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CAREGIVERS' PERCEPTIONS OF THE BABY MAT PROJECT

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Johannesburg, South Africa November 2012

Declaration

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

Signature: _____ Date: _____

Abstract

This study set out to investigate the parent-infant interventions that are run by a community-based organisation on the outskirts of Johannesburg's Alexandra township, South Africa. Community-based interventions that support the parent-infant dyad present an ideal opportunity to shape the development of youth as they aim to foster secure attachment relationships thereby providing the bedrock for future growth. This research specifically explores caregivers' perceptions of the Baby Mat project in order to understand why some caregivers make optimal use of this intervention whereas others do not. It also gives insight into why some caregivers who are referred for parent-infant psychotherapy on the Baby Mat fail to take up this offer. In addition, it identifies needs caregivers have that are not being met by the Baby Mat. Data for this study was collected by holding a focus group with 11 caregivers in group discussion. The results of the data analysis indicate that caregivers are increasingly having to navigate the transition to motherhood alone, and are often overwhelmed with anxiety. Possibly this is because the support gleaned from extended families has diminished over the last few decades in South Africa. Consequently caregivers are often very receptive to the Baby Mat, which they see in the role of "grandmother". By visiting the Baby Mat, caregivers realise that they are not alone in the challenges they face and often leave the mat feeling more hopeful about their problems. Yet several factors block them from making full use of this intervention. The primary one is their socially and economically weak position. They are also concerned that actions that they would rather avoid might be taken when facilitators on the mat learn of the abuse they are exposed to. Having limited resources, they are often looking for information and guidance and when this need cannot be met, frustration follows. Generally they want people running relevant interventions to come to them, as opposed to their going out to seek support. This may explain their failure to take up parent-infant psychotherapy. It is also was evident that the caregivers want to reach out to each other.

Key words: *caregiver-infant dyad, community-based prevention, parent-infant psychotherapy, Baby Mat project, attachment in South Africa, facilitating reflective functioning, caregivers in South Africa*

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Contents

Declaration 1
Abstract 2
Acknowledgements 3
Chapter 1: Introduction 7
1.1 Aims 7
1.2 Rationale 7
1.3 Research questions 10
Chapter 2: Literature review 11
2.1 The Baby Mat project 11
2.2 The significance of the caregiver-infant relationship 13
2.2.1 Attachment theory 13
2.2.2 Mentalisation and reflective functioning 16
2.2.3 Holding and containing 18
2.2.4 Inter-subjective exchange, implicit relational knowing and recognising the infant as subject 20
2.2.5 Inextricable link between brain development and the parental environment 21
2.3 The benefits of secure attachment and risks associated with insecure and disorganised patterns of attachment 22
2.4 Parental antecedents of attachment 24
2.5. Risks to the caregiver-infant attachment in South Africa 25
2.5.1 Poverty and its related risks, including postnatal depression 25
2.5.2 Power imbalance between women and men in South Africa 26
2.5.3 Anxiety provoked by the passage to motherhood 27
2.5.4 Stigma associated with the onset of illness 28
2.6 Patterns of attachment in South Africa 28
2.7 The relevance of a psychodynamic approach 29
Chapter 3: Method 31
3.1 Research design 31
3.2 Participants 33
3.3 Data collection 34
3.4 Procedure 35
3.4.1 Research questions 35
3.4.2 Topic guide for focus group discussion 35
3.4.3 Focus group 36

3.4.4 Position of the researcher 37
3.5 Data analysis 39
3.6 Ethical considerations 40
Chapter 4: Results 42
4.1 Caregivers' experiences of the Baby Mat 42
4.2 Factors pushing caregivers to visit the Baby Mat 46
4.3 Factors that prohibit caregivers from visiting the Baby Mat and parent-infant psychotherapy 48
4.4 Other needs 52
4.5 Context 53
4.6 Summary of results 54
Chapter 5: Discussion 57
5.1 How the disempowered position of caregivers blocked them from visiting the Baby Mat or taking up parent-infant psychotherapy 57
5.2 Why caregivers mask their vulnerability and choose not visit the Baby Mat or take up parent-infant psychotherapy 59
5.3 Exploring the caregivers need for a "good enough grandmother" and whether the Baby Mat and parent-infant psychotherapy meet this expectation 60
5.4 Examining the caregivers' desire for a support matrix 63
5.5 Understanding how caregivers benefitted therapeutically from their experience on the Baby Mat 64
Chapter 6: Conclusion 65
6.1 Research findings 65
6.2 Recommendations based on the findings 66
6.3 Limitations of the research 67
6.4 Suggestions for further research 67
6.5 Concluding remarks 68
References 70
Appendices 80
Appendix 1: Topic guide for focus group discussion 80
Appendix 2: Participant's information sheet 82
Appendix 3: Participant's consent form for focus group 85
Appendix 4a: Participants consent form for video recording 86
Appendix 4b: Participants consent form for audio recording 87
Appendix 5: Letter requesting permission from the community based organisation 88

Appendix 6: Letter requesting permission from the Chief Executive Officer of the health care clinic in Alexandra township 90
Appendix 7: Application to the Human Research Ethics Committee (HREC Non-Medical) .. 92

Chapter 1: Introduction

1.1 Aims

This research explores caregivers' perceptions of the Baby Mat so as to better understand why some caregivers make optimal use of this intervention whereas others do not. Specifically, the research hopes to shed light on why some caregivers repeatedly visit the Baby Mat while others fail to return. It also provides insight into why some caregivers who are referred for parent-infant psychotherapy on the Baby Mat fail to take up this offer of support. These findings will be used in conjunction with other studies to develop and refine the service described.

1.2 Rationale

In 1855 American William Ross Wallace wrote a poem entitled "What rules the world." In this he acknowledged the power of motherhood and coined the phrase "For the hand that rocks the cradle is that hand that rules the world" (Wallace, 1890, p.248). This has become an accepted idiom in the English language as it neatly encapsulates our innate recognition of the profound influence that mothers have on the development of their children. Austrian psychoanalyst Sigmund Freud, renowned for revolutionising western thinking about human behaviour, also acknowledged the importance of this early relationship. He described the relationship between a mother and her infants as "unique, without parallel, laid down unalterably for a whole lifetime, as the first and strongest love-object and as the prototype of all later love relations - for both sexes" (Freud, 1938, p.56). Then British psychologist John Bowlby (1958, p.350) gave further impetus to the role played by mothers by putting forward his theory of attachment to explain the "nature of a child's tie to his mother." Shortly thereafter Winnicott (1960a, p.587), an influential British psychoanalyst and paediatrician, declared that "there is no such thing as an infant... wherever one finds an infant one finds maternal care."

In South Africa an infant's primary caregiver is often not the child's biological mother but rather the grandmother (Frost, 2007). In light of this, the term "caregiver" is used in this study to denote the infant's mother or mother figure.

Today, researchers recognise the positive outcomes of adaptive caregiver-infant relationships and the risks of dysfunctional relationships. Certainly the relationship between caregivers and their infants seems to provide the bedrock for later development. According to attachment theory, the quality of this relationship significantly influences the infant's capacity to engage in exploratory behaviour and, in so doing, to learn about the environment and to develop mastery. Infants are more likely to explore their environment if they can trust their mothers to be there when they need them. Not only does this relationship directly impact on their behaviour, it also shapes the development of their brain (Schore, 2000, 2001). As a result, one might say that the relationship between caregivers and their charges allows for the development of factors that protect infants in the years that lie before them.

Donald, Lazarus & Lolwana (2010) advocate community-based interventions that foster resilience and thereby promote prevention of developmental difficulties. In this manner, they encourage educational psychologists to reach beyond the consulting room and into broader communities. As the caregiver-infant relationship shapes learning and development, interventions that promote secure attachments are especially relevant. They give educational psychologists opportunities to prevent problems before they arise, such as insecure attachment. The Baby Mat project is an example of such an intervention. It supports caregivers so that they are able to foster secure attachments.

Currently the Baby Mat is running in three primary health care clinics in Alexandra township, a peri-urban settlement within northern Johannesburg and which is characterised by poverty and all its associated ills. Caregivers regularly visit these primary health care clinics to weigh, measure and immunise their infants (Frost, 2012). This intervention requires that a mat is placed on the floor of the immunisation clinic. In attendance on the mat are two therapists: a trained psychologist and a multi-lingual social worker/social-auxiliary worker. Caregivers are invited to join them on the mat, with their infants. Following greeting and introductions for all taking part, the caregivers are invited to discuss the matters that brought them to the mat. As the caregiver starts talking about these issues, the co-therapists carefully listen and attend to both the caregiver and the infant. According to Frost (2012), the problems that caregivers bring to the mat are generally concrete. For example, caregivers may complain that their infants are not sleeping.

Typically the co-therapists respond to these issues by acknowledging both the caregiver and the infant. They also encourage caregivers to reflect on their own mental states as well as that of their infants.

This intervention was based on outreach work conducted by the Lane Hospital in England (Frost, 2012). This institution, like the Baby Mat project, serves a marginalised community and the appeal of its approach is that it attempts to de-stigmatise psychotherapeutic intervention by "normalising" this service. It does so by offering psychotherapeutic services within the context of ordinary health care delivery. In a similar vein, the Baby Mat provides caregivers with support within the context of the health care clinic.

Although the intervention is not strictly psychoanalytic, it is informed by several psychoanalytic principles, including attachment theory, mentalisation, intersubjectivity, implicit relational knowing and recognising the infant as subject (Frost, 2012). Over the past few years, the number of caregivers making use of this service has grown. Although very few caregivers made use of this service when it was launched in 2007, between March 2010 and February 2011 there were 556 mothers and infants who visited the Baby Mat (Frost & van De Walt, 2010; Ububele Annual report, 2010/2011).

Interventions aimed at fostering secure attachment are particularly relevant in contexts where the caregiver-infant dyad is at risk. Peri-urban settlements in South Africa are poignant examples of at-risk communities as they are marked by a high incidence of postnatal depression (Cooper, Tomlinson, Swartz, Woolgar, Murray & Molteno, 1999; Murray & Cooper, 1997) and high levels of disorganised attachment among children (Tomlinson, Cooper & Murray, 2005). Poverty also directly and indirectly affects the ability of caregivers to look after children (Donald *et al*., 2010). In these circumstances various resources are often inadequate and this generates stress which can lead to physical illness and emotional exhaustion in caregivers. To help them withstand these stresses, Donald *et al*., (2010) suggest that community-based interventions provide these caregivers with social support. In Khayelitsha, a partially informal settlement in Cape Town, South Africa, an intervention was successfully implemented by a community-based organisation to support the mother-infant dyad (Cooper, Tomlinson, Swartz, Landman, Molteno, Stein &

McPherson, 2009). This intervention achieved significant improvements in maternal sensitivity through visits to caregivers in the weeks preceding the birth of their infants, and for several months thereafter. Like this intervention, the Baby Mat project similarly supports caregivers so that they are able to foster secure attachment.

In a recent study, caregivers' experiences and perceptions of the Baby Mat were explored (Bromley, 2009). This research revealed that caregivers do perceive Baby Mat positively. However, it did not explain why they do not make more use of this intervention. Currently only 10% of caregivers repeatedly access the Baby Mat and very few, if any, take up the referral for parent-infant psychotherapy. This research strives to provide insight into why caregivers fail to make repeated visits to the Baby Mat or to take up the offer of parent-infant psychotherapy when offered to them on the Baby Mat.

1.3 Research questions

The questions this research addresses are:

- Why do some caregivers repeatedly access the Baby Mat?
- Why do other caregivers fail to make repeated use of this intervention?
- Why do caregivers not take up parent-infant psychotherapy when it is offered to them on the Baby Mat?
- Do caregivers have other needs that are not being met by the Baby Mat?

Chapter 2: Literature review

The Baby Mat will be explored further, specifically focusing on the ideas that led to its conceptualisation. Thereafter the theoretical constructs that underpin the Baby Mat project will be examined. These theories highlight the significance of the caregiver-infant relationship, and include attachment theory, mentalisation and reflective functioning, holding and containing, inter-subjective exchange, implicit relational knowing, and recognising the infant as subject.

This will be followed by a discussion on the benefits of secure attachment, as well as the risk of insecure and disorganised attachment. Attention will then shift to the possible causes of these patterns of attachment, specifically focusing on parental antecedents of attachment and the risks presented by the South African context. The patterns of attachment that are prevalent in South Africa will also be examined. Finally, the relevance of adopting a psychoanalytic approach within the South African context will be explored.

2.1 The Baby Mat project

To prevent adverse outcomes, early intervention in the caregiver-infant relationship has been recommended (Bakermans-Kranenburg, van IJzendoorn & Juffer, 2003). In South Africa, interventions have focused on supporting caregivers so that they can successfully fulfil their role and foster secure attachment. The Baby Mat project is one of these interventions and is currently running in three health care clinics in Alexandra. The primary aim of this intervention is to support the caregiver-infant dyad. It also strives to model reflective functioning, with the hope that caregivers will assimilate this way of being.

Reflective functioning requires the caregiver to bear the infant in mind and to reflect on what the child might be feeling or thinking. In addition, this intervention facilitates the development of a coherent sense of self in the infant, by engaging with them directly. It also allows for referrals when infants appear to be at risk of insecure attachment, or are suffering from developmental delays. Referrals can also be made when it is evident that a caregiver is suffering from postnatal depression.

The Baby Mat is based on the outreach work conducted by the Lane Hospital (Frost, 2007; Frost 2012). Like the Baby Mat project, Lane Hospital serves a marginalised community. Many of the patients who utilise this hospital are homeless and struggle to make ends meet. As a result, they have a lot in common with the caregivers who visit the Baby Mat in Alexandra. Another appeal of the approach adopted by Lane Hospital is that it strives to destigmatise psychotherapeutic intervention. It does so by normalising the service. Psychotherapeutic services are provided within the context of ordinary health care delivery (The Anna Freud Centre, 2010). Opportunities are created for caregivers and their infants to best engage with one another. This is facilitated by providing mats, toys and chairs for caregivers and infants to use while they wait for other services. Since everything is done on a level conducive to playing with a baby, the environment helps interaction to take place. It also provides opportunities for caregivers to learn from each other. In addition, a multi-disciplinary team is on hand to offer additional support and to make referrals if needed.

The Baby Mat approach is also influenced by a community-based intervention piloted in Khayelitsha, a similarly depressed area of Cape Town. The latter intervention was implemented to improve the quality of mother-infant relationships. It involved visiting the pregnant mothers twice before the birth of their infants and on a weekly basis for six months thereafter (Cooper, Landman, Tomlinson, Molteno, Swart & Murray, 2002). In 2009 a randomised, controlled trial was undertaken to formally assess the effectiveness of this work. The findings of this study showed that mothers in the experimental group were far more sensitive towards their infants and less intrusive than those in a control group (Cooper *et al*., 2009). From the results of this study, it is possible to conclude that early prevention can be effective. The experience of caregivers in these home visits were also explored in order to understand reasons for positive changes fostered by this programme (Landman, 2009). This research emphasised the caregiver's need for respect, acceptance and a supportive ally, and was consistent with the hypothesis that a therapeutic alliance is an important ingredient of parent-infant psychotherapy (Stern, 1995).

Dilys Dawes' (1985, p.77) approach of "standing next to the weighing scales" was also taken into consideration when the Baby Mat approach was conceived. By standing next to weighing scales during weekly baby clinics, Dawes (1985) was able to observe the interaction between caregivers

and their infants. In so doing, she was able to monitor the progress of infants that visited the general health care centre and easily identify caregiver-infant dyads that were at risk. In addition, she was more accessible to caregivers, should they have concerns and want a second opinion. Since the focus in the clinic was on sustaining wellness as opposed to treating illness, this intervention employed the principles of psychoanalytic theory to support normal, as opposed to abnormal, growth and development.

2.2 The significance of the caregiver-infant relationship

The Baby Mat provides emotional support for caregivers and their infants. As such, it is important to consider the significance of this relationship, and to examine prominent theories that try to explain how caregivers influence the development of their infants. These theories are especially relevant to the field of educational psychology as they shed light on how this early relationship provides a foundation for later development.

2.2.1 Attachment theory

Attachment theory gives primacy to the early relationship between caregivers and their infants. The theory was first formulated by John Bowlby (1958, 1969/1982) and expanded by Mary Ainsworth (1978). Bowlby (1969, p.xi) believed that "what is … essential for mental health is that the infant and young child should experience a warm, intimate and continuous relationship with his mother." Indeed, he was one of the first psychoanalysts to acknowledge the pivotal role played by mothers. Although Freud realised that we are products of our past, it was only during the last decade of his life that he acknowledged the importance of the relationship between mothers and their children. As Bowlby (1958, p.351) says, "It was not until comparatively late that he appreciated the reality of the infant's close tie to his mother, and that it was only in his last 10 years that he gave it the significance we should all give it today."

As a result, Bowlby is heralded for noting the link between mental illness and disruption of the bond between caregivers and their infants. He made this discovery while working at a home for maladjusted boys. Since he was interested in understanding the origins of delinquent behaviour, he later studied 44 juvenile thieves and the relationships each had with their mothers (Bowlby, 1944). Follan and Minnis (2010) recently revisited this research and found that the clinical

features of the offenders might now be recognised as reactive attachment disorder. In 1969 Bowlby attempted to explain the nature of the relationship children have with their mothers and he put forward his theory of attachment. This theory looked at the behaviour exhibited by infants and children in order to maintain physical closeness to their caregivers.

For his part, Bowlby (1969) described four phases of attachment behaviour, which is behaviour directed at increasing proximity to the caregiver. In the first phase, infants visually track movement, reach out and grasp, smile and babble. However, their ability to discriminate between people is limited. As a result, Bowlby (1969, p.266) described this as "orientation and signals without discrimination of figure." In the second phase, infants start discriminating between the mother figure and others. Consequently it was described as "orientation and signals directed towards one or more discriminated figures" (Bowlby, 1969, p.266). In the third phase, the infant was less friendly to others, as their attention was focused on the mother figure. Bowlby noted (1969, p.267) that in this phase children tended to use their mother figure as a base and described this as "maintenance of proximity to a discriminated figure by means of locomotion as well as signals" (Bowlby, 1969, p.267). The final stage saw the "formation of a goal-corrected partnership" (Bowlby, 1969, p.267). During this stage Bowlby noted that the infant begins to recognise the caregiver's feelings and motives, thereby enabling a more complex relationship to develop.

Essentially, attachment theory attempts to explain how infants use their caregivers as a secure base from which to explore the world. Bowlby (1969) postulated that this system of behaviour was an evolutionary adaptation as it enhanced the safety of the infant. It was also self-regulating. Like a thermostat, which invokes the heating system when the temperature drops below a certain point, so attachment behaviour is triggered when an infant strays too far from their caregiver.

American-Canadian developmental psychologist Mary Ainsworth built on Bowlby's theory of attachment (Ainsworth, 1978). She was interested in observing attachment behaviour and developed a laboratory-based research methodology to activate it, namely the Strange Situation Protocol. This required that one-year old infants and their caregivers be placed in an unfamiliar

playroom. The caregivers were then separated from their infants, who were left with strangers. They were then re-united with their caregivers.

Throughout this process, researchers monitored infant responses to separation and reunion through a one-way mirror. Prior to conducting this research, Ainsworth (1978) believed that separation would invoke attachment behaviour. She expected that infants might cry, run after or call for their mothers when they separated. She found instead that separation was not the key to understanding infant responses and noticed that attachment behaviour was linked to the nature of the caregiver-infant relationship. Infants who were confident in their caregiver's ability to meet their needs were less anxious on separation, and their attachment behaviour less marked. These infants seemed to trust their caregivers to meet their attachment needs. She described this style of attachment as "secure". Although these infants protested against the departure of their caregivers, and sought their comfort on return, they were not overwhelmed with anxiety and allowed strangers to comfort them. In contrast, children with an insecure/avoidant pattern of attachment failed to respond to their caregiver's departure or return. They also treated the stranger and caregiver in the same way. Ambivalent/resistant patterns of attachment were characterised by proximity-seeking prior to separation, distress on separation and ambivalence, anger or reluctance upon return.

After linking attachment to the nature of the relationship between infants and their caregivers, Ainsworth (1978) became interested in how to foster secure attachment. Through research she found that maternal sensitivity, acceptance, co-operation, and accessibility were important, yet a mother's sensitivity to her infant's signals had the strongest correlation with secure attachment (Ainsworth, 1978). This led her to postulate that the more sensitive and responsive the caregiver, the more secure the infant. Securely attached infants believed that their caregivers would be there for them when they needed them, based on their earlier experience.

American researchers Mary Main and Judith Solomon (1990) continued to explore patterns of attachment using the Strange Situation Protocol and identified a fourth style of attachment, namely disorganised attachment. The disorganised attachment pattern is characterised by

inconsistent attachment behaviour. They postulated that infants with disorganised attachment experienced their caregivers as frightened or frightening. As Lyons-Ruth (2006, p.605) says, "For these infants, the caregiver had become both the source of comfort and a source of alarm." Since they were scared, they failed to develop a consistent strategy for maintaining proximity to their caregiver, preferring to use a mixture of behaviours that were typical of other patterns of insecure attachment.

The study of individual differences in attachment continued. However, research moved to focus on the internal representation of attachment (Main, Kaplan & Cassidy, 1985). For example, American and Canadian researchers Alan Scroufe and Everett Waters (1977) explored "felt security" and interpreted internal cues such as mood, illness and fantasy as representative of a child's response to separation. The shift from behaviour to internal representation enabled the concept of attachment to extend beyond early childhood. To identify patterns of attachment in adulthood, an "adult attachment interview" was developed (George, Kaplan & Main, 1984, 1988, 1966). In the interview, adults are asked to reflect on and evaluate their relationships with their parents, and how they have been affected by these relationships.

Initially, attachment theory was not widely accepted within psychoanalytic circles. It was rejected by leaders in the field, including Anna Freud and Melanie Klein, as it negated several aspects of traditional psychoanalytic thinking, such as drives, the Oedipus complex and unconscious processes (Fonagy, 2001). More recently, changing approaches have allowed the integration of attachment theory with psychoanalysis. This was made possible by a shift from focusing on behaviour to a concern with internal representations, an acceptance within attachment theory that a purely cognitive approach was limited, the recognition of the value of systematic observation within psychoanalysis and a greater openness to plurality of theory and approach (Fonagy, 2001).

2.2.2 Mentalisation and reflective functioning

Hungarian psychoanalyst and clinical psychologist, Peter Fonagy, led the integration of attachment theory and psychoanalysis with his concept of "mentalisation", which is defined as "the ability to experience the mental in terms of representation" (Jurist, 2010, p.11). A mother's capacity to "hold a representation" of her infant's feelings, desires and intentions in mind allows

for a sense of heightened security in the infant as well as the development of that infant's mind (Slade, 2005). Thus, for example, infants often cry when they wake up and find themselves alone in the crib. Mentalisation describes the process whereby a mother perceives and acknowledges this fear.

A person who is able to mentalise is able to interpret the thinking and feelings of others, and so better understand themselves (Slade, 2005). This is not an ability that a person is born with. Instead, it is a skill that is mostly learned through the caregiver-infant relationship. When a caregiver can interpret an infant's desires, feelings and thoughts, the infant learns to understand these mental states in themselves.

Reflective functioning describes how mentalisation can be put into practice. "Reflective functioning refers to the essential human capacity to understand behaviour in light of mental states and intentions" (Slade, 2005, p.269). Building on the example provided above, reflective functioning is the process mothers go through in order to understand their infants' minds. When mothers find their infants crying, they often respond by picking them up and offering them the breast. When infants reject the breast and continue to cry, mothers are prompted to think about why they are so unhappy. This encourages them to spend time thinking about the feelings and thoughts their infants might have. This can only be achieved if mothers draw on their own experiences. If they are able to do so, these mothers come to realise that their infants are not hungry, but rather that they are afraid. However, this example also shows how difficult it is to hold a representation of another person's feelings in mind. Sometimes mothers mistake their infants' cries for hunger and do not take time to consider that the cries may be linked to other mental states.

Later Fonagy (2003) linked his notion of mentalisation to neurocognitive processes. He introduced the idea that we all have an internal interpretive mechanism. He postulated that this was made up of neurocognitive processes, and was used to interpret new experiences. He theorised that this mechanism matured through the process of attachment, and shaped how people respond to experiences throughout their lives.

2.2.3 Holding and containing

Donald Winnicott and Winfred Bion were both influential British psychoanalysts who used different metaphors to describe the nature of the relationship that a mother has with her infant. Whereas Winnicott (1960) used the term "holding", Bion (1962) focused on the model of the "container-contained". Although these concepts sound similar, they describe different, but equally important, aspects of the relationship between mother and infant (Ogden, 2004).

Winnicott (1958) noticed that mothers tended to become preoccupied with their infants just prior to birth and in the first few weeks thereafter. He realised that during this time mothers tended to fuse with their infants, and described this as a phase "when the infant has not separated out a self from the maternal care on which there exists absolute dependence in a psychological sense" (Winnicott, 1960a, p.592). He felt that this fusion was critical. It ensured that mothers were able to meet their infants' needs and allowed for the "continuity of being" and protection from the fear of annihilation, which he identified as a primary anxiety (Winnicott, 1969, p.595). Winnicott (1960a) introduced the concept of holding to describe the type of maternal care needed. Essentially, he saw holding as a process of insulation, where the mother safeguards the infant's developing ego from impingements. He said that holding referred to "not only the actual holding of the infant, but also the total environmental provision" (Winnicott, 1960a, p.589). In order to be able to provide this, he realised that mothers also needed to be held, and said "mothers who have it in them to provide good enough care can be enabled to do better by being cared for themselves in a way that acknowledges the essential nature of the task" (Winnicott, 1960a, p.591). Interestingly, he did not believe that a mother who lacked these skills could learn them through psycho educational training, saying, "There are those who can hold an infant and those who cannot; the latter quickly produce in the infant a sense of insecurity, and distressed crying" (Winnicott, 1960a, p.592).

He advocated "good enough mothering". According to this, consistent and reliable caregiving led to "a continuity of being" and gave the infants the ego strength to withstand the impingements they would experience as they grew towards independence (Winnicott, 1960a, p.595). While he felt it to be essential for mothers to meet their infant's needs when they were absolutely dependent on them, he thought that this was less important when the infant became more

independent. Indeed, he actively encouraged mothers to occasionally "fail", as this encouraged the infant to draw on their own internal resources in order to cope. He described these incidences as optimal failures in maternal provision. But he warned caregivers against withdrawing holding too soon. Winnicott (1960b) pointed out that when this happened, the infant was driven to adapt and, in the process, became falsely compliant and reactive (Rappaport, 1998). As Watts (2009, p.148) says, "When the mother doesn't respond to the true self experiencing, the child has no option but to adapt to the false expectations of the mother".

Bion (1962) was interested in people's ability to think about their own, specifically unwanted, experiences, as well as those of others. His theory examined how the relationship between an infant and their mother shaped the development of thought. Since a developing ego does not have the strength to cope with impingements, he described how infants expel their intolerable experiences onto their mothers in a process described as "projective identification". Having received these unwanted experiences, the mother's job was then to contain them - to process these experiences, and to present them back to the infant in a more palatable form so that they could be re-ingested.

By means of the container-contained, infants acquired the capacity to process unwanted experiences and "house" these previously intolerable thoughts (Ivey, 2009, p.113). Bion (1962, p.116) described the mother's ability to do this for her infant as her capacity for "reverie". He said that in order to be a container, mothers needed to be able to receive their infants' unwanted experiences and allow these experiences to be invoked in themselves (Britton, 1992). The mother then needed to draw on her own resources to process these experiences and to attend to her infant. He pointed out that when a mother couldn't do this for her infant, the infant was "reduced to continued projective identification, carried out with increasing force and frequency" (Bion, 1962, p.115). As a result, all intolerable thoughts are treated like bad objects that need to be ejected and the development of the apparatus for thinking, the alpha function, was disturbed (Britton, 1992). When thinking is blocked in this way, the infant's reality ego could not gradually replace the pleasure-seeking ego (O'Shaughnessy, 1988). Through his model of the container-contained, Bion's theory highlighted the long-lasting effect on this early relationship.

2.2.4 Inter-subjective exchange, implicit relational knowing and recognising the infant as subject

The theories and ideas discussed so far, including attachment theory with its current focus on mentalisation, and reflective functioning, as well as the concepts of holding and containing, have focused primarily on the caregiver in the parent-infant psychotherapy. Not surprisingly, this has led critics, such as Lojkasek, Cohen and Muir (1994, p.208), to wonder where the infant is in infant intervention. The theory of inter-subjective exchange, implicit relational knowing and the idea of recognising the infant as subject marks the beginning of a change in thinking. These approaches recognise an infant's motivation for companionship.

The theory of inter-subjective exchange highlights how infants purposefully strive to engage with older people. For example, the theory recognises that an infant will smile or gurgle at people who are sympathetic to their responses. As a result, the theory of intersubjective exchange reframes attachment theory. Instead of seeing attachment as behaviours that are used to encourage proximity to the caregiver, the theory of inter-subjective exchange recognises that infants " … are specially motivated, beyond instinctive behaviours that attract parental care for immediate biological needs, to communicate intricately with the expressive forms and rhythms of interest and feeling displayed by other humans" (Travarthen & Aitken, 2001, p.3). When caregivers fail to respond to their infants' attempts to engage socially, the development of movement, perception, learning and self- regulation is negatively affected (Travarthen & Aitken, 2001).

Lyons-Ruth, an American professor in developmental psychology, introduces the notion of "implicit relational knowing," which refers to people's knowledge about how to behave in relationships (Lyons-Ruth *et al.*, 1998, p.284). For example, implicit relational knowing includes knowing how to joke around with others, how to show affection, or how to attract attention (Lyons-Ruth *et al.*, 1998). This knowledge guides social interactions from moment to moment and includes "all the things that are the stuff of the interactive flow, such as gestures, vocalisations, silences and rhythms" (Lyons-Ruth, 2007, p. 844).

It is important to point out that this knowing is neither non-verbal nor verbal but rather a combination of both. The process of acquiring this knowing begins during infancy, before

language is acquired, and it continues throughout life at an unconscious level. However, the caregiver-infant relationship contributes significantly to the repository of implicit relational processes that an infant acquires. Although future social interaction is often defined by this repository, these processes can change. This change is facilitated through interaction with others. Lyons-Ruth *et al.* (1998) suggests that the therapeutic relationship can facilitate shifts in implicit relational knowing. They identify this as the "something more" needed to facilitated change in psychoanalytic treatment (Lyons-Ruth *et al.*, 1998, p. 282).

More recently, Australian infant mental health clinician, Frances Thompson-Salo (2007), described how implicit relational knowing can be remodelled by therapeutic interventions that recognise the infant as subject. This idea challenges traditional psychoanalysis, which associates an infant's symptom with their caregiver's unresolved issues. The notion is eloquently captured by Selma Fraiberg, an American pioneer in the field of parent-infant psychotherapy. She describes how "intruders from the parental past may break through the magic circle in an unguarded moment, and a parent and his child may find themselves re-enacting a moment or a scene from another time with another set of characters" (Fraiberg, 1987, p.100).

In contrast to these traditional views, Thomson-Salo (2007) argues that infants should be entitled to their own intervention and points out that this idea was first put forward by Winnicott in 1941. She describes how therapists at the Royal Children's Hospital in Melbourne, Australia, interact directly with distressed infants in order to gain insight into their experience, and then provide feedback to their parents. Research indicates that this approach has been very successful (Thomson-Salo, 2007).

2.2.5 Inextricable link between brain development and the parental environment

Allan Schore (2001, 2002), a leading American researcher in the field of neuropsychology, focused on attachment from a neurobiological perspective. His research highlighted the role of mothers in brain development. He found that the exchange between a mother and her infant facilitated the development of neural networks in the right hemisphere of the brain (Schore, 2001). When maternal responses were absent or inconsistent, he found that an infant's brain failed to develop normally. To be more specific, he found that the functioning of the right brain

and corticolimbic system was impaired. In addition, there was a depletion of the neurotransmitter serotonin and growth-releasing hormone.

All the theories discussed so far highlight the critical nature of the relationship between caregiver and infant. Attachment theory describes how infants use caregivers as a secure base from which to explore the world. Fonagy's notion of mentalisation links attachment to the capacity to hold the infant in mind. Winnicott's theory of holding shows how important it is for caregivers to be attuned to their infant's needs, so that they develop a "true self". Bion's metaphor of the container-contained describes how the relationship between caregiver and infant fosters the capacity to think. The theory of intersubjective exchange postulates how infants purposefully strive to engage with other people. The concept of implicit relational knowing describes how experiences build up to form a repository, which is used to inform later relationships. Schore sheds light on how the caregiver-infant relationship impacts neurobiological development. All these theories suggest that this relationship is of paramount importance as it shapes and colours a person's future development.

2.3 The benefits of secure attachment and risks associated with insecure and disorganised patterns of attachment

The benefits of attachment go beyond merely protecting the infant. There is extensive research indicating that there is a relationship between attachment and intelligence (Jacobsen, Edelstein & Hofmann, 1994; Jacobsen & Hofmann, 1997; van IJzendoorn & van Vliet-Visser, 1988). Also, it would seem that attachment impacts the ability to stay focused on a task (Fearon & Belsky, 2004). Adams (2005) provides some insight into why this may be the case.

She suggests that when a caregiver is able to be a secure base, a child feels safer to explore the world and, in so doing, increases opportunities for learning and mastery. In contrast, children with an insecure pattern of attachment focus on ensuring proximity to their caregiver, consequently limiting their capacity for exploration. In addition to behaviour, the relationship between a caregiver and infant also affects the neurological development of the brain. This was explored earlier when discussing the inextricable link between brain development and parental

environment (Schore, 2001, 2002). In light of these finding, it is not surprising that children who are securely attached prove to be more intelligent.

There are also short-term and long-term psychosocial benefits of secure attachment. Research shows that secure attachment fosters good peer relationships and social emotional adjustment in early and middle childhood (Greenberg, 1999; Schneider, Atkinson & Tardiff, 2001). Like children, adolescents also thrive when they feel securely attached. Several positive outcomes, including popularity among peers, higher self-esteem and a reduced incidence of depression and delinquency, have been associated with attachment security in adolescents (Allen, Moore, Kuperminc & Bell, 1998; Kobak, Sudler & Gamble, 1991; van IJzendoorn & Bakermans-Kranenburg, 1996). Adults who are securely attached also have fewer mental health problems, as revealed by a meta-analysis undertaken in 1997 (de Wolff & van IJzendoorn, 1997).

The relationship between caregiver and infant can also promote better physical health. Ranson & Urichuk (2008) explored the impact of attachment relationships on bio-psychosocial outcomes in children and found that secure attachment was associated with a reduced incidence of the failure to thrive in infancy, as well as fewer chronic and recurrent health problems. They also found that secure attachment fostered less risky health-related behaviours such as smoking, drug use and risky sexual behaviour.

Attachment theory hypothesises that a failure to formulate secure patterns of attachment leads to problems later on. Early theorists postulated that anxiety would be an outcome of insecure attachment (Bowlby, 1973; Stayton & Ainsworth, 1973). More recently, a meta-analysis of 46 studies from 1984 to 2010 ascertained the validity of the relationship between attachment insecurity and anxiety. Its findings showed that there is a moderate relationship between these variables ($r = 0.30$) and recommended attachment interventions for child anxiety (Colonnesi *et al.*, 2011).

Aggression and antisocial behaviour are two other risks associated with insecure and disorganised patterns of attachment. In a study conducted in 1993, Lyons-Ruth, Alpern and Repacholi found that disorganised patterns of attachment are associated with high levels of

hostile behaviour in the classroom. A recent meta-analytic review of 69 samples showed that the externalisation of problems was significantly associated with patterns of insecure and disorganised attachment (d = 0.31) (Fearon, Bakermans-Kranenburg, Lapsley & Roisman, 2010). These findings highlight some of the benefits of secure attachment, and show how the relationship between caregiver and infant forms a bedrock for intellectual, psychosocial and physical development. They also highlight the risks associated with insecure attachment and link this to anxiety, aggression, antisocial and externalising behaviour. In so doing, these studies build a strong case for interventions that foster secure attachment.

2.4 Parental antecedents of attachment

The Baby Mat provides emotional support for caregivers and their infants. In light of this, the factors that contribute to a healthy relationship between caregiver and infant are now considered. It is equally important to consider the factors that are unfavourable and lead to maladjustment. According to research, maternal sensitivity seems to facilitate the development of secure attachment, whereas maternal depression reduces this likelihood. A meta-analysis exploring the relationship between maternal sensitivity and secure attachment confirmed a positive association between these variables (de Wolf & van Ilzendoorn, 1997). The relationship between maternal depression and avoidant or disorganised patterns of attachment was found following a meta-analysis of seven American and British studies that explored the effects of maternal depression on attachment (Martins & Gaffan, 2000). Similarly, a meta-analysis of 35 studies exploring the relationship between three maternal mental health correlates found a significant relationship between attachment security and social-marital support (Atkinson *et al*., 2000).

For many years people have understood that attachment is transmitted from one generation to the next. Research has identified a correlation between a caregiver's internal representation of the relationships that they had with their own caregiver, and the quality of attachment that they are able to provide their infants (Main *et al.,* 1985; Main, 1995, 2000; van IJzendoorn, 1995). In 1995, van IJzendoorn conducted a meta-analysis of 13 studies and found that 75% of mothers and infants shared a secure or insecure pattern of attachment. A later study by Shah, Fonagy and Stratheam (2010) indicated that the transmission of secure attachment was more robust than other patterns of attachment.

Although it is understood that the transmission of attachment is intergenerational, there has been a limited understanding of how this happens. However, Fonagy and Target (2007) recently suggested that there was a biological basis for the transmission of attachment and proposed that the attachment bond influenced the development of the brain. They also postulated that this was an evolutionary adaption facilitating better collaboration between offspring and parents, saying "It also fulfils an evolutionary role in ensuring that the brain structures that come to subserve social cognition are appropriately organised and prepared to equip the individual for the collaborative existence" (Fonagy & Target, 2005, p.333).

All these studies highlight specific factors within the caregiver-infant relationship that play a pivotal role in the propagation of attachment. For example, these studies point out how important it is for caregivers to be sensitive to their infant's needs. They also draw our attention to the negative impact of maternal depression on the infant. Further, they emphasise the importance of addressing problems so that insecure patterns of attachment are not passed down from one generation to the next via the plasticity of the brain.

2.5. Risks to the caregiver-infant attachment in South Africa

As Winnicott (1960a) reminds us, caregivers are only able to provide infants with a holding environment if they in turn feel held. This affects their ability to foster secure attachment. However, in South Africa there are several factors that seriously hamper the capacity of caregivers to look after their infants. To understand these risks, it is necessary to examine the social and cultural factors that impact their lives.

2.5.1 Poverty and its related risks, including postnatal depression

Poverty threatens the quality of care that a caregiver can provide. As Dawes (1977, p.193) points out, "Poverty is a powerful predictor of negative psychological outcomes for children … as a consequence of the multiple stressors associated with poor living conditions." Donald *et al.*, (2010) highlight direct and indirect stress associated with poverty. The direct effects are fairly clear. Poverty is associated with inadequate housing, poor nutrition, limited access to health care

and a lack of information about normal child development and health. In South Africa, children who grow up in economically depressed peri-urban settlements are sometimes vulnerable to poor physical and emotional health, violence and a lack of educational stimulation (Barbarin & Richter, 2001).

Indirectly, poverty can lead to physical illness and emotional exhaustion in the caregiver. Since caregivers are often unable to cope with the stress of raising children under these circumstances, they can become depressed (Donald *et al.*, 2010). As discussed earlier, research has shown that postnatal depression places infants at risk of insecure attachment. This happens because depressed mothers are often not responsive to their infants' needs (Martins & Gaffan, 2000). Tessa Baradon (2005, p.49), manager of the parent-infant project at the Anna Freud Centre in the United Kingdom, captures the trauma that infants experience when their mothers are depressed. She describes their reaction to these circumstances as "dead baby complex" where infants "lie slumped and blank, they seem careless of the maternal presence or non-presence beside them and appear non-present in their bodies. Their precocious defences of avoidance of emotional engagement with the mother, freezing and disassociation put them in a state of unrailed/derailed development." From this account it is clear that maternal depression has a devastating impact on the infant and should be avoided.

A study undertaken in 1999 revealed that the prevalence of postpartum depression in peri-urban settlements in South Africa was three times higher than in Britain (Murray & Cooper, 1997). A more recent study by Rochat, Tomlinson, Bärnighausen, Newell & Stein (2011) indicates that women living in South Africa are also at risk of antenatal depression, which negatively affects the development and growth of the foetus. In addition to depression, there are other risks associated with poverty. These include unplanned teenage pregnancies, poor education, marital disharmony, human immunodeficiency virus (HIV), poor antenatal health accompanied by low birth weight and preterm deliveries, and domestic violence (Landman, 2009).

2.5.2 Power imbalance between women and men in South Africa

Traditional African culture places importance on fertility and patrilineal descent. While a man's social status is linked to how many children he has, women are valued for the ability to bear and

raise children (Meyer-Weitz, Reddy,Weijts, van den Borne & Kok, 1998). Male sexual prowess is encouraged, and in heterosexual relationships men are expected to be dominant. In contrast, women are required to be submissive and should strive to keep their men happy. In a study exploring the socio-cultural context of sexually transmitted diseases conducted by Meyer-Weitz *et al*. (1998), it was evident that most women accept this gender inequality. As one of the female respondents in the study said, "… a boy is always regarded higher than girls" (Meyer-Weitz *et al*. 1998, p.48). They also do not often seem to challenge their partner's need for other sexual relationships. As another respondent in this study said, "I know that a man cannot stop going to the street. I am happy" (Meyer-Weitz *et al*. 1998, p.48). However, due to their subordinate position, women are sometimes forced into sexual relationships where they are powerless to protect themselves from unwanted pregnancy and sexually transmitted diseases, such as HIV (Panday, Makiwane, Ranchod & Letsoalo, 2009; Wood & Jewkes, 2006). The unequal distribution of power in heterosexual relationships is one of the root causes of teenage pregnancy (Jewkes, Morrell & Christofides, 2009). It has also led to the spread of HIV and violence against women. Sometimes men use violence to assert their power over women, leading to intimate partner violence (Jewkes, Sikweyiya, Morell & Dunkle, 2011).

2.5.3 Anxiety provoked by the passage to motherhood

Mireille Landman (2009), who co-developed and supervised a community-based intervention piloted in Khayelitsha, highlights how caregivers living in peri-urban settlements in South Africa are often deprived of family support and feel alone and anxious. This isolation seems to be exacerbated by a need for nurturing and care during the early months of motherhood, which is something that Daniel Stern, a well-known American psychiatrist and psychoanalyst, wrote about. He found that the passage into motherhood evoked the need for a "good enough grandmother" (Stern, 1995, p.186). After giving birth, mothers, especially first-time mothers, keenly sought guidance and support from a mother figure. Generally these encounters were regarded as invaluable, especially when the mother figure was encouraging and shared her own experience. Stern described this state of being as the "motherhood constellation" (Stern, 1995, p.172). He said that it explained why caregivers were often very receptive to parent-infant interventions, as they tended look to these interventions as they would to a grandmother. As a result, there is a need for these interventions to be responsive rather than emotionally abstinent.

2.5.4 Stigma associated with the onset of illness

Traditional cultural beliefs about illness in infants influence caregiver's willingness to seek help. When an infant is born with a handicap, this seems generally to be accepted (Berg, 2003). However, difficulties arise when an infant becomes ill. A traditional belief is that ancestors have stopped protecting the infant and left them vulnerable to evil forces, to the "impundulu" (Berg, 2003, p.269). Thus the infant has been bewitched or invaded by evil. These beliefs can stigmatise the ill, making it harder for them to seek treatment. Certainly, stigma is one of the factors fuelling the spread of HIV and has blocked interventions that have been set up to curb the spread of the virus (van der Walt, Bowman, Frank & Langa, 2007). Since one in three caregivers who visit the Baby Mat are HIV positive (Frost, 2007), they may be particularly susceptible to the judgments of others.

By exploring the impact of poverty, the power imbalance between men and women, the passage to motherhood, as well as the stigma associated with illness, it is evident that caregivers in South Africa are a vulnerable group. Many of them live on or below the bread line, and struggle to meet the physical and emotional needs of children in their care, as well as their own. In view of the traditional role of women in African culture, they struggle to protect themselves against unwanted pregnancy and HIV. They are also often victims of intimate partner violence. Another risk factor is the anxiety provoked by the passage into motherhood, especially when the caregiver is a first-time mother. Traditional beliefs about illness can also make it difficult for them to seek help for fear of being negatively judged. Together these factors place the caregiver-infant dyad in a precarious position.

2.6 Patterns of attachment in South Africa

By analysing the patterns of attachment in South Africa, the need for interventions such as the Baby Mat project becomes evident. Prior to 2005, no studies had been undertaken on patterns of attachment in South Africa. The only relevant research that had been conducted was among the Dogon people in Mali. There the researcher assessed patterns of attachment using the Ainsworth strange situation protocol and found high levels (25%) of both secure and disorganised

attachment (True, Pisani & Oumar, 2001). In 2005, research was undertaken in a peri-urban settlement in South Africa to assess the infant-mother relationship and infant attachment (Tomlinson *et al*., 2005). This study had similar findings to the one conducted in Mali. It found high levels of securely attached infants (62%), as well as high levels of disorganised attachment (26%). The percentage of securely attached infants was higher than expected in light of the extreme levels of social adversity.

Tomlinson *et al.* (2005) presented "ubuntu" (an African humanist philosophy) as a possible explanation for this unexpected finding since it encourages members of the community to reach out and support one another. They ascribed the high incidence of disorganised attachment to psychosocial stress and pointed out that in both studies, the mothers of infants with disorganised attachment were more frightened or frightening than the other mothers in the sample. Domestic violence and abuse, rape, HIV and AIDS were put forward as possible maternal preoccupations. The research also confirmed that problems in the mother and infant relationship (such as the mother's being unresponsive or imposing) were associated with adverse outcomes for the infant.

2.7 The relevance of a psychodynamic approach

The Baby Mat project is underpinned by psychoanalytic principles. As such, it is important to explore the applicability of psychoanalytic thinking within the South African context.
The origins of psychoanalytic thinking can be traced back to the Victorian era in Western Europe. Although theories and techniques have developed following the 19th century, the basic assumptions of the psychoanalytic approach have remained the same (Berg, 2009). However, in South Africa most people are not of European descent. Rather, South Africa is a multicultural society. In view of this, we must understand whether the fundamental principles of psychoanalytic thinking are universal. As South African child psychiatrist and psychoanalyst Astrid Berg (2009) asks, "What basic patterns are inherent in all human beings? For example, is the Oedipal complex a universal phenomenon?" (Berg, 2009, p.103). She also suggests that African traditions, like the rite of passage into adulthood, need to be considered in terms of psychoanalytic thinking. Finally, she suggests that clinical practice move beyond the consulting room, so that clinicians are not seen as rigid and elitist.

Fortunately, the history of psychoanalysis in South Africa has been progressive. In the 1980's Dr Buhman applied theories from depth psychology to interpret traditional healing practices, thereby winning respect for these practices within the field of mental health (Berg, 2009). Years later, Gill Straker (2000) examined the effects of trauma as well as racism on thinking in South Africa. In 2006, the South African Psychoanalytic Confederation (SAPC) was formed to unite practitioners who used psychoanalytic theory to inform their therapeutic work (SAPC, 2012). Recently this organisation showcased how the principles and practices of psychoanalytic approach have been rolled out to the broader South African community. The community-based organisation managing the Baby Mat project forms part of the confederation.

Most of the confederation's initiatives blend Western psychoanalytic thinking with African indigenous knowledge. In doing so, they have moved away from a one-way form of communication, in which knowledge is imparted to the less knowledgeable (Berg, 2009). Instead, these interventions embrace a reciprocal exchange of information. This is important as in South Africa we speak of the spirit of *ubuntu*, which can be summed up as meaning "A person is a person because of another person" (Berg, 2003, p. 271). This reflects an interdependent notion of self, and contrasts sharply with the Western model of the self, which encourages independence (Berg, 2003). The African self is predominantly interdependent and collective. As Markus and Kitayama, (1991, p.227) point out, "Africans are extremely sensitive to the interdependence among people and view the world and others as extensions of one another, the self is not viewed as a hedged closure but as an open field." In light of this, it has been important to revisit the psychoanalytic frame and it would seem that this is what the Baby Mat project has done. As described by Frost (2007, p.6), the Baby Mat "is not a strictly psychotherapeutic space." However, the intervention is informed by psychoanalytic principles.

Within the school of psychoanalysis, it appears that the field of parent-infant psychotherapy has been particularly open to change. Perhaps, as Berg (2007, p.217) says, "babies awaken in us the ability to look at the world anew and dare to act differently." However, the credit for breaking with tradition should go to Fraiberg. She initially led the way by starting "psychotherapy in the kitchen" (Fraiberg, 1987, p.108) to address the needs of the caregiver-infant dyad. This has enabled many others to follow in her footsteps.

Chapter 3: Method

3.1 Research design

This was a qualitative-descriptive exploratory study. Its goal was to provide a rich, interpretative understanding of the Baby Mat and how this intervention was experienced by the caregivers who made use of this service. It also sheds light on the caregivers' perceptions of parent-infant psychotherapy and any other need they may have. Data for the study was collected by encouraging participants to tell their own stories of the Baby Mat in their own words. This took place within the context of a focus group.

The participants were caregivers who had accessed the Baby Mat within the last six months or longer. Purposive sampling was used to select these participants. By selecting participants who were knowledgeable about the area in question, it was possible to ensure the validity of the data (Rice & Ezzy, 1999; Polit & Beck, 2008). Essentially, validity is a measure of the trustworthiness of the data, and increases the confidence in the inferences made (Freeman, de Marrais, Preissel, Roulsont & St. Pierre, 2007).

Fossey, Harvey, McDermott and Davidson (2002) define criteria to ensure the quality of qualitative research and suggest criteria to ensure methodological as well as interpretive rigour. To ensure the trustworthiness of the method adopted, they advocate congruence, responsiveness to social context, adequacy and transparency (Fossey *et al.,* 2002, p.724). To ensure congruence, the researcher needs to ask whether the research design is appropriate. When there is limited understanding about a phenomenon, a qualitative research design should be adopted (Hseih & Shannon, 2005). Fossey *et al.* (2002) add to this argument, saying that "qualitative research lends itself to developing poorly understood, or complicated, areas of health care."

Although research had previously been conducted on the Baby Mat, it was not extensive and more needed to be done in order to understand why caregivers failed to make optimal use of this intervention. In spite of there being a theoretical foundation for parent-infant psychotherapy, no research had ever been done to understand caregivers' perceptions of this intervention. The methodology used was responsive to social context. Data was gathered by conducting a focus group, which is recommended for programme evaluation and health research (Rice & Ezzy,

1999; Polit & Beck, 2008). This method is also well suited to marginalised populations, as people often feel more comfortable in the presence of others who have had similar experiences (Fossey *et al*., 2002). Adequacy requires that the sample is sufficient. The focus group was made up of 11 caregivers, which is between the minimum and maximum number of participants needed for an adequate focus group according to Krueger and Casey (2000). It would have been ideal if half of these participants could have been repeat visitors to the Baby Mat, and this is one of the limitations of this research. In the end, only one third of the sample comprised repeat users. Transparency was achieved by documenting the procedures used for data collection and analysis. This was particularly important as documentation is regarded as one of the key standards of practice for qualitative research (Freeman *et al.,* 2007). In addition, the vantage point adopted by the researcher was documented. As Parker (2004, p.97) points out, "the person carrying out research always has a certain stance towards questions that are being explored." In view of this, it was necessary to make the position of the researcher explicit (Parker, 2004).

The trustworthiness of the interpretations made was ensured by complying with the criteria put forward by Fossey *et al.* (2002), namely authenticity, coherence, reciprocity, typicality and permeability. To guarantee that the interpretations were authentic, verbatim quotes from the data collected were used. These quotes needed to include diverse views. Coherence looks at whether there is a link between the data collected and the findings. This was achieved by getting a supervisor to cross-examine the researcher's findings. Reciprocity is achieved when the researcher involves the participants in the study. This was achieved by letting the participants lead the way during the focus group discussion and by asking them open-ended questions. In addition, clarifying questions were posed to confirm interpretations made, based on what was said. Typicality addresses the generalisation of the findings. Due to the limited sample size and lack of randomised sample, no generalisations were made. Finally, permeability of the researcher was addressed by documenting the position of the researcher.

The data was analysed using thematic content analysis to identify the meaning and reality that the Baby Mat project had for the participants. The approach put forward by Braun and Clarke (2006) was applied. This provides clear guidelines on how to conduct thematic analysis in a manner that is not tied to a particular theoretical position. Since this approach is standardised, it also allows

for the data to be compared or synthesised with other related research. The process described consists of six phases, including becoming familiar with the data, identifying codes within the data, searching for themes from the codes identified, refining these themes, and then coming up with names to define them (Braun & Clark, 2006). Finally the process involves identifying verbatim extracts from the data collected, in order to present the essence of each theme in the research report (Braun & Clark, 2006).

3.2 Participants

Purposive sampling was used to select the participants, as this was a practical way of locating participants who were knowledgeable about the area in question (Babbie & Mouton, 2004). In addition, this method of sampling contributed towards credibility of the data collected, thereby ensuring trustworthiness (Rice & Ezzy, 1999; Polit & Beck, 2008). Selection of the participants was based on the following inclusion criteria: (a) they had visited the Baby Mat once or more at the relevant health care clinic in Alexandra township, (b) they served as the parent or primary caregiver of a child, who in most cases was still an infant, and (c) they were contactable telephonically.

Potential participants were identified from the records that were kept by the community-based organisation. These records included the caregiver's name, their child's name, their telephone number and whether they had visited the Baby Mat once or repeatedly. These potential participants were then contacted telephonically and informed about the research that was being conducted, using the participant's information sheet as a guide (see Appendix 2). They were then invited to take part in this study. Those who agreed were given further details, including the date and time of the focus group discussion. In addition, an offer was made to cover their transport costs to and from the venue.

To avoid selection bias, it was hoped that half of the sample would comprise caregivers who had made repeated use of the Baby Mat in the previous six months. The other half would comprise caregivers who had only visited the Baby Mat once. However, this was not possible since there were very few records of caregivers who had repeatedly visited the Baby Mat. In the end it was only possible to ensure that one third of the participants were repeat visitors.

Krueger and Casey (2000) point out that five to 10 people are typically selected to participate in a focus group. Generally, participants are chosen because they share something in common. Using the community-based organisation's records, 16 people were invited to attend the focus group. More people than needed were invited so as to counteract potential participant dropout. In keeping with the philosophy of the Baby Mat approach, these caregivers were invited to bring their infants with them. Of the 16 potential participants who were invited to attend the focus group discussion, 11 arrived. Most of these brought their infants along with them, and in some cases they also brought their older children. Of the participants, all but one had visited the Baby Mat. The one who had not, decided to join a friend who was coming to the focus group discussion, as she had seen the Baby Mat at the clinic and was hoping she could get further support using it. Generally, the participants were able to understand and express themselves in English. However, there were three who relied on the translator as well as other group members to help them convey their thoughts, ideas and feelings in English.

3.3 Data collection

Data was collected by running a focus group. The discussion that took place in the group was video-recorded and transcribed verbatim. In cases where the participants spoke in an African language, this was also recorded verbatim and later translated into English with the help of a translator. To ensure confidentiality, the translator was also the co-facilitator for the focus group.

There was a reason why the focus group discussion was video recoded, rather than simply audio recorded. The video recording was useful as it provided the researcher with an additional source of information to corroborate findings. This was particularly valuable as there were many participants in the focus group discussion, and the video enabled the researcher to understand what was said by whom. It also shed light on the subtle nuances of the communication that took place. Often the participants used nonverbal cues to convey that they agreed with what another caregiver was saying. By watching the video, the researcher was able to detect these cues.

Krueger and Casey (2000, p.4) clarify the purpose of focus groups by saying that they are set up "to understand how people think or feel about an issue, service or idea." Carlsen and Genton

(2011) point out that focus groups are useful for evaluating health services as they shed light on subject's perceptions and opinions. This method of data collection was selected as it provided the participants with a natural setting. Being part of a group, where we influence others and are in turn are influenced by them, is part of our everyday experience (Krueger & Casey, 2000). Another reason for focus groups being chosen is that people often feel safer and are more willing to share when they are in the presence of others who have had similar experiences to themselves (Kruger & Casey, 2000; Fossey *et al.*, 2002).

3.4 Procedure

3.4.1 Research questions

In 2009, a master's student from the University of the Witwatersrand explored the experiences and perceptions of caregivers who had visited the Baby Mat at the health care clinic in the Alexandra township (Bromley, 2009). In this study, data was collected by undertaking semi-structured interviews with eight caregivers immediately after they had visited the Baby Mat. The findings of this research indicated that caregivers valued this service, and were very positive about the intervention. However, these results failed to explain why caregivers do not make optimal use of the service. According to the community-based organisation involved, not many caregivers visit the Baby Mat more than once, even if they are encouraged to do so. Caregivers also fail to take up the offer to parent-infant psychotherapy when it is offered to them on the mat. This research was undertaken with the hope of providing some answers to these questions.

3.4.2 Topic guide for focus group discussion

Ritchie and Lewis (2003) suggest that a topic guide should be developed to guide focus group discussions. This document lists the key sections as well as sub-topics to be discussed, and ensures that the focal points of the research are addressed. Although the focus group may not unfold in a prescribed manner, Ritchie and Lewis (2003) indicate that it is important to arrange the key sections in a manner that makes sense. For example, they say that a focus group should open with a topic that puts the participants at ease and encourages the flow of conversation, like contextual questions. Later, more targeted questions can be asked. They also advocate that the

researcher put together an initial draft topic guide, which should then be refined through both internal discussion with a supervisor and input from outsiders.

In light of these recommendations, a topic guide was developed for this research project. It was based on the research objectives of the study and refined through feedback from supervision and the community-based organisation. The topics in the topic guide included persona context. Here the researcher asked the participants to introduce themselves and their infants to the group. This was followed by focusing on the caregiver's general perceptions of the Baby Mat. Caregivers were encouraged to share what they did not like, as well as what they did like, about the Baby Mat. They were then asked about their personal experiences on the Baby Mat, and whether they felt supported. In addition, they were asked if the intervention met with their expectations and what more they hoped for. They were then asked to share their thoughts on why caregivers fail to return to the Baby Mat. Lastly, they were asked why caregivers don't take up parent-infant psychotherapy when it is offered to them.

3.4.3 Focus group

The focus group discussion was hosted at a clinic in Alexandra township during an afternoon. Participants and their infants sat in a circle on blankets on the floor, like they do on the Baby Mat. To ensure that they remembered to come to the focus group discussion, they were sent a friendly reminder about date, time and venue a few days prior. Posters were also erected around the clinic on the morning of the focus group discussion to direct participants to the right place.

When the caregivers arrived for the focus group discussion, they were provided with a copy of the information sheet as well as two consent forms. One of the consent forms was for participating in the focus group (see Appendix 3). The other was for video-recording the session (see Appendix 4a). The facilitator read through these forms and then asked the participants if they were comfortable giving their consent. Since they agreed, she asked them to sign both consent forms. As none of the participants were uncomfortable with being video-recoded, it wasn't necessary for the researcher to discuss the possibility of audio-recording the focus group discussion (see Appendix 4b).

The researcher facilitated the focus group at the health care clinic with the help of a translator, who was proficient in the caregivers' mother tongues. The group was run for approximately two hours, followed by a tea break. To guide discussion, a topic guide was used (see Appendix 1). The researcher opened the group by introducing herself and her co-facilitator. She then talked about the purpose of the group and told the participants that she was exploring the Baby Mat project, and was interested in understanding their opinion of this service. She then told them that she would be asking everyone a few questions to guide the discussion, that there were no right or wrong answers and that everyone's opinion would count. In this process she re-emphasised that the participants would not be disadvantaged in any way if there were negative things they wanted to express. She also assured them that at no time would they be forced to answer any questions. Before the group began, she asked each of the participants to maintain confidentiality and not share the details of the discussion with outsiders. She also informed them that she would use pseudonyms when she wrote up the results.

Kruger and Casey (2000) point out that the role of the researcher in a focus group is to create a climate that is conducive to sharing. This is important as focus groups are less structured than in-depth interviews, and data emerges through the interactions that take place within the group. A climate of friendliness and warmth was created by welcoming each of the participants and setting ground rules to ensure that they all felt safe enough to open up. To initiate discussion around the topics listed in the topic guide, she used open-ended questions. This type of question is not leading, but encourages the participants to share their thoughts and feelings about certain matters (Brems, 2001). To facilitate the flow of conversation, the researcher reflected on the content and feelings of what the participant had said and sometimes used basic empathy (Brems, 2001).

3.4.4 Position of the researcher

In contrast to quantitative research, which strives to be objective and value free, qualitative research embraces the subjectivity of the researcher. It sets about making the standpoint of the researcher clear and requires the researcher to step back and shed light on their vantage point (Parker, 2004).

In light of this, it is important to point out that the difference in race, social class and culture between the researcher and the participants may have impacted the data collected. Whereas the researcher was a white, English-speaking middle class woman, the participants in this study were black African women of a lower socio-economic status. In light of the political history of South Africa, it is important to consider whether these factors blocked the participants from openly sharing their experiences and perceptions with the researcher. Previous research indicates that these factors do have an impact as participants are unsure whether the researcher would understand them (Bromley, 2009). As has been done in the previous study, the researcher tried to overcome this barrier by conveying her interest in participant responses to her questions using verbal and non-verbal behaviour. She listened attentively and reflected on what they were saying. In addition, the risk was partially mitigated by co-facilitating the group with a black middle-aged woman who was from another Johannesburg peri-urban settlement.

Like the participants, the researcher is also a mother. This seemed to be an advantage as it enabled the researcher to be more receptive to what the participants were saying, having gone through similar experiences. However, it was important for her not to impose this understanding on the caregivers. She achieved this by becoming aware of her own thoughts and feelings, and putting these aside.

It was important for the researcher to make it clear to the participants that she was not affiliated with the community-based organisation running the Baby Mat programme. Only then would they feel comfortable about sharing their negative experiences and perceptions of the Baby Mat. It was similarly important that the researcher point this out, especially when the participants made this link. In addition, it was imperative that the research was conducted in a way that did not link it to the Baby Mat project. This was achieved by conducting the focus group discussion on site rather than at the premises of the community-based organisation. In addition, it was critical that the co-facilitator for the focus group was not one to the co-facilitators for the Baby Mat, but an outsider to the organisation.

3.5 Data analysis

Thematic content analysis was applied according to the six-phase process described by Braun and Clarke (2006). These phases are not linear. Instead, the researcher alternates between them. In the first phase, the researcher needs to familiarise herself with the data. This was achieved by immersing herself in the data and spending many hours transcribing the focus group discussion, which involves creating a 'verbatim' account of everything said. Although this was very time-consuming, it proved a valuable exercise. By listening and watching the focus group discussion again and again, the researcher came up with ideas for coding the data. Familiarity with the data was also achieved by reading and re-reading the transcript.

In the second phase, initial codes are generated from the data. These are features of the data that are of interest to the researcher. This was done by identifying and highlighting poignant phrases within the data. For example, the researcher identified the phrases "it's not only for the baby" and "So eish, I thought, ai ya, I am not alone" as features within the data.

In the third phase, themes were identified from the codes. This was done by arranging and grouping the codes. The researcher did this by grouping the phrases that were highlighted in the second phase of this process. For example, the following phrases were grouped together under the banner of fear: "I think people are afraid", "Whenever you got a problem, you keep it in your chest" and "They are so shy - they are so abused that they are scared of everything." It should be noted that in some cases a code formed a theme, while in other cases codes were broken down into different themes or formed sub-themes.

In the fourth phase, the candidate themes that emerged from the third phase were reviewed and refined. For example, the researcher revisited the theme of fear that emerged during the third phase of this process and realised that the caregivers were afraid of many things. They were afraid of being pejoratively judged and worried that the facilitators on the Baby Mat would take action and have their husbands arrested when they learnt more about the abuse that they suffered. In light of this, the researcher decided to break this theme into sub-themes, including the fear of being humiliated and the fear that action might be taken.

The fifth phase is concerned with defining and naming themes. Braun and Clark (2006) encourage simplicity and advise the researcher to try to capture the "essence" of each theme by the "story" it tells (Braun & Clark, 2006, p. 92). Having identified themes, the research then set about finding a descriptive name for each.

The sixth phase focused on reporting the findings of the analysis. Braun and Clark (2006) highlight the need for vivid data to demonstrate each theme. In addition, they indicate the need to embed these extracts within a narrative that makes an argument in relation to the research question. In this phase the researcher identified verbatim extracts from the data collected in order to capture the essence of each theme. For example, the following phrase was used to convey the universality of the caregiver's experience: "So eish, I thought, ai ya, I am not alone." The researcher also used other verbatim extracts within the discussion of each theme to add to this understanding.

3.6 Ethical considerations

Before embarking on this research, permission was obtained from the relevant health care clinic in Alexandra, as well as from the community-based organisation responsible for the Baby Mat project. Authorisation was also obtained from the University of the Witwatersrand's ethics committee.

Once permission to conduct the research was granted, eligible participants were informed about the study and invited to participate in it. To ensure that they did not feel coerced, they were told that their participation was voluntary and that they could withdraw at any stage without being disadvantaged in any way. Eligible participants who agreed to take part in the study were required to provide written consent for both their participation in the research and the video-recording of the focus group interview. To enable participants to ask for further information, clarify matters or report any negative experience regarding the research, they were given the contact details of both the researcher and the researcher's supervisor.

Although the researcher did not anticipate that the focus group would harm participants in any way, she provided with them with contact details of organisations offering free therapy services.

These included the Ububele Umdelzane parent-infant psychotherapy service, Emthomjeni Community Psychology Clinic and Lifeline.

Confidentiality was achieved by encouraging participants not to disclose personal information that others revealed during the focus group discussion. In addition, no identifying details were included in the transcription of the data or quotes used to present the findings, since copies of the research report would be made available to both the health care clinic and the project manager for the Baby Mat.

Safety measures were also employed to ensure the safety of both the data collected and the researcher. During the course of the study, the original video recordings were kept in a safe place and only viewed by the researcher and, where necessary, the translator. Similarly, the transcripts were kept in a safe place, and only viewed by the researcher and the researcher's supervisor. After the research is concluded, both the video-recording and the transcripts are to be kept in a safe place for up to six years, to enable publication, and then destroyed.

It was important to ensure the safety of the researcher when entering Alexandra to access the health care clinic. As a result, the researcher agreed to follow the safety procedures of the community-based organisation and use their transport service for transit to and from the clinic.

Chapter 4: Results

An inductive approach was used to identify the themes within the data. In other words, the researcher gradually allowed themes to emerge from the data that were collected, as opposed to imposing a pre-existing framework onto these data and employing a deductive approach (Pope, Ziebland & May, 2000). Since data were derived inductively, no attempt was made to fit data to the research questions during the initial stages of data analysis. As a result, some of the themes that emerged bear no relation to the research questions. These themes were then grouped into five overarching areas. They included: the caregivers' experience of the Baby Mat; the factors that pushed them to visit the Baby Mat; the factors that stopped them from accessing the Baby Mat and parent-infant psychotherapy; other needs; and context. The first four of these overarching areas were then linked back to the research questions in order to provide some answers. Even though an inductive approach was used, it is important to note that the data analysis did not take place in a vacuum, and that the research questions were at the back of the researcher's mind.

4.1 Caregivers' experiences of the Baby Mat

Themes emerged from the data collected that shed light on the caregivers' experience of the Baby Mat. These themes provide insight into why some caregivers repeatedly access the Baby Mat and include offering release, instillation of hope, realisation that experience is universal, provision of genuine care and support, and self-realisation. They are discussed in more detail below.

> **Offers release:** *"When you stand up on the baby mat you find that there is something that is gone out from you."*

The caregivers found the Baby Mat cathartic. By making use of this intervention, they were able to release some of the anxiety and stress they were holding. When their infants were ill or having difficulties, they struggled to be productive. As one caregiver said, "You can't work well if the baby has got a problem, you can't work well. So we must come …" By visiting the Baby Mat they were able to let go of some of these feelings and, in doing so, felt emotionally lighter. One of the caregivers used a metaphor to describe the release they experienced, saying "the little stone you were having inside of you, it went out." However, for those who don't take the opportunity to visit the Baby Mat, "they will go back home with the stress."

Instills hope: *"Even if it can't be that easier, but you find it much easier, because now you have got someone who is advising you."*

Some caregivers liked to go to the Baby Mat as it made them feel more hopeful about their problems. In the words of one, "Whenever you go to Baby Mat, and you tell them your problem, and they ask you, they tell you, from here you can do this, you try it…You know your way. Where can you go. What can you do. " The experience seems to make them feel more positive about their difficulties and helps them to plot a course of action.

Highlights the universality of experience: *"So eish, I thought, ai ya, I am not alone." (Here, "eish" is a South African slang term of disbelief, first transliterated from Xhosa into Afrikaans, and "ai ya" is an exclamation, according to the Urban Dictionary (2012).)*

By visiting the Baby Mat, many of the caregivers realised for the first time that they were not alone. This sentiment was expressed by one of the caregivers as follows "I am not alone - I have got some people who are having the same problem, so it becomes easy for mothers. I mean mothers, we've got similar problem." This knowledge was very comforting for the caregivers, as they did not generally seem to talk to each other about the things that were worrying them. According to one of the caregivers, "Even if we are at the clinic we, we don't discuss anything. We are just there." Many of them felt very isolated and expressed this by saying "… and we've been alone, let us be honest here. As I am saying, as women we've got similar problems." For many of the caregivers it was a revelation to learn that they were not the only ones with these types of problems. "There are many people somewhere out there, you see, those problems" were the words of another caregiver.

Offers genuine care and support: *"It feels good to know that there is someone who is caring."*

The caregivers felt that the facilitators on the Baby Mat were genuinely caring and supportive. When asked why they came to the Baby Mat, one caregiver responded by saying "Because they care." It would seem that they drew comfort from this. As another caregiver said, "It's comforting somewhere, somehow, because you can see that they care." In their effort to build a therapeutic rapport with the caregivers, it was evident that the caregivers experienced the facilitators as being attentive and listening, caring and empathic, respecting the need for

confidentiality, and being non-judgmental. They also valued the follow-up support that they were given. Further details are provided below.

i) **Attentive and listening:** *"By listening to you, there is something that they have done."*

The caregivers liked the fact that the Baby Mat was for them as well as for their infants. The following phrase captures this: "It's not only for the baby." Although they often came to the Baby Mat to obtain advice, they valued the experience of being listened to. They seemed to appreciate this and one said "Even if they can't solve your problem, but by listening to you, there is something that they have done - a lot."

ii) **Offers something unique:** *"So I went to the Baby Mat because I wanted someone to tell me something else."*

It was evident that the caregiver's experience on the Baby Mat contrasted sharply with their experience in other relationships. The caregivers felt that other mothers dismissed their concerns. One of the caregivers explained how her baby tended to sweat a lot, and this worried her enormously, especially because her nephew had recently died from a heart attack and also tended to sweat a lot. She said "When I share with other mothers, they take it as if it's nothing. It's normal." In contrast to other mothers, the focus group caregivers felt that facilitators on the Baby Mat acknowledged their concerns. One even said "…so I went to the Mat, because I wanted someone to tell me something else." She was tired of being dismissed and undermined by her peers.

iii) **Caring and empathy:** *"They want to know who you are. What's your problem."*

The caregivers experienced the facilitators on the Baby Mat as caring and empathic. They felt welcome. In addition, they appreciated the interest that facilitators showed them. In view of this, one of the caregivers said "*They are welcoming. They smile. They play with the baby … They are so welcoming."*

iv) **Confidentiality:** *"And whatever you are saying to them, it will be between you and them. It won't go, like next door."*

Confidentiality was critical to the success of the Baby Mat. Caregivers really appreciated that facilitators on the Baby Mat did not share their personal information with others. They were especially worried that others in their community might learn of their difficulties and therefore wanted to make sure the news wouldn't "go next door." The fear that confidentiality would be broken was something that seemed to stop caregivers from visiting the Baby Mat. This was gleaned from another caregiver, who said "I think people are afraid that, tell my problem and people will … publish it and people will know that I have got this problem." They didn't want others to know about the difficulties they were experiencing.

v) **Non-judgmental:** *"And they won't laugh on what you will be saying."*

The non-judgmental attitude of facilitators was another critical success factor. Caregivers took great comfort from the fact that the facilitators didn't judge them. As one caregiver said, "They won't laugh on what you are saying." They felt accepted on the Baby Mat. However, the fear of being judged seemed to be a factor that discouraged some caregivers from visiting the Baby Mat. The caregivers in question felt that other caregivers might be scared of being humiliated and undermined, and said "I think people are afraid that, tell my problem, and people will laugh at me…" As such it was an enormous relief when this was not their experience.

vi) **Follow-up support:** *"It's not like they just met you once and they want to know your problem and then after that they just put you behind. They make follow-ups."*

The caregivers really valued the follow-up support that the facilitators on the Baby Mat provide. When the facilitators called on them to find out how things were going, caregivers felt that that they were cared for. Through facilitator follow-ups, caregivers felt that the facilitators were genuinely interested in them. It is possible that this accounted for the good turnout at the focus group session. Indeed, one of the caregivers came to the focus group in order to give thanks and said "So they phone me and I just enjoyed …and come and thank you." As another put it, "They make a follow-up. They called me and wanted to know what is happening with the baby, you know." Another caregiver added, saying "And they are always phoning and asking about her."

Fosters self-realisation: *"Yes, I've got that problem of my baby but deep inside was my own problems."*

By visiting the Baby Mat, many of the caregivers realised that the difficulties their infants were experiencing were linked to their own struggles. Some of the caregivers acknowledged that they came to the Baby Mat with a presenting problem and an underlying problem. As one said, "I just prefer to say that problem to them…" Many found their experience on the Baby Mat helpful because it allowed them to talk about underlying problems. Another conveyed this by saying "She doesn't deny that the baby mat can help her. She got with her problem at her own house with her boyfriend."

4.2 Factors pushing caregivers to visit the Baby Mat

Several themes describe why caregivers visit the Baby Mat. These include anxiety about the baby, a desire to do what is best for the baby, a need for information and guidance, acceptance of á problem, and a need for personal support. These are discussed in more detail below.

Felt anxious about their baby: *"Me, I am scared for my baby."*

One of the factors pushing the caregivers to seek help was their anxiety. It stressed them enormously when their infants cried a lot, struggled to defecate, slept poorly, had a rash or sweated a lot. As one caregiver said, "It wasn't easy for me to see her suffering, the situation she was in. So when you hear them talking about helping mothers, and everything, I thought maybe I should enter that, 'cause I didn't know." They were filled with questions and desperately wanted some guidance. The level of anxiety they felt is conveyed by one caregiver, who said "You see, if you keep quiet you will be stressed - why is she doing that? You will ask yourself many questions." It would seem that their anxiety arose when they compared their infants to others. As one caregiver said, "Because when I look at other infants, they don't sweat, so why mine is sweating?" It was evident that the stress they felt was so great, it enabled them to overcome the barriers to visiting the Baby Mat. For example, many of the caregivers were scared to go to the Baby Mat as they didn't want to be judged by their peers. However, they were so anxious about their infants that they were able to stop worrying about what others might think: "I don't mind 'cos I feel for my baby. So I don't mind about it, anybody, what he talks and what he, anything," were the words of one.

Wanted to do what's best for their baby: *"I wanted him to have a better future."*

One of the principal factors that drove participants to make use of the Baby Mat was their desire to do their best for their infants. Even the quietest and most anxious caregiver in the focus group managed to capture this by saying "I want to be strong. I want to treat my baby right… to keep it out of focus." She spoke about how her mother had sold her to a man who had coerced her into having sex, and as a result she fell pregnant. Now having run away from this man, she wanted to treat her baby better than she was treated. However, she was finding this very difficult, as her baby looked like his father. Another caregiver listening to her story explained: "So now it so difficult for her to take care of the baby. But she loves this baby because he's innocent. But whenever she looks at this baby he reminds her of that man." Like the other participants in this study, she didn't want to repeat history and said "I come because I want to be free … I want to get rid of this problem. I know now. I don't want to stress my baby." Instead she wanted "to be strong." Because of this she, like many of the other participants, was willing to seek support and make use of the Baby Mat.

Needed information and guidance: *"I was wondering, why is it like that and what else, and I just like, hmm, let me ask why she's doing that and…"*

Generally, the caregivers decided to visit the Baby Mat because they wanted information and guidance. One caregiver said "so I didn't know what is this inside, ja." Many felt that the Baby Mat managed to meet this need. As one caregiver said, "Yes, it guides me, like when I was having this problems with my boy, when I didn't understand what was happening to him." However, other caregivers felt frustrated as they did not get the help they needed. As another caregiver said, "You know I wanted some answers and they didn't have answers for me, for everything that I was asking."

Accepted that there was a problem: *"And so you have to, to understand and accept whatever is happening to your child and do the right thing"*

Help was only sought when caregivers felt that there was a problem. If a caregiver was able to acknowledge and accept that their child was experiencing difficulties, they were more likely to seek support. This was captured by one of the caregivers, who said "I started understanding, and realised I was wasting my son's time. Whenever you take things the way you want them to be, and they are not like that, you are wasting your child's time." As this caregiver said, she had to

"accept that my child is whatever he is." However, this wasn't easy for her. As she says, "We just keep it for yourself and you say it's fine. It will be fine."

Needed personal support: *"Your own problem forces you to go."*

Many of the caregivers realised that one of the reasons they visited the Baby Mat was their own difficulties. As a caregiver said, "your own problem forces you to go." They pointed out that many caregivers struggled to be proactive and seek support, possibly hoping someone would notice that they were struggling. This tendency to apathy was identified by a caregiver, who said "Because if you just sit there, they don't know that you have a problem, so you, you know your problem, so it forces you to go there."

4.3 Factors that prohibit caregivers from visiting the Baby Mat and parent-infant psychotherapy

Several themes emerged as barriers that blocked caregivers from visiting the Baby Mat and explain why caregivers fail to make repeated use of the Baby Mat. These themes also seemed to explain why caregivers do not take up the offer of parent-infant psychotherapy when it is offered to them on the Baby Mat. They included adopting a subservient role in relationships, fear, self-recrimination, devaluation of the offering, denial, the struggle to reach out for help, oversensitivity to advice given, and an unwillingness to make an effort. These themes are discussed in more detail below.

Adopted a subservient role in relationships: *"I have to ask 'Can I go?' and you see, and that becomes so difficult."*

Although many of the caregivers wanted to visit the Baby Mat, they found it difficult to do so as they were not in charge of their time. This struggle was captured by one of the caregivers, who said "They help her but she couldn't go." One of the primary barriers stopping them was that they adopted a subservient role in relationships. Many of the caregivers were unemployed. Those who were employed worked as domestic workers and needed to seek permission from their employers to visit the Baby Mat. To attend the focus group discussion one of the caregivers got her employer to call the researcher so that there would be no doubt as to her whereabouts that afternoon. In addition, many of the caregivers seemed to be in relationships where men held

power. As a result, it was difficult for them to be assertive and to make plans independently of their partners. Also, it would seem that these relationships were often abusive. As a caregiver said, "They were fighting, her husband, and they were having, like an argument so she couldn't make it." These words provide some insight into the types of relationships these women have with men, and shed light on how they feel trapped.

Fearful: *"They are afraid."*

The caregivers were scared for several reasons.

i) **Fear of being humiliated:** *"You start standing up and they will think 'Oh my God. Her husband is beating her every day. Or maybe her husband has left her.'"*

One of the factors blocking caregivers from making use of the Baby Mat was their fear of being humiliated. They were scared of what others might think. To understand this fear, it is important to remember that this intervention took place in full view of everyone at the clinic. As discussed earlier, a mat was placed on the floor of the immunisation clinic. In attendance on the mat were two facilitators. Caregivers were invited to visit the Baby Mat with their infants, to talk about the things that were worrying them.

During the focus group discussion, the caregivers indicated that the caregivers who got up to go to the Baby Mat drew attention and were judged. As one caregiver said, "People start wondering. They know. I wonder what her problem. Why is she going there?" Another caregiver added to this by saying "So whenever you stand up going to the Baby Mat, really everyone is looking at you. Maybe she's sick, or this and that." This fear of being humiliated was exacerbated by the manner in which the Baby Mat was introduced to them each Thursday morning. As another caregiver said, "Especially like when the facilitator stands there and talk to the mothers and say 'ay whenever you got a problem, whenever you are fighting with your husband.'" Before visiting the Baby Mat, they generally look around to see if they recognise anyone else at the clinic. Only if they are sure that no-one will recognise them, do they get up to go to the Baby Mat. As a caregiver said "You look, who knows me in here, and then you start 'Ah, let me not go because now you won't be free.'"

ii) **Scared that action might be taken:** *"So you think, if I go there at the Mat, what action they will take?"*

The caregivers are also scared that action will be taken if they share their problems. This is captured by the following words: "And you ask yourself what is that person going to do with the problem, that you have told her or him. Is he going to take actions against that? Or, or, so that's why mothers don't go to the baby mat and discuss." One of the reasons this is a real concern for caregivers is that many of them seem to be trapped in abusive relationships. As another caregiver said, "Some of us we are living in abusive relationships. So you think, if I go there, at the Mat, what action they will take?" One of the main concerns about this is that they are worried that their husbands will be arrested as they depend on them for money. One of the caregivers explained this further by saying "They are scared because like, because you know in African culture, we believe in our husbands. They are the ones that that are working for us. They are the ones that brings the plates for us to eat. So whenever he get arrested you, you ask 'What are we going to eat now?'"

iii) **Suffered from generalised anxiety:** *"They are so abused that they are scared of everything."*

The caregivers indicated that many of the women in their community seemed to suffer from generalised anxiety. They attributed this to the fact that many women live in abusive relationships, and are scared to talk to anyone about their problems. "They are so shy. They are so abused that they are scared of everything," were some of the words used to convey this understanding. Consequently, they chose to say nothing, not even to their friends. As one caregiver said, "Even if we are at the clinic we don't discuss anything. We are just there. Just there to bring our kids there to, to injection, and after that we go home."

Guarded against self-recrimination: *"What kind of a mother am I, who can come to somebody, and asks for help?"*

Caregivers judged themselves for seeking support. There was an expectation that they should be able to solve their own problems. Seeking assistance from an outsider was frowned upon. Said one: "This is my inside problem, I should solve it inside." One of the reasons caregivers gave for feeling ashamed to ask for help was that they tended to fail to acknowledge the importance of

their difficulties. This was demonstrated by a caregiver who said "'Cos they take it as a small problem and become too embarrassed to share those problems." Another caregiver added to this: "I think that person will think it's a small problem. What, what kind of mother I am who can come to somebody and ask for help for such a small problem?"

Devalued the offering: *"Ag, what about that mat!"*

Caregivers who had never visited the Baby Mat seemed to devalue the intervention and say things like "Ag, what about that mat!" One reason the service was devalued was that it had no concrete offering. This led caregivers to question what they could get from it. As one caregiver said, "There is nothing there, so they just feel like, it don't help, this thing." As a result, there seems to be some misunderstanding about the service. This emerged during the focus group discussion. One of the caregivers didn't understand the questions about the Baby Mat and the remark was made that "I don't think she understood very well about the Baby Mat." Many of the caregivers were frustrated by the Baby Mat as they didn't get the answers they needed. This was captured by a caregiver who said "I wanted some answers, and they didn't have answers for me, for everything that I was asking."

Denied the problem:*"We just keep it for yourself and you say 'It's fine. It will be fine.'"*

As highlighted earlier, acknowledgement that there was a problem tended to propel caregivers to seek help. In contrast, denial of the issue made it possible for caregivers to maintain the status quo and continue as is. However, there was a trade-off. As one caregiver pointed out, "I started understanding, and realised I was wasting my son's time. Whenever you take things the way you want them to be, and they are not like that, you are wasting your child's time".

Struggled to reach out for help

Although some caregivers were very vocal, others struggled to talk openly. One caregiver decided to wait until after the group session to tell her story. It was evident that she had suffered terribly. Although she had previously visited the Baby Mat, she was not very open about her situation and her need for on-going support. In light of her pressing needs, one might ask why she did not make more use of this service. She seemed to lack the inner strength to ask for help.

Overly sensitive to advice given: "*So they told I must love my baby, even if he's crying."*
While most of the caregivers indicated that they didn't feel judged, one mother shared a different experience. She recounted how she decided to visit the Baby Mat because her baby tended to cry a lot at night, making it difficult for her to sleep. Although the facilitators tried to be supportive, the caregiver did not like what they said and seemed to feel judged. She said "So they told I must love my baby, even if he's crying. It was hard time. I feel angry when he's crying… Yoh, eish!!" Like many other caregivers, she had not been sleeping well and was possibly overly sensitive to their responses.

Unwilling to make an effort: *"You see, we only want things to come to us. So, we don't want to go to things that will help us."*

When asked why caregivers do not make use of parent-infant psychotherapy, one caregiver responded by saying "I think some of us, we are so irresponsible, really to be honest. I don't know. It's my suggestion. I think we are irresponsible." She explains this further, pointing out that caregivers do not want to make an effort. As such, it would seem that apathy is a contributing factor. Another seems to be ignorance, for a caregiver said that "So, like some parents, they are just ignorant. They don't want to do anything."

4.4 Other needs

Other needs emerged from the data that was collected and they answer the question about whether caregivers have needs that are not fulfilled by the Baby Mat. These needs included the caregivers' desire to reach out to other caregivers and the needs for a support group. These are discussed in more detail below.

Altruistic strivings: *"I just want to come and share my ideas with everybody."*

During the focus group, some of the caregivers expressed a desire to reach out to other caregivers. In most cases, these caregivers had experienced difficulties and decided to visit the Baby Mat for support. Now, having got through this period in their lives, they wanted to reach out to other caregivers, in an effort to instil hope and provide guidance. This altruistic striving was captured by a caregiver who said "I just want to come and share my ideas with everybody so that next time when they'd got their own problems, they must share." From this it was evident

that she wanted to spread goodwill. Another said that she likes to advise other parents to visit the Baby Mat, saying "And now I can advise other parents that whenever they have got problems and things that they can go there." Through their own experience, they had learned that parents tended to dismiss their problems. As one caregiver said, "I think that person will think it's a small problem." However, having benefitted from visiting the Baby Mat, they said that they would now "advise other parents that whenever they have got problems, and things, that they can go there."

> **Needed to know they were not alone and wanted a support group:** *"There is a need for a group, for the mothers to meet."*

The caregivers expressed a need to share their experiences so that other caregivers start to realise that they are not alone. They said that "There is a need for mothers to meet, to talk about their problems, listening to each other and hmm, I think it will make easier for us as mothers to understand that all of us, we got a problem." Even though some of the caregivers were shy to speak, they really found it helpful to share their experiences with others, who often had similar difficulties. This feeling was conveyed by a caregiver who said "I think it's nice really to meet as a group and as we are sharing now. It's a big relief." By meeting as a group, they also felt less prone to being judged. As one caregiver said, "No one will know what's happening, 'cause we will be meeting like this." However, there was some concern as to whether people would make the effort to come to a group. As another caregiver said, "I won't come. I won't come. I won't come." They seemed to think that only caregivers who have previously visited the Baby Mat would be likely to come to a support group, as they knew what to expect. They knew about the Baby Mat.

4.5 Context

Several themes emerged that shed light on the contextual matters. These include the silence that surrounds abuse, the caregiver's need for maternal care and nurturing, and helplessness in the face of bureaucracy.

> **The silence enshrouding abuse:** *"It's very rare to find that mothers are sharing their problems. That's why we find ourselves in abusive, eh, eh, in abusive relationships."*

The caregivers said that they did not speak openly to one another and share their difficulties. It would seem that they do not speak because they are scared. Often they have good reason to be scared and many seem to be trapped in abusive relationships. As one caregiver said, "They are so shy. They are so abused that they are scared of everything." Some of the stories they recounted during the group highlighted their fear of making their partner unhappy. For example, one caregiver said "the father is drinking and she don't want noise because, the baby is crying." She added to this, saying "the father of the baby is shouting - making noise when the baby cries."

Need for nurturing and care: *"Is the first time to meet u, your friendly. I believe or one day you help me."*

Caregivers really appreciated being part of the focus group and appeared to leave feeling more hopeful. One caregiver felt so optimistic and hopeful that she sent the facilitator the following message, "I'm so happy, is the first time to meet u, your friendly. I believe or one day you help me. God bless u and ur family… " In light of their needs it would seem that a little went a long way. Through being treated with respect and through being listened to, caregivers seemed to feel acknowledged and heard.

Helplessness in the face of bureaucracy

Although the person who reviews all research at the health care clinic was very helpful, the researcher often felt helpless in the face of the clinic's bureaucracy. In light of her experience, the researcher wondered whether the caregivers didn't also felt helpless. From the stories they recounted during the focus group discussion, it would seem that many of them had struggled to get the support and guidance they needed. This possibly explains why one of the participants, who had never visited the Baby Mat, decided to come. She urgently needed support and since she did not know where to turn, she came to the focus group hoping that this would be helpful.

4.6 Summary of results

The data collected addressed the research questions. It provided some answers and shed light on why some caregivers repeatedly access the Baby Mat. The results indicate that the experience the

caregivers had on the Baby Mat encourages them to go back. They find their time on the mat to be cathartic and like the release they experience. It instils hope and they leave the mat with some ideas on how best to move forward. In addition, it helps them to see that they are not alone. Since they often feel undermined and can get the impression that no-one really cares, their experience on the Baby Mat stands out in positive contrast to some of their other relationships. For many, it is a unique experience to have someone listening and attending to them. They also really appreciate the follow-up support that they are given, and experience the facilitators as empathic and non-judgmental.

Knowing that what they share will remain confidential, it is easier for them to open up about their difficulties. The experience seems to foster self-awareness. After visiting the Baby Mat, many of the caregivers are able to link their baby's difficulties to the stresses they experience generally.

The data collected also highlighted several factors that pushed caregivers to seek support, providing more reasons to explain their repeat visits to the Baby Mat. It was evident that the caregivers were anxious about their infants. These feelings were increased by their desire to do what is best for their baby. It was also evident that they desperately needed information and guidance and support on a personal level. However, it was clear that they only sought help when they accepted that there was a problem.

Answers were also given to the question as to why caregivers fail to make repeated use of this intervention. Several factors seemed to hinder them from visiting the Baby Mat, and act as barriers. These factors also stopped caregivers from taking up parent-infant psychotherapy when it was offered to them on the Baby Mat. Caregivers felt disempowered at work and at home. As a result, they struggled to be assertive and to proactively seek support. They were also scared and many factors contributed towards this fear.

They worried about being humiliated. Since many of them were trapped in abusive relationships, they were scared that action might be taken if they opened up about their circumstances. They said that they were afraid of losing the partners on whom they depended for financial support and so preferred to keep quiet. In light of the abuse they experienced, many seemed to suffer from

generalised anxiety and were scared of everything. However, it was clear that they were their own worst judges. Often they chose not to seek support because they felt that they should be able to cope without it and judged themselves for not being able to do so. Since the Baby Mat offered nothing concrete, they tended to devalue the service. They were also prone to denial and preferred to believe that everything was fine. Many struggled to reach out for help as they lacked the strength so do so. They were also overly sensitive to advice that was given and unwilling to make an effort.

The data collected also addressed the question about needs that were not fulfilled by the Baby Mat. It was evident that the caregivers wanted to reach out to other caregivers. They also indicated that they would like a support group as it helped them realise that they were not alone.

Chapter 5: Discussion

From the data collected, several themes emerged and it was possible to identity factors that pushed caregivers to make use of these services as well as barriers that blocked them from doing so. In addition, new needs emerged. These findings have been consolidated and will be discussed into terms of:

- How the disempowered position of caregivers blocked them from visiting the Baby Mat or taking up parent-infant psychotherapy;
- Why caregivers needed to mask their vulnerability and chose not to visit the Baby Mat or take up parent-infant psychotherapy;
- Whether the Baby Mat and parent-infant psychotherapy meets the caregivers' need for a "good enough grandmother";
- The caregivers' desire to create a support matrix; and
- How caregivers benefitted therapeutically from their experience on the Baby Mat.

5.1 How the disempowered position of caregivers blocked them from visiting the Baby Mat or taking up parent-infant psychotherapy

One of the reasons for caregivers failing to make optimal use of the Baby Mat or taking up parent-infant psychotherapy was that they felt disempowered. It was evident that poverty had contributed to their oppression. Many of the caregivers were living on or below the bread line and had limited access to resources. Only half of the caregivers who took part in the study were employed. Those who were working had jobs as domestic workers. They all lived in Alexandra township, an economically depressed peri-urban settlement. Living conditions within the township are poor and, according to a survey conducted in 2006, the settlement comprised an area of 7.6km² and was home to some 328,579 people living in 20,000 shacks (Alexandra Renewal Project, 2006). Although a programme was rolled out in 2001 to improve the standard of living in this settlement, News24 recently reported that the results have been disappointing (Alexandra renewal project disappointing - survey, 2012).

The power imbalance between men and women in traditional African culture has further entrenched the caregivers' sense of powerlessness. According to some cultural expectations, men

hold the balance of power in heterosexual relationships (Meyer-Weitz *et al.*, 1998). The caregivers in this study subscribed to this tradition. They depended on men for their survival. Research points out that abuse often follows in the wake of gender inequality, and that sometimes men in South Africa use violence as a way of asserting their authority over women (Jewkes *et al*., 2011). Although very few of the caregivers revealed their own experience of being abused, they alluded to how this stopped others from visiting the Baby Mat. They said that caregivers were scared that action would be taken if they opened up about their circumstances. Essentially, the caregivers were dependent on the men who beat them and were scared that if the abuse was discovered, they would lose their livelihood. In addition, they indicated that the level of abuse experienced by caregivers made them scared of everything.

When caregivers are abused, they do not feel held. As a result they are unable to hold their infants in the manner described by Winnicott (1960a). This leaves these infants vulnerable to impingements from the environment, and they are pushed to develop a False self to protect themselves from the fear of being annihilated (Winnicott, 1960b). This fear may account for the high prevalence of disorganised attachment in South Africa (Tomlinson *et al.,* 2005). Infants who experience this pattern of attachment sense that their caregivers are frightened, or are frightened of their caregivers (Main & Solomon, 1990). If caregivers are frightened, their capacity for reverie is broken and they are not able to act as containers for their infants' intolerable experiences (Bion, 1962). As a result, infants fail to develop the capacity to think, preferring to live in a state in which awareness is deadened. To protect themselves against unwanted thoughts and feelings, infants become locked into a process of projective identification, where all thoughts are treated like bad objects that need to be ejected.

The caregivers in this study indicated that one of the reasons they failed to take up parent-infant psychotherapy was that they were unwilling to make the necessary effort. They wanted help to come to them, as opposed to going out to find help. Although one of the caregivers put this down to ignorance and said that they were "irresponsible", it would seem that their apathy was symptomatic of their depression, which in turn can be linked to their disempowered position.

Apathy is often linked to depression and is associated with a loss of motivation (Marin, 1997). Research undertaken in South Africa reveals that caregivers in this country are prone to antenatal depression (Rochat *et al.,* 2011) as well as postpartum depression (Murray & Cooper, 1997). Rochat *et al*. (2011) explored the clinical presentation of antenatal depression in caregivers and found that suicidal ideation, depressed mood and loss of interest were more prominent features of this condition. Several factors seem to place caregivers at risk of depression, including poverty, intimate partner violence and HIV (Brandt, 2009; Dunkle, Jewkes, Brown, Gray, McIntryre & Harlow, 2004; Jewkes, Dunkle, Nduna & Shai, 2010; Stein, Krebs, Richter, Tomkins, Rochat & Bennish, 2005). Many of these factors can be attributed to the disempowered position of caregivers in South Africa.

5.2 Why caregivers mask their vulnerability and choose not visit the Baby Mat or take up parent-infant psychotherapy

The caregivers were worried about what other people thought of them. They felt judged for making use of the Baby Mat. Some of these judgments stemmed from the manner in which the Baby Mat was introduced to them each week at the clinic. The introduction created the impression that the Baby Mat was for mothers who had problems and were possibly trapped in abusive relationships. In light of this, some of the caregivers found it humiliating to get up in front of everyone and go to the Baby Mat. They described how they would look around to make sure they did not know anyone there before going to the Baby Mat. Although they seemed to be scared of what others thought, it soon became apparent that they were self-critical. Some of the caregivers chastised themselves for being unable to cope with the job of raising an infant. Denial was also cited as a reason for the failure to seek support. As one caregiver intimated, only once they were prepared to accept that there was a problem could they take action.

Winnicott (1960b) provides a framework for understanding why the caregivers needed to mask their vulnerability. He was interested in the True and False self and postulated that the job of the False self was "to hide and protect the True self, whatever that may be" (Winnicott, 1960b, p.142). According to his theory, the False self comes into being when a mother fails to meet her infant's real needs and instead offers them a substitute. When the infant responds by complying with the mother, a False self develops. In this way, the False self defends the needs of the True

self. In light of this theory, one might hypothesise that the caregivers did not themselves experience good enough mothering and so learnt to mask their real needs behind a False self. Instead of seeking support and owning their vulnerability, they chose to hide behind a veneer of social acceptability. This hypothesis would explain their susceptibility to the judgments of others. In addition, it sheds light on why they were sometimes overly sensitive to feedback that was given. It also explains why they lacked the strength to ask for help.

5.3 Exploring the caregivers need for a "good enough grandmother" and whether the Baby Mat and parent-infant psychotherapy meet this expectation

Many of the caregivers who took part in this study seemed to find themselves caught up in the motherhood constellation described by Stern (1995). Stern (1995, p.171) points out that the motherhood constellation is a "new and unique psychic organisation" that follows the passage to motherhood. This constellation defines the types of problems experienced by mothers, as well as the type of support they tend to seek. However, he points out that it is not universal. Instead, it is specific to mothers who are living in Western, post-industrial societies that value infants and strive to optimise their well-being, yet fail to support them in this endeavour (Stern, 1995).

The caregivers in this study were not typically Western in that they were also influenced by traditional African culture. However, the motherhood constellation as described by Stern (1995) was still applicable to them. Traditional African culture, like Western culture, places enormous value on infants. It also values women for their ability to bear and raise children (Meyer-Weitz *et al*., 1998). The caregivers in this study wanted to do their best for their infants, and felt extremely anxious when difficulties arose and their infant struggled to sleep, eat, make bowel movements or suffered from rashes. Like Western mothers, these caregivers lacked the support they needed to fill this role. They felt extremely alone and isolated.

Stern (1995) attributes the lack of support given to mothers to the diminishing role of the extended family in child rearing. In light of this, he points out that interventions for mothers and infants are generally very well received (Stern, 1995). Perhaps this was why caregivers were so receptive towards the Baby Mat project. Stern (1995) explains that mothers who are in the motherhood constellation long for nurturing and care. They tend to cast interventions, like the

Baby Mat, in the role of the "good enough grandmother" and look to them for support (Stern, 1995, p.186). The findings of this study reflect this. The caregivers strongly valued the manner in which the facilitators on the Baby Mat attended and listened to them, especially as this was not something their friends and family were able to do sufficiently. It was particularly meaningful for them when the facilitators on the Baby Mat followed up to see how they were coping. They also found comfort in the way the facilitators tried to see things from their perspective and that they were not judgmental.

However, since the caregivers looked to the Baby Mat as they would to a grandmother, their expectations of this intervention were high. Stern (1995, p.186-187) explores this further and highlights the need for therapists in parent-infant psychotherapy to be "more active, less abstinent emotionally, freer to 'act out' in the sense of making home visits, giving advice, touching the patients, and so on, and more focussed on assets, capacity and strengths." He points out that the inability to do so can "exact a heavy price on the therapeutic alliance" (Stern, 1995, p.186) and it would seem that this may explain why the Baby Mat was devalued by some caregivers. Some of the caregivers in this study indicated that were frustrated with the Baby Mat as they hoped for more information and guidance. When the facilitators could not provide this, these caregivers felt despondent about the intervention, with one suggesting that the facilitators should do some background work and then call them with the information they needed.

Generally the act of giving advice is discouraged within the psychoanalytic tradition, as it strips the client of the opportunity to make discoveries on their own. However, guidance and information was something that the caregivers keenly wanted and needed. Research suggests that this tension between being non-directive and meeting the client's need for advice is something that dominates counselling services offered in underprivileged communities (Van Rooyen, 2008).This need for the clinician to direct decision making also emerged in a study exploring a consultative approach to assessment (Amod, Skuy, Sonderup & Fridjhon, 2000). Although the approach set out to help clients arrive at their own decisions, most of the respondents in this study wanted the decision to be made for them. Amod *et al*. (2000) understood this in terms of the socio-political history in South Africa, where the majority were severely oppressed by the Apartheid regime and grew accustomed to others making decisions on their behalf.

Recently Landman (2009) studied the nature of the therapeutic alliance between caregivers and counsellors who took part in a parent-infant intervention that was run in a Cape Town township. Her findings indicated that it was not beneficial to withhold basic information when working within severely deprived communities, and she has encouraged clinicians to rethink their stance on this matter (Landman, 2009). She warned that "unless knowledge is accessible, in tune with and responsive to the mothers' specific needs, and offered within a supportive and reflective therapeutic relationship, it tends not to be sought out or utilised and is therefore ineffective" (Landman, 2009, p.209). Even though some caregivers were frustrated with the Baby Mat as they did not get the advice and information that they were hoping for, it should be noted that many others felt that they did get what they needed. This was possibly because the facilitators on the Baby Mat were able to empathise with their experiences.

In addition to information and guidance, Stern (1995) highlights a mother's need to be acknowledged by a mother figure. He says that "the transference that evolves in this situation involves the elaboration of a desire to be valued, supported, added, taught and appreciated by a maternal figure" (Stern, 1995, p.186). All the caregivers in this study indicated that they felt acknowledged on the Baby Mat. The experience made them feel better about themselves. As a result, they indicated that they would revisit the Baby Mat.

Berg (2009) adds to our understanding of the type of therapeutic alliance needed when running parent-infant psychotherapeutic interventions in economically depressed, often peri-urban, settlements in South Africa. She points out how important it is to meet clients on their terms. In other words, she says that "It is important to meet where he or she came from, as opposed to having individuals out of the community come to the professional" (Berg, 2009, p.217). This aligns with the reasons put forward to explain why some caregivers do not take up parent-infant psychotherapy. "You see, we only want things to come to us. So, we don't want to go to things that will help us" were the words they used. In light of this, one gets the impression that the parent-infant psychotherapy offered by the community based organisation still needs to be adapted to accommodate its context.

5.4 Examining the caregivers' desire for a support matrix

During the focus group discussion it was evident that some caregivers wanted to share their experiences and ideas with others. According to Yalom and Leszcz (2005) this may be seen as altruism and they point out that members of therapeutic groups receive by giving. They receive benefit not only through the reciprocal process of giving and receiving, but from the intrinsic act of giving. This seems to be something that the caregivers yearn for. It was also evident that, by coming together to discuss their experiences, they realised that they were not alone in them. Again, Yalom and Leszcz (2005) shed light on this. They point out that one of the therapeutic values of group work is the universality of experience. In the focus group in this research study, as the group members shared the stories of their lives, so they started to realise that they were not alone.

One might ask why this need to reach out to others has arisen. Stern (1995) says that when mothers move into the motherhood constellation, their focus shifts. They become more interested in other women in general. In addition, they are driven to create a supportive network, so that they are able to focus on the primary tasks of being a mother and promoting the growth of their infants as well as engaging with them on a social and emotional level. Traditionally, this network comprised other women and mothers.

With the disappearance of the extended family structure or phenomenon, new mothers are increasingly reliant on their partners to fill this role (Stern, 1995). But this is often unrealistic, especially in many South African communities where men do not usually get involved with the daily care of children (Berg, 2009). Stern (1995, p.177) points out that one of the functions of the support matrix is to make mothers feel "surrounded, supported, accompanied, valued, appreciated, instructed, and aided - each to different degrees for different mothers." He draws our attention to the fact that motherhood is something that is learned through apprenticeship. As such, guidance is a key element of parent-infant interventions.

In a culture that prides itself on the interdependence of people, what has stopped women from reaching out and supporting one another? Several factors seem to have eroded the spirit of the "ubuntu" that is typical of African culture. The prevailing influence of individualistic Western

culture, accompanied by urbanisation, has led to the erosion of traditional cultural practices. In addition, the stigma associated with illness and disease may have contributed to the problem. As discussed earlier, when infants become ill after birth, a traditional belief is that ancestors have withdrawn their protection, and thus made the infant vulnerable to evil spirits (Berg, 2003). In light of this, caregivers do not want others to know what they are going through for fear of being negatively judged.

5.5 Understanding how caregivers benefitted therapeutically from their experience on the Baby Mat

The results of the study indicated that the Baby Mat was a therapeutic experience for the recipients of this service. It seems to offer the caregivers release. On the Baby Mat they are able to express some of their pent-up feelings and they left the mat feeling a little lighter. They indicated that the experience instilled hope and they welcomed the guidance they were given. They also realised that they were not alone. This gave them enormous comfort. In addition, the experience seemed to facilitate self-realisation. Many of the caregivers reflected that by spending time on the mat they had come to realise that their infant's difficulties were linked to their personal problems. They also realised that sometimes the problem that presented was not the real reason for which they had sought support. Interestingly, these factors emulate those that make group work an effective therapeutic intervention (Yalom & Leszcz, 2005). It possibly indicates that these participants would benefit from a support group for caregivers.

Chapter 6: Conclusion

6.1 Research findings

This research set out to investigate caregivers' experiences and perceptions of parent-infant interventions that are run by a community based organisation on the outskirts of Johannesburg's Alexandra township. These interventions support caregivers and infants and, in so doing, foster secure attachment relationships. Since the benefits of secure attachment are fundamental to future learning and development, these interventions fall into the scope of educational psychology.

The specific aims of this research were to understand why some caregivers repeatedly visit the Baby Mat whereas others fail to return. It also hoped to provide insight into why caregivers who are referred for parent-infant psychotherapy on the Baby Mat fail to take up this offer. In addition, the research hoped to determine whether caregivers had other needs that were not being met by the Baby Mat. The data collected sheds light on these questions. It identified the factors that stopped caregivers from visiting the Baby Mat or taking up parent-infant psychotherapy. It highlighted the factors that encouraged caregivers to make use of these interventions and it shed light on the therapeutic benefits offered by the Baby Mat. In addition, new needs emerged.

One of the primary barriers stopping caregivers from visiting the Baby Mat or taking up parent-infant psychotherapy was their disempowered position. Since they did not hold the balance of power at home or at work (if they had employment), they needed to ask permission to go to the clinic. This made it very difficult for them to make optimal use of these interventions. In addition, they were scared. They feared that action would be taken if the reality of their circumstances was revealed. It was also evident that they were afraid of being judged and, as a result, tended to mask their vulnerability and masquerade behind a False self. Since their need for support and guidance was extensive, they became easily frustrated when these needs could not be met. This possibly explained why caregivers who failed to visit the Baby Mat devalued the service offering. It was clear that these caregivers wanted the interventions to meet them on their own terms. They didn't want to have to go looking for help. In view of this, they failed to take up parent-infant psychotherapy. Their need for responsiveness was explained by the type of therapeutic alliance demanded by mothers in the motherhood constellation. As Stern (1995)

points out, it is important for therapists in parent-infant interventions to break with tradition and to reach out to their clients.

Like mothers in Western cultures, these caregivers wanted the best for their infants, yet they felt terribly alone and isolated. As a result, they were very receptive towards the Baby Mat, which they seemed to cast in the role of the "good enough grandmother." On the Baby Mat they felt acknowledged, which is crucial according to Stern (1995). Not only do mothers want information and guidance, they also want to be acknowledged by a mother figure. In addition to being acknowledged, they experienced several other therapeutic benefits on the Baby Mat. Many of the caregivers indicated that they felt release and were able to get rid of some of their pent-up anxiety by visiting the Baby Mat. The experience also instilled hope and they often left with more ideas on how they should tackle the problems they were facing. They also gleaned comfort from the fact that they were not alone. In addition, they were able to make links between their own personal struggles and the difficulties their infants were experiencing.

Through the process of collecting data, it became evident that caregivers wanted to reach out to other caregivers. Some of them wanted to share their experiences to help others. Others found it helpful to listen, as they realised that they were not alone in their experiences. It would seem that the caregivers were striving to create a support matrix. This was something Stern (1995) talks about. Caregivers need to be supported and aided by a maternal figure during their passage into motherhood. Since the support provided by the extended family has diminished, this need is greater than before.

6.2 Recommendations based on the findings

Although the caregivers valued the support they received on the Baby Mat, this research identified ways in which this intervention could be refined. From the data collected, it was evident that the project team needs to revise the way in which they introduce the intervention at the clinic. During the focus group discussion the caregivers spoke about the value judgments made about those who used the Baby Mat. For example, they wondered if these caregivers were being beaten by their husbands. In view of this, it would be important to explore ways of reframing the intervention so that those who seek support do not feel prejudiced.

It was also evident that the caregivers were very frustrated when their needs for information and guidance were not met. This needs to be understood in terms of their poor access to information and their need for guidance from a maternal figure. Although giving advice and information does not fit with psychoanalytic approach, this possibly needs to be re-examined.

During the focus group discussion, caregivers expressed the need to reach out to other caregivers or to be part of a group. It would seem that they perhaps wanted to develop a support network. This could be explored further to ascertain whether the caregivers would attend such a group.

Finally, the data highlighted the need to review parent-infant psychotherapy, and explore ways in which this service could be adapted to meet the needs of the caregivers. It was apparent that caregivers wanted the service to come to them, as opposed to going to the service. However, this needed to be explored further.

6.3 Limitations of the research

Initially it was hoped that half of the focus group would be made up of caregivers who had visited the Baby Mat once, and half who had visited it repeatedly. In the end only one third of caregivers who attended the focus group were repeat users. Since the sample in this study was relatively small and was not randomly selected, it was not possible to generalise the findings. As a result, it is not clear whether the data that emerged was representative of the caregivers attending the health care clinic, or whether they were the views of an unrepresentative select few. A further limitation was that during the focus group discussion, some of the caregivers were very vocal and openly shared their experiences and feelings while others were shy and did not speak as much. These participants only felt comfortable to share towards the end of the discussion.

6.4 Suggestions for further research

It would be ideal to run a second group in order to validate some of the results of this research. This next stage of research could explore the feasibility of starting a support group. In addition,

future research should be undertaken to explore how parent-infant psychotherapy could be adapted to meet the needs of caregivers.

6.5 Concluding remarks

Mwamwenda (2008, p.7-8) reminds us that "educational psychology has a unique and important contribution to make to the progress of African children, whose success in life is partly dependant on how well we prepare them to take their rightful place in their respective countries and beyond." Community-based interventions that support the caregiver-infant dyad present an ideal opportunity to shape the development of the youth. When caregivers feel held, they are better able to focus on their infants (Winnicott, 1960a). Since the support gleaned from extended family structures has diminished over the last few decades, increasing numbers of caregivers have had to navigate the transition into motherhood alone and are sometimes overwhelmed with anxiety. In South Africa, caregivers are confronted with additional challenges that make this role even more difficult, like poverty and the power imbalance between men and women. In view of this, there is an increasing need for interventions that fulfil the role of the grandmother. This research sheds light on how interventions like the Baby Mat project and parent-infant psychotherapy meet this need. It also provides guidance on how these interventions could be refined to better meet the needs of these caregivers. Most importantly, the study acknowledges the powerful role played by them. In a poem Wallace (1890, p.248) praises caregivers by saying,

> "Blessings on the hand of women!
> Angels guard its strength and grace.
> In the palace, cottage, hovel,
> Oh, no matter where the place;
> Would that never storms assailed it,
> Rainbows ever gently curled,
> For the hand that rocks the cradle
> Is the hand that rules the world."

Although it is more than a century later and many things have changed, much has stayed the same. In spite of their pivotal role, caregivers still seem to hold a disempowered position in society. Englebrecht (2004, p.27) challenges educational psychologists in South Africa to "create

the future they wish to inherit by taking the lead in directing their specialised insight, skills and practices towards the development of collaborative, consultative, developmental and preventative action." The Baby Mat project has gone some way to achieving this. It is now incumbent on others to follow their lead.

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Appendices

Appendix 1: Topic guide for focus group discussion

(Preamble: My name is Belinda Aspoas and this is my co-facilitator _____. As we discussed over the telephone, I am studying at the University of the Witwatersrand. For my research I would like to explore the Baby Mat project and am interested in understanding your opinion of this service. In this focus group I will ask everyone a few questions to guide the discussion. It is important to point out that there are no right or wrong answers. Everyone's opinion counts and in some cases I imagine you will not agree with each other. Also I would like to re-emphasise that you will not be disadvantaged in any way if there are negative things you would like to express. We would like to hear what you really feel and not what you think we'd like to here. At no time will you be forced to answer any questions. It will be your decision to respond as and when you wish. Before the group begins, I will ask each of you to agree not to talk to about things other people in this group discuss with outsiders. From my side I would like to reassure you that your names will be kept confidential. When I write up the details of this session, I will use pseudonyms. The focus group will take an hour and a half to two hours. We will have a break half way through the session.)

1. Personal context
    - Could you please introduce yourself?
2. General perceptions of the Baby Mat
    - What do you not like about the Baby Mat?
    - What do you like about the Baby Mat?
3. Experience of the Baby Mat
    - What was your experience of the Baby Mat?

        Did you feel supported?

        Did your experience meet your expectations?

        Were there things you were hoping for that were not provided?
4. Failure to return to the Baby Mat

- Some of you have visited the Baby Mat once but have not returned. Could you tell why you decided not to go back?

5. Repeat visits to the Baby Mat
    - Some of you have visited the Baby Mat more than once. Could you tell us more about why you decided to return to the Baby Mat?
6. Parent-infant psychotherapy
    - On the Baby Mat some caregivers are offered further support, like parent-infant psychotherapy. Although this is a free service, very few caregivers take up this offer. Why do you think this is the case?

Appendix 2: Participant's information sheet

Hello, my name is Belinda Aspoas. I am studying at the University of the Witwatersrand and I would like to invite you to take part in my research project. Research is a process of finding out about something and I am interested in learning more about the Baby Mat project. In order to do this, I would like to understand your opinion of the Baby Mat and what you think of this service.

Participation in this study will be voluntary. You can choose to participate or not. If you decide not to take part in this study, you will not be disadvantaged in any way. Likewise, if you agree to participate there will be no direct benefits.

Should you be willing to take part, I would like to invite you to come to a focus group which is a group discussion to which other caregivers will also be invited. The focus group will be held at the health care clinic and you will be refunded for your transport costs. I will facilitate the focus group with someone else who can assist with translations as I only speak English.

In the focus group I will ask everyone a few questions to guide the discussion. It is important to point out that there are no right or wrong answers. Everyone's opinion counts and in some cases I imagine you will may not agree with each other. At no time will you be forced answer any questions. It will be your decision to respond as and when you wish. The focus group will take an hour and a half to two hours with a break for lunch. Like the Baby Mat, you will be invited to bring your baby along.

Since it is a focus group and others will share your experience, it will not be possible to guarantee confidentiality. However, before the group begins, I will encourage everyone not to disclose information that is shared by others in the group. In addition, your identity will be protected as no identifying details will be included in the transcription of the recordings or quotes used to present the findings.

So that I can remember as much detail as possible, it will be necessary for me to video record the focus group. However, this recording will only be heard by myself and if necessary my co-

facilitator to assist with translations. This video recording will be kept in a safe place. Later when I write up the details of what we discussed in the focus group I will remove your name and use a pseudonym. These transcripts will only be seen by my research supervisor and myself. They will also be kept in a safe place. When I write up my report, I will use direct quotes from the group discussion. However, once again no identifying information will be included.

After the final report has been written, it will be necessary to keep the recording as well as the transcripts in a safe place for up to 6 years to make it possible to publish the findings. Once this period is over, these records will be destroyed.

An overview of the findings will be provided to the Chief Executive Officer of the health care clinic, and the finished report will be distributed to the therapists who run the Baby Mat, the people who mark my report and a copy will be kept in the library at the University if the Witwatersrand. If you would also like an overview of the research results and findings or a copy of the full report, I will provide you with these with pleasure. My contact details and those of my supervisors are attached to this form.

Should you choose to participate, please complete the two consent forms. The one is your consent to participate in this research. The other is your consent for the audio recording.

If you would like further information, or have any other questions, or would like to report any negative experience regarding this research, please feel free to contact either me or my supervisor.

I don't anticipate that the focus group will harm you in any way. However, if you experience difficulties after participating, you may access one of the following free therapy services:

- Ububele Umdelzane parent-infant psychotherapy service (contactable on 011 786 5085)
- Emthomjeni Community Psychology Clinic (contactable on 011 717 4513)
- Lifeline (contactable on 0861 322 322)

Yours faithfully

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Appendix 3: Participant's consent form for focus group

I _____ consent to participate in the focus group that will be facilitated by Belinda Aspoas and _____as part of Belinda's Masters degree in Educational Psychology at the University of the Witwatersrand.

I understand that my participation in this research project is voluntary and that I do not need to answer any questions I do not want to. I am also aware that I can excuse myself from the focus group at any time.

It is clear to me that my confidentiality will be maintained as far as possible and no personal information will be included in the transcripts or the final report.

I am aware that a copy of the finished report will be kept in the library at the University of the Witwatersrand and will be available to people who have access to this library. In addition I understand that it will be necessary to keep the recording as well as the transcripts in a safe place for up to 6 years, depending on whether the research is published or not.

I know there are no direct benefits for me in participating in this study. However, I am also aware that there are no anticipated risks for me to participate in this study.

Signed _____

Date _____

Appendix 4a: Participants consent form for video recording

I _____ give my consent that the focus group on Caregiver's perceptions of the Baby Mat, which Belinda Aspoas and _____ will facilitate on _____ _____ can be video recorded.

I understand that the video recording will only be heard and processed by Belinda Aspoas and her co-facilitator when translations are necessary. For the duration of this study and a period of 6 years thereafter, I know that the video recording will be kept in a safe place. Afterwards I understand that these records will be destroyed. I also know that when the video recordings are written up, no identifying information (including my name or my infant's name) will be used. In addition, no identifying information will be used in the final report to reflect the results of this study.

Signed _____

Date _____

Appendix 4b: Participants consent form for audio recording

I _____ give my consent that the focus group on Caregiver's perceptions of the Baby Mat, which Belinda Aspoas and _____ will facilitate on _____ _____ can be audio recorded.

I understand that the audio recording will only be heard and processed by Belinda Aspoas and her co-facilitator when translations are necessary. For the duration of this study and a period of 6 years thereafter, I know that the video recording will be kept in a safe place. Afterwards I understand that these records will be destroyed. I also know that when the video recordings are written up, no identifying information (including my name or my infant's name) will be used. In addition, no identifying information will be used in the final report to reflect the results of this study.

Signed _____

Date _____

Appendix 5: Letter requesting permission from the community based organisation

Dear Sir or Madam,

Re: Request for permission to undertake research on Baby Mat project

Hello, my name is Belinda Aspoas and I am currently enrolled as a student for a Masters in Educational Psychology in the Department of Psychology at the University of the Witwatersrand. In partial fulfilment of the requirements for this degree, I need to complete a research project. The proposed study I wish to undertake is an exploration of caregivers' perceptions of the Baby Mat in order to understand why some caregivers make optimal use of this intervention whereas others do not. Specifically the research hopes to address the following questions:

- Why do some caregivers repeatedly access the Baby Mat?
- Why do other caregivers fail to make repeated use of this intervention?
- Why do caregivers not take up parent-infant psychotherapy when it is offered to them on the Baby Mat?
- Whether caregivers have other needs that are not being met by the Baby Mat?

Participants will be caregivers who have visited the Baby Mat within the last six months and voluntarily agreed to take part in this study. They will be selected via purposive sampling and required to provide written consent in order to participate in this research. In addition, they will be required to provide written consent for video recording of the data collection. I feel it is important to point out that when potential participants are approached, they will be informed that they not be disadvantaged in any way if they chose not to take part take part in this study or rewarded if they do take part. A copy of the information sheet that will be provided to participants, as well as the consent forms they will be required to sign, have been attached for your perusal.

Data will be collected by means of a focus group. This group will be facilitated at the health care clinic in conjunction with a co-facilitator, who is proficient in the caregivers' mother tongue. At this stage it is envisaged that the group will run for approximately 1.5 to 2 hours, with a break in

between. To guide discussion, a topic guide will be used. A draft copy has been attached for your perusal. Your input into this document would be welcome.

Since data will be collected via a focus group, confidentiality and anonymity cannot be guaranteed. However, an effort will be made to achieve confidentiality by encouraging participants not to disclose the personal information that others reveal during the focus group. In addition, the participant's identities will be protected as no identifying details will be included in the transcription of the recordings or quotes used to present the finding.

The video recording of the focus group will be kept in a safe place and viewed only by myself, and if necessary my co-facilitator to assist with translations. Similarly the transcriptions will also be kept in a safe place and viewed only by myself and my supervisor. To enable publication, it will be necessary to keep the recording as well as the transcripts in a safe place for up to 6 years. Afterwards these records will be destroyed.

To analyse the data collected, thematic analysis will be applied to the focus group material in order to identify themes. Once a final report has been compiled, I will provide a copy to your organisation.

Permission from your organisation to go ahead with this study would be greatly appreciated. Should you have any queries or concerns, please don't hesitate to contact me or my supervisor using the contact details listed below.

Yours faithfully

Mrs Belinda Aspoas
(Educational Psychology Student)
Contact no. +27 83 308 8573
Email: maspoas@discoverymail.co.za

Dr Zaytoon Amod
(Research Supervisor)
Contact no. +27-11-717-8326
Email: Zaytoonisha.Amod@wits.ac.za

Appendix 6: Letter requesting permission from the Chief Executive Officer of the health care clinic in Alexandra township

To whom it may concern,
Re: Request for permission to undertake research on Baby Mat project

Hello, my name is Belinda Aspoas and I am currently enrolled as a student for a Masters in Educational Psychology in the Department of Psychology at the University of the Witwatersrand. In partial fulfilment of the requirements for this degree, I need to complete a research project. The proposed study I wish to undertake is an exploration of caregivers' perceptions of the Baby Mat in order to understand why some caregivers make optimal use of this intervention whereas others do not. Specifically the research hopes to address the following questions:

- Why do some caregivers repeatedly access the Baby Mat?
- Why do other caregivers fail to make repeated use of this intervention?
- Why do caregivers not take up parent-infant psychotherapy when it is offered to them on the Baby Mat?
- Whether caregivers have other needs that are not being met by the Baby Mat?

Participants will be caregivers who have visited the Baby Mat and voluntarily agreed to take part in this study. They will be selected via purposive sampling and required to provide written consent in order to participate in this research. In addition, they will be required to provide written consent for video recording of the data collection. I feel it is important to point out that when potential participants are approached, they will be informed that they not be disadvantaged in any way if they chose not to take part take part in this study or rewarded if they do take part. A copy of the information sheet that will be provided to participants, as well as the consent forms they will be required to sign have been attached for your perusal.

Data will be collected by means of a focus group. This group will be facilitated at the health care clinic in conjunction with a co-facilitator, who is proficient in the caregivers' mother tongue. At this stage it is envisaged that the group will run for approximately 1.5 to 2 hours, with a break in

between. To guide discussion, a topic guide will be used. A draft copy has been attached for your perusal.

Since data will be collected via a focus group, confidentiality and anonymity cannot be guaranteed. However, an effort will be made to achieve confidentiality by encouraging participants not to disclose the personal information that others reveal during the focus group. In addition, the participant's identities will be protected as no identifying details will be included in the transcription of the recordings or quotes used to present the finding.

The video recording of the focus group will be kept in a safe place and viewed only by myself, and if necessary my co-facilitator to assist with translations. Similarly the transcriptions will also be kept in a safe place and viewed only by myself and my supervisor. To enable publication, it will be necessary to keep the recording as well as the transcripts in a safe place for up to 6 years. Afterwards these records will be destroyed.

To analyse the data collected, thematic analysis will be applied to the focus group material in order to identify themes. Once a final report has been compiled, I will provide a copy to your organisation.

Permission from your organisation to go ahead with this study would be greatly appreciated. Should you have any queries or concerns, please don't hesitate to contact me or my supervisor using the contact details listed below.

Yours faithfully

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Appendix 7: Application to the Human Research Ethics Committee (HREC Non-Medical)