteno, C., Swartz, L., & Murray, L. (2002). Impact of a mother-infant intervention in an indigent peri-urban South African context. *The British Journal of Psychiatry, 180*, 76-81.

Cooper, P. J., & Murray, L. (1995). *The Impact of Postnatal Depression on Infant Development: A Treatment Trial.* Paper presented at the Infant Mental Health Congress. University of Cape Town, Cape Town.

Cooper, P. J., Tomlinson, M., Swartz, L., Landman, M., Molteno, C., Stein, A., McPherson, K., & Murray, L. (2009). Improving the quality of mother-infant relationship and infant attachment in a socioeconomically deprived community in South Africa: Randomised controlled trial. *British Medical Journal, 338:b974, doi:10.1136/bmj.b974, 338*,

Cooper, P. J., Tomlinson, M., Swartz, L., Woolgar, M., Murray, L., & Molteno, C. (1999). Post-partum depression and the mother-infant relationship in a South African peri-urban settlement. *British Journal of Psychiatry, 175*, 554-558.

Cramer, B., & Palacio Espasa, F. (1993). *La Pratique des Psychotherapies Meres-Bebes: Etudes Cliniques et Techniques*. Paris: Presses Universitaires de France.

Cramer, B., & Stern, D. (1988). Evaluation of changes in mother-infant brief psychotherapy: A single case study. *Infant Mental Health Journal, 9*(1), 20-45.

Cudmore, L. (2009). Forging the Missing Link Between Couples, Parents and Children in an Under Fives Service. Paper presented at the Under Five Short Course at the Tavistock Clinic, London.

Dahl, R. E. (1998). The development and disorders of sleep. *Advanced Pediatrics, 45*, 73-90.

Davies, J. (2002). *Behavioural Problems or Relationship Difficulties.* Paper presented at the Conference on Infant Mental Health: Infants in Changing Cultures, University of Cape Town, Cape Town.

Davies, J. (2012). *Babies and Bathwater: Keeping the Baby in the Bath*. Paper presented at the 13th World Congress of the World Association for Infant Mental Health: Babies in Mind - the Minds of Babies: a view from Africa. Cape Town, South Africa.

Daws, D. (1985). Two papers on work in a baby clinic: Standing next to the weighing scales. *Journal of Child Psychotherapy, 12*(1), 103-111.

Daws, D. (1989). *Through the Night: Helping Parents and Sleepless Infants*. London: Free Association Books.

Daws, D. (1999). Parent-infant psychotherapy: Remembering the Oedipus complex. *Psychoanalytic Inquiry, 12*(2), 267-278.

Daws, D. (2002). *Further Thoughts on "Standing by the Weighing Scales" - Primary Health Care and Infant Mental Health.* Paper presented at the Conference on Infant Mental Health: Infants in Changing Cultures, University of Cape Town, Cape Town.

De Villiers, S. (2011). *Mothering as a Three-Generational Process: The Psychological Experience of Low-Income Mothers Sharing Childcare with their Mothers.* University of Stellenbosch, Stellenbosch.

Denzin, N. K., & Lincoln, Y. S. (Eds.). (2003). *Collecting and Interpreting Qualitative Materials*. USA: Sage Publications.

Docherty, N. (Writer). (1995). When the Bough Breaks, *The Fifth Estate*. Canada: Canadian Broadcasting Corporation.

Dolto, F. (1971). *Psychanalyse et Pédiatrie*. Paris: Editions du Seuil.

Dowling, D. (2006). 'The capacity to be alone': Rediscovering Winnicott and his relevance to parent-infant psychotherapy. In M. Lanyado & A. Horne (Eds.), *A Question of Technique* (p. 63-80). London and New York: Routledge.

Duflo, E. (2003). Grandmothers and granddaughters: old age pension and intra-household allocation in South Africa. *World Bank Economic Review, 17*(1), 1-25.

Dugmore, N. (2007). The Tavistock Clinic Short Course for Work with Under Fives: The model and its applicability for private practitioners in South Africa. *Psycho-Analytic Psychotherapy in South Africa, 15*(1), 71-84.

Dugmore, N. (2009). Ghosts, aliens and things that go bump in the night: Parent-child psychotherapy in relation to childhood sleep difficulties. *Psycho-Analytic Psychotherapy in South Africa, 17*(1), 36-58.

Dugmore, N. (2011). The development of parent-infant/child psychotherapy in South Africa: A review of the history from infancy towards maturity. *Journal of Child and Adolescent Mental Health., 23*(2), 75-90.

Dugmore, N. (2012a). The development of psychoanalytic parent–infant/child psychotherapy in South Africa: Adaptive responses to contextual challenges. *Journal of Child and Adolescent Mental Health, 24*(1), 73-88.

Dugmore, N. (2012b). *The Grandmaternal Transference in Parent-Infant Psychotherapy*. Paper presented at the 13th World Congress of the World Association for Infant Mental Health: Babies in Mind - the Minds of Babies: A view from Africa. Cape Town, South Africa.

Edwards, D. J. A. (1998). Types of case study work: A conceptual framework for case-based research. *The Journal of Humanistic Psychology, 38*(3), 36-59.

Edwards, D. J. A. (2007). Collaborative versus adversarial stances in scientific discourse: Implications for the role of systematic case studies in the development of evidence-based practice in psychotherapy. *Pragmatic Case Studies in Psychotherapy, 3*(Article 2), 6-34

Edwards, J., & Maltby, J. (1998). Holding the child in mind: Work with parents and families in a consultation service. *Journal of Child Psychotherapy, 24*(1), 109-133.

Eisold, K. (2005). Psychoanalysis and psychotherapy: A long and troubled relationship. *International Journal of Psychoanalysis, 86*, 1175-1195.

Elliott, R., Fischer, C. T., & Rennie, D. L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology, 38*, 215-228.

Elmhirst, S. I. (1990). The value of grandparents. *Psychoanalytic Psychotherapy, 5*(11-19).

Emanuel, L. (2002). *The Impact of Domestic Violence on Infants and Small Children.* Paper presented at the Conference on Infant Mental Health: Infants in Changing Cultures, University of Cape Town, Cape Town.

Emanuel, L. (2007). *Clinical Interventions with Under Fives and their Families: A Framework for Thinking.* Paper presented at the Short Course on Infant Mental Health and Work with Under Fives: The Tavistock Clinic Model, Tavistock Clinic, London.

Emanuel, L. (2008). A slow unfolding - at double speed: Therapeutic interventions with parents and their young children. In L. Emanuel & E. Bradley (Eds.), *"What Can the Matter Be?" Therapeutic Interventions with Parents, Infants and Young Children* (p. 81-98). London: Karnac.

Emanuel, L. (2009). Transference and Countertransference. Paper presented at Short Course on Infant Mental Health and Work with Under Fives: The Tavistock Clinic Model. Tavistock Clinic, London.

Emanuel, L. (2012). *Symposium 17: Evaluation of Brief Psychodynamic Parent-Infant and Toddler Interventions*. Paper presented at the 13th World Congress of the World Association for Infant Mental Health: Babies in Mind - the Minds of Babies: a view from Africa. Cape Town, South Africa.

Emanuel, L., & Bradley, E. (Eds.). (2008). *"What Can the Matter Be?": Therapeutic Interventions with Parents, Infants and Young Children.* London: Karnac.

Emde, R. N. (1991). Positive emotions for psychoanalytic theory: Surprises from infancy research and new directions. *Journal of the American Psychoanalytic Association, 39S*, 5-44.

Emde, R. N. (1994). Developing psychoanalytic representations of experience. *Infant Mental Health Journal, 15*(1), 42-49.

Emde, R. N., & Fonagy, P. (1997). Guest Editorial: An emerging culture for psychoanalytic research? *International Journal of Psychoanalysis, 78*, 643-651.

England, B. (1997). Parent-infant psychotherapy: A review article. *Journal of Child Psychotherapy, 23*, 255-264.

Esman, A. (1996). Review: The Motherhood Constellation: A Unified View of Parent-Infant Psychotherapy. *The International Journal of Psychoanalysis, 77*, 415-417.

Esman, A. H. (1983). Psychoanalytic play therapy. In C. E. Schaefer & K. O'Connor, J. (Eds.), *Handbook of Play Therapy*. New York: John Wiley & Sons.

Ferenzi, S. (1913). The grandfather complex *(2002). Further Contributions to the Theory of Psychoanalysis* (p. 323-324). London: Karnac.

Flink, P.-O. (2001). Response to Norman. *The International Journal of Psychoanalysis, 82*, 990-991.

Flink, P.-O. (2002). Reply to Norman and Thomson-Salo. *The International Journal of Psychoanalysis, 83*, 267-268.

Fonagy, P. (1998). Prevention, the appropriate target of infant psychotherapy. *Infant Mental Health Journal, 19*(2), 124-150.

Fonagy, P. (2001). *Attachment Theory and Psychoanalysis*. New York: Other Press.

Fonagy, P., Steele, M., Moran, G., Steele, H., & Higgitt, A. (1993). "Measuring the ghost in the nursery": An empirical study of the relation between parents' mental representations of childhood experiences and their infants' security of attachment. *Journal of the American Psychoanalytic Association, 41*, 957-989.

Fossey, E., Harvey, C., McDermott, F., & Davidson, L. (2002). Understanding and evaluating qualitative research. *Australian and New Zealand Journal of Psychiatry, 36*, 717-732.

Fraiberg, S. (Ed.). (1980). *Clinical Studies in Infant Mental Health*. New York: Basic Books.

Fraiberg, S., Adelson, E., & Shapiro, V. (1975). Ghosts in the nursery: A psychoanalytic approach to the problems of impaired infant-mother relationships. *Journal of the American Academy of Child Psychiatry, XIV*, 387-421.

Freud, A. (1929). On the theory of analysis of children. *International Journal of Psycho-Analysis, 10*, 29-38.

Freud, A. (1945). Indications for child analysis. *Psychoanalytic Study of the Child, 1*, 127-149.

Freud, S. (1909). Analysis of a phobia in a five-year-old boy. In J. Strachey (Ed.), *The Standard Edition of the Complete Psychological Works of Sigmund Freud* (Vol. X 1909: Two Case Histories 'Little Hans' and the 'Rat Man'). London: Hogarth Press.

Freud, S. (1910). Five lectures on psycho-analysis. In J. Strachey (Ed.), *The Standard Edition of the Complete Psychological Works of Sigmund Freud* (Vol. XI 1910: Five Lectures on Psycho-Analysis, Leonardo da Vinci and Other Works). London: Hogarth Press.

Freud, S. (1912). *The dynamics of transference* (Vol. XII 1911-1913:The Case of Schreber, Papers on Technique and Other Works). London Hogarth Press.

Freud, S. (1914). *Remembering, repeating and working-through. Further recommendations on the technique of psycho-analysis II* (Vol. XII 1911-1913:The Case of Schreber, Papers on Technique and Other Works). London: Hogarth Press.

Freud, S. (1917). *Introductory lectures on psycho-analysis* (Vol. XVI 1916-1917:Introductory Lectures on Psycho-Analysis Part III). London: Hogarth Press.

Freud, S. (1927). The question of lay analysis. In J. Strachey (Ed.), *The Standard Edition of the Complete Psychological Works of Sigmund Freud* (Vol. XX 1925-1926: An Autobiographical Study, Inhibitions, Symptoms and Anxiety, The Question of Lay Analysis and Other Works, p. 183-258). London: Hogarth Press.

Freud, S. (1936). Inhibitions, symptoms and anxiety. *Psychoanalytic Quarterly, 5*, 261-279.

Frost, K. (2012). Paper presented at the 13th World Congress of the World Association for Infant Mental Health: Babies in Mind - the Minds of Babies: a view from Africa. Cape Town, South Africa.

Frost, K., & Esterhuizen, M. (2012). *Ububele Baby Mat Project: Facilitating a Dialogue between Psyche and Soma in Primary Health Care Clinics in Alexandra Township in Johannesburg*. Paper presented at the 13th World Congress of the World Association for Infant Mental Health: Babies in Mind - the Minds of Babies: a view from Africa. Cape Town, South Africa.

Frost, K., & Van Der Walt, C. (2009). *The Baby Mat Project - A Community Attachment Based Intervention at a Primary Health Care Centre in Johannesburg, South Africa.* Paper presented at the Johannesburg Association of Psychoanalytic Psychotherapy Study Groups Conference: 30 Years On – Celebrating Thirty Years of Diverse Psychoanalytic Work. Ububele, Johannesburg, South Africa.

Furlong, A. (2006). Further reflections on the impact of clinical writing on patients. *International Journal of Psychoanalysis, 87*, 747-768.

Gabbard, G. O. (2000). Disguise or Consent: Problems and recommendations concerning the publication and presentation of clinical material. *International Journal of Psychoanalysis, 81*, 1071-1085.

Gabbard, G. O., Horwitz, L., Frieswyk, S., Allen, J. G., Colson, D. B., Newsom, G., & Coyne, L. (1988). The Effect of therapist interventions on the therapeutic alliance with borderline patients. *Journal of the American Psychoanalytic Association, 36*, 697-727.

Geissman, C., & Geissman, P. (1992). *A History of Child Psychoanalysis*. London: Routledge.

Gerhardt, S. (2004). *Why Love Matter: How Affection Shapes a Baby's Brain*. London and New York: Routledge.

Gerson, M. (1998). The significant other and the psychoanalytic relationship: Reflections on couples therapy. *Psychoanalysis and Contemporary Thought, 21*, 61-84.

Gibbs, A. (1997). Focus groups. *Social Research Update, 17*,

Gibson, M. A., & Mace, R. (2005). Helpful grandmothers in rural Ethiopia: A study of the effect of kin on child survival and growth. *Evolution and Human Behavior, 26*(6), 469-482.

Greenberg, J. (1995). Psychoanalytic technique and the interactive matrix. *Psychoanalytic Quarterly, 64*, 1-22.

Greene, B. (1990). Sturdy bridges: The role of African-American mothers in the socialization of African-American children. In J. P. Knowles & E. Cole (Eds.), *Woman-Defined Motherhood* (p. 205 - 225). New York and London: Harrington Park Press.

Greenwood, D., & Loewenthal, D. (2005). The use of 'case study' in psychotherapeutic research and education. *Psychoanalytic Psychotherapy, 19*, 35-47.

Griff, M. D. (1983). Psychoanalytic play therapy. In C. E. Schaefer & K. O'Connor, J. (Eds.), *Handbook of Play Therapy*. New York: John Wiley & Sons.

Grotstein, J. A. (1999). Projective identification reassessed: Commentary on papers by Stephen Seligman and by Robin C. Silverman and Alicia F. Lieberman. *Psychoanalytic Dialogues, 9*(2), 187-203.

Harel, J., Kaplan, H., Avimeir-Patt, R., & Ben-Aaron, M. (2006). The child's active role in mother-child, father-child psychotherapy: A psychodynamic approach to the treatment of relational disturbance. *Psychology and Psychotherapy, 79*(1), 23-36.

Harris, M., & Carr, H. (1966). Therapeutic consultations. *Journal of Child Psychotherapy, 1*(4), 13-19.

Heimann, P. (1950). On counter-transference. *International Journal of Psycho-Analysis, 23*, 8-17.

Hellman, I. (1990). *From War Babies to Grandmothers: Forty-Eight Years in Psychoanalysis*. London: Karnac.

Herman, J. (2005). Psychoanalytic insight-oriented parent counseling based on concepts of projective identification and reparative repetition: An object relations perspective. *Journal of Infant, Child, and Adolescent Psychotherapy, 4*(4), 442-456.

Hilliard, R. B. (1993). Single-case methodology in psychotherapy process and outcome research. *Journal of Consulting and Clinical Psychology, 61*(3), 373-380.

Hofacker, N. V., & Papousek, M. (1998). Disorders of excessive crying, feeding, and sleeping: The Munich Interdisciplinary Research and Intervention Program. *Infant Mental Health Journal, 19*(2), 180-201.

Hoffman, J. (1997). The psychoanalyst as frame. *Scandinavian Psychoanalytic Review, 20*(2), 232-237.

Hoffman, L. (2004). When daughter becomes mother: Inferences from multiple dyadic parent-child groups. *Psychoanalytic Inquiry, 24*, 629-656.

Homan, R. (1991). *The Ethics of Social Research*. London and New York: Longman.

Hopkins, J. (1992). Infant-parent psychotherapy. *Journal of Child Psychotherapy, 18*, 5-17.

Hopkins, J. (2008). Infant-parent psychotherapy: Selma Fraiberg's contribution to understanding the past in the present. In L. Emanuel & E. Bradley (Eds.), *"What Can the Matter Be?": Therapeutic Interventions with Parents, Infants, and Young Children* (p. 54-65). London: Karnac.

Hopkins, J., & Phillips, G. (2009). Some contributions of attachment theory and research. In M. Lanyado & A. Horne (Eds.), *The Handbook of Child and Adolescent Psychotherapy: Psychoanalytic Approaches* (2 ed., p. 38-50). London and New York: Routledge.

Imber, R. R. (2010). Treating patients who are parents: The good grandparent transference and countertransference. *Journal of the American Psychoanalytic Association, 58*, 489-511.

Ivey, G. (2009). The Case Study Method in Psychotherapy Research and Writing up Case Material for Publication. Department of Psychology, University of the Witwatersrand.

Jackson, J. (1992). Screaming from birth: Therapeutic explorations of a two year old's failure to find a maternal lap. *Journal of Child Psychotherapy, 18*, 5-17.

Jackson, J. (1995a). *An Experimental Investigation of Winnicott's Set Situation: A Study of South African White, Black and Institutionalised Infants Aged Seven to Nine Months.* Paper presented at the Infant Mental Health Congress. University of Cape Town, Cape Town.

Jackson, J. (1995b). *Screaming from Birth: Therapeutic Explorations of a Two Year Old's Failure to Find a Maternal Lap.* Paper presented at the Infant Mental Health Congress, University of Cape Town.

James, J. (2002). Developing a culture for change in group analytic psychotherapy for mothers and babies. *British Journal of Psychotherapy, 19*(1), 77-91.

Joffe, A. (2008). Three forms of container pathology: Towards a classification. *Psychoanalytic Psychotherapy in South Africa, 16*(2), 1-30.

Jones, A. (2006a). How video can bring to view pathological defensive processes and facilitate the creation of triangular space in perinatal parent-infant psychotherapy. *Infant Observation, 9*(2), 109-123.

Jones, A. (2006b). Levels of change in parent-infant psychotherapy. *Journal of Child Psychotherapy, 32*(3), 295-311.

Jones, E. (Ed.). (1913). *Significance of the grandfather for the fate of the individual* (4 ed.). Baltimore: William Wood.

Joseph, B. (1985). Transference: The total situation. *International Journal of Psychoanalysis, 66*, 447-454.

Juffer, F., Van Ijzendoorn, M. H., & Bakermans-Kranenburg, M. J. (1997). Intervention in transmission of insecure attachment: A case study. *Psychological Reports, 80*, 531-543.

Kaplan-Solms, K., & McLean, D. (1995). Differential diagnosis of language disorder in a child-analytic setting. *Bulletin of the Anna Freud Centre, 18*, 187-204.

Keren, M., Spitzer, S., & Tyano, S. (1998). Dyadic psychotherapy for early relationship disorders: A case study. *The Israel Journal of Psychiatry and Related Sciences, 35*(4), 262-270.

Kitzinger, J. (1995). Introducing focus groups. *British Medical Journal, 311*, 299-302.

Kitzinger, S. (1978). *Women as Mothers*. Great Britain: Fontana/Collins.

Klein, M. (1946). Notes on some schizoid mechanisms. In M. Klein, P. Heimann, S. Isaacs & J. Riviere (Eds.), *Developments in Psycho-Analysis* (p. 292-320). London: Karnac.

Klein, M. (1952a). On observing the behaviour of young infants. In M. M. R. Khan (Ed.), *Envy and Gratitude and Other Works 1946–1963* (p. 94-121). London: The Hogarth Press and the Institute of Psycho-Analysis.

Klein, M. (1952b). The origins of the transference. *International Journal of Psycho-Analysis, 33*, 433-438.

Klein, M. (1955). The psycho-analytic play technique: Its history and significance. In M. Klein, P. Heimann & R. E. Money-Kyrle (Eds.), *(2003). New Directions in Psycho-Analysis: The Significance of Infant Conflict in the Pattern of Adult Behaviour* (p. 3-22). London and New York: Routledge.

Klein, M. (1961). *Narrative of a Child Analysis*. London: International Psycho-Analytic Library.

Knowles, J. P., & Cole, E. (Eds.). (1990). *Woman-Defined Motherhood*. New York and London: Harrington Park Press.

Koursaris, J., & Maharaj, S. (2012). *A Mental Health Care Intervention with Premature Infants at a South African Community-Based Hospital*. Paper presented at the 13th World Congress of the World Association for Infant Mental Health: Babies in Mind - the Minds of Babies: A view from Africa. Cape Town, South Africa.

Künstlicher, R. (1996). The function of the frame: To protect the psychoanalytic room. *Scandinavian Psychoanalytic Review, 19*, 150-164.

LaBarre, M. B., Jessner, L., & Ussery, L. (1960). The significance of grandmother in the psychopathology of children. *American Journal of Orthopsychiatry, 30*, 175-185.

Landman, M. (1995). *Adapting the 'Healthy Start' Model in South Africa.* Paper presented at the Congress on Infant Mental Health. University of Cape Town, Cape Town.

Landman, M. (2009). *Inside the Black Box of a Successful Parent-Infant Intervention in a South African Settlement: Mothers' and Counsellors' Account of the Process.* Stellenbosch University Stellenbosch.

Lanyado, M. (2009). Brief psychotherapy and therapeutic consultations. How much therapy is 'good-enough'? In M. Lanyado & A. Horne (Eds.), *The Handbook of Child and Adolescent Psychotherapy: Psychoanalytic Approaches. Second Edition* (2 ed., p. 191-205). London and New York: Routledge.

Lazarus, J., & Kruger, L.-M. (2004). Small meetings: Reflections on the application of psychodynamic thought in community work with low-income South African children. *Psycho-Analytic Psychotherapy in South Africa, 12*(1), 52-73.

Levy, S. T., & Inderbitzin, L. B. (2000). Suggestion and psychoanalytic technique. *Journal of the American Psychoanalytic Association, 48*, 739-758.

Lieberman, A. F. (1991). Attachment theory and infant-parent psychotherapy: Some conceptual, clinical and research considerations. In D. Cicchetti & S. L. Toth (Eds.), *Rochester Symposium on Developmental Psychopathology: Models and Integrations* (Vol. 3, p. 261-294). New York: University of Rochester Press.

Lieberman, A. F. (1992). Infant-parent psychotherapy with toddlers. *Development and Psychopathology, 4*(2), 559-574.

Lieberman, A. F. (1999). Negative maternal attributions: Effects on toddlers' sense of self. *Psychoanalytic Inquiry, 19*, 737-756.

Lieberman, A. F. (2004a). Child-Parent Psychotherapy: A relationship-based approach to the treatment of mental health disorders in infancy and early childhood. In A. J. Sameroff, S. C. McDonough & K. L. Rosenblum (Eds.), *Treating Parent-Infant Relationship Problems: Strategies for Intervention*. New York and London: The Guildford Press.

Lieberman, A. F. (2004b). Traumatic stress and quality of attachment: Reality and internalization in disorders of infant mental health. *Infant Mental Health Journal, 25*(4), 336-351.

Lieberman, A. F. (2007). Ghosts and angels: Intergenerational patterns in the transmission and treatment of the traumatic sequelae of domestic violence. *Infant Mental Health Journal, 28*(4), 422-439.

Lieberman, A. F., Padron, E., Van Horn, P., & Harris, W. W. (2005). Angels in the nursery: The intergenerational transmission of benevolent parental influences. *Infant Mental Health Journal, 26*(6), 504–520.

Lieberman, A. F., & Pawl, J., H. (1993). Infant-parent psychotherapy. In C. H. Zeanah (Ed.), *Handbook of Infant Mental Health* (p. 427-442). New York and Boston: Guilford Press.

Lieberman, A. F., & Van Horn, P. (2008). *Psychotherapy with Infants and Young Children: Repairing the Effects of Stress and Trauma on Early Attachment*. New York and London: The Guilford Press.

Lieberman, A. F., Weston, D. R., & Pawl, J. H. (1991). Preventive intervention and outcome with anxiously attached dyads. *Child Development, 62*, 199-209.

Likierman, M. (2003). Post natal depression, the mother's conflict and parent–infant psychotherapy. *Journal of Child Psychotherapy, 29*(3), 301-315.

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic Inquiry*. USA: Sage Publications.

Lindon, J. A. (1994). Gratification and provision in psychoanalysis: Should we get rid of "The Rule of Abstinence?". *Psychoanalytic Dialogues, 4*, 549-582.

Long, C. (2009). *Contradicting Maternity: HIV-Positive Motherhood in South Africa*. Johannesburg: Wits University Press.

Long, C. (2012). *Motherhood and Adversity*. Paper presented at the 13th World Congress of the World Association for Infant Mental Health: Babies in Mind - the Minds of Babies: a view from Africa. Cape Town, South Africa.

Ludwig-Korner, C. (1999). Effects of severely disturbed parents on early parent-infant interaction. *International Forum of Psychoanalysis, 8*, 25-31.

Ludwig-Korner, C. (2003). Parent-infant psychotherapy and psychoanalytic treatment: Contradiction or mutual inspiration? *International Forum of Psychoanalysis, 12*, 252-258.

Lund, L. K., Schindler Zimmerman, T., & Haddock, S. A. (2002). The theory, structure, and techniques for the inclusion of children in family therapy: A literature review. *Journal of Marital and Family Therapy, 28*(4), 445-454.

Mahler, M. S. (1963). Thoughts about development and individuation. *The Psychoanalytic Study of the Child, 18*, 307-324.

Maiello, S. (1995a). *On Infant Observation.* Paper presented at the Infant Mental Health Congress,University of Cape Town. Cape Town, South Africa.

Maiello, S. (1995b). *The Sound Object.* Paper presented at the Infant Mental Health Congress, University of Cape Town. Cape Town, South Africa.
Maiello, S. (2000). The cultural dimension in early mother-infant interaction and psychic development: An infant observation in South Africa. *International Journal of Infant Observation and its Applications, 3*(2), 80-92.
Maiello, S. (2003). The rhythmical dimension of the mother-infant relationship - transcultural considerations: Clinical perspectives. *Journal of Child and Adolescent Mental Health., 15*(2), 81-86.
Martin, J., Hiscock, H., Hardy, P., Davey, B., & Wake, M. (2007). Adverse associations of infant and child sleep problems and parent health: An Australian population study. *Pediatrics, 119*(5), 947-955.
Masur, C. (2009). Parent-infant psychotherapy. *Journal of the American Psychoanalytic Association, 57*(467-473).
Melega, M. P., & Almeida, M. M. (2007). Echoes from overseas: Brazilian experiences in psychoanalytic observation, its developments, and therapeutic interventions with parents and small children. In M. E. Pozzi-Monzo & B. Tydeman (Eds.), *Innovations in Parent-Infant Psychotherapy* (p. 23-42). London: Karnac.
Merbaum, J. (1999). Primary maternal preoccupation: Maternal-child transference and countertransference in the analysis of a pregnant patient. *Modern Psychoanalysis, 24*, 97-106.
Mertens, D. M. (2005). *Research and Evaluation in Education and Psychology: Integrating Diversity with Quantitative, Qualitative, and Mixed Methods* (2 ed.). London: Sage Publications.
Midgley, N. (2004). Sailing between Scylla and Charybdis: Incorporating qualitative approaches into child psychotherapy research. *1*, 89-111.
Midgley, N. (2006). The 'inseparable bond between cure and research': Clinical case study as a method of psychoanalytic inquiry. *Journal of Child Psychotherapy, 32*(2), 122-147.
Midgley, N. (2012). Peter Heller's A Child Analysis with Anna Freud: The Significance of the Case for the History of Child Psychoanalysis. *Journal of the American Psychoanalytic Association, 60*, 45-69.
Miller, L. (1992). The relation of infant observation to clinical practice in an under fives counselling service. *Journal of Child Psychotherapy, 18*(1), 19-32.
Miller, S. (1999). Home thoughts from abroad. Psychoanalytic thinking in a new setting: Work in South Africa. *Journal of Child Psychotherapy, 25*(2), 199-216.
Milton, J., Polmear, C., & Fabricius, J. (2004). *A Short Introduction to Psychoanalysis*. London: Sage Publications.
Mindell, J. A., Owens, J. A., & Carskadon, M. A. (1999). Developmental features of sleep. *Child and Adolescent Psychiatric Clinics of North America, 8*(4), 695-725.
Motsoaledi, P. A. (2010). National Department of Health Strategic Plan 2010/11-2012/13. Retrieved from http://www.doh.gov.za/docs/misc/stratplan/2010-2012/foreword.pdf.
Muir, E., Lojkasek, M., & Cohen, N. (1999). Observant parents: Intervening through observation. *The International Journal of Infant Observation and its Applications, 3*, 11-23.
Mukotsanjera-Kowayi, V., & Godknows, G. (2011). A review of the 2011 budget. Retrieved from http://www.idasa.org.za/media/uploads/outputs/files/budget_analysis_2011.pdf
Norman, J. (2001). The psychoanalyst and the baby: A new look at work with infants. *International Journal of Psychoanalysis, 82*, 83-100.
Norman, J. (2004). Transformations of early infantile experiences: A 6-month old in psychoanalysis. *International Journal of Psycho-Analysis, 85*, 1103-1122.
Ogden, T. (1994). *Subjects of Analysis* (Vol. Jason Aronson): Northvale, New Jersey.

Onions, C. (2009). Parent-infant psychotherapy. In M. Lanyado & A. Horne (Eds.), *The Handbook of Child and Adolescent Psychotherapy: Psychoanalytic Approaches. Second Edition.* (p. 220-234). London and New York: Routledge.

Oren, K., & Solan, M. (2002). Ghosts in the corridors of business administration schools: The 'Unconscious' at work. *Organisational and Social Dynamics: An International Journal of Psychoanalytic, Systemic and Group Relations Perspectives, 2*(1), 53-74.

Osofsky, J. D., & Fitzgerald, H. E. (Eds.). (2000). *WAIMH Handbook of Infant Mental Health. Vol. 1: Perspectives of Mental Health*. Canada: John Wiley & Sons.

Palacio Espasa, F. (2004). Parent-infant psychotherapy, the transition to parenthood and parental narcissism: Implications for treatment. *Journal of Child Psychotherapy, 30*(2), 155-171.

Patterson, A. (1999). The publication of case studies and confidentiality - an ethical predicament. *Psychiatric Bulletin, 23*, 562-564.

Paul, C., & Thomson-Salo, F. (2007). Babies in groups: The creative roles of the babies, the mothers and the therapists. In M. E. Pozzi-Monzo & B. Tydeman (Eds.), *Innovations in Parent-Infant Psychotherapy* (p. 134-153). London: Karnac.

Perkel, J. (2007). *Babies in Mind: Understanding your baby's psychological needs*. Landsdowne, South Africa: Juta.

Piaget, J. (1952). *The Origins of Intelligence in Children*. New York: International Universities Press.

Piovano, B. (2003). Comment on "Parent-infant psychotherapy and psychoanalytic treatment: Contradiction or mutual inspiration?" by Christiane Ludwig-Korner. *International Forum of Psychoanalysis, 12*, 259-264.

Pozzi-Monzo, M. E., & Tydeman, B. (Eds.). (2007). *Innovations in Parent-Infant Psychotherapy*. London: Karnac.

Pozzi, M. E. (1999). Psychodynamic counselling with under-5s and their families: Clinical and technical issues. *Journal of Child Psychotherapy, 25*(1), 51-17.

Pozzi, M. E. (2003). *Psychic Hooks and Bolts: Psychoanalytic Work with Children Under Five and their Families*. London: Karnac.

Pozzi, M. E., & Tydeman, B. (2005). Setting up a counselling service for parents, infants and young children. *Psychoanalytic Psychotherapy, 19* (4), 294-309.

Quinodoz, D. (1992). The psychoanalytic setting as the instrument of the container function. *International Journal of Psychoanalysis, 73*, 627-635.

Raphael-Leff, J. (2002). *Perinatal Therapy.* Paper presented at the Conference on Infant Mental Health: Infants in Changing Cultures, University of Cape Town, Cape Town.

Raphael-Leff, J. (2009). *Psychological Processes of Childbearing* (4 ed.). Great Britain: The Anna Freud Centre.

Raphael-Leff, J. (Ed.). (2003). *Parent-Infant Psychodynamics: Wild Things, Mirrors and Ghosts*. London and Philadelphia: Whurr Publishers.

Rappaport, E. A. (1958). The grandparent syndrome. *Psychoanalytic Quarterly, 27*, 518-538.

Renschler, T. S. (2009). Sleeping on the couch: Interpretation-in-action in infant-parent psychotherapy. *Journal of Infant, Child, and Adolescent Psychotherapy, 8*(3-4), 145-155.

Reynolds, D. (2003). Mindful Parenting: A group approach to enhancing reflective capacity in parents and infants *Journal of Child Psychotherapy, 29*(3), 357-374.

Richter, L. (2002a). *Strengthening Infants and Children.* Paper presented at the Conference on Infant Mental Health: Infants in Changing Cultures. University of Cape Town, Cape Town.

Richter, L. (2002b). Strengthening infants and children: South African perspectives *Southern African Journal of Child and Adolescent Mental Health, 14*(2), 128-134.

Richter, L. (2012). *Too Much, Too Soon: Toxic Stress in Early Childhood*. Paper presented at the 13th World Congress of the World Association for Infant Mental Health: Babies in Mind - the Minds of Babies: a view from Africa. Cape Town, South Africa.

Robbins, M. A. (1990). Mourning the myth of motherhood: Reclaiming our mothers' legacies *Woman-Defined Motherhood* (p. 41-60.). New York and London: Harrington Park Press.

Robert-Tissot, C., Cramer, B., Stern, D., Rusconi Serpa, S., Bachmann, J.-B., Francisco, P.-E., Knauer, D., De Muralt, M., Berney, C., & Mendiguren, G. (1996). Outcome evaluation in brief-mother infant psychotherapies: Report on 75 cases. *Infant Mental Health Journal, 17*(2), 97-114.

Rosen, C. L. (1997). Sleep disorders in infancy, childhood, and adolescence. *Current Opinion in Pulmonary Medicine, 3*(6), 449-455.

Rosenbaum, L., Bain, K., Esterhuizen, M., & Frost, K. (2012). 'My baby cries for nothing': Mentalisation challenges in the face of negative countertransference when working with mothers who struggle to hold their babies in mind. *Psycho-Analytic Psychotherapy in South Africa, 20*(1), 69-101.

Rotter, J. C., & Bush, M. V. (2000). Play and family therapy. *The Family Journal, 8*, 172-173.

Ruble, N. (1999). The voices of therapists and children regarding the inclusion of children in family therapy: A systematic research synthesis. *Contemporary Family Therapy, 21*(4), 485-503.

Russell, R. C., Grignon, M., & Royer, J. (1995). Infant observation: A relevant educational method for psychiatrists and other mental health practitioners. *Child and Adolescent Psychiatric Clinics of North America, 4*(3), 529-538.

Rustin, M. (1988). Encountering primitive anxieties: Some aspects of infant observation as a preparation for clinical work with children and families. *Journal of Child Psychotherapy, 14*(2), 15-28.

Rustin, M. (2003). Research in the consulting room. *Journal of Child Psychotherapy, 29*, 137-145.

Rustin, M. (2005). Looking in the right place: Complexity theory, psychoanalysis, and infant observation. In A. Briggs (Ed.), *Surviving Space: Papers on Infant Observation* (p. 256-276). London and New York: Karnac.

Rustin, M., & Emanuel, L. (2010). Observation, reflection and containment: A psychoanalytic approach to work with parents and children under five. In A. Lemma & M. Patrick (Eds.), *Off the Couch: Contemporary Psychoanalytic Applications* (p. 82-97). London: Taylor & Francis.

Salomonsson, B. (2007). 'Talk to me baby, tell me what's the matter now': Semiotic and developmental perspectives on communication in psychoanalytic infant treatment. *The International Journal of Psychoanalysis, 88*(1), 127-146.

Salomonsson, B., & Sandell, R. (2011a). A randomized controlled trial of mother–infant psychoanalytic treatment: I. Outcomes on self-report questionnaires and external ratings. *Infant Mental Health Journal, 32*(2), 207-231.

Salomonsson, B., & Sandell, R. (2011b). A randomized controlled trial of mother–infant psychoanalytic treatment: II. Predictive and moderating influences of qualitative patient factors. *Infant Mental Health Journal, 32*(3), 377-404.

Salzberger-Wittenberg, I. (1991). Brief therapeutic work with parents of infants. In R. Szur & S. Miller (Eds.), *Extending Horizons: Psychoanalytic Psychotherapy with Children, Adolescents and Families*. London: Karnac.

Sameroff, A. J., McDonough, S. C., & Rosenblum, K. L. (Eds.). (2004). *Treating Parent-Infant Relationship Problems: Strategies for Intervention*. New York and London: The Guildford Press.

Schachter, J. (1992). Concepts of termination and post-termination patient-analyst contact. *International Journal of Psychoanalysis, 73*, 137-154.

Scharff, D. (2008). Frame and frame of mind as fractals: Commentary on Anthony Bass's "When the frame doesn't fit the picture". *Psychoanalytic Dialogues, 18,* 230-238.

Schore, A. N. (2002). Advances in neuropsychoanalysis, attachment theory, and trauma tesearch: Implications for self psychology. *Psychoanalytic Inquiry: A Topical Journal for Mental Health Professionals, 22*(3), 433-484.

Schore, A. N. (2010). Relational trauma and the developing right brain: The neurobiology of broken attachment bonds. In T. Baradon (Ed.), *Relational Trauma in Infancy: Psychoanalytic, Attachment and Neuropsychological Contributions to Parent-Infant Psychotherapy* (p. 19-47). London and New York: Routledge.

Sear, R., Mace, R., & McGregor, I. A. (2000). Maternal grandmothers improve nutritional status and survival of children in rural Gambia. *The Royal Society, 267*(1453), 1641-1647.

Segal, H. (1957). Notes on symbol formation. *International Journal of Psycho-Analysis, 38*, 391-397.

Segal, H. (1979). *Klein*. New York: The Viking Press.

Shapiro, V. (2009). Reflections on the work of Professor Selma Fraiberg: A pioneer in the field of social work and infant mental health. *Clinical Social Work Journal, 37*, 45-55.

Shapiro, V., & Gisynski, M. (1989). Ghosts in the nursery revisited. *Child and Adolescent Social Work, 6*(1), 18-37.

Silove, M., Schön, J., Berg, A., Green, J., & Levy, S. (2011). Introduction to the Code of Ethics of the South African Psychoanalytic Confederation. *Psycho-Analytic Psychotherapy in South Africa, 19*(2), 103-120.

Silverman, R. C., & Lieberman, A. F. (1999). Negative maternal attributions, projective identification and the intergenerational transmission of violent relational patterns. *Psychoanalytic Dialogues, 9*, 161-186.

Slade, A. (2006). Reflective parenting programs: Theory and development. *Psychoanalytic Inquiry, 26*, 640-657.

Smith, C. (2011). NHI Green Paper Submission. NHI Policy Document: Comments on the NHI as it pertains to Psychological Services. Division of Psychiatry, Department of Neurosciences, School of Clinical Medicine, Faculty of Health Sciences,University of the Witwatersrand, Johannesburg.

Solms, M. (2012). *Babies and Bathwater: Why Depression Feels so Bad.* Paper presented at the 13th World Congress of the World Association for Infant Mental Health: Babies in Mind - the Minds of Babies: a view from Africa. South Africa, Cape Town.

Sorensen, P. (2003). Looking at the symptoms as a starting point for understanding. In M. Pozzi (Ed.), *Psychic Hooks and Bolts: Psychoanalytic Work with Children Under Five and their Families*. London: Karnac.

Sorensen, P., Foster, L., Jarrell, J., Mack, D., Presberg, J., & Weeks, R. (1997). The art of the ordinary: The role of observation in the study and treatment of young children and their families. *International Journal of Infant Observation and its Applications, 1*(1), 9-30.

Sossin, K. M. (2002). Interactive movement patterns as ports of entry in infant-parent psychotherapy: Ways of seeing nonverbal behavior *Journal of Infant, Child, and Adolescent Psychotherapy, 2*, 97-131.

Stajner-Popovic, T. (2001). Internet Discussion Review: 'Disguise or consent: Problems and recommendations concerning the publication and presentation of clinical material' by Glen O. Gabbard and the Editorial by David Tuckett. *International Journal of Psychoanalysis, 82*, 415-424.

Stake, R. (2000). The case study method in social inquiry. In R. Gomm, M. Hammersley & P. Foster (Eds.), *Case Study Method*. London: Sage.

Steele, M., & Baradon, T. (2004). Clinical use of the Adult Attachment Interview in parent-infant psychotherapy. *Infant Mental Health Journal, 25*(4), 284-299.

Steele, M., Steele, H., & Murphy, A. (2009). The Adult Attachment Interview and relational trauma: Implications for parent-infant psychotherapy. In T. Baradon (Ed.), *Relational Trauma in Infancy: Psychoanalytic, Attachment and Neuropsychological Contributions to Parent-Infant Psychotherapy* (p. 180-193). London and New York: Routledge Taylor & Francis Group.

Sterling, C. (2002). From idealism to reality: Learning from community interventions *Reflective Practice: Psychodynamic Ideas in the Community* (p. 23-32). Cape Town: Human Sciences Research Council.

Stern-Bruschweiler, N., & Stern, D. (1989). A model for conceptualizing the role of the mother's representational world in various mother-infant therapies. *Infant Mental Health Journal, 10*(3), 142-156.

Stern, D. (1977). *The First Relationship: Infant and Mother*. Cambridge: Harvard University Press.

Stern, D. (1985). *The Interpersonal World of the Human Infant: A View from Psychoanalysis and Developmental Psychology*. New York: Basic Books.

Stern, D. (1995). *The Motherhood Constellation: A Unified View of Parent-Infant Psychotherapy*. London: Karnac.

Stern, D. (2004). The motherhood constellation: Therapeutic approaches to early relational problems. In A. J. Sameroff, S. C. McDonough & K. L. Rosenblum (Eds.), *Treating Parent-Infant Relationship Problems: Strategies for Intervention* (p. 29-42). New York London: The Guilford Press.

Stern, S. (2009). Session frequency and the definition of psychoanalysis. *Psychoanalytic Dialogues, 19*(6), 639-655.

Swartz, L., Gibson, K., & Gelman, T. (Eds.). (2002). *Reflective Practice: Psychodynamic Ideas in the Community*. Cape Town: Human Sciences Research Council.

Swartz, S. (2007). Reading psychoanalysis in the diaspora: South African psychoanalytic psychotherapists' struggle with voice. *Psycho-Analytic Psychotherapy in South Africa, 15*(2), 1-18.

Szur, R., & Miller, S. (Eds.). (1991). *Extending Horizons: Psychoanalytic Psychotherapy with Children, Adolescents and Families*. London: Karnac.

Tesch, R. (1990). *Qualitative Research: Analysis Types and Software Tools*. Bristol, PA: Falmer.

Thomson-Salo, F. (2001). Response to Dr Flink. *International Journal of Psycho-Analysis, 82*, 1259-1262.

Thomson-Salo, F. (2002). The interface with infant research: The continuing gains for psychoanalysis. *Psychoanalysis Downunder - the Online Journal of the Australian Psychoanalytical Society*,

Thomson-Salo, F. (2007). Recognizing the infant as subject in infant-parent psychotherapy. *International Journal of Psychoanalysis, 88*, 961-979.

Thomson-Salo, F., & Paul, C. (2001). Some principles of infant-parent psychotherapy: Ann Morgan's contribution. *The Signal: Newsletter of the World Association for Infant Mental Health, 9*(1 & 2), 14-18.

Thomson-Salo, F., & Paul, C. (Eds.). (2004). *The Baby as Subject: New Directions in Infant-Parent Psychotherapy from the Royal Children's Hospital, Melbourne*. Victoria: Stonnington Press.

Thomson-Salo, F., Paul, C., Morgan, A., Jones, S., Jordan, B., Meehan, M., Morse, S., & Walker, A. (1999). 'Free to be playful': Therapeutic work with infants. *International Journal of Infant Observation and its Applications, 3*, 47-62.

Tomlinson, M. (2001). Mother-infant attachment, culture and research: A pilot study. *Southern African Journal of Child and Adolescent Mental Health, 13*(1), 41-54.

Tomlinson, M. (2002). *Cultural Diversity in Infant Studies.* Paper presented at the Conference on Infant Mental Health: Infants in Changing Cultures, University of Cape Town, Cape Town.

Tomlinson, M. (2003). Culture and infancy: A critical examination. *Southern African Journal of Child and Adolescent Mental Health, 15*(1), 45-48.

Tomlinson, M. (2012). *"155 Million Infants and Children in Search of an Evidence Base": Thoughts Towards an African Research Agenda*. Paper presented at the 13th World Congress of the World Association for Infant Mental Health: Babies in Mind - the Minds of Babies: a view from Africa. Cape Town, South Africa.

Trevarthen, C. (2001). Intrinsic motives for companionship in understanding: Their origin, development, and significance for infant mental health. *Infant Mental Health Journal, 22*(1-2), 95-131.

Trevarthen, C., & Aitken, K. J. (2001). Infant intersubjectivity: Research, theory, and clinical applications. *Journal of Child Psychology and Psychiatry, 42*(1), 3-48.

Tronick, E. Z. (2003). "Of course all relationships are unique": How co-creative processes generate unique mother-infant and patient-therapist relationships and change other relationships. *Psychoanalytic Inquiry, 23*, 473-491.

Trotman, F. K. (2002). African-American mothering: Implications for feminist psychotherapy from a grandmother's perspective. *Women & Therapy, 25*(1), 19-36.

Trowell, J., Paton, A., Davids, Z., & Miles, G. (1998). The importance of observational training: An evaluative study. *The International Journal of Infant Observation and its Applications, 2*(1), 101-111.

Trowell, J., & Rustin, M. (1991). Developing the internal observer in professionals in training. *Infant Mental Health Journal, 12*(3), 233-245.

Tucker, L. (2006). The grandparent syndrome: A case study. *Psychoanalytic Study of the Child, 61*, 82-98.

Tuckett, D. (1993). Some thoughts on the presentation and discussion of the clinical material of psychoanalysis. *International Journal of Psychoanalysis, 74*, 1175-1189.

Tuckett, D. (1998). Evaluating psychoanalytic papers: Towards the development of common editorial standards. *International Journal of Psychoanalysis, 79*, 431-448.

Tyson, P. (1989). Two approaches to infant research: A review and integration. In S. Dowling & A. Rothstein (Eds.), *The Significance of Infant Observational Research for Clinical Work with Children, Adolescents, and Adults* (p. 3-12). Madison and Connecticut: International Universities Press Inc.

Vivona, J. M. (2006). From developmental metaphor to developmental model: The shrinking role of language in the talking cure. *Journal of the American Psychoanalytic Association, 54*, 877-902.

Von Klitzing, K. (2003). From interactions to mental representations: Psychodynamic parent-infant therapy in a case of severe eating and sleep disorders. *Journal of Child Psychotherapy, 29*(3), 317-333.

Von Klitzing, K., Simoni, H., & Bürgin, D. (1999). Child development and early triadic relationships. Part 1. *International Journal of Psychoanalysis, 80*, 71-89.

Watillon-Naveau, A. (1999). The contribution of baby-observation to the technique of parent-infant psycotherapy. *The International Journal of Infant Observation and its Applications, 3*(1), 24-32.

Watillon-Naveau, A. (2010). Parent-infant therapy as an application of the Esther Bick method of infant observation. *The International Journal of Infant Observation and its Applications, 13*(1), 29-36.

Weltner, J. S. (1982). One-to three-session therapy with children and families. *Family Process, 21*(281-289).

Widlöcher, D. (1994). A case is not a fact. *International Journal of Psycho-Analysis, 75*, 1233-1244.

Willig, C., & Stainton, W. (Eds.). (2008). *The Sage Handbook of Qualitative Research in Psychology*. London and Los Angeles: Sage.

Winnicott, D. W. (1941). The observation of infants in a set situation. In D. W. Winnicott (Ed.), *(1958). Through Paediatrics to Psycho-Analysis* (p. 52-69). London: Tavistock.

Winnicott, D. W. (1947). Hate in the countertransference. In D. W. Winnicott (Ed.), *(1958). Through Paediatrics to Psycho-Analysis* (p. 194-203). London: Tavistock.

Winnicott, D. W. (1957). *The Child and the Outside World: Studies in Developing Relationships*. London: Tavistock Publications.

Winnicott, D. W. (1960). The theory of the parent-infant relationship. In D. W. Winnicott (Ed.), *(1987). The Maturational Processes and the Facilitating Environment: Studies in the Theory of Emotional Development*. London: The Hogarth Press.

Winnicott, D. W. (1963a). Communicating and not communicating leading to a study of certain opposites. In D. W. Winnicott (Ed.), *(1990). The Maturational Processes and the Facilitating Environment: Studies in the Theory of Emotional Development*. London: Karnac.

Winnicott, D. W. (1963b). The development of the capacity for concern. In D. W. Winnicott (Ed.), *(1987).The Maturational Processes and the Facilitating Environment* (p. 73-82). London: Hogarth Press.

Winnicott, D. W. (1963c). From dependence towards independence in the development of the individual. In D. W. Winnicott (Ed.), *(1990). The Maturational Processes and the Facilitating Environment: Studies in the Theory of Emotional Development*. London: Karnac.

Winnicott, D. W. (1971a). *Playing and Reality*. London: Penguin.

Winnicott, D. W. (1971b). *Therapeutic Consultations in Child Psychiatry*. London: Hogarth Press.

Winnicott, D. W. (1978). *The Piggle*. London: Hogarth Press.

Wolke, D., Rizzo, P., & Woods, S. (2002). Persistent infant crying and hyperactivity problems in middle childhood. *Pediatrics, 106*(9), 1064-1060.

Woodhead, J. (2004). 'Dialectical process' and 'constructive method': Micro-analysis of relational process in an example from parent-infant psychotherapy. *Journal of Analytical Psychology, 49*, 143-160.

Woodhead, J., Bland, K., & Baradon, T. (2006). Focusing the lens: The use of digital video in the practice and evaluation of parent-infant psychotherapy. *Infant Observation, 9*(2), 139-150.

Wright, B. M. (1986). An approach to infant-parent psychotherapy. *Infant Mental Health Journal, 7*(4), 247-263.

Yin, R. K. (1993). *Applications of Case Study Research*. USA: Sage Publications.

Youell, B. (2005). The relevance of infant and young-child observation in multidisciplinary assessments for the family courts. In A. Briggs (Ed.), *Surviving Space: Papers on Infant Observation* (p. 117-134). London and New York: Karnac.

Zadik, A. (1973). The approach of brief conjoint psychotherapy – a case of separation anxiety. *Journal of Child Psychotherapy, 3*(4), 71-82.

Zeanah, C. H. (Ed.). (2009). *Handbook of Infant Mental Health, Third Edition*. New York and London: The Guilford Press.

# APPENDIX I

## Interview participants — information letter and consent forms

**N I C O L A  D U G M O R E**
**Educational Psychologist**
B Soc Sci Hons (Psych) (UCT)  H Dip Ed (Wits)  M Ed Psych (Wits)

practice address: 94 Henrietta Road, Norwood, 2192
cell: + 27 82 458 9487 fax + 27 866 724 460
**practice number: 0133825**

Dear ……..

PROPOSED STUDY INFORMATION SHEET

I am currently doing a PhD including Publication through the University of the Witwatersrand and would like to request your participation in my research. This Information Sheet is intended to provide you with sufficient information so that your consent can be considered informed. If there is further information you require, please feel free to contact me. If you agree to take part in this study, you will be asked to sign this document and you will be given a copy to keep.

The topic of my PhD study is *Psychoanalytic parent-infant psychotherapy in South Africa: Opening ports of entry and flexing the frame*. As part of this study I intend documenting past and current work in the parent-infant/child psychotherapy field in this country. You are a practitioner in this field and as such I would value being able to ask you about projects you have been or are involved in, be they at the level of private, public or community health. I would also like to enquire as to your particular approach to parent-infant/child psychotherapy and as to any training you might have had in your approach. I am also interested in what, in your experience, has been effective or ineffective and what your thoughts are on the current status and future potential of the infant mental health field in this country.

I will be conducting a one-hour, semi-structured, recorded interview with each participant. The interview will take place at a time and venue that is convenient to you. I am asking for your permission to interview you, to record that interview and to use the transcription of our interview as data in my research. I am ethically bound to protect you in terms of confidentiality should you so wish but given that I am interviewing you in your professional capacity, I would prefer to identify both you and the projects you have been involved with by name. I will offer you the opportunity of reading and responding to a final draft of my paper before I submit it as part of the PhD dissertation or for publication in a peer-reviewed scientific journal.

The possible benefit of your participation in this study it that it will contribute to building up a field of psychotherapy that is relatively undeveloped in South Africa. There are no risks to participating as you will be able to review a final draft of any material in which you are quoted or cited. Your participation is entirely voluntary and you can decline to participate or withdraw from the study at any time without furnishing a reason. This clinical study protocol has been submitted to the University of the Witwatersrand Human Research Ethics Committee (HREC) and written approval has been granted by that committee. If you want any information regarding your rights as a research participant you may visit the website at www.wits.ac.za/Academic/Research/Ethics.htm. The final PhD thesis will be stored in the Thesis Collection at the Library of the University of the Witwatersrand and some chapters of the thesis will be published in yet to be decided psychology journals.

My contact details should you have any enquiries are:


Cell: 082 458 9487
Address: 94 Henrietta Road
Norwood
2192
email: dugmorenicola@gmail.com


Yours sincerely

Nicola Dugmore.

## Informed Consent Form

- I hereby confirm that I have been informed by Nicola Dugmore about the nature, conduct, benefits and risks of her proposed clinical study.
- I have read and understood the above Information Sheet regarding the clinical study.
- I am aware that the results of the study will be written up as a PhD thesis and possibly published in scientific journals.
- Some of what I say may be quoted directly.
- I may, at any stage, without prejudice, withdraw my consent and participation in the study.
- I have had sufficient opportunity to ask questions and (of my own free will) declare myself prepared to participate in the study
- If I so choose I will be guaranteed confidentiality but I have been made aware that the researcher would prefer to refer to me by name. I indicate my preference below.

  Please delete whichever is inapplicable:

  I may be named in the final report  I wish to remain anonymous

……

Printed Name  Signature  Date

I, NICOLA DUGMORE, herewith confirm that the above participant has been fully informed about the nature, conduct and risks of the above study.

……

Printed Name  Signature  Date

## Tape-recording Consent Form

I …… consent to my interview with Nicola Dugmore for her study on infant/child-parent psychotherapy in South Africa being tape-recorded.

I understand that the tapes and transcripts will only be processed by the researcher

Signed ……

Date ……

# APPENDIX II

## Interview Schedule

Thank you for agreeing to be interviewed.

1. I am interested in how you first became aware of and/or interested in the infant mental health field and particularly the field of infant/child-parent psychotherapy?

2. Can you narrate in a chronological manner the extent of your involvement in this field; be that in terms of private practice, research, community or clinic/hospital settings? (Are there any non-confidential documents that detail any of this history, such as minutes of meetings, registering of programmes/projects, correspondence with funders, websites etc. that might be made available to me?)

3. Please would you describe in some detail the technical aspects of your approach/model/practice (or refer me to documentation) that might explain what it is you do?

4. Would you classify these endeavours as successful? Or as unsuccessful?

5. I am interested in how you are defining "success"/"failure"?

6. And also to what factors you might attribute this relative success/failure?

7. Do you think the infant-mental health field and in particular infant/child-parent psychotherapy need to developed in South Africa?

8. (If yes) In what ways/directions do you think this development needs to advanced.

9. (If yes to Q7) What do you imagine the benefits of promoting awareness of infant/child-parent psychotherapy might be, generally and in South Africa in particular?

10. What would you say are the major theoretical influences that inform your practice in this field?

11. Would you describe your practice as being aligned to any particular approach or model already existing in the field?

12. If so, which one and how have you perhaps adapted it to meet local needs and conditions?
    If not, how would you describe your approach and in what ways has it developed in order to meet local needs and conditions?

13. What particular challenges or limitations do you think infant/child-parent psychotherapy faces in South Africa in terms of practice?

14. What obstacles do practitioners in this field need to overcome in order to develop and expand services offered?

15. Have you had or are you involved in any training in this field – either training that you have undergone or that you provide?

16. Where would you like to see infant/child-parent psychotherapy in South Africa in five years' time?

17. Are there any other comments or thoughts that you would like to share with me?

# APPENDIX III

## Case study participants — information sheet and informed consent form

**N I C O L A  D U G M O R E**
**Educational Psychologist**
B Soc Sci Hons (Psych) (UCT)  H Dip Ed (Wits)  M Ed Psych (Wits)

practice address: 94 Henrietta Road, Norwood, 2192
cell: + 27 82 458 9487 fax + 27 866 724 460
**practice number: 0133825**

Dear ……..

PROPOSED STUDY INFORMATION SHEET

I am currently doing further academic study through the University of the Witwatersrand in order to obtain a Doctoral degree and you and your child are invited to consider participating in my research. Your participation is entirely voluntary. Before you agree to participate, it is important that you understand the purpose of the study and that you understand what is involved. Please feel free to ask me any questions or to provide you with more information. If there are words that are used that you do not fully understand, please ask me to clarify them for you. You may take home an unsigned copy of this consent form to think about or discuss with family or friends before making your decision. If you decide to take part in this study, you will be asked to sign this document to confirm that you understand the study and you will be given a copy to keep.

The topic of my PhD study relates to parent-infant/ psychotherapy, which is a kind of therapeutic intervention where parent(s) and child are seen together in order to understand and treat an emotional difficulty. The particular purpose of my study is to explore how parent-infant/child psychotherapy is practised; how it works and in what cases it can be considered effective. You contacted me requesting my professional help and because parent-infant/child psychotherapy was a recommendation in your particular situation it means that you and your child could be participants in my study. I will be doing what is called case study and case vignette research which means that I will be using material (verbal discussions and non-verbal play) that emerges during therapy sessions to illustrate or explore particular aspects of my study. I am asking for your permission, should it be applicable to my research, to describe the therapy as it naturally proceeds/proceeded during our sessions and to choose, where applicable, to use these written-up descriptions as the data in my research. I am ethically bound to protect you and your family in terms of confidentiality. This means that should I choose to write up any aspect of the therapy I will not disclose your real names or any identifying details. To further ensure confidentiality and anonymity, I may disguise the cases with “red herrings”, or use what is called a composite case study; that is combining different aspects of several cases into one. All case material used in the final dissertation or

published in scientific journals will be treated as confidential and your identity will be protected as described.

## Informed Consent

- I hereby confirm that I have been informed by Nicola Dugmore about the nature, conduct, benefits and risks of her proposed study.
- I have read and understood the above Information Sheet regarding the study.
- I am aware that the results of the study will be written up as a PhD dissertation and possibly published in scientific journals.
- I have been guaranteed confidentiality.
- Some of what I say may be quoted directly.
- I may, at any stage, without prejudice, withdraw my consent and participation in the study.
- I have had sufficient opportunity to ask questions and (of my own free will) declare myself prepared to participate in the study
- Because my young child (under seven years of age) is also a participant in this study, I am aware that as his parent I am signing on his/her behalf .

……

Printed Name Signature Date

I, NICOLA DUGMORE, herewith confirm that the above participant has been fully informed about the nature, conduct and risks of the above study.

……

Printed Name Signature Date

# APPENDIX IV

## University of the Witwatersrand Human Research Ethics Committee (Non Medical) Clearance Certificate

---

**UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG**

Division of the Deputy Registrar (Research)

**HUMAN RESEARCH ETHICS COMMITTEE (NON MEDICAL)**
R14/49 Dugmore

| | |
|---|---|
| **CLEARANCE CERTIFICATE** | **PROTOCOL NUMBER H0 90903** |
| **PROJECT** | Child parent psychotherapy in South Africa: Exploring and developing the psychoanalytic approach |
| **INVESTIGATORS** | Ms NA Dugmore |
| **DEPARTMENT** | Psychology |
| **DATE CONSIDERED** | 11.09.2009 |
| **DECISION OF THE COMMITTEE*** | Approved Unconditionally |
| **NOTE:** | |

**Unless otherwise specified this ethical clearance is valid for 2 years and may be renewed upon application**

**DATE** 13.10.2009 **CHAIRPERSON** .....
(Professor R Thornton)

cc: Supervisor : Prof C Long

---