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The Baby Mat Project : similarities and differences between the experiences and perceptions of mothers and therapists.

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CHAPTER 1: INTRODUCTION

"Intimate attachments to other human beings are the hub around which a person's life revolves, not only when he is an infant or a toddler or a schoolchild but through his adolescence and his years of maturity and on into old age." (Bowlby, 1980b, p.442). This statement highlights the importance and extent of the individual's bond with others beginning at a very early age. It is argued that the bond established from the beginning of the child's life with his/her caregiver can inform the way the child will later interact with others in his/her life. It therefore seems important that secure attachments are formed in the early years of life so as to inform the child's way of being and interacting with others later in life. Although ideal, secure attachments do not prevail, and it becomes necessary for some intervention to take place in order to facilitate the creation of healthier bonds between mother and child. There are various interventions which seek to target the mother-infant dyad and effect relational change between mother and child. The Ububele Baby Mat project is one such intervention. As a way of better understanding these important interventions and their effects, the current study looked into the experiences and perceptions of mothers who have accessed a specific intervention, of the Ububele Baby Mat project at Alexandra Clinic, Johannesburg and also of the therapists who work on this project.

Research Aims

The aim of this study was to explore the subjective experiences and perceptions of both mothers who access the Baby Mat intervention and of the therapists who offer therapy to these mothers. A further aim was to uncover and discuss the similarities and differences between these two groups' experiences and explore how they separately experienced the process of mother-infant psychotherapy on the Mat. Data was gathered by conducting in-depth semi-structured interviews with both the mothers who had accessed the Mat and the therapists who were on the Mat with the mothers. Thematic analysis was used to analyse the interviews. By exploring the perceptions and experiences of both mothers and therapists, this study sought to deepen the understanding of the project and of the mother-infant therapeutic process.

In analysing the experiences of both mothers and therapists, the study sought to establish how the intervention might or might not have helped the mothers think differently about their babies and their relationships with their babies and whether or not the intervention had brought about any

perceived relational change within the mother-infant dyad according to the mothers and the therapists. This project aimed to contribute to the body of literature concerned with short-term interventions targeting mother-infant dyads in the South African context, with potential relevance to other limited resources contexts outside South Africa. Short-term parent-infant psychotherapy informed interventions such as these are not yet common in South Africa and are of vital importance as they aim to help mothers develop a capacity for reflective functioning which is significant in the development of a secure attachment between mother and child.

Rationale

The Baby Mat Project was begun in 2007 and by 2011 had been in operation for five years (Frost 2011). The project has seen a growing number of mothers utilising its services over those five years suggesting its effectiveness in the Alexandra community. This project was adapted from a similar project used in the Anna Freud Centre, yet this uniquely adapted version of the same project has not been well studied. This research was therefore undertaken as a means of broadening the literature which is available to help better understand the project and its impact on the Alexandra community. It is also hoped that this project and similar ones to follow will be able to highlight the importance of short-term mother-infant interventions, especially in the case of South Africa. These interventions are important in that they identify attachment problems early in the mother-infant dyad and accordingly can try to intervene in the development of insecure attachments by encouraging reflective functioning. They are also vital in that many mothers, especially those from previously disadvantaged backgrounds, cannot easily access psychological services. This free and readily available service serves to ease the burden on the demand for mental health care services.

The literature available dealing with short-term mother-infant interventions reveals a concentration on the subjective experiences of mothers who were involved in similar interventions and little is recounted about the subjective experiences of the therapists or trained workers involved in the delivery of the interventions. Bromley (2010) conducted a study in Alexandra Township, South Africa which studied the caregivers' experiences and perceptions concerning the Ububele Baby Mat intervention. This study is one of the few that has investigated the subjective experiences of caregivers experiencing such an intervention. Bromley (2010)

conducted eight in-depth interviews with women who received the short-term intervention. Another study conducted by Cooper, Landman, Tomlinson, Molten, C., Swatz and Murray (2002) looked at mother's experiences and perceptions of a mother-infant intervention in Khayelisha, Cape Town. This study used a four-point scale questionnaire to assess the 32 participating mothers' perceptions of the success of the intervention in enhancing their sensitivity to their infants' needs. A third study was conducted in Australia on a sample of ten mothers with postnatal depression (Buultjens, Robinson & Liamputtong, 2008). The study used in-depth interviews which were conducted before and after the mothers who were involved in the intervention. In each of these examples, the focus of research was on the mothers and not simultaneously on therapists.

What is unique about the current study is that it explored both the mothers' and therapists' experiences and perceptions of the Baby Mat intervention. This study will serve to widen the literature base by reporting the experiences and perceptions of both those who receive short-term interventions and those who offer the service, as there is little to no research that includes the experiences and perceptions of both participants and therapists or counsellors. The current study also aimed to identify and explore points of difference and similarity between the experiences and perceptions of mothers and therapists, which is why it was important to include not only the thoughts and experiences of the mothers but also those of the therapists involved in the intervention.

Context of the Ububele Baby Mat Project

The Baby Mat Project, run by an NGO known as Ububele, is a primary mental health service that is available in four primary health care clinics in Alexandra, Johannesburg, South Africa. The Baby Mat Project began in 2007, at the Alexandra Health Care Centre in Alexandra Township, Johannesburg, which is the main clinic in Alexandra. This project began as a conceptual idea spearheaded by Tessa Baradon of the Anna Freud Centre (AFC) with the aim of developing a community-based parent-infant intervention (Frost, 2011).

The Mat is situated in an open area in the baby immunisation section of the clinic which is an open hall-like area. The therapists place blankets on the floor in the same small area every week

to create the ‘Mat’ space. This is done in full view of all the mothers who bring their children to the clinic for routine weigh-ins. This was suggested by a nursing sister in charge as she felt that it would be useful to set up the Mat in public view so as to reduce any HIV/AIDS stigmatisation which could lead to some caregivers feeling ostracised, since South Africa has such a high rate of HIV/AIDS infections (Frost, 2011). The Baby Mat Project is run by an intern psychologist and a co-therapist, who also functions as an interpreter. When the project began, only the psychologist would sit on the Mat with the mothers, but the later addition of an interpreter saw an increase in the number of mothers approaching the therapist on the Baby Mat as English was no longer the only language used to communicate (Frost, 2011). This community-based mother-infant intervention is part of a larger NGO project called the Ububele Umdlezane Parent-Infant Project (UUPIP) (Frost, 2011).

Each Thursday morning in the Baby Wellness Clinic, or the immunisation hall, mothers are invited in different local languages to approach the therapists on the Mat to share their problems and experiences about their relationship with their children with two trained therapists. The Baby Mat Project involves once-off, 20 minute, contact between mother, therapist and co-therapist. Although the therapists see most of the mothers only once, some mothers do come back for re-visits. The Project sees the mother-infant relationship as the client, and therefore aims to offer caregiver support as a means of initiating shifts in mother-infant attachment. This is done by encouraging reflective functioning which requires caregivers to go beyond merely identifying physical symptoms, but also to try to understand what the symptoms may represent psychologically (Frost, 2011). This free service is available to all the mothers who come to the clinic and live in or around the Alexandra Township, Johannesburg (Frost, 2010).

As previously mentioned, the Baby Mat project is run in Alexandra Clinic, known shortly as Alex Clinic, which is on the outskirts of Alexandra. This clinic was established eighty years ago, in the 1930s by a nurse, Sister Ruth Cowles, who was then director. It was begun as a mission nursing service supported by the American Board Mission (Susser, 2006). The health centre started off as a corrugated iron nursing service and has now become a model community-based health care facility (www.alexandra.org.za).

Alexandra Township is very diverse in the composition of its residents, with a variety of ethnicities, languages and income levels (Wilson, 2011). Alexandra is located approximately 13

kilometres north-east of Johannesburg, South Africa, between Johannesburg and the wealthy suburbs of Sandton (Jochelson, 1990). Alexandra was declared a black freehold Township in 1912 when attempts by the government to upgrade it into a white township failed (Vogel, 1996). This 'native township' was originally designated to accommodate people. Vogel (1996) documented that in 1996 there were an estimated 350 000 people residing there due to a massive increase of migrants attracted by job opportunities in the city beginning from the 1920s.The overcrowding in the area has led to the further degrading of the already limited resources available that are dedicated to its residents (Mgquba & Vogel, 2004). Alexandra township has a very high unemployment rate that results in high levels of poverty and low standards of living (Lucy, 2004). This would mean that a number of mothers who access the Mat intervention may have not only emotional but also material needs for themselves and their children which they cannot readily provide for.

Structure of Research Report

This study consists of five sections. This first section serves as an introductory section which seeks to give the reader an overall understanding of the current study. This section covers the aims of the current research along with its rationale and the context of the intervention on which this study is focused.

The second section is the literature review which places its emphasis on the theoretical underpinnings and concepts which establish a hypothetical foundation for the current study. This section covers literature the importance of attachment theory and related contemporary concepts such as mentalisation as these inform many of the practices of parent-infant psychotherapy. The section goes on to understand the practice of parent-infant psychotherapy within the South African context and some hindrances to parent-infant psychotherapy. These hindrances may not be unique to the current circumstances here but may be applicable to other contexts as well.

The third section elucidates the methods employed in the course of the study in order to collect data. Along with this, the type of analysis which was employed in this study, thematic content analysis, is clarified and its applicability to the current study is elaborated on.

The fourth chapter covers the themes derived from the collected data. This section is further subdivided into sections. These subsections align with the study's research questions and

highlight the mother participants' responses, the therapist participants' responses and lastly, a comparative look at the two groups' subjective experiences. Following this section is the discussion section which endeavours to understand the results recorded in the results section. The aim of this fifth section is appreciate the participants' responses in connection with the literature. In concluding the study the limitations and recommendations for future research are stated followed by the reference list of all resources cited in the study.

CHAPTER TWO: LITERATURE REVIEW

The mother-infant relationship: Attachment theory

Over the course of the years, much has been written regarding the relationship between mother and child and the different aspects that are found within this relationship. This increase in literature has been due to the recognition that it is within the mother-infant relationship that an infant develops a sense of self and of other and how to regulate him/herself in society (Bretherton & Munholland, 2008). John Bowlby (1988), a British researcher, identified as the founding father of attachment theory (Levine & Heller, 2011), argues that an attachment is a bond that an infant has with its mother. An attachment is evolutionary in nature as babies seem to be strongly disposed to seeking proximity with the caregiver for feeding and protection (Senior, 2009). Attachments are also said to be persistent and can change only slightly over time (Main, 2000).

In order to ensure that attention and proximity are obtained from the caregiver, the infant is able to use certain attachment behaviours. Attachment behaviours are "any of the various forms of behaviour that the person engages in from time to time to obtain and/or maintain a desired proximity" (Bowlby, 1988, p. 31). These attachment behaviours are not learnt but are automatic as they serve an evolutionary purpose, which is to promote the survival of the infant since it is vulnerable and helpless (Senior, 2009). For example, a child does not learn to cry, but this seems almost an automatic response to distress. These attachment behaviours are seen as protests from the infant to being separated from the caregiver and are accordingly engaged in from time to time (Simpson & Belsky, 2008). Attachment behaviours are only exhibited by infants in situations of emergency, when they feel frightened, scared or distressed. In other words they serve a survival function. Their activation serves to draw the caregiver to the infant to provide relief. This can only occur when the mother is sensitive enough to recognise and respond to these behaviours (Ainsworth & Bell, 1970; Rutter, 1981). These attachment behaviours are organised into "an evolutionary-adapted behavioural system" (Senior, 2009) which comprise behaviours known by the baby to draw the caregiver's attention and ensure a maternal response.

A child's early experiences and interaction patterns with the caregiver are internalized and go on to shape the formation of mental representations, which are also popularly known as internal

working models (Goodman, 2007). There are two models, the self-model and the other model. The self-model "contains perceptions of one's own worth and lovability" (Senior, 2009, p. 219). Essentially it is the ability to guide one's own behaviour in relation to others (Bretherton, 1990). The other model "contains expectations regarding the essential goodness, trustworthiness, and dependability of important others in one's social world" (Senior, 2009, p. 219). This model serves to help the child predict the behaviour of others (Bretherton, 1990), for example, expecting others to be dependable and available when needed. When one understands him/herself as being worthy and competent he/she is said to have had available and emotionally sensitive caregivers who gave him/her a sense that the world is a safe place and can be explored. Yet the opposite is also said to be true. If a child distrusts others, has negative expectations of them and has low levels of self-worth, he/she can be said to have had inadequate care giving (Senior, 2009).

Mary Ainsworth's work is an empirical means of validating the assumptions made by attachment theory. Ainsworth and Bell (1970) revealed that children had different ways of reacting to being separated from attachment figures and reacted differently when they were reunited with the attachment figures. The Strange Situation laboratory procedures revealed that individual children displayed varying attachment behaviours when separated from their caregivers. These behaviours were then categorised into three attachment patterns, namely secure and insecure attachment patterns, with insecure attachment being further divided into ambivalent, avoidant (Ein-Dor et al., 2010) and in later studies disorganised attachment (Hesse & Main, 2000).

Upon administering the Strange Situation procedure, Ainsworth and her colleagues identified three categories of children according to their behaviours and reactions. The first group of children was classified as securely attached. These children became distressed when separated from attachment figures, but showed relief and reacted warmly towards attachment figures upon their return. While left in the room with a stranger, these children's despair would often give way and they would engage with the stranger and freely explore their surroundings (Ainsworth & Bell, 1970). The second group of children was classified as ambivalent. These children were reported to exhibit both contact-resisting and contact-seeking behaviours towards the mother. These behaviours were aggressively heightened during separations accompanied by angry outbursts (Ainsworth & Bell, 1970). According to Reader, Duncan and Lucey (2003) ambivalent

children maximise their reactions or overreact so as to ensure a parental response during times of distress as their parents are highly inconsistent. The last group consisted of children with an avoidant attachment style. These children resisted proximity to their mothers by looking or turning away for some time appeared distant towards them, as if they were strangers (Ainsworth & Bell, 1970).

The fourth pattern, disorganized attachment, was the last of the attachment patterns to be discovered. This is not truly regarded as an attachment strategy but is rather a lack of a strategy (Solomon & George, 2010). Children in this category were hard to classify in the organised category as they exhibited varied odd, mixed, conflicting and disorganised behaviours. These behaviours are disorganized in that they do not fit into the context of the environment (Hesse & Main, 2000). Newman and Stevenson (2008) observed that infants who were disorganized grew up to be very hostile and aggressive pre-schoolers.

One resounding concern about the subtly deterministic nature of attachment classification is the question of whether or not attachment can change. There is a common misconception that the infant's attachment to the mother at the age of one year is a precursor to consequent development and consequent to how one will relate to self and others (internal working models) and attach in future relationships. This suggests that, once a person/child is settled into an attachment style, he/she is predisposed to only relate to others according to that pattern of behaviour. Main (2000) argues that according to Ainsworth, there are opportunities for attachments to shift. This is because "stability of attachment classification during infancy depends, not surprisingly, on the stability of the infant's environment" (Hazan & Shaver, 1987, p. 70). This would explain how attachment styles can change towards other individuals in later life. This is not to say that the style which an individual had formed with the caregiver during infancy is done away with. Attachment patterns can continue into adulthood but they are not resistant to change (Hazan & Shaver, 1987).

There is much written on the effects of insecure attachments in the later development of children. This emphasises the importance of ensuring the development of a secure attachment relationship between mother and child as a child internalises early interactions with the mother (Bohlin, Eninger, Brocki & Thorell, 2012). A study by Eliot and Cornell (2009) revealed that children who were more prone to be bullies are predominantly those who are insecurely attached. These

children are often aggressive, hostile and antisocial and are in danger of becoming delinquent in future. Abela, Hankin, Haigh, Philp, Adams, Vinokuroff and Trayhern (2005) have found that there is a link between insecure attachment and the development of excessive reassurance seeking which leads to symptoms of depression in children between the of six to fourteen. Although studies show links between depression, aggressive and externalising behaviour and insecure attachment, there is not always a linear relationship between these and insecure attachment. The development of psychosocial and emotional problems is mediated by a number of factors and does not merely develop as a result of an insecure attachment.

Over the past few years attachment researchers have identified the important role that parental reflective function plays in the development of a secure attachment pattern in children. It is understood that mothers who hold their children in mind or who are able to metallise are more aware of their own feelings and thoughts and those of their children. The presence of parental reflective functioning is highly linked to mothers' high maternal sensitivity and their responsiveness and ability to mirror the child's affective state, which could explain the development of secure attachments between these mothers and their children (Tomlin, Strum & Koch, 2009). Reflective function is a mental function that underpins mentalisation. The literature reveals that the reflective function in mothers is important for the development of secure attachment. Postpartum depression, when the mother is not highly sensitive or responsive, has been found to have moderate to large adverse effects on the mother-child relationship which can lead to the development of insecure attachments and other subsequent developmental and behavioural problems (Beck, 1998; Wrate, Rooney, Thomas & Coz, 1985).

Fonagy, a pioneer in the field of reflective function, and his colleagues argue that reflective functioning begins to develop in early childhood between two and three years of age. When children develop the capacity to metallise they then develop the ability to interpret their own and other people's behaviours by attributing beliefs and feelings to these behaviours. The child can therefore respond to other people's behaviour as behaviours are made meaningful and predictable to the child. The development of reflective function is important in that it leads to the ability to organise one's own and others' behaviour and affect (Fonagy & Target, 1997). The importance of this mental function is best appreciated when it is absent in some individuals. Giannoni and Corradi (2006) give an account of an autistic individual who felt like an alien

amongst other people as she could not understand meaning, or identify with the mental states of others. As a result of this, children with autistic disorder cannot comprehend or respond to social cues (Kaplan & Sadock, 2007).

As has been mentioned above the presence of parental reflective function in mothers is strongly linked with a mother's high level of maternal sensitivity, leading to maternal responsiveness. Maternal responsiveness plays a vital role in the development of secure attachments. There is a need for short-term primary mother-infant interventions, such as the Baby Mat project, that aim to increase maternal sensitivity, responsiveness and reflective function in caregivers and consequently promote the development of secure attachments. Mothers need to learn the "ability to reflect beyond what is immediately known" (Capstick, 2008, p. 9). This implies that there are mothers who do not have the capacity to reflect on and understand the psychological state and behaviour of their children. The implications of this are that the mother cannot mirror back to the child his or her emotional state and in the future the child will consequently not develop the ability to hold the minds of others in minds. Mothers, therefore, through such short-term intervention, need to be given a space where they can talk and think about the psychological states of their children, moving from a concrete or physical understanding of these to a more abstract and psychological level of understanding (Capstick, 2008). Maternal sensitivity is not, of course, an exclusive factor to the development of a secure attachment, but it is a very important one (Wolff & van Ijzendoorn, 1997). Maternal responsiveness and deprivation have been identified in literature as playing an enormous role in influencing a child's emotional, social, linguistic and intellectual development (Rutter, 1981; Bornstein & Tamis-LeMonda, 1989; Tamis, LeMonda, Bronstein & Baumwell, 2001; Drake, Humenick, Amankwaa, Younger & Roux, 2007). According to Evans, Boxhull and Pinkava (2008), maternal responsiveness can be defined as a parent being "attuned to their children's emotional and instrumental needs" (p. 233). In further support of the argument presented here Drake, Humenick, Amankwaa, Younger and Roux (2007) state that "responsive and sensitive maternal interactions promote secure infant attachment" (p. 119). Mothers who are sensitive to their children's needs, and also continually respond to them are more likely to foster secure attachments between them, and their infants. This shows how much a mother's reaction towards her child influences attachment which is further said to influence a child's personality and intellectual development (Bowlby, 1969; Rutter, 1981). There are many predictors of maternal responsiveness. These predictors include,

amongst others, a mother's satisfaction with her life, the number of children she has and her self-esteem (Drake et al., 2007). It is important to have a grasp of the attachment theory and above-mentioned related concepts such as the reflective function these inform much of the parent-infant psychotherapy intervention practices which are covered next.

Parent-infant psychotherapy and its existence in South Africa

Parent-infant psychotherapy is a form of intervention that involves both therapists and parents reflecting on/thinking about what the parents tell the therapist in order to reach an understanding of what is really happening in the mother-infant relationship (Daws, 1999). This can be said to be true of the Baby Mat Project. Mothers often bring concrete problems or concerns about their babies to the therapists. An important function of such interventions is to help mothers develop a deeper understanding of presenting problems by reflecting or wondering about them. This encourages the development of mentalisation in mothers, to understand the emotional meaning of their babies' presenting problems (Frost, 2011). Parent-infant psychotherapy employs psychoanalytic mechanisms that were first developed by Freud (Acquarone, 2004). This form of psychotherapy is flexible as it can be adapted for either long or short-term therapy (Masur, 2009) and can be used in different forms such as with individual mother-infant dyads, as with the Baby Mat intervention or in a group format (Bain et. al., 2012).

Parent-infant psychotherapy is connected to a body of work that is drawn from a Public Health literature base. Interventions based on the Public Health model concern themselves with preventing or minimising relational risk factors which may exist within the mother-infant dyad that could lead to mental or emotional disorders and increasing protective factors (Albee & Gullotta, 1997). Like most Public Health interventions, the Baby Mat project seeks to address the whole population of mothers in Alexandra instead of only offering individual psychotherapy, which is often costly and slower in yielding results for such a large group of people (Albee, 2007). Parent-infant interventions also serve to decrease the incidence of mental and emotional disorders which develop as a result of poor attachment patterns. The Baby Mat mother-infant intervention offered at Alexandra Clinic is not the only intervention of its kind. There have been several of prevention programmes with similar goals, directed at intervening at the early stages of the formation of the mother-infant attachment bond, yet which are carried out differently.

Three of such programmes were pioneered by George Albee and his colleagues. The programme trials were implemented in Elmira, Memphis and Denver in the United States of America. Nurses were dispatched to visit large numbers of expectant mothers at their homes and it was hoped that building rapport with the mothers and showing empathy towards them, among other things, would alter the mothers' internal working models before the birth of the children so as to improve maternal and child functioning (Albee & Gullotta, 1997). In the South African context, though, and especially within poor urban areas such as Alexandra, there may not be enough resources to initiate and sustain such programmes. There are however similar programmes that exist within the South African context which also aim to intervene as early as possible between mother-infant dyads. This project can be said to be limited in that mothers only come to the Mat sessions once they have already given birth, instead of being seen before child birth. The Baby Mat Project is still relevant and helpful in its context in that it is situated within the Baby Wellness clinic where mothers bring their infant babies and young children for routine immunisation and weigh-ins. The mothers are therefore exposed to such an intervention early on in the child's life, instead of later on when the child is already in school and is exhibiting emotional or mental disorders. Intervening at this early stage of the mother-child bond can help in fostering foundations for healthy emotional development (Dugmore, 2011). It is also advantageous that nurses involved in such prevention programmes in the United States have the opportunity to see first-hand the living conditions of the mothers and to intervene not only in relation to the mother and infant but also related to the system to which they belong. The resources of this country and specifically of Alexandra Township allow for this type of intervention, and this is why it is advantageous to evaluate periodically the delivery and effectiveness of such interventions in order to identify early on points where improvement is necessary.

An advantage of parent-infant psychotherapy is that it is seen as important to intervene early in the infant-parent relationship and therefore has a considerable impact as not too much damage has occurred during development as the relationship is still forming. Parent-infant psychotherapy is increasingly being used in community settings and is adapted accordingly to accommodate the emotional needs of each community in which it is employed (Pozzi, 2007). Specific to the Baby Mat intervention, an interpreter had to be added during the various Mat sessions so as to accommodate mothers who could not communicate well in English. The introduction of an

interpreter led to an increase in the number of mothers approaching the therapists on the Mat (Frost, 2011). Statistics South Africa revealed that only 8.3 percent of the Black-African population over the age of 20 was educated beyond Grade 12 and 10.5 percent have no formal schooling (Statistics South Africa, 2012). These statistics which reveal the low levels of literacy in the South African context especially amongst the Black-African population, could account for the need of an interpreter on the Baby Mat.

Parent-infant psychotherapy is an intervention that targets the parent-infant dyad as the patient, as it is in this relationship that development and consequent mental health takes place (Paris, Spielman & Bolton, 2009; Acquarone, 2004; Baradon & Broughton, 2005; Masur, 2009; Galbally et al., 2006). Having the mother-infant relationship as the primary focus of treatment communicates the importance of recognising that infants and their caregivers influence each other enormously and that the parent's problems impact on the child just as the experience of the infant creates challenges for the parent. Within psychotherapy, the mother and the child are not treated in isolation, but both mother and child are addressed together so as to deal with the issues within the dyad more effectively. The practice of parent-infant psychotherapy understands that infants develop their physical and emotional regulation within the parent-infant dyad (Masur, 2009) and therefore seeks to "address the intergenerational repetitions to free the infant from the burden of the past and to prevent or repair derailed development" (Steele & Baradon, 2004, p. 287).

South Africa has seen the late introduction of parent-infant psychotherapy, possibly as a result of the political and professional isolation characterising the apartheid era (Dugmore, 2011). There has been an increased utilisation of parent-infant psychotherapy interventions in the South African context over the years (Berg, 2003). A prime example of this is the Baby Mat Project, a short-term infant-parent intervention adapted to be more useful in the South African context. Another intervention of this nature was run as a pilot study in Khayelisha, Cape Town. This context seems similar to that of Alexandra in that Khayelisha is densely populated and poverty-stricken (Cooper, Landman, Tomilnson, Swartz, Molteno & Murray, 2002). The objective of the pilot study was to identify whether the intervention could increase the maternal sensitivity of mothers in Khayelisha. The model of intervention was adapted from the Health Visitor Preventative Intervention Programme, and incorporated principles from the World Health

Organisation (1995) document (Cooper et al., 2002). The pilot study failed to yield any strong evidence in favour of the intervention's ability to increase maternal awareness, yet did reveal that mothers who had participated in the intervention showed a more positive quality of mother-infant engagement (Cooper, et al., 2002). Parent-infant psychotherapies are important in South African contexts, especially in places where poverty exists, and an infant's emotional needs are not a priority, and where mothers are the primary caregivers and often suffer in silence (Berg, 2003), such as Alexandra and Khayelisha and other such similar areas in South Africa. Such interventions are freely offered to the community and serve to support the mother.

Counter-transference in parent-infant psychotherapy

Before concluding this section on parent-infant psychotherapy, it is important to consider an important phenomenon in all forms of psychotherapy and its effect. Counter-transferential responses are salient and ubiquitous elements found within psychotherapy (Gabbard, 2004). It is understood that therapy in its various forms is relational as it involves both client and therapist interacting. Within therapeutic interactions the therapist may experience emotional or psychological reactions or responses towards a client or patient and this is better known as counter-transference (Lemma, 2003; Tansey & Burke, 1989). Over the decades, counter-transference has elicited mixed reactions from psychologists as there seems to be no one definition, understanding or opinion of this phenomenon. (Rusbridger, 2002; Giovacchini, 1989; Holmes, 2005).

When reviewing the literature it also became evident that there is a consensus about the birth of the concept. Freud is seen as the originator of the concept as it is in his work that the idea of the therapist's counter-transference first appeared (Racker, 2007). Yet is it is interesting to know that in all his complete works Freud only mentioned the concept of therapist counter-transference five times (Holmes, 2005). It would seem that the frequency with which Freud mentioned this concept is insignificant compared to the strong opinions he held about it, which greatly influenced how it was received and understood in his times and even in contemporary days. Holmes (2005) goes on to mention that upon his review of the literature the concept of counter-transference has been given much less consideration than its counterpart transference. He understands this to be due to the fact that the therapist is often considered to be more objective than the client and that focus of therapy is on the client and her problems and not really on

therapists. Holmes' (2005) understanding of why counter-transference seems less popular than transference in the literature, though now encountering some growing interest in recent years, reflects Freud's understanding of counter-transference. When first discussing this concept Freud already had what could be seen as a negative view of the phenomenon of counter-transference. Freud (1910; 1912a) deplored counter-transference in psychoanalysts insisting that therapists were to remain 'mirrors' or 'blank slates' to be used by their clients but never themselves to show any affect in the therapy towards the client. He felt that therapists who did develop a counter-transference reaction towards to their patients were in danger of disturbing the psychoanalysis. They therefore needed to undergo more thorough psychoanalysis themselves, as Freud understood the emergence of the counter-transference reaction to be the unresolved unconscious feelings of the therapist. Giovacchini (1989) critiques Freud's conviction of how the therapist should behave with her clients. He mentions that having to act as a mirror is a pose that the therapist has to put on from day to day, and that consequently they have to pay a heavy price for this as they come to view psychoanalysis as difficult or even impossible as any frailty in the therapist is frowned upon. Ever since Freud's initial understanding of counter-transference other writers have come forth with their own views of counter-transference which are sometimes contrary to those of Freud. Carnochan (2001) contrasts the objective perspective, which is consistent with Freud's thoughts about counter-transference, with the constructivist perspective which differs from the former. The difference is that within the constructivist perspective, contrary to the objective perspective, the nature of being is seen as relational, thus allowing for the therapist's affects to be understood as "an inescapable human form of judgment" and "a source of knowledge" (Carnochan, 2001, p. 16). In addition he asserts that the consequence of accepting this constructivist perspective rather than the objective perspective is that one admits that the therapist is subjective and not purely objective.

As can be seen from above, there are mainly two broadly held understandings of counter-transference found within the literature (Racker, 2007; Lemma, 2003; Gabbard, 2004). Some idea held about counter-transference reactions is that they "may interfere with our understanding of the client" (Lemma, 2003, p. 236), can "cloud judgment" (Carnochan, 2001), or may be understood as unresolved conscious feelings of the therapist (Freud, 1910). These understandings of counter-transference reactions by therapists constitute a negative idea of counter-transference and support its disruptiveness in the therapeutic process. On the other hand counter-transference

responses are viewed as a potentially useful therapeutic tool in understanding the client's experience (Holmes, 2005; Racker, 2007) and as a way to "inform interpretive understanding" (Gabbard, 2004). In his book *Long-Term Psychodynamic Psychotherapy* Gabbard (2004) comments on how the therapist's transference is sometimes parallel to that of the client's transference and can be used to gain an in-depth understanding of the client's experience of the world to the therapist. This may then lead to the therapist interpreting this affect back to the client, at the appropriate time during the course of the therapy. A danger in accepting the former perspective on counter-transference reactions and rejecting the latter could be that the therapy never moves from a one-person therapy to a two-person therapy (Gabbard, 2004), where the therapist and client relate as a dyad. Instead the therapist is emotionally removed from the therapy and this may leave the client feeling unimportant to the therapist. This would then seem to point to the latter as a solution in that the therapist admits that he/she is not all objective but that his/her also bring in their own subjective view of issues which may influence the way they are in therapy with their clients. This latter idea about therapy also allows for the therapist to use her counter-transference responses as a means of better understanding the client at a seemingly more unconscious level. There are, however, pitfalls in adopting the latter stance to counter-transference reactions. Lemma (2003) proposes that counter-transference reactions may be wholly attributed to the client and therefore used as a way of excusing the therapist's own unresolved issues. Therapists need to follow Freud's advice in this sense and seek to resolve these issues through the use of their own personal therapy. Gabbard (2004) and Little (1951) therefore suggest the importance of the therapist's self-disclosure about his/her feelings to the client and to explore these with the client. Gabbard (2004) goes on to comment on how self-disclosure can also be therapeutic to the therapist and that not all counter-transference feelings should be disclosed to the client. It seems, then, that there is some merit in both arguments for and against the place of counter-transference within long-term psychoanalytic therapy. Completely discarding the one and accepting the other does not seem appropriate but rather it would be advantageous always to hold in mind that both views of counter-transference affect can be present at different times within the same therapeutic process with one client. A therapist should be aware of this possibility so as to avoid falling prey to the pitfalls of attached to either of the counter-transference responses.

Along with the split in the understanding of the concept of counter-transference as either good or bad, there also exist varied definitions about this concept. For Giovacchini (1989) counter-transference either homogenous reactions or idiosyncratic responses with the former being those "…general ways of reacting to things…" (p. 20), and the latter being individual reactions which are different from the ways in which other therapists would generally respond. He argues that both these types of reactions are present within therapy and that there are therefore counter-transferential elements in all therapists' responses. Similarly, Racker (2007) understands counter-transference to be "the totality of the analyst's psychological response to the patient" (p. 735). Empathy is seen as part of counter-transference reactions, which are better known as positive counter-transference (Racker, 2007) or normal counter-transference (Holmes, 2005).

Related to counter-transference phenomenon is what is known as projective identification. Projective identification can be understood as either being a defence, as being adaptive or as being a means of communication and as taking place interpersonally (Tansey & Burke, 1989). In defining this concept the literature suggests that it is seen as one person, the subject, disposing of his/her unwanted or unbearable feeing into another which is the object and which the object later feels as not belonging to him/herself and then treating the object according to the projection (Holmes, 2005; Lemma, 3003; Schoenewolf, 1993; Tansey & Burke, 1989). The danger at this point, Schoenewolf (1993) goes on to explain, is that, should the therapist be untrained in recognising these projections into him/herself he/she will act them out. Projecting into the client undesirable feelings is not where the process of projective identification ends, but as Tansey and Burke (1989) show, the object (or the therapist within a therapeutic setting) processes this disposed feeling and projects it back for the client to re-introject in a more manageable form. What is given back to the projector, as Lemma (2003) states, is not the same as what was originally deposited into the therapist, yet it is "altered by our own personal experiences and phantasies" (p. 235). Projective identification is important within the field of psychology as, just as with the wider concept of counter-transference, it is widely recognised as being a means of the client communicating to the therapist unconscious thoughts and feelings.

In concluding this section it is clear that the infant's attachment to the caregiver is an important bond as it sets the tone for the child's way of being in the world and his/her relation with others. It can however be difficult for mothers to form healthy attachment bonds with their children as

there are other factors competing for their attention such as poverty and unemployment. It is thus important that exist interventions within the South African context exist such as the Baby Mat project which focus on helping mothers be the best mothers they can be. These interventions have as their foundation parent-infant psychotherapy theory which encourages mothers to mentalise and develop the capacity for reflective functioning and maternal sensitivity. These interventions are, however, scarce within the South African context, yet their role is an important one. Practitioners who facilitate these interventions can be subject to counter-tranference feelings which are evoked by the mothers who access the Mat intervention. Different reactions can be manifested by different therapists according to their individual world views. It is important to acknowledge that therapists are not blank slates but that they also experience counter-transference feelings. This is useful in that, when these are recognised within the therapist, they can be used as a tool to facilitate rather than to hinder the therapy. The next section will focus on the methods that were used in conducting the current study.

CHAPTER THREE: METHODOLOGY

Research Questions

The research questions listed below were used to inform the semi-structured interview schedules for both participant groups.

1. How do mothers subjectively experience the Baby Mat intervention?
2. How do the therapists subjectively experience the Baby Mat intervention?
3. How are the perceptions of the mothers and therapists similar or different?

Research approach

According to McMillan and Shumacher (1993), qualitative research is "primarily an inductive process of organising data into categories and identifying patterns (relationships) among categories" (p. 479). Qualitative research is not pre-emptive but is exploratory in nature and seeks to discover what the data will reveal. Open-ended questions in the form of semi-structured interviews were often utilised in this study. Qualitative research seeks to build a holistic and narrative description of a social or cultural phenomenon. When collecting data in a qualitative method, the data needs to be naturalistic. This can be challenging, for qualitative methods of collection as recorded (audio or video) interviews have to be transcribed, meaning that the non-verbal communication can be lost. The qualitative research method concerns itself with minimising data reduction. This implies that the researcher should ensure that the words of the interviewees are changed as little as possible. Reduction can only begin at the data analysis stage (Willig, 2008). To adhere to this the researcher made notes after each interview regarding non-verbal information so as to add context to the transcribed interview of the participants.

An aim of this research was to explore the perceptions and subjective experiences of both mothers and therapists using and offering the Baby Mat intervention. This required in-depth engagements with the participants in order to gain an understanding of their subjective experiences. This research study used a qualitative research design to approach and inform the researcher's understanding of the phenomenon that was studied. In analysing the data, thematic analysis as described by Braun and Clarke (2006) was used to help in analysing and reporting themes that emerged within the data.

There has been an increased interest in programme evaluation within the social sciences (Owen & Rogers, 1999; Royse, Thyer & Padgett, 2010). Programmes refer to services or interventions or planned activities that are meant to serve the purpose of affecting those who experience the interventions in the chosen area of focus (Royse, Thyer & Padgett, 2010). The current study is a formative and process evaluation of the Baby Mat intervention, which is a community-based intervention, aimed at influencing mother-infant dyad attachment relations. Evaluations on programmes are undertaken in order to investigate systematically the progress of a programme (Joint Committee on Standards for Educational Evaluation, Sanders and Associations of School Administrators, 1994) so as to guide those administering the programmes on whether the intervention is achieving its goals, whether those who are accessing the service are benefiting from the intervention, and to identify where the intervention can be amended so as to improve interventions (Royse, Thyer & Padgett, 2010). The current study partly sought to address this task. Some of the questions in the interview schedules elicited the participants' perceptions of the intervention and these could be used by the project's management to better grasp what the project meant to those offering the service and to those accessing the service. The results of this study could also have implications and recommendations that could be implemented in the future running of the programme.

Sampling

The sample consisted of seven mother participants and two therapist participants. Sample sizes for qualitative research studies tend to be small in number. The reason for this lies in the fact that conducting qualitative interviews and analysing the data for findings is both labour intensive and time consuming (Willig, 2008). The one half of the sample consisted of mothers who brought their infants to attend the primary health care clinic for routine weigh-ins and immunisation. The clinic is opened for immunisation on Thursdays and the Baby Mat sessions run concurrently with the immunisation. The majority of the mother-infant dyads resided in Alexandra Township, while others may be from surrounding areas. The mothers who attended the Baby Mat sessions were self-referred. These mothers were black and varied in their ethnicity. The participants' ages were varied, with the youngest participant who was interviewed being 21 years of age. All of the participants who brought children to the therapists on the Mat were the children's biological mothers and none were relatives.

This study included individuals who could communicate in English so as to make communication between researcher and participant easier to avoid any language limitations. Another important reason for conducting the interviews in English was that, although the researcher could communicate in other African languages, much of the richness and meaning of the data would have been lost in the translation of the interviews and this would have compromised the data. The researcher then interpreted what the participant had said as accurately as possible so as to not lose the essence of what was said. The second half of the sample consisted of the two therapists who facilitated sessions with the mothers who had attended the Baby Mat intervention and had agreed to participate. The interviews with the therapists were conducted in English as both participants were comfortable with this. The therapist participants, as with the mother participants, were interviewed separately so as to ensure complete expression of their subjective views.

A non-probability purposive sampling technique was used. In purposive sampling there is no random selection of cases from the population as may be the case in other types of sampling techniques. The population in this study consisted of the mothers from Alexandra and other surrounding areas who brought their children to the baby clinic to be immunised. The subjects freely volunteered as they were approached and invited by the researcher according to how they fitted the sample criteria. The sample was therefore composed of subjects who had been selected for a certain purpose (Subong, 2005).

At this point, it is important to mention the sampling criteria. Sampling criteria are usually defined in inclusionary terms. The researcher decided on the cases to select based on explicitly stated criteria (Lindlof & Taylor, 2010) and the participants approached gave their consent to being part of the study. The sample consisted of mothers above the age of 18 years, with the youngest being 21 years of age, who resided in Alexandra Township, either stay at home mothers or working class mothers, whether biological mothers or caregivers, and who had brought their babies to be immunised at Alex clinic. The mothers had all used the Baby Mat service at least once and were able to communicate in English. The sample also consisted of the therapists who worked on the Mat intervention with those mothers who had agreed to participate. The mothers' transcripts were matched with the therapists' transcripts which had facilitated their

Baby Mat sessions. This was done so as to be able to explore the similarities and differences between experiences by the two individuals groups of the Baby Mat sessions.

The sample consisted of two groups. One group was made up of mothers who had previously accessed the Mat intervention for at least one session, and the other of those therapists who has seen the mothers on the Mat for sessions. Seven mothers were chosen for the study and interviews were conducted until a saturation point was reached, meaning that there were no longer any new concepts that could be derived from the interviews (Lasch, Marquis, Vigneux, Abetz, Arnould, Bayliss, Craword & Rosa, 2010). The second group of participants consisted of two therapists who had conducted short-term psychotherapy on the Mat space with the mothers who had been interviewed. The same two therapists work on the project every Thursday and were therefore interviewed more than once. There was a minimum of seven interviews conducted with the therapists, as with the mothers. This means that both therapists were interviewed more than once.

Procedure and Interviews

The interviews were conducted with those mothers who had accessed the Baby Mat intervention and the therapists who offered the Baby Mat service at Alexandra Clinic. The Baby Mat sessions lasted for approximately 20 minutes for each mother-infant couple and mothers usually had once off contact with the therapist and co-therapist. Included in this sample group were mothers who were returning to the therapists who offered short-term parent-infant psychotherapy for more than one session. Interviewing those mothers who had accessed the Mat service only once might have been a disadvantage in that there could have been a limit in the amount of data generated in interviews. This was not necessarily the case. In general the mothers are mostly only seen once and the purpose of this study was to explore whether a once-off contact on the Mat intervention had any impact in influencing the mothers' view of themselves and the way they related to their babies. The data that was collected was seen as being relevant in answering the research questions. Permission was sought from the Alexandra Health Care Clinic management who allowed the researcher to attain access to the participant group and use their premises for the interviews as per ethical clearance granted by the Human Research Ethics Committee (HREC – Medical). Permission was sought from the management of the Ububele Baby Mat Project firstly to observe some sessions taking place while mothers and therapists were on the Mat, to access

the mother-infant dyads that used their services and for the researcher to interview the therapists who facilitated the Mat sessions for the mother participants. Beginning from the second sit-in, the researcher approached mothers who had received sessions from the therapists working on the Baby Mat intervention and invited them to participate in the study. The therapists offering sessions informed potential participants after their sessions, before leaving the Baby Mat area, about this study and when any of the mothers showed interest the therapists would indicate this to the researcher. Mothers were approached and the information sheet detailing the aims and process of the study was given to them and the study was explained after which they had an opportunity to decide whether they would participate in the study or not. Those who agreed to participate were given interview and audio-recording consent forms which they signed. Interviews with the mothers were conducted at the premises of Alexandra clinic on Thursdays after the mothers went off the Mat area, so as to avoid having to ask the mothers to return on another day which might have involved extra costs.

Both or one of the therapists who had had sessions with the mother participants who had participated on the Baby Mat project were also asked to participate in the study as their experiences of the therapy sessions were also important to the research. These interviews were conducted the following day at the Ububele premises. This was because the therapists and the researcher had prior commitments straight after the Baby Mat intervention time frame. A minimum of 10 interviews were conducted, three of which were pilot interviews. Pilot interviews, one with a mother and two with the therapists which were in the session with the mother, was conducted so as to ascertain whether there were areas that the researcher had not covered in the interview or needed to improve on. These pilot interviews were included when analysing data. The interviews lasted approximately 20 minutes. The researcher made notes after each interview as a way of noting important non-verbal data. Taking notes also allowed for the recording of important counter-transference information for reflexivity purposes.

Semi-structured interviews are well known for the flexibility they afford, not only to the interviewer, but also the interviewee in that interviewees are given the freedom to answer in an unrestricted yet guided manner (Morse & Field, 1995). What is meant by this is that questions are asked in such a way that interviewees are not restricted to yes or no or rather close ended answers. This was possible as semi-structured interviews consisted of predetermined open-ended

questions which allowed for a large degree of exploration. These guided the interview around specific themes but also allowed for the exploration of other points of interests to the interviewer that arose during the interview with the use of prompts (Schensul, Schensul & LeCompte, 1999). This study used semi-structured interviews so as to benefit from the use of open-ended questions that allowed for free expression. Semi-structured interview schedules of the mother and therapist participants are attached as Appendix A. The interview schedules were both developed by examining the aims of the study and literature. The questions posed in the interview schedules were based on the theory of reflective function as it required the mother participants to think about their relationship with their children before and after their sessions with the Baby Mat therapists, while the second interview schedule required the therapists to reflect on their experiences of the Baby Mat intervention and the mothers who had accessed the Baby Mat service. It was essential that the interviews be recorded so as to transcribe and analyse them at a later stage. Participants were informed of this and asked to sign audio-recording consent forms.

Data analysis: Thematic content analysis

Thematic analysis was used to analyse the transcribed interviews. This method was used because it was useful in "identifying, analysing and reporting patterns (themes) within data" (Braun & Clarke, 2006, p. 79). Thematic content analysis therefore went beyond just retelling the stories of participants but was used to look for patterns of similarities and differences between the subjective accounts of the participants. This mode of analysis allowed the researcher not only to simply report the experiences of participants but also to comment on how realities and meanings in the participants' lives impacted on and influenced the reported experiences of participants. Instead of seeking to report one aspect that might have emerged from the current research, a rich thematic description of the data set has been provided so as to highlight the overall emerging themes (Braun & Clarke, 2006). An inductive approach or 'bottom up' manner was used in identifying the themes as found in the analysis section of this study. The researcher thus I played an active role in the process of 'discovering' and including themes that are of interest to the current research (Braun & Clarke, 2006). The themes were identified primarily on the latent level. There was a progression from the semantic, which includes merely describing and presenting the themes, to the latent level, which includes interpreting the themes and trying to see beyond what is merely said (Braun & Clarke, 2006).

In the current research, the six phase step-by-step guide of Braun and Clarke (2006) to doing thematic analysis was employed: familiarising oneself with the data, getting initial codes, searching for themes, reviewing themes, defining and naming themes, and producing the report. There were the six steps which this study employed when analysing the data. In the first phase I familiarised myself with the data. It seemed advantageous to collect my own data as it allowed for a prior knowledge of the data before analysing it. It also allowed for the collection of important non-verbal data e.g. how the mother or therapist said certain things. It was of great importance that I was familiar with the content of the data. I then conducted the interviews personally which meant being exposed to the data so as to start identifying patterns before analysing began. This phase also involved reading and rereading the data as this helped in searching for themes. Before I could read the data, it had to be transcribed verbatim. Transcribing one's own data is also a good way of familiarising oneself with the data.

The second phase, generating initial codes, involved generating a list of codes. These codes "identify a feature of the data (semantic content or latent) that appears interesting to the analyst" (Braun & Clarke, 206, p. 88). Organising raw data into codes helped me to understand the data in a more meaningful way. Data can be coded manually or by computer programme. The data of the current study was coded manually as only a small number of transcripts were included. Various ways can be used to code data manually. One of the ways, which was used in this study, was to use highlighters or coloured pens to track possible patterns. As many codes as possible were identified so as to include what might be of interest at a later stage.

The third phase, searching for themes, required that I organize the existing codes and sort them into themes, which are broader than codes. Initially there were several possible themes and sub-themes which were later refined, reduced and sometimes increased as further analysis was conducted. This marked the beginning of the fourth phase. This phase consists of two levels, internal homogeneity and external heterogeneity. Internal hegemony is when the coded data within the themes fit together. This was done by means of reviewing the coded data to ensure that it formed a coherent pattern within a theme. If this was not the case, then some parts of the data were not included, or the theme was re-worded in order to accommodate the data. At the second level, I looked at each individual theme and assessed its validity in relation to the whole

data set so as to see if they reflected the meaning in the data set. This process involved looking at the data set again and identifying new codes that had been overlooked.

After finding the themes and making sure that they were internally homogenous and externally heterogeneous, I then moved on to the next phase, phase five. This phase involved naming the themes which had been identified in the previous phase and also included further refining of the themes. During the refining process it was important to capture the essence of each theme and be able to sum it up in a few sentences. It was essential at this point to make sure that the identified themes were not simply paraphrasing the words of the participants but that they convey the meaning, of and interest in, the themes. I also checked to ensure that there were not too many overlaps between the themes and, when this was the case, much thought was given to deciding as to whether the themes should be merged. Three overarching themes were identified by the end of this step together with a number of subthemes under each major theme.

The final stage involved producing the final report. At this point the final analysis was found to be logical, coherent and non-repetitive. Themes are accompanied by extracts from the data that capture what the themes are about and that support the themes. The analysis attempted to go beyond just describing the data, but further sought to make an argument for the themes formulated.

Qualitative methods have in the past not been afforded the status of being scientific or empirical and have been regarded as being less objective than quantitative methods (Jessor, 1996). There has been a concern about the generalisability or validity of qualitative methods as they heavily rely on subjective human experiences and primarily on the researcher as a non-objective tool to interpret the data collected (Elliot, 1999; Jessor, 1996). This is an issue in that researchers are human themselves and may be influenced by their own biases when collecting or interpreting data. Over the past years there has been a move towards assessing the quality of qualitative methods of research (Kopala & Suzuk, 1999). Qualitative research cannot be subjected to the same measures of quality that are used for quantitative research such as credibility, validity and, generalisability, as this might sacrifice its relevance (Krefting, 1991). Instead qualitative equivalents of quantitative measures of quality or rather ‘parallel criteria’ have been devised (Kopala & Suzuk, 1999).

Lincoln and Guba (1985) have identified four key aspects of trustworthiness that can be said to be relevant in the case of both qualitative and quantitative research. The first criterion, truth value, assesses whether the researcher is confident concerning the truth of the findings in his study. Truth value in qualitative research is said to be subject-orientated and involves the discovery of human experiences as they are lived and experienced by participants. In quantitative research, truth value is captured in the concept of internal validity, while in qualitative research it is known as credibility. There was sufficient engagement in the data by the researcher in order to identify and verify themes. To obtain even further truth value, direct quotations were included in order to increase confidence in the credibility of the reported themes. Applicability refers to the degree to which the results of studies can be generalised to other contexts or other groups of people, i.e. from the sample population to the larger populations (Lincoln & Guba, 1985). For a study to have applicability its results should have the ability to be generalised to other contexts. In order to reduce biases and subjectivity and increase objectivity and applicability to a wider context the study was subject to the supervision process. This strategy allowed for an outside and unbiased view and opinion and also served to confirm the findings of the study. Lincoln and Guba (1985) included consistency as the third criterion in their model. This criterion requires that research be consistent in that if conducted again by a different researcher on a differ sample results should not significantly differ from each other. This is more possible when applied to quantitative research, better known as reliability. To achieve this, both data and investigator triangulation were employed as a tool in this study. In addition, the questionnaires were repeatedly assessed to ensure that they were clear when read to the participants, therefore ensuring that they measured what they were meant to measure. Equivalent to this, qualitative research should be dependable, which would indicate that the findings of a research study are consistent and could be repeated. The last criterion for the establishment of trustworthy qualitative research is neutrality, which refers to the research procedure and results being free any bias on the part of the researcher (Lincoln & Guba, 1985). This criterion is known as objectivity in quantitative research and confirmability in qualitative research. In order to ensure the neutrality the results of the study were drawn from the data collected and not influenced by the biases of the researcher. External personnel were involved in assessing and confirming the authenticity of the results so as to increase neutrality. It can then be said that the current study is trustworthy.

Ethical considerations

This research did not harm the participants in any way. Participants were informed that they were allowed to withdraw from the study at any point and that there would be no negative consequences for participants who might have chosen to withdraw. Participants voluntarily participated in the study after its aims and intents had been explained to them to their satisfaction. Informed consent for the interviews and audio-recording was sought. Participants were debriefed at the end of the interviews and expressed no real distress caused by the interview. They were however given counselling referrals should they need to speak to a professional. Participants were referred to Ububele for counselling.

Upon concluding the study, a one page summary of the findings will be sent to the management of Alexandra clinic. The mother participants were also given an opportunity to receive summaries of the study yet they declined. A full report will be given to the management of the Baby Mat Project. Participants were assured that, although anonymity could not be granted within the interviews (since the researcher could see those whom she was interviewing) they were guaranteed anonymity thereafter and in the research report, along with confidentiality. Care was taken so as to not include any identifying information in the research report. Pseudonyms were used and identifying information was changed so as to protect anonymity. The data which was collected along with the transcripts was stored electronically under a password protected folder to ensure that only the researcher and supervisor have access to it. The data will be destroyed within two years should publication occur or it will be destroyed after five years should publication not happen.

It is considered a breach of confidentiality for therapists to share confidential information conveyed to them by their clients to others. To counter this, the researcher asked permission from the mother participants to interview the therapists whom they were with during sessions. This was also included in the participant information sheet. It was explained to the mothers that any confidential information that they had volunteered to the therapist would be kept confidential.

CHAPTER 4: RESULTS

The data collected in the form of semi-structured interviews was analysed using thematic analysis. The themes which are presented in this section were derived from an inductive process guided by the research questions. From this process three overarching themes were discovered. The themes were: i) the mothers' subjective experiences of the Baby Mat intervention; ii) therapists' subjective experiences of the Baby Mat intervention; and lastly iii) the similarities and differences between mothers' and therapists' subjective experiences of the Baby Mat sessions. The three themes will be discussed in the above-mentioned order. These three overarching themes were further divided into sub-themes as will be seen below.

MOTHERS' SUBJECTIVE EXPERIENCES OF THE BABY MAT INTERVENTION

Overall the mothers who were interviewed in relation to their experiences of the Baby Mat[1] intervention stated that it was a positive experience for both themselves as individuals and for their relationships with their children. Some mothers described their experience of the Mat intervention as "fun", "nice" and helpful". Although all the mother participants' responses concerning their experiences of the Mat intervention were positive, the ways in which they described this to the interviewer were diverse, owing to the individuality of the mother participants. The mother participants, moreover, expressed some thoughts about their experience of the therapists had been were interacting with them on the Mat space. Furthermore, in this section of the analysis the responses the mothers gave regarding their expectations of the Mat service and what their actual experience of the intervention was will be recorded. Before moving onto the second overarching theme, this theme also explores the reasons why some participants have returned to the Mat area for further sessions along with their perceived therapeutic progression before and after accessing the services of intervention.

Mothers' perceptions of the intervention

The researcher has, as far as possible, kept the original words of the participants in order to retain the spirit of the various interviews.

[1] 'The Mat' is a term often used by the therapists who work on the Baby Mat Project to refer to the Baby Mat intervention. This way of referring to the Baby Mat intervention has been retained throughout the study.

"I loved talking you know, releasing": A space to talk openly

A consistent response from the mothers with reference to their experience of the intervention was that they appreciated the space the therapists on the Mat offered them to talk about and discuss whatever they needed to with someone in whom they felt they could trust. Veronica's description of her Mat experience captures much of what the rest of the mothers seemed to have been left feeling after accessing the Mat intervention: "I loved talking you know, releasing, releasing everything, talking about things that I don't talk about with other people, jah that was very nice." She also added that, before having had her first session, she was often reluctant to share some personal details about herself and her life with other people, especially strangers or people she was not used to. One thing in particular which she was even surprised about sharing during her Mat session and during the interview was that both her parents had passed away and that she had broken up with the father of her child, leaving her with little support, especially during a period she felt to be hard since she was a mother for the first time. She spoke about how she still yearned for the presence of her mother in her life to guide her through being a mother and to share her problems with. She was therefore grateful that she had opened up to the therapists on the Mat space and talked about things that matter to her. It seems possible that for this mother the (female) therapists offering the Baby Mat service might have assumed, in her mind, a certain maternal or motherly role which seemed absent in her life currently. The idea of perceiving the therapists as maternal figures appeared to have allowed Veronica to be at ease with the therapists and entrust them with her fears, concerns and cares regarding her current circumstances. It is also interesting that although the therapists offering on the Baby Mat intervention could not give any material things to Veronica, such as money perhaps to ease her financial burdens, she still left the Mat space grateful and feeling that she had been held and contained after speaking to the therapists.

Samantha, on the other hand, shared with the researcher that she had no friends at the time of the interview and that she lived only with her aunt. She felt she could not open up to this aunt who was still angry with Samantha as she had fallen pregnant at what she believed to be a young age. Samantha expressed similar sentiments as Veronica: "Well it felt like not everything was lifted off me but that I felt like, like (sighs) I talked to someone." It seems an important role the therapists on the Mat play for some mothers is to allow for them the space initially to open up

and vent about their current or past experiences or anxieties about the future. This seems to allow the mothers to leave the Mat space with a sense of them having shed a certain burden which was proving to be hard to carry on their own. Considering the above-mentioned thought of the idea of the Mat sessions as a space to talk openly it is then no wonder that Petunia shared this about her experience of the intervention: "Jah my experience of being on the Mat was helping because sometimes there is a time when you need to talk to somebody. It's healing a lot jah. Jah, when I am on the Mat I have a problem with my baby so when I speak about my experience and what happened it is healing me a lot, jah.". It is an important notion to hold onto, that having this experience as patients during the Mat sessions seems to bring about for them an emotionally containing experience.

In trying perhaps to understand what might have further contributed to the participants' high opinion of the Mat service, it is clear that they were treated differently by the therapists who offered the Mat service than they were by other strangers. Some participants admitted that it was difficult for them at first to bring some of their concerns and problems to the fore as the therapists were strangers to them, yet they shared how they felt a sense of relief once they were able to open up in that space. Veronica, for example, admitted that at first "it wasn't easy" for her to share her feelings and problems on the therapists on the Mat but after some time of having been in the session she felt as if she could.

What appeared to be related to the mother's ability to talk and share feelings and problems with the therapists who ran the intervention was the feeling that the sessions were a safe space as Judy's statement reveals: "When I am there it is like I am talking to a sister or someone close to me, I feel safe. I feel safe as if I am talking to someone who is close to me whom I can share with and receive a proper answer, not someone who will tell me the wrong answer or mislead me you see." It is important for even this short-term therapeutic process for a trusting relationship between mother and therapists to be established as it appears to allow for a close and meaningful bond or connection between mother and therapists, which then allows for the mothers to express their concerns more freely to the therapists and also more trustingly receive what the therapists had to say in response. Andrea felt that "If you have a friend sometimes you have a friend and you tell your friend something and if you go there to the Mat, it's only them that know your life. If you break down with your friend they will say, 'you know Andrea is so so so!'" The idea that

the Mat sessions are confidential allows mothers to feel that they can talk openly to the therapists as Betty expressed: “I am free when I talk to them.”

Also related to the ability of the mothers to talk openly during on the Mat sessions is the feeling of not being judged when sharing with the therapists their difficulties and concerns. Petunia particularly expressed that “sometimes it’s difficult to speak with people you know some may react in another way so I just like to speak to them like I sit on the Mat it is lovely.” It seems possible that some participants anticipated some judgment from the therapists offering the sessions as this is what they might have usually met with in their everyday lives. It was therefore comforting for mothers to realise that this was not the case and this allowed the participants to be more open when addressing the two strangers offering the service, who by the end of the sessions were felt to have grown to become more close to them.

For some mothers the Mat intervention served as a source of support as Veronica puts it: “Yes, extra support! Like my grandmother and aunt are there for me at times, they help me. But you know sometimes you just need support.” This participant’s mother died shortly before her child was born. She does value having other maternal figures in her life to support her in her role as a young mother, but would have loved to have that special support from her mother still. Some mothers seem to have used the Mat intervention as an extra space for support amongst other support systems they may have established yet for some participants the Mat intervention was the only place for them to find support. This has been Samantha’s experience: “Actually I’m not a, I don’t know like, I’m not a friendly person I didn’t have friends and I actually live with my aunt and well she doesn’t talk to me because she’s angry that I had a baby when I was young and stuff. It’s kinda hard.” This participant does not currently have maternal support, or any other kind of support, available to her as she added that she not only lacks a relationship with her aunt or other family members, but also does not have a relationship with the father of her child. She said: “Jah actually I told them that like [child’s name]’s father he’s not supportive and then like growing up problems and then they [Baby Mat therapists] said that like they can help.” Both participants were referred for further therapy at the Ububele offices. It appears that the Mat services serves an important function for some mothers in that it is a space not only for those mothers seeking extra help from professionals, but also those who barely have support in their

day to day lives. This is important for mothers who fall within the latter group as they find a special place where they can safely voice their concerns to someone else.

"Find a solution to my problems": Receiving answers

Most participants expressed that they had expected to receive answers to their questions and some relief from their worries about their babies and the conditions that sometimes plague them by going onto the Mat. An example of such a participant was Andrea who had approached the Mat intervention to find answers about how to raise her second child. She had some questions and concerns to the therapist as she had told the researcher that it was the first time that she was raising a child as her first-born child had been raised by her mother. This mother had approached the Baby Mat therapists to receive advice regarding whether or not she should inform her first-born son that she was his real mother. She said: "You know to be there I like when I… When I went to a person asking for something she must give me a nice answer you know jah…" Andrea's quotation reveals that she had indeed expected to receive some direct answers from the therapists. Later in the interview Andrea further expressed that the therapists taught her a number of things related to child development during her session. She stated: "It's nice uh they teach us to take care of our kids. If your kid doesn't sit they teach him how to sit, everything. I'm very appreciative of the Mat." It was interesting to see from the data that some mothers merely accessed the Mat service so as to ask questions and receive direct answers as was customary with doctors and nurses, yet during their sessions found something other than direct answers, such as talking which was helpful in allowing the mothers to express how they felt and ended up leaving the Mat space with a feeling of relief.

One participant felt that she had received a useful solution which would help with a concern she had. This participant was worried as her daughter was not eating to her satisfaction and had reported this to the therapists. Eunice felt that the Mat was "…really helpful because I think they understand children so the problem I came with and they were able to help me because my child doesn't eat well. My child doesn't eat so they gave me one helpful thing. Like she doesn't eat veggies so I should mix her favourite food, which are yoghurt or Purity apple, and put [the vegetables] inside so that she will eat."

"There is nothing I dislike about the Mat intervention": The negative side of the intervention

Most participants expressed only positive experiences of the Mat, reporting that there was nothing they disliked about the Baby Mat intervention. When asked about what she disliked about the Mat intervention Betty simply said "Nothing." Judy responded saying "I can't say I've seen something I don't like. Well on my side there is nothing wrong that I have seen so far." Another participant said, after a silent pause: "Hmmm I don't know. There is nothing I dislike about the Mat." It is interesting that although some participants did not receive what they had expected, they still felt that there was nothing negative they had identified about their Mat experiences. It seems that what the mothers individually received, which was somewhat different from what they had expected, as will be demonstrated later, was new and profound for them in that they ended up having a good experience during their sessions despite their different expectations.

There were, however, two participants who mentioned one similar disadvantage regarding the Baby Mat service, although they had stated that they enjoyed attending the sessions. When asked what she disliked about the intervention Veronica said: "Honestly I don't know. I loved every moment about it I don't want to lie to you. I just enjoyed and just wished it could not stop but just carry on and on until I say stop. But unfortunately it's not like that." In similar words Samantha responded saying: "There was nothing to hate about being there. Well maybe it's because the time was short but I enjoyed being on the Mat actually." The time limit of the sessions appears too short for some participants as they expressed a desire to have longer sessions.

Mothers' perception of the therapists on the Mat intervention

"Fine… kind… sweet… understanding": Perceptions of therapists

All the participants who were interviewed insisted that they were satisfied and seemed content about the encounters they had with the Baby Mat therapists. They all have appreciation of the therapists as individuals and how they work on the Mat. The participants reported that they experienced the therapists as understanding, open and comforting, which made it easier for them to open up progressively during their sessions and share their troubles with the therapists who were to some of them strangers. Samantha was surprised at how she could talk to the therapists

about her problems and that they listened to her although they were complete strangers. She had this to say: “They listened to my problem, that’s what I liked that they were good listeners… It was weird you know talking to strangers but then it was fine, it wasn’t hard.” What was perhaps unusual for this participant might have been that she felt more comfortable talking to strangers about her problems more than she possibly did with her own aunt and other family members. Betty, a frequent visitor had this to say concerning the therapists: “They are so lovely nice people. Like I said before like I can talk to them about my secrets and about my privacy.” She felt that their politeness allowed her to reveal her secrets. It seems some participants found it easy to discuss their problems as the therapists were able to make them feel comfortable and were warm hearted. Petunia said: “They are so sweet people. Like when you have a problem all the time. I wish like everybody could come to them and speak like they have very open hearts and will open you with a warm hand, jah.” Veronica felt that: “… they comforted me… I felt comfortable around them because they comforted me well.” Similar to what the other participants reported, Andrea, who has accessed the Mat sessions a number of times, said: “They are nice, they are always nice. Yeah they are nice because if someone if he’s smiling for you it’s nice. If you are not smiling even to a child you are not nice. If you talk to somebody you have to smile you know.” Things such as smiling to the mothers, listening to them, and having an interest in them seem to be some important aspects in helping the mothers open up to the therapists. Yet these are not the only reasons that some mothers had a positive view of the therapist.

A different reason which Eunice had when explaining why she liked the Baby Mat therapists and could open up to them was that they were older women and had experience with working with children: “Yeah they’re both females, I’m sure they’re both mothers jah so it’s much easier then. And again they are older you see I am young and then they are older so they’ve experienced some of the things.” She described the therapists on the Mat as “…professionals who have experience.” The participants generally had a positive view of both the therapists that they saw and spoke to during their sessions. As reported above it is clear that the participants had different reasons why they liked or approved of the two therapists. Some descriptions of the therapists were “professional”, “friendly”, “nice” and “caring”. It might be that the reason why the participants had different yet somewhat similar positive views of the therapists was because the participants did not simply just perceive the therapists in different ways, but that the therapists

themselves acted differently towards the participants, whether consciously or unconsciously, to the different feelings that they had towards the participants who had accessed the baby Mat intervention.

"…they helped each other…": Perception of therapists' interaction on the Mat intervention

According to what they perceived, the participants felt that the therapists were cooperative with each other which lead to them working very well together. Regarding this Judy said: "If you discuss with them they agree on something before telling you." Eunice said: "… very helpful considering the way they were talking to each other first and then gathering their thoughts and then they helped each other, it was perfect." Similarly, Veronica said: "Jah they interact well with each other because when one is not understanding well she just asks for a clue from the other person and the other one just gives her that clue and then you know they have a conversation with that and try to make something out of nothing you know." The alliance between the therapists seemed to be perceived by the participants as helpful as it allowed the therapists to help them understand what they were about to discuss by first thinking about it amongst themselves. This cooperation between the therapists may also model for the mothers how they should interact with their children in that they should consider the thoughts or feeling of their children as any decisions they might make would affect their children in one way or the other.

Mothers' expectations versus actual experience on the Mat intervention

Participants came to the Mat intervention for various reasons and expected to receive different things. A few of the participants' expectations were not directly met during sessions, but they discovered something else from having spoken to the therapists, while some of the participants' expectations were met.

Some mothers approached the therapists seated on the Mat intending to ask questions and find answers, especially answers that were medical in nature, around their child's health or development. Samantha shared with the therapists her concerns regarding the slow growth of her child's teeth. Her one year, five month old daughter had only grown four teeth and this was worrying her to the point that she lied about her child's age, telling people that she was younger than she really was. She felt that her daughter was too old just to have a few teeth and wondered

why it is that they grew so slowly compared to those of her contemporaries. She received the answer that she would have to seek medical advice from a doctor instead. She said: “Jah well I asked them like I told them that I was worried about (child’s name)’s teeth. Actually they did not give me a solution because they are not doctors but then they told me something.” This participant admits that she did not find the answer as to why her daughter’s teeth grew more slowly but she did report that she realised something else from having had a Baby Mat session. She came to realize that she should accept her child as an individual and that she should be more patient with her child. She said: “… they made me realise that well it’s okay she’s an individual…” and later said “before they talk to me I think she’s a stubborn person. Sometimes when I want to change her nappy, she doesn’t want and then she beats me, she bites me and stuff but then they made me realise I should be more patient with her and I think I’m gonna be more patient with her from now on.” Towards the end of the interview this participant said that she felt better after leaving the Mat space, even though she left without receiving the exact answer she needed. This would imply that the therapists working for the Baby Mat intervention understand that it is not just answers that would bring the mothers who visit the therapists on the Mat relief but it is getting to get in touch with, thinking about and understand their underlying fears and worries. This is perhaps why the mothers valued talking so much, as shown towards the beginning of this section.

Petunia also came to the Mat to get medically related answers. Her baby has been having reoccurring seizures ever since she was eight months old and by now she was three years old and Petunia was afraid that her child would develop epilepsy. She could not understand how the doctors could not help cure her child’s fits and so brought this matter to the therapists working on the Baby Mat intervention. She said: “Jah my baby’s got fits you know, fits. Jah this thing started when she was eight months and when time goes it’s happening again and again so it is stressing me a lot.” When asked if her expectations were met she had this to say: "Jah the therapists I shared my story so they told me that like she’s a therapist and not a doctor and some answers need to be given by a doctor so but she told me everything that I need to know, I’m fine.” This participant also admitted that she did not receive those answers she thought she would, but that what she did find during the Mat session was helpful. Later in the interview this participant said that she was not entirely satisfied with her experience of the Baby Mat service. Although she was happy in a way with what she had instead received such as speaking with the

therapists and finding help, she was not fully satisfied that her expectation of being told what to do regarding her child's condition was met. She said: "Jah but not yet because I need some answers as I have said that I have a problem with my baby's health. Like sometimes I don't know what I can do because like I said earlier when I come to the clinic they don't tell me what I'm supposed to do." After leaving the Mat space, she was still preoccupied about finding answers. This mother was the only one among those interviewed who had voiced some dissatisfaction about the Mat service. Some mothers came to the Baby Mat therapists with medical concerns as did this mother, but she seemed to be more concerned with wanting answers and advice than the other mothers. This might imply that the Mat intervention may not always be successful in helping mothers move from concentrating on concrete concerns to mentalising.

Veronica was another participant who shared that what she had expected from the Mat sessions was not what she had received, but that she was happy with what she had received as it was comforting. This participant had approached the therapists on the Mat area as she was concerned about her baby having stomach cramps. She thought that she would simply question the therapists, obtain answers and be questioned in return. She said: "My expectations were like when I got there I thought to myself they are going to question me or am I going to questions them (laughs)." She then added this: "Jah I really found something different because they told me things that I never knew about you see. They were willing to help me. To help me go through whatever that troubles me… I was just relieved…" It seems that some participants brought concrete problems to the therapists, such as their children's physical sicknesses, as a way of validating their being on the Mat. The mothers also did not seem to know much of what the Mat service was about, as Veronica pointed out, and therefore felt they might be taken more seriously if they brought tangible and physical problems to the therapists.

While other mothers found something very different from what they had expected, Judy found that she had received exactly what she had expected. She said: "What we spoke about was what I expected exactly. Like what can I say, jah it was exactly what I expected. Talking to them and making me understand some of the things, that is exactly what I thought they would help me with." This might be because this participant had been onto the Mat before and has seen how the Mat works, while other participants had never been on the Mat. It seems that past encounters on during the Baby Mat sessions orientates participants to what they should expect when returning

to the Mat intervention. There is also an implication here that the approach of the Baby Mat intervention to the mothers remains consistent over time and this helps the mothers know what to expect if and when they do return to the Mat sessions.

Why mothers have returned or would hope to return to the Mat intervention

The researcher interviewed both participants who had never been on the Mat and some participants who had returned to the Mat. Participants who had returned to the Mat had their own reasons as to why they returned which were different from the reasons why first time visitors to the Mat said they would return.

"The fourth time": Why mothers have returned to the Mat intervention

Mainly, participants seemed to return to attend sessions offered by the Baby Mat therapists for two reasons: because they believe that they have received the help that they needed from the Mat and because they had good relationships with the therapists working on the Mat service. Some participants who returned to the Mat intervention felt that bringing their problems to the Mat was really helpful. Judy who had been to the Mat for the fourth time now said: "It helps most of the times to talk to them and share my child's problems and they make you see other things. It just helps to talk to them, as a mother who is HIV positive it helps me…" In agreement to this Andrea, who had been on the Mat for the past five times, said: "Yes on my side it's helpful for me I don't know about another people you know on my side it's helpful."

Some mothers, on the other hand, had returned to the Mat space because they felt that they had developed a good relationship with the therapists on the Mat. For example, Betty shared that she always tried to go onto the Mat space to see the therapists even though there she had nothing in particular she would like to discuss with the therapists: "Always when I'm there I try to see them even there's no reason just to greet them and say 'Hello'." This is a result of her feeling comfortable around them: "I feel free and comfortable, I enjoy being with them." Andrea is another mother who goes to the Mat because she relates well with the therapists: "I love them they are so friendly, you know I'm saying again they are friendly. Even when you are angry they make you feel better, you know."

Reasons why mothers would return to the Mat intervention

First time visitors to the Mat intervention all expressed that they would want to return to the Mat space in future. First time visitors enjoyed the experience of being listened to and being taken seriously on the Mat. Petunia articulated this in saying: "Like when I have a problem, especially if my problem is with my baby, when I have a problem and I talk to you and you listen I feel like I'm in the right place at the right time." Similarly, Samantha also valued being listened to and said: "And then I feel like actually it's time I talk to someone and someone listened." Being listened to seemed to bring a sense for mothers that they were being taken seriously as Eunice felt. When asked why she would return to the Mat her response was: "…being taken seriously, jah being taken seriously." This is a mother who valued the therapists on the Mat because of their professionalism and experience.

What seemed to stand out for one mother, together with feeling listened to, is the idea of returning to the Mat space for a sort of check – up visit. The mother felt that she would return to the Mat space to express her gratitude to the therapists for the help that she had received during her sessions. She said: "Jah I would go to them and say 'thank you, you guys actually helped.'"

Perceived therapeutic progression: Before and after the Mat experience

Before approaching the Mat, most mothers, except for a few cases, really seemed to have some struggles with their children or their relationship with their children. In trying to describe their thoughts about their children and their relationship with their children before having had a session on the day of the interview, some mothers shared that before being in a session, they had either some developmental concerns concerning their children's development or they could not connect with their children as they could not understand them. When asked about how they viewed their relationships with their children after having had a session, it became apparent that all the participants said that they felt that there had been some shift in the way that they thought about their relationships with their children and were very appreciative of this shift which they perceived.

Some mothers thought that, before accessing the Mat service, their relationships with their children were negatively influenced by their lack of understanding of their children's development. Betty was a second time mother who was having some trouble handling her son.

Her daughter was in her twenties and, while they were all on the Mat space, seemed more maternal towards the child than Betty was. After the interview her daughter brought the little boy as he was crying for his mother and he was almost instantly comforted by her. She simply said: "When he was young he was giving me a lot of trouble." The mother did not go into much detail about what kind of trouble she experienced. When asked if she thought differently of her relationship with her son after having been on the Mat service for a number of times, she said that she thought that it has changed as she has since learnt that she should love her child, support him and care for him. Upon observing the participant and her child interact off the Mat, it did seem as if they had a good relationship.

Other mothers thought that their relationship with their children was negatively influenced by their inability to understand their children's needs which led to difficulties connecting with their children. Andrea, a return visitor to the Mat, said: "Sho, it was horrible because I was fast asleep during the night not hearing what the child wants no whatever, if he's sleeping that's my time to enjoy you know." Before she had ever gone onto the Mat for her session, this mother felt that she could not connect with her child's needs and did not understand him. When asked if she thought differently about her relationship with her child after having been through a Mat session, she said: "I think it's nice because everyone is saying 'your baby is fit, strong' jah." It seemed as if this participant learnt from the Mat session how to understand the needs of her child better and how to respond to them more effectively, leaving her feeling as though her child is developing well and that this is even showing so much that people are commenting on her child's development. Later in the interview this participant said: "I'm feel better because I think my life has changed from being here." It seems that for return visitors it is more possible not only to involve the mother in merely thinking about perceived relational change but also to 'see' some results from the participants' reports of how things have actually changed. This may be hard to ascertain with first-time visitors to the Mat intervention, but it might be that repeated visits to the Mat intervention did yield some shift in relational change between mothers and their children.

Petunia felt that before she had her session on the Mat she did not understand her child and wanted to progress towards being a certain kind of mother towards her child. She said: "I think my relationship with my child the thing is I must know my child because she is my child. I must know and understand her all the way as a mother." After being on the Mat and interacting with

the therapists, she reported that the way she thought about her relationship with her child had changed. She said: "Jah I think it's changed because there is a time when she is annoying me like I want to beat her like not I learn that I must be patient to a child, especially since she's a small one, young girl. I must be patient with my child and not beat her [hit her] every time or something like that. Like I learn I want to be a strong mother, I must be strong for her." Being on the Mat seemed to have helped the participant reach this conclusion.

Unlike the above-mentioned participants, a few of the participants who were interviewed thought that they already had good relationships with their children and regarded themselves as good mothers even before being on the Mat. Veronica said: "I always knew I was a good mother to her…" Similarly Eunice shared this: "Uhm one thing for sure I'm a good mother, a great mother so me and my child we're great. Jah we've always been great. It's just that some of the problems you know jah you have to ask some people. Like when a child is sick you have to go to the doctor jah, so some of the things because they are child psychologists so they understand the child better, so I am still young…" It seemed that some mothers related well with their children without any intervention from the Mat service. These participants, therefore, did not come onto the Mat space because of any perceived relational problems with their children but because they were was worried about the health of their children. It turned out later both in these participants' interviews that they, as individuals, had their own personal anxieties underlying their concrete concerns about their children's conditions. It seems that the Baby Mat intervention is not just a space for talking about and understanding relations between mothers and their children, but also a space that is open for mothers to bring their own personal concerns and anxieties, and how this may be affecting the child. This is something that the next participant perceptively outlines.

Before going onto the Mat space for her session, Judy admitted that she did not realise that her not being emotionally well had affected her child. She said: "I didn't think about when I was emotional I didn't realise it affects her before. Then when we went there as they mentioned that I realised." She felt that after ending her sessions on the Mat area, she now knew and understood what was causing her child to be sick most of the times. She said: "Now I know that when she gets sick, before I run to the hospital, I should first realise how the home environment is and how I am feeling and what problems I'm facing so that I don't just go to the hospital. I might come here running and they find that there's nothing wrong with the child, whereas I see that the child

is sick." This participant seems to have "realised" the problem for herself without the therapists having to point it out for her. It seems that some mothers who approach the Mat need little help in understanding some issues within their relationships with their children, but appear to have the capacity within themselves to think about the minds of their children simply by just being in a space that allows them to do this.

THE THERAPISTS' SUBJECTIVE EXPERIENCES

Along with the mothers who come onto the Mat space, the therapists are also active members of the Mat sessions and it was thought important that their subjective experiences of the Mat were taken note of and looked into. It is interesting to know that the therapists' subjective experiences sometimes differ somewhat to those of the mothers', but this will be further discussed under the next theme. This section will seek to capture how the therapists experienced the process of being working on the Mat service with the participants and how they think the Mat works for the participants.

Mother's effect on the therapists on and off the Mat intervention

It seemed that some participants left the therapists with various lingering feelings when they came off the Mat and these were expressed by the therapists. Some of these feelings were positive feelings, while some were very negative.

Negative feelings therapists were left with

Jane and Cynthia reported in some interviews that they felt that some mothers had left them with certain negative feelings such as sadness, pity and depression. They felt that these feelings were counter-transferential in nature, as they had not felt that way before they saw certain mothers on the Mat intervention. In some instances the therapists would feel sorry for the mothers who they saw for Mat sessions. Cynthia had this to say when referring to a certain mother: "Shame for her I wanted to hug her, to be her mother you know, that was my counter-transference I think. I wanted to mother her, I wanted to be there for her baby and also for her so that she could you know see her baby as different baby and that she is doing very well and to tell her you know that keep up the good work." Similarly the same therapist said, referring to another case: "It was very sad to hear her story as a young mom that he had lost her mom and it was three weeks back then you know. Like it was very raw and it was very new… because I felt sad for her, I felt it was bereavement counselling for us and you know it was something that happened to her and it was a trauma… I felt sorry. Actually I felt sorry that I could say 'here's money, go home' you know." Again, in another case the therapist experienced feelings of being depressed and cut off from the Mat session. She said: "…after her I just felt that she was felt I was cut off or depressed mmmm…. I think she was projecting that to me. Something was happening that I was picking

up, but I'm not too sure what was happening. I think she was also a mom who was, I think, maybe frustrated or depressed by uhm the environment of the clinic." It seems some cases that are presented on the Mat leave the therapists feeling sadness, and pity along with rescuer feelings and depression. This appears to be linked to the mother's sad and sometimes painful stories coupled with the mother's apparent lack of ability to cope with her circumstances.

Positive feelings therapists were left with

It was interesting to note that it was only for two mothers who were part of the sample that the therapists reported a positive experience. The rest of the mothers left the therapists feeling negative feelings as described above. For one case, Jane had this to say: "I feel good about it like I feel it was a positive experience for Cynthia and I. And I think it was a positive experience for the mom and for her baby… uhm so I just feel like. Like I said I don't feel anxious about their relationship, I don't feel anxious about whether or not they will take up the referrals we offer them or if they will come back to the Mat." For another mother the same therapists felt that:

> "Uhm jah I feel really good about it because like as I was saying she came to the Mat I remember it was really awkward she wasn't really looking at me, like she didn't make eye contact at all. Uh she had her baby on her back kind of like bound up and she was very, like I said, guarded and quite closed off, and at the end of it the baby was like sitting on the Mat with us just standing and sitting and chewing my fingers, you know, and mom was making some eye contact. So it was jah it was a really nice session, I think."

It would seem that most participants who access the Mat service are already sometimes in distress and in need of the service which could try to explain why it is that most mothers leave feeling negative rather than more positive feelings with the therapists. The therapists appear to use the feelings evoked in them by the mothers to better understand and empathise with what the mother is feeling or going through. When they are in touch with this, they can be in a better position to find where to take the mother while in the session.

Mothers' effect on therapists' relationship

The therapists voiced that all mother-infant dyads they come in contact can impact, in one way or the other, the therapists' relationship between each other. Jane said: "Uhm obviously it's kind of a relationship and it's affected a lot by what's going on with the mom and the baby that come. So sometimes we'll find, which is interesting, that if a baby and mom don't communicate well like our communication will start breaking down or if a mom is very anxious, I'll find myself really left out. And it often tells you a lot about what's going on with the client who is on the Mat." This experienced impact that the mother-child relationship has on the relationship between the therapists can also be used to understand therapeutically what may be going on between a mother and her child.

In further describing how mother-child relationships influence the relationship between the two therapists. Cynthia had this to say: "…Between the two of us we can act that out in terms of sometimes not being in agreement or someone felt like she was cut off or she was not part of, included in the conversations or she felt like uhm we don't agree about something and it can affect us. And then we try to take it to supervision and think probably what is that the mother brought or what was happening. So it does really affect because we are also partners you know…"As an example of what the therapists have described above, Jane shared a specific example of how their relationship could be affected: "And one thing I do remember is kind of both me and Cynthia moving quite close to her when she became quite teary. Uhm so I feel like we were quite in tune with each other…" This raises the idea of an unconscious dynamic known as parallel process. In this instance the whole definition may not apply, but the idea that the therapists are possibly unconsciously enacting the relational dynamics of mother-child dyad rings true. When used in this manner, the parallel process benefits the client as the therapists can have a better grasp of how to respond to the couple since they are going through something similar.

The therapists working on the Mat had many points of agreement such as the above-mentioned similarities in their understanding of how mother-child relationships influenced their relationship. There were, however, times when they differed on certain points such as the type of referral to give to a mother, how they saw and understood some mothers and their relationships with their children and how they saw and described some mothers' therapeutic progress. For

example, it was revealed that the two therapists on the Mat do not always agree on what type of referral to give to some mothers. Jane pointed this out: “It was actually quite an interesting Mat session because uhm Cynthia really wanted her to go get a PIP and… I thought that it might be useful for her to join the group.” it seems that even their disagreements can be viewed therapeutically in that they reveal to the mother that she and her child both have their own separate minds, and sometimes there will be a difference in their thinking, and that this is acceptable.

Therapists’ subjective understanding of the processes of the intervention

The Baby Mat intervention seems to fulfil a variety of functions in trying to help the mothers who come onto the Mat. The therapists share a few thoughts about what they believed the functions of the Mat to be. Firstly it was emphasized that the Mat is not a place for giving advice to the Mothers. Cynthia had this to say on the issue: “Uh yes as a Baby Mat practitioner we are not giving advice…” Again the same therapist said in another interview: “…it took her by surprise because the, it was not like that kind of a straightforward answer.” Going beyond giving advice, therapists attempt to help mothers begin to shift towards thinking more about their children, which is discussed below.

Continuing with the comment the therapist mentioned something else that seems to be done on the Mat: “We would probe more about what is happening and how she understands the whole things and when it started, what she think triggered it, all those kind of questions and it was more of questioning her just trying to facilitate the function of the Mat intervention exactly what is it that she’s trying to tell us.” Since the therapists do not give advice, they rather use probing as a means to enhance the mothers’ current levels of mentalisation or being mindful of and thinking about their children. One of the therapists said that the Mat serves to, “…encourage some thought and some thinking and some mentalising about what cause the shift and things like that. I guess again I would hope that it makes them mindful about their child and reminds them to be thoughtful about their child.” So probing seems to help facilitate mentalisation as the mothers can think for themselves about what is going on and can try to understand their relationship with their children.

Empathy was identified as being important when probing the mothers and asking them questions. Concerning this, Jane said: "Uhm I just think kind of like being empathetic with her and trying hard to understand, like being curious. That's a big thing around Ububele like just being curious. Uhm so jah just kinda being like okay she understands she's not actually here then for like kind of a medical opinion, and like she's here for something else…" In addition to being empathetic, another factor that seemed important in facilitating mentalisation in mothers was having a good relationship with the therapists and the idea that the intervention should be consistent and predictable for the mothers, although the therapists offering the intervention changed. This helps the mothers be more open and feel safe on the Mat. In explaining this Jane had this to say: "Uhm but I think there is also something very healing about the relationship that they have with the people on the Mat. So uhm maybe not in a not interaction with me but in an interaction with Cynthia to see that she's consistent and there's someone from Ububele who is always there if you need them and that we're predictable and consistent and thoughtful." It was felt by one therapist that being consistent, predictable and thoughtful was a way of modelling how they would like the mothers to be like with their children: "I think all of that is like modelling the kind of relationship we want them to have with their children." modelling is therefore another function of the Mat.

The Mat is also described as being flexible and able to accommodate all mothers who approach the Mat. Cynthia said:

> "…but I think the space of the Mat is a space where, it's an environment where the mothers bring their own languages and present their own uhm presenting problem… So I don't know, for me it's always. Look I've got seven years on the Mat I don't understand what is going on. It always amazes me how mothers bring their own presentation and even the way they come and approach the Mat it's different, and I don't know maybe some of the therapists who are, who will be willing to work on this Mat they will be willing to understand. For me it's always like uhm it surprises me and I'll be like amazed at how each and every mom bring their own story. The approach of the Mat is very different so it doesn't have a name for me, I cannot name it yet. I don't know it's just a unique space for me."

It seems important that the Mat is flexible and able to accommodate a variety of different mothers as the mothers are not the same and are not on the same level, so different approaches are necessary in order to try and reach every mother that approaches the Mat intervention. This sentiment was alluded to by Jane who said: “Jah. I think you have to kind of really like jah you can’t access people at the same level. So for some people who come for advice and just want advice you’ve really just got just like… we’ve got to just sit with it.” It is possible that it is this flexibility of the therapists that contributes to the success of the Mat intervention, as some mothers may feel that they are being addressed on a level that they understand.

COMPARISON BETWEEN THE SUBJECTIVE EXPERIENCES OF MOTHERS AND THERAPISTS

There emerged similarities and differences between the subjective experiences of the mothers and the therapists. There seemed to be considerable similarities between therapists and mothers seen in the data but it is important also to look at the differences between these two groups as it will help to gain a better understanding of the intervention.

Similarities in the subjective experiences of mothers and therapists

There seemed to be similarities in many aspects of the mothers' and therapists' subjective experiences, including why mothers have come to the Mat sessions, what their expectations of the Mat were, and the views of the mothers' relationships with their children before having sessions on the Mat, and the way the mothers thought about their children after leaving the Mat sessions. Veronica mentioned in her interviews that even before having been on the Mat she knew that she was a good mother to her child. After being on the Mat thought she further learnt that she was even a much better mother than she had imagined herself to be and had learnt that the little things she was doing meant a great deal. She said: "I knew that I am a good mother to her but not that good. But when I went to the Mat they made me feel that I'm this wonderful mother. You know they just made me realise things that I didn't realise that I'm doing to my baby." In agreement with this, therapist one said: "I think her baby means a lot to her and she has quite a strong bond of her baby and she is quite conscious of those things. That she sees her baby as a gift and she jah values her relationship with her child and jah I think that's how she saw her relationship before."

In another case Judy had come to the Mat because she was HIV positive and worried that she might have infected her child because the child was becoming sick, although the child had recently tested negative. She said: "Uhm the thing is I'm HIV positive and the sickness that she was having I thought it was HIV positive so… And that day I was supposed to go for HIV testing. It was very difficult for me…" Consistent with this Jane reported that she had observed that the mother was still trying to process the news that she was HIV positive and that a secondary worry she had was that she might be infecting her child: "Uhm I think again somebody taking the time to push what she comes with and really seeing her fear like her fear for

her baby, like her own difficulty processing her status…" Just as the mother had mentioned about it having had been difficult for her at first to be on the Mat the Jane also picked this up: "Uhm initially it was a bit strange because she was avoiding my eye contact… because she kind of came guarded I think…"

At other times, therapist and participant shared a similar understanding of the participant's presenting problem. Petunia reported that she had come to the Mat so as to find answers about how to handle or stop baby's seizures which were brought on by the rise in her body temperature. Jane felt that the mother brought a medical presenting problem onto the Mat concerning her child's seizures she said: "… maybe partly because she presented a medical thing that day, it was about her baby's temperature. Uhm probably she needed an immediate answer… probably maybe she wanted to deal with the problem of the baby's temperature and be fixed and be given advice and go…"

Differences in the subjective experiences of mothers and therapists

Differences between the subjective experiences of mothers and therapists seemed to be specific to mother-infant couples. For example, what can be seen in the case of Eunice is that there was a difference between what the mother felt she came away with and what Cynthia hoped that the mother came away with. This mother had come to the Mat as she did not know whether it was the right time for her to go back to work or not. Upon leaving the Mat the mother felt that her baby was not yet ready to separate from her and this was why she would not yet return to work: "Uhm for the first time I think basically that my child isn't ready to be like apart from me even like if I'm ready to go back to work and leave her… I learnt that my baby is still a baby and she is a different baby from the other babies okay she won't like, she won't eat or do the same things that other children do. I must accept and not want her to skip that stage." Contrary to this, Cynthia felt that it was the mother who was not yet ready to separate from her child: "…and obviously we talked about the separation and guilt of her going back to work as a mother and she really did agree that she is guilty of leaving her little one and going back to work as a mother… it's not easy for her because she comes late from work and yes the separation is difficult." It seems that the Baby Mat was not able to shift the mother's thinking as her issue was too deep.

Whereas in the previous case the mother did not understand the problem another case shows the opposite. Judy seemed to have had a better understanding of the problem than Cynthia. In this case it seems that the Mat had a deeper impact on the mother more than the therapist anticipated. Judy said: "I didn't think about, when I was emotional I didn't realise it affects her before. Then when we went there as they mentioned that I realised." Later she said:

> "When a child is young she gets a lot of things from you. So when you have a problem this also reacts in the child in the form of a physical sickness instead of it being emotional… Now I know that when she gets sick, before I run to the hospital, I should first realise how the home environment is and how I am feeling and what problems I'm facing so that I don't just go to the hospital. I might come here running and they find that there is nothing wrong with the child, whereas I see that the child is sick so such a thing. I have to first start and see if I am okay and whether or not the child's problem is caused by problems in the home environment."

This mother seemed to have understood without much probing that, on the other hand, this is what both therapists had similar things to say which did not completely capture the deep impact the Mat had on the mother. Jane said that she thinks that the mother would begin to think about her child and her needs and that this would not overwhelm her: "… but I think we allowed it to be less painful to think about or maybe allow her to be okay to think about it and not feel like she was going to be overwhelmed, jah." Cynthia said: "I think for us to be with her on the Mat, to talk about her difficulty and her worry and for her to disclose her status to us I think it's a huge thing. For the fact that she was able to talk about and think about their relationship, I think that it will help them to repair or reconnect the two of them." It seemed that none of the therapists could capture the depth of what the mother had learnt on the Mat. It may be that the mother's repeated visits to the Mat have helped her internalise the ability to hold her baby in mind.

Along with a shared understanding of the presenting problem between therapist and participant, there were also times when the two parties had a different understanding of the presenting problem. Andrea shared that she had come onto the Mat in order to receive help on how to raise her second-born child as she did not have experience in this because her mother had raised her first-born child. She said: "… because my friends, they always laughing for me because this is my first child to raise up, my first child because I was not taking care for her [first born

daughter]…" She only later in the interview mentioned that she had also come to seek advice on how to break the news to her first born child that his grandmother had passed away. She said: "When I came to them I was talking about how my mother passed away and my first child growing up with my mother and I didn't raise him. He always to saying this is my mother and they tell me that I must go to tell him that your mother she's dead you know. I was so disappointed, how can I tell him you don't have a mother I'm your mother." Cynthia understood the mother as coming solely for an opportunity for "bereavement counselling" as her mother had recently died and she did not know how to tell her first-born child about the death.

CHAPTER 5: DISCUSSION

The aim of the current research project was to explore the subjective experiences and perceptions of both participants who have accessed the Baby Mat and therapists who work on the Baby Mat project in Alexandra Clinic, Alexandra. Furthermore, the study sought to explore the differences and similarities between the subjective experiences and perceptions of these two groups regarding their sessions on the Mat. This was achieved by conducting seven semi-structured interviews with mothers who have had sessions on the Mat before, as well as corresponding interviews with the therapist and co-therapist who saw the mothers on the Mat. There has been limited research reporting on the experiences and perceptions of both participants and therapists regarding mother-infant short-term interventions. It is, therefore, the aim of this to study to offer new insight regarding the differences and similarities of perceptions between these two above-mentioned groups.

The purpose of this current section is to summarise the themes discussed in the previous chapter and also to explore the limitations and suggestions for future research. The findings will be summarised under three research questions, namely: i) How do the mothers subjectively experience the Baby Mat intervention?; ii) How do the therapists subjectively experience the Baby Mat intervention?; and iii) How are the perceptions of the mothers and therapists similar or different?

Mothers' subjective experiences of the Baby Mat

Overall, it seems that the mother participants stated that their experience of the Mat sessions were positive and largely enlightening. It is interesting to note that what the participants experienced on the Mat during their sessions was mainly found not to match what they had expected to receive from the Mat. This alludes to the idea that most mothers, although approaching the Mat intervention of their own free will, do so without a clear understanding of what the Mat provides for them. It can be seen from the data that a number of mothers approached the Mat in an effort to gain more insight into their children's difficulties from a medical doctor's perspective. This then helps one to understand how a majority of the mothers' understanding of the Mat intervention and of their children's difficulties was concrete and often limited to the physical or to the body. Having received something different from the Mat sessions

than what they originally expected may have led to some disappointment, but later to a feeling of emotional gain. It seems the Mat, as experienced by the mothers, seemed to draw them deeper than the physical and concrete complaints or issues they might have initially presented with, to more abstract and psychological ways of viewing themselves, their children and their relationship with their children. This seems to be the main aim of most parent-infant psychotherapy interventions, to seek to alter caregivers' mental representations of their children and their relationship to their children (Cohen et. al., 1999). Although mothers seem to approach the Mat with the aim of gaining tangible answers to the (physical and body related) problems of their children such as a refusal to eat, they described instead the experience of being challenged to think about their and their children's motives, feelings and behaviours. Understanding problems, or rather beginning to think about and understand their problems from a different perspective, seemed to have led the mothers to an unexpected experience of emotional gain from the Mat. Together with this, mothers seemed also to have felt that they were given a supportive space to talk openly about what they felt was worrying them in relation to their children.

Dugmore (2012) describes this as being a common occurrence amongst parent-infant psychotherapy interventions. Dugmore highlights that a challenge for Parent-infant psychotherapy practitioners is that patients often bring concrete material to discuss and they expect concrete solutions such as being given medication to fix the problem. It is then the role of the practitioner to move past these concrete problems, yet this proves a challenge as patients take some time to understand the role of the practitioners and the role of such interventions. In trying to understand this pattern, Dugmore (2012) conveys to the reader the idea that preconceived ideas about what help is seems to play a role in creating this tension between what mothers believe they need and what practitioners believe the patients needed.

Mothers were also asked to comment on any perceived relational change in the way they thought about their children and their relationships with their children before and after accessing the Mat intervention. Before accessing the Mat intervention it seemed that some mothers had not realised a number of things such as, for example, how they did not understand their children's development or needs and how their emotional well-being was affecting their children. This seems to allude to the fact that accessing the Mat even for a single session seems to be able to

exert an influence and to enable different thinking, at least, in the minds of the mother and this seed, which it is the aim of the Mat to plant, is hoped to grow in the course of time.

The Mat intervention thus attempts to try to develop the ability to mentalise in the mothers. This is the ability of holding another in mind, or in this case the mother holding the infant in mind. The absence of this ability leads to the mother's poor capacity to reflect on and understand the psychological state and behaviour of her child. The mother is therefore unable to mirror back to the child his or her emotions and this, in future, leads to child's inability to metalize, or hold others in mind. This inability of the mother to understand and think about her child and his/her behaviour and emotional state can leads to the development of an insecure attachment between mother and child as the mother would not be able to understand and accurately respond to the child's behaviour. It is therefore important that mothers learn to be able to "reflect beyond what is immediately known" (Capstick, 2008, p. 9), this being the concrete and physical symptoms of their children.

It seems that what the Mat intervention offers a re-exposing of patients to previously difficult to handle emotions under favourable circumstances so as to allow them a better ending or rather a new positive experience associated with previous difficult emotions. Exposing patients to their previously traumatic experiences more while in a therapeutic and containing context helps the mothers in that they begin to become capable of facing situations to which they found difficult to negotiate in the past. In understanding this idea better one can look to the article of Fraiberg, Adelson and Shapiro titled *Ghosts in the Nursery:*

"There are, it appears, a number of transient ghosts who take up residence in the nursery on a selective basis. They appear to do their mischief according to a historical or topical agenda, specialising in such areas as feeding, sleeping, toilet training, or discipline, depending upon the vulnerabilities of the parental past. Under these circumstances, even when bonds between parent and child are strong, the parents may feel helpless before the invasion and may seek professional guidance" (p. 388).

This article touches on how a new mother-child relationship can awaken past introjected objects and ways of thinking and dealing with similar relationships. It seems that the Mat intervention therefore acts as a therapeutic space which allows mothers the opportunity to expose their

haunting past vulnerabilities and difficulties, yet offers a different response to them which may be different to usual responses shown by these mothers in the past. This then allows the mothers to "transform their painful emotional conflicts within the therapeutic relationship" (Bridges, 2006, p. 551).

Mothers' experience of the therapist(s) on the Mat

All mothers expressed that they experienced the therapists who work on the Mat as being empathetic and understanding towards them. This seemed to have allowed the mothers to open up progressively to the therapists on the Mat and express their difficulties and problems. Some mothers for example were surprised that they found it easier to speak to the therapists on the Mat, who were strangers to them, than they would to their own family members. Adding to this, the therapists were also perceived to be professional and all-knowing, therefore possibly allowing for mothers to entrust some previously undisclosed difficulties to the therapists. The therapists' conduct and ways of relating to the mothers seems to be something that was well highlighted by the mothers' reports. Although there were different aspects reported by the mothers about the way in which they experienced the therapists, the general outcome was very similar in that the mothers felt safe enough to speak about those sensitive matters they would usually consider to be private to their own family members and more especially to strangers. Not only were the mothers able to begin opening up during the Mat sessions, but it appeared as though the Mat experience also allowed them to open up even to the researcher who interviewed the mothers after their Mat sessions. Mothers were given the choice of not talking about the content of their Mat sessions, but rather their experience of it, yet all mothers ended up speaking about what had brought them to the Mat. Some mothers even noticed that they were able to speak about their private matters first to the therapist and again to the researcher which surprised them.

On the other hand the mother's expression of surprise in speaking about things they considered private to the therapists and researcher reveals that some of these mothers tended to shy away from speaking about their problems to others for fear of imagined or actual judgment, not being understood or seen as not so good enough mothers by others in their environment. It seems then that both the 'space' of the Mat and the conduct and engagement of the therapists facilitating the sessions were unique encounters to these mothers.

Not only were the therapists perceived as having positive interactions with the mothers but also between each other. Mothers reported that they experienced the therapists as cooperative with each other and working well together to help each other in the sessions. It appears as if the mothers perceived a working alliance between the two therapists which was effective in assisting the therapists to understand, contain and help the mothers. This cooperation between the mothers is possibly important way for the therapists to model for these mothers their interaction with their children. This would be important for mothers as they need to be mindful of their children's thoughts and feelings, and of the fact that their children have a mind of their own in the same way the mother has her own mind. Seeing the therapists communicate with each other in a mindful, respectful and understanding way, even during points of conflict for example, can help the mothers begin to internalise that way of being with their own children.

It was interesting to realise that the way that the mothers felt treated a positive manner by the therapists on the Mat and the relationships they believed had been formed between themselves and the therapists on the Mat was one of the main reasons why mothers have returned or say they would return to the Mat sessions. The patients described the feeling of a therapeutic alliance or client rapport between them and the therapists. Leach (2005) states that it is very important for the therapist to establish rapport with the patient as this can have a profound influence on the therapist/patient relationship. Rapport can be established within the first few minutes of a session and the presence of a good rapport or alliance allows the patient to begin trusting the therapist and opening up to him/her. The attributes that he patients have described about the therapists on the Mat such as being friendly, warm, attentive and caring are the building blocks of a therapeutic alliance and they allow the patients to lower their defences and therefore improve the quality of therapy sessions.

Something worthy of note to add at this point is how much of what has been mentioned so far in the discussion has centred on the mothers and their feelings and emotions concerning their children. Not much mention has been made about the children and their own emotions. This is a critique offered by Cohen et al., (1999, p. 431): "A challenge in mental health interventions for infants is that although it is infants who are of greatest clinical concern, the actual focus of treatment is on the parents." The authors point to the ideas that since, it is the children who are presenting with problems they should be the ones to direct the therapy and also should be more

of a central focus other than in most parent-infant psychotherapies where the opposite is true. This then begs the question: who is the Mat for? Most research points to the relationship between the mother and the child as the patient, rather than the mother or the infant separately. Another important point to consider is children's experiences are medicated by their mothers or primary caregivers. Therefore the mother's way of relating to the child is an important point of intervention in order, in the long run, to shift and improve attachment styles between mother and child. It seems that the Baby Mat then acts as a holding environment for the mothers as in the words of Winnicott (1960b). The idea is that the therapists, like fathers, produce a holding environment for the mothers so that they can mother their children.

Therapists' subjective experience of their patients and of the Baby Mat

As active members of the Mat sessions it was important to look at and try to understand the therapists' own subjective views of the Mat sessions and their processes. This section will discuss the therapists' counter-transferential feelings and other related processes which take place on the Mat.

It was interesting to note that the therapists repeatedly commented during their interviews how they were left feeling after they had had sessions with their patients on the Mat. The therapists highlighted how they were left with both positive and negative feelings in relation to the patients they saw. With some patients, both therapists would be left with the same kind of feelings, either both negative or both positive in relation to the same patients. Yet with regards to some other patients the therapists' views and feelings about the patients would differ. In trying to understand this divergence it would be useful to consider a few points. One point is that therapists, in contrast to what Freud postulated, are subjective and not blank slates. As outlined in the literature (e.g. Benedek, 1953 & Langs, 2004), therapists also bring in their own subjective experiences in understanding the patients in front of them. This therefore explains why, in the first place, therapists are left with these either negative or positive feelings in relation to their patients. Something else to consider in understanding why therapists experience the same patients in different ways is the idea that individuals, even therapists, are different and carry inside of them diverging views about certain things in life. This is important point to consider

when understanding why it is that the therapists on the Mat may experience the same patient in different ways.

Something else that emerged from what the therapists expressed about being left with positive and negative feelings towards their patients was how the more negative feelings they were left with were harder to manage and process. The therapists described an internal struggle within themselves which centred around providing for the mothers' emotional needs versus providing for their material needs. In general, therapists primarily take on the role of helping patients to understand their internal world and their emotions within therapy. It seemed however that this was difficult to do for these therapists as they continually expressed how they felt the longing to help their patients not only with emotional needs of the latter but also with their material needs such as giving them money for food or transportation. This may link to the context of the Baby Mat intervention in that it is situated in an area where the mothers or patients who access the Mat intervention seem to have very obvious material needs which may be viewed as preventing them from being able to be more emotionally in tune with their own feelings and that of their children.

Another important point that came up was how the patients seen on the Mat not only influenced the Mat therapist individually, but how some patients even influenced the relationship between the therapists. The therapists expressed how they could, at times, react to each other in uncommon ways, such has having poor communication, as a result of what was happening in their patients' relationship with their babies. However that when the therapists do behave in ways contrary to how they usually behave when working together as a unit they are able, unlike some of their patients, to think about and understand these behaviours and then respond in more constructive ways. This then affords them the opportunity to model to the mother how people can be individuals with different minds but still be able to work together. As some mothers who attend the Mat sessions might lack to ability to mentalise, having a live demonstration at times might help to introduce to them the understanding that it is important to understand both one's own feelings and those of another.

The therapists' counter-transferential feelings and associated thoughts in relation to some of the mothers who were seen during sessions on the Mat can be seen as an important aspect to explore. Counter-transference is widely known as the therapist's feelings or responses based on feelings towards specific patients or clients. From the data, it is evident that both therapists experienced

counter-transferential feelings towards their patients. With some patients, the therapists were left with the same feelings and thoughts about the mothers, but with other patients the therapists experienced different counter-transferential feelings. This goes to show that although more than one person can see and listen to the same patient at the same time, the way they feel about or respond to the patient will differ at times.

When discussing about counter-transference, the question arises as to whether or not the therapist's counter-transference is useful in therapy. Some scholars (e.g. Freud, 1910; Freud, 1920) argue that therapists should guard against all counter-transferential feelings as these can be a hindrance to the therapy process. This is because, at times, a therapist may respond automatically to what the patient has evoked in him/her without thinking of and processing his/her counter-transferential feelings towards the patient. It is however widely recognised that therapists do develop counter-transference feelings towards almost all of their patients. Then what is to be done about such feelings on the part of the therapist? There is hope in the fact that counter-transferential feelings can be used as a tool in therapy to understand and interpret the patient's internal world (Gabbard, 2004), but this can only be achieved if the therapist processes these feelings instead of immediately acting upon them. Upon processing their counter-transference feelings, therapists can then feed back to the patient a more digested form of their feelings leaving the patient feeling more contained. This appears to be the case with the therapists on the Mat in that, although they feel certain feelings towards their patients, they do not act on these without thinking about them and what they mean in relation to the patient. In further understanding this point it would be useful to introduce Bion's concept of maternal reverie. The therapists on the Mat may thus serve to reshape and transform the patients' intolerable feelings and feed them back to the patient so that the patient may be able to assimilate and integrate the digested feelings and experience into their own mental functioning.

The therapists working on the Mat intervention related how they understood different aspects of the Mat intervention as useful to use in the intervention. One thing that arose was that of being able to listen to patients and acknowledge their feeling states. Something else that was mentioned was the importance of showing empathy, and lastly the significance of forming a relationship with the patients. When considering all of these ingredients within the arena of psychotherapy seems that empathy is the most important. Empathy can be described as "the ability to

understand and enter into the feelings of another" (Watts, p.412, 2009). Empathy then seems to be the primary means through which one can sensitively listen to another which therefore leads to the establishment of a healthy rapport between patient and clinician. The therapist's empathetic stance allows the patient to feel listened to, to feel as if they matter and to feel that another person cares about what they are going through. This then facilitates how the patients on the Mat open up more to the therapist during and leave the Mat sessions with a sense of connection with the therapists. This is consistent with what Greenberg et al., (2001) and his colleagues describe in their article titled *Empathy*. Empathy is said to lead to god outcomes as it increases patient's feelings of safety, increases patient's feeling of satisfaction, compliance and self-disclosure. It is important not only to be empathetic but also to be flexible. This would mean to meet different patients and their different emotional and mental needs. Even though some patients may, for example, have similar problems they may view them and think about them differently as a result of their psychological make-up. The therapists working on the Mat expressed the importance of working with patient on their level so as to reach them more effectively, as opposed to applying one hard and fast rule to all patients that approach the Mat.

In considering the Baby Mat intervention as a whole, its focus is largely on the mothers who approach the Mat rather than the mother-infant relationship. Within the Parent-infant-psychotherapy literature one can find a number of authors emphasising how the mother-infant relationship is the patient rather than either the mother or the baby (e.g. Acquarone, 2004; Baradon & Broughton, 2005; Masur, 2009). The literature focuses on the mother-infant relationship as it is believed that it is within this relationship that development takes place (Paris, Spielman & Bolton, 2009). How then can one understand the mother focus that the Baby Mat intervention employs which is different from the more popular mother-infant focus? Within the context of Alexandra mothers are more emotionally impoverished and without much internal and material resources. This may then pull the intervention and the therapists towards more of a mother focus. This would then serve the purpose of containing and equipping the mothers to be more sensitive and responsive mothers towards their children.

Comparison between the subjective experiences of mothers and therapists

From the data it appeared that there were various similarities between the therapists and the patients in terms of their thinking on a number of issues on the Mat. This was remarkable

considering that therapists and patients come from such different world views and are expected to view and understand a variety of matters in different ways. Another reason why this is interesting is that the some of the mothers have only been to the Mat once. The similarities lay in the same expressed experiences of being on the Mat and also the similarities of understanding the presenting problems in some cases. The mothers on the Mat were able to describe in their own way their important experience of empathy and rapport during the sessions. The therapists also confirmed this when describing the essential elements to psychotherapy that are present during Mat sessions. It seems that it is very important for a therapist to be flexible or rather client centred. Carl Rogers highlights the importance of being client centred as this is a route to personality change (Rogers, 1954). This finding also implies the effectiveness of the intervention. As noted in the beginning of this study, it was stated that the Baby Mat intervention has grown over the years and has seen more and more patients on the Mat. Although the contact with mother and child may be short-lived, it seems to be effective to some extent.

There also existed differences between the mothers and therapists. These difference centred on the understanding of presenting problems between some mothers and therapists but not on experiences of the Mat. At times the therapists had a better understanding of the problem than the mother did. Even at the end of a Mat session, some mothers still could not shift their way of seeing the problem. This may be seen as resistance from the mothers. One may not be sure of the exact root of their resistance but it can be postulated that it may be difficult to drop all of one's defences when with others, especially during first encounters. Resistance does not only hinder therapy but can also be a useful way to get to get to understand the individual who is being deal with in therapy (Newman, 1994). Especially with re-visiting patients, therapists can use this defence as a way to gather information about the patient and plan around future treatment. However, this is not always the case as it is seen that at other times it was apparent that a few mothers had a better understanding of the problem than did the therapists. This may indicate that at times the therapists underestimated the profundity of the experience that the mothers encountered while on the Mat.

Limitations of the Study

The following limitations were applicable to this study. Firstly, the researcher only interviewed ten women and two therapists for the study. This can be considered to be a small sample of participants on which to base a research study. The second limitation is that the study only draws on the in depth experience of its 12 participants, and generalisability may be limited. A third limitation would be that the participants in this study might have not been able to express their criticism of the intervention fully. The mothers on the one hand might have not been able to express their criticism fully as they might have still identified the researcher with the intervention. On the other hand therapists might not have been able to criticize the Mat fully as they are involved in the Mat project. Because interviews were only based on one Baby Mat intervention, the experience discussed in the interviews would be limited. However, this is a feature of the intervention generally so while it perhaps has been a limitation it may have offered a more true to life perspective. Another limitation was that the semi-structured interviews were conducted in English. The disadvantage to this could be that the English language might not always have captured the essence of what the participants may have wanted to communicate. In such instances the participants had the option of using an alternative and more familiar language to them during parts of the interview.

Recommendations for future research

One recommendation for future research would be that a larger sample size be obtained in order to make the study more generalisable to the larger population.

Another recommendation would be to follow up the mothers who have accessed the Mat after a period of time (for example six months) and interview them on how having accessed the Mat has affected the way they see themselves as mothers and how they see their children. This would be useful in helping the Baby Mat intervention gain a better understanding of the long-term impact of their work on their patients. In relation to this one could interview the mothers who have repeatedly accessed the Mat and find out from them why it is that they continue to attend sessions on the Mat.

The third recommendation would be to speak to some of the mothers who have not accessed the Mat before and find out from them the reasons for this and whether they have any opinions about

the Mat. Related to this recommendation could be to interview the mothers who were offered follow-ups on the Mat and to other Mat related services and declined in order to understand what their basis for declining might have been.

The above recommendations are particularly focused on the Baby Mat project. There is, however, also a great need for research on other parent-infant intervention approaches relevant to the South African context.

Conclusion

This research has sought to explore the subjective experiences of both mothers and therapists participating in the Baby Mat Project. The main findings of this study indicate that the mothers overwhelmingly experienced the Baby Mat intervention, and their contact with the therapists, as positive. This is noteworthy given that mothers reported that what they had expected to have received from the intervention what they had expected to receive. Mothers reported initial disappointment at not having received concrete solutions but, reported having left the intervention with more positive and emotionally eye-opening experiences. Mothers' ability to open up and to move from a superficial to a deeper level of understanding their children seemed to be due to their positive perception of the Baby Mat therapists. These findings indicate the potential of Baby Mat therapists to assist mothers to begin to develop the capacity to mentalise.

Therapists described many counter-transferential feelings towards the patients. Negative feelings were at times difficult to tolerate. In addition the therapists identified skills which they believed to be effectual in helping them access their patient's deeper feelings during Mat sessions. These included empathy, openness to listen to the patient and flexibility in dealing with different and unique clients.

The study found that the similarities between the two participant groups were far greater than had been anticipated. A predominant similarity was that of the parallel subjective experiences of Baby Mat sessions reported by both therapists and mothers. There were fewer differences between therapists' and mothers' perceptions. Some notable differences included either an overvaluation or an undervaluation of the therapists' evaluations of the extent to which mothers shifted in response to the intervention and differences in understanding the core presenting problem.

The study offers several implications for the Baby Mat Project. First, this study suggests that the quality and value of the service is noted and appreciated by mothers. In short term, often once-off, interventions, it is sometimes difficult to evaluate the impact of an intervention on its consumers; these findings suggest that the Baby Mat Project is greatly valued by mothers, whose main negative comment was that they would like more access to the Baby Mat. Second, the approach of the Baby Mat Project to focus on mother and infant more broadly rather than strictly

on offering solutions seems to hold value. Although mothers had expected more concrete solutions, it seemed that the self-discovery they accessed was much more highly valued by them. Third, it should be acknowledged that the work undertaken by therapists is both enormously rewarding and very challenging. This indicates that support for therapists is essential. Fourth, differences between therapists' and mothers' perceptions indicate that it may be useful, at times, to explore mothers' understanding of the presenting problem and the message they have gained from the Baby Mat before a particular intervention is concluded. Finally however, the more predominant similarities between mothers and therapists indicates the responsiveness of both parties to work that is highly valued by both.

It is hoped that this study has contributed to a deeper understanding of the subjective experiences of those involved in the Baby Mat project – both therapists and clients. Because of the uniqueness of this project, this research also hopes to offer perspectives on mother-infant work in deprived contexts and in third world settings where resources are limited. It has been clear from this study that the therapeutic work conducted within this setting has had an important impact on all parties. Mother-infant work holds great possibilities for future intervention and research.

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APPENDIX A

INTERVIEW SCHEDULE FOR MOTHERS

1. How did you experience being on the Mat?
    - Is it what you had expected?
    - How was it different to what you expected, if it was not what you expected?
2. How did you experience the therapists on the Mat?
    - Did you find it easy connecting with and opening up to the therapists on the Mat?
    - Which therapist did you find it easiest to open up to?
3. How did you think of your relationship with your child before being on the Mat?
4. Has the way you think about your relationship with your child changed after being on the Mat?
5. What did you like about being on the Mat?
6. What did you dislike about being on the Mat?
7. Would you return to the Mat?
    - What is it about having been on the Mat that would make you want to return?
8. What have you learnt from being on the Mat?
9. Do you think being on the Mat has helped you in any way?
10. How do you feel now?

INTERVIEW SCHEDULE FOR THERAPISTS

1. How did you experience being on the Mat with mother _____?
    - Were you able to connect with her?
    - Was she participating in the therapeutic process?
2. How did you experience her as a mother during the process?
    - What was her interaction with her child like?
3. How do you think she thought about her relationship with her child before accessing the Mat?
4. Do you think that she thinks of her relationship with her child in a different way after having accessed the Mat?
5. How do you think that being on the Mat will impact their relationship in future?

6. Do you think they would benefit from being on the Mat again?
7. What do you think they have specifically learnt from being on the Mat?
8. How do you feel now?

APPENDIX B

School of Human and Community Development

Private Bag 3, Wits 2050, Johannesburg, South Africa

PARTICIPANT INFORMATION SHEET (therapists)

The Baby Mat Project: Similarities and differences between the experiences and perceptions of mothers and therapists

Hello,

My name is Nonhlanhla Nkosi. I am a Master's student at the University of the Witwatersrand and I am conducting research as part of my degree. The study aims to examine the experiences and perceptions of those mothers who access the Baby Mat and the therapists who offer the Baby Mat service. I wish to explore the similarities and differences between the mothers' and therapists' responses so as to understand which aspects of the Baby Mat service mothers and therapists may experience differently or similarly.

I would like to invite you to participate in this research study.

If you choose to participate, I will ask you to spend about an hour with me answering questions about a particular session you have had on the Baby Mat. I will ask you to reflect on the session that you have had, how you understand the mother you have had your session, with and your evaluation of how the session went. The interview will be conducted at a place convenient to you, most likely on the premises of Alexandra Clinic. I will ask your permission for the interview to be tape recorded.

Participation in the study will involve no risks. There are no personal benefits to participating in the study, although you may find the interview, and the resulting research report, to be helpful to your work.

Participation in the study is voluntary. There will be no consequences for you or your work if you decide not to participate in the study. You may choose to withdraw from the study at any time or to decline to answer any of the questions asked.

I will ensure confidentiality by making sure nobody knows that you participated in the study. Your real name will not be used at any point in the research report and will not be known to my supervisor or anybody else. I will also disguise any identifying information mentioned in the interview that could reveal your identity or that of your client.

The research will be written up in the form of a research report and possibly published as a journal article. I will send you a summary of the research if you so choose. Interview data will be securely kept in a password protected file for a maximum of five years.

Should you feel that you need further counselling you may contact Lifeline, a free counselling service, on 011 268 6396.

Thank you.

Nonhlanhla Nkosi (Researcher)

0735703619

Email: keneishir@gmail.com

Carol Long (Supervisor)

011 717 4510

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APPENDIX C

School of Human and Community Development

Private Bag 3, Wits 2050, Johannesburg, South Africa

PARTICIPANT INFORMATION SHEET (mothers)

The Baby Mat Project: Similarities and differences the experiences and perceptions of mothers and therapists

Hello,

My name is Nonhlanhla Nkosi. I am a Master's student at the University of the Witwatersrand and I am doing research as part of my degree. Research is a way to learn an answer to a question. In this study I want to learn about what it has been like for you and your therapist to use the Baby Mat service. This will help us to understand better what it is like for mothers to use the Baby Mat and how this is different or similar for therapists. I am interested in talking to mothers who are over the age of 18.

I would like to invite you to volunteer to take part in this research study.

If you decide to talk to me, I will ask you some questions about what it was like for you to be on the Baby Mat. I will ask you to talk in English. We will spend about an hour talking together at Alexandra Clinic. I will also ask you if I can tape record our interview so that I can remember exactly what you said. With your permission, I will also talk to the therapist who was with you on the Baby Mat.

There will be no risks to you if you decide to talk to me and your decision will not affect your treatment at Alexandra Clinic. There will be no benefits involved in to talking to me.

You can choose whether or not you want to volunteer to be part of this study. You can also change your mind and decide not to talk to me, or not to answer some of my questions, whenever you want to.

I will not tell anybody that you have talked to me and nobody except me will know your name. I will not use your real name or your child's real name when I write about the study. I will also make sure to change anything that may identify you to others.

I will write about all the interviews in a research report and possibly a journal article. I will send you a summary of the research if you would like me to. I will keep all your information safe in a password protected file for a maximum of five years.

If you want to talk to a counsellor after our interview, you can phone Lifeline (011 268 6396) or the Ububele Umdlezane Parent Infant Psychotherapy Service (011 786 5085). Both of these services are free.

If you want to find out more about my study before deciding, or if you want to contact me, I have included my numbers below.

Thank you

Nonhlanhla Nkosi (Researcher)

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APPENDIX D

School of Human and Community Development

Private Bag 3, Wits 2050, Johannesburg, South Africa

INTERVIEW CONSENT FORM

I _____, agree to participate in this project.

- The purpose, nature and procedures of the study have been explained to me and I understand what is expected of me if I agree to participate in the study.
- I know that I do not have to answer any questions that I do not want to answer during the interview and that there will be no negative effects if I choose to do so.
- I understand that by signing this consent form I am agreeing to my participation in this study of my own free will.
- I will also be guaranteed confidentiality in that none of the information I give will be used in the research report in a way to identify me.
- I give consent that my direct words be used, yet not at the risk of revealing my identity.
- I know that I can withdraw from the interview at any time I wish to and if I choose to do so I will not experience any negative consequences.
- I know that there are no risks or benefits associated with participating in this study.
- The data will be destroyed within two years should publication occur and after five years should publication not occur.

Signed: _____

Date: _____

APPENDIX E



School of Human and Community Development

Private Bag 3, Wits 2050, Johannesburg, South Africa

RECORDING CONSENT FORM

I _____, hereby consent that my interview be audio-taped.

I understand that:

- My identity will be protected and that the information I give during the interview will be kept confidential and only seen by the researcher and her supervisor.
- The audio-recordings will be kept in a safe place on the University premises so as to ensure confidentiality, and access to these tapes will be protected.
- The data will be kept in password protected files on the researcher's computer and the audio-recordings will be destroyed after that study is completed.
- The data will be destroyed within two years should publication arise and after five years should publication not arise.

Signed: _____

Date: _____