

https://dspace.org/

Practitioners' perceptions and experiences of the baby mat mental healthcare intervention

Preston, Nicole Louise

2017

https://hdl.handle.net/10539/26008

Preston, Nicole Louise (2018) Practitioners' perceptions and experiences of the baby mat mental healthcare intervention, University of the Witwatersrand, Johannesburg, <http://hdl.handle.net/10539/26008>

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

Practitioners' Perceptions and Experiences of the Baby Mat Mental Healthcare Intervention

A research report submitted to

The Department of Psychology

The School of Human and Community Development

Faculty of Humanities

University of the Witwatersrand

In partial fulfilment of the requirements

of the degree of Masters in Education (Educational Psychology)

Nikki Preston

Johannesburg, South Africa June 2017

Supervisor: Dr Zaytoon Amod

Declaration

I hereby declare that the work of this research report is my own. This work has not been previously submitted in whole, or in part, for the award of any degree. Acknowledgments and referencing of all sources consulted during the research have been made.

Signed:_____ Date: 18-06-2017

Acknowledgements

There are many people whom I would like to thank for their contribution and support. I am grateful to the participants who sacrificed their supervision time to attend the focus group discussions and individual interviews. This study would not have been possible without their input. I would also like to express my gratitude to the community-based organisation for giving me permission to undertake this study. I am especially grateful to the director of the Baby Mat intervention for her guidance and encouragement. Additionally, I am thankful to the individual organisers for assisting in arranging a venue, so that the focus group discussions and individual interviews could take place at the community-based organisation.

I would like to thank my supervisor, Dr Zaytoon Amod, for her sincere passion in this research. Her support, insights and guidance have been invaluable. I would also like to thank my friends and colleagues for their unwavering support over the past year.

Finally, I would like to thank my family for enabling me to further my studies. With their care and support I was able to overcome the challenges presented. I am especially grateful to all my loved ones for their unconditional patience and continuous encouragement during this time.

Table of Contents

Declaration i
Acknowledgements ii
Abstract iii
Chapter 1: Overview and Rationale of the Study 1
1.1 Aims of the Study 1
1.2 Introduction to the Study 1
1.3 Rationale for the Study 7
1.4 Research Questions 8
1.5 Demarcation of the Study 8
Chapter 2: Literature Review 10
Introduction 10
2.1 Theoretical Foundations of Parent-Infant Psychological Interventions 10
2.1.1 Attachment theory 10
2.1.2 Mentalisation and reflective functioning 13
2.1.3 Holding 15
2.1.4 Acknowledgement of the infant 16
2.2 The Baby Mat Intervention 18
2.2.1 Origins of the Baby Mat intervention 19
2.2.2 Relevance of the psychodynamic approach 20
2.3 The Baby Mat Practitioners 21
2.3.1 Practitioner training 21
2.3.2 Implementation of co-facilitation 22
2.3.3 Therapeutic alliance 25
2.4 Attachment Patterns in South Africa 29
2.4.1 Investing in attachment systems in South Africa 29
2.4.2 Attachment-fostering interventions in South Africa 31
2.4.3 Factors impeding secure attachment relationships in South Africa 32
Conclusion 35
Chapter 3: Method 37
Introduction 37
3.1 Methodological Paradigm 37
3.2 Research Design 37

3.3 Context of the Study 38
3.3.1 Living conditions within South African townships 38
3.3.2 Alexandra Township 39
3.3.3 Alexandra Township clinics 40
3.3.4 The caregivers accessing the Baby Mat intervention 41
3.4 Participants and Sampling 42
3.5 Data Collection 44
3.5.1 Semi-structured interview schedule 46
3.6 Procedure of Data Collection 47
3.7 Data Analysis 48
3.8 Ethical Procedures and Considerations 50
3.9 Considerations to Ensure Rigor of the Study 52
3.9.1 Credibility 52
3.9.2 Dependability 52
3.9.3 Authenticity 53
3.9.4 Transferability 53
3.9.5 Confirmability 53
3.10 Position of the Researcher and Reflexivity 54
Conclusion 55
Chapter 4: Results 56
4.1 Practitioners' Lived Experiences of the Baby Mat Intervention 57
4.1.1 An occupation with meaning 57
4.1.2 Feelings of hopelessness 58
4.1.3 Ghosts of therapy 58
4.2 The Therapeutic Relationship 59
4.2.1 Formation of trust through consistency and availability 59
4.2.2 Non-judgemental and unconditional positive regard 60
4.2.3 Reflection of caregivers' childhood experiences 61
4.2.4 The mothering role and *umdlezane* 61
4.2.5 Co-facilitators 62
4.2.6 The mat: A physical therapeutic frame 63
4.3 Practitioners' Perceptions of Developments made in relation to the Baby Mat Intervention 64
4.3.1. Developments made in relation to the quality of mothering 65

4.3.2 Improvements in infant development 66
4.3.3 Developments regarding the caregiver-infant relationship 67
4.3.4 Practitioners' perceptions as to why progress transpires 67
4.4 Challenges Experienced by the Baby Mat Practitioners 69
4.4.1 The Baby Mat 'talk' 69
4.4.2 Resistance to approach the Baby Mat intervention 70
4.4.3 Language, race and culture 71
4.4.4 Experiences of the lay practitioners and the psychologists 72
4.5 Baby Mat Training 74
4.5.1. Experiential learning 74
4.5.2 Innate qualities of being a Baby Mat practitioner 74
4.6 Personal Implications of being a Baby Mat Practitioner 75
4.7 Necessity for Supervision and Support 76
Conclusion 76
Chapter 5: Discussion 77
Introduction 77
5.1 Aims and Findings of the Research Study 77
5.2 The Lived Experiences and Perceptions of the Baby Mat Practitioners 78
5.2.1 The reality of therapeutic work within a South African context 78
5.2.2 Difficulties and challenges 81
5.2.3 Training and support 86
5.3 Developments Perceived by the Baby Mat Practitioners 88
5.3.1 Fostering awareness and insight 88
5.4 Factors Contributing to the Therapeutic Alliance 93
5.4.1. Culturally sensitive facilitation 94
5.4.2 Mutual respect 97
5.4.3 Consistency and reliability 98
5.4.4 Unconditional positive regard 99
Conclusion 102
Chapter 6: Conclusion 103
6.1 Summary and Overview of the Study 103
6.2 Implications of the Results and Recommendations Based on the Findings 105
6.3 Limitations of the Research 108

6.4 Suggestions for Further Research 109
6.5 Concluding Remarks 110
References 112
Appendices 128
Appendix 1: Participant Information Sheet (Focus Group) 128
Appendix 1b: Participant Consent Form (Focus Group) 131
Appendix 2: Participant Information Sheet (Individual Interview) 132
Appendix 2b: Participant Consent Form (Individual Interview) 135
Appendix 3: Focus Group Confidentiality Request 136
Appendix 4: Participant Consent Form (Video Recording of the Focus Group) 137
Appendix 5: Participant Consent Form (Audio Recording of the One-to-One Interview) 138
Appendix 6: Focus Group Semi-Structured Interview Schedule 139
Appendix 7: Semi-Structured Interview Schedule 141
Appendix 8: Human Research Ethics Committee (HREC Non-Medical): Clearance Certificate 143

List of Tables

Table 1: Description of Participants……...44

Table 2: Themes and Sub-Themes Emerging from the Results…….55

Chapter 1: Overview and Rationale of the Study

Chapter 1 contextualises the research study of practitioners' perceptions and experiences of the Baby Mat intervention. The aims of the study are highlighted, followed by an introduction and overview of the research study. Thereafter, the motivating factors and rationale behind the research will be clarified. Lastly, the research questions are specified.

1.1 Aims of the Study

The overall aim of this qualitative research study was to gain insight into the perceptions and experiences of the practitioners who facilitate the Baby Mat intervention. This was conducted through two focus group discussions and three individual interviews. The additional sub-aims of this research study included the exploration of the practitioners' perceptions of the Baby Mat intervention in relation to: (a) the developments within the caregiver-infant relationship; (b) the improvements in the quality of mothering; (c) the infants' development; and (d) the therapeutic relationship shared between the practitioners and caregivers[1]. It also provided insight into the effectiveness of having culturally diverse co-facilitators in community-based interventions in South Africa. These findings will be used in conjunction with other related research to develop and enhance the understanding of the service described.

1.2 Introduction to the Study

The early relationship between mother and child is one that has received extensive attention in psychological literature. Melanie Klein, one of the founding figures of psychoanalysis, acknowledged the importance of an infant's first relationship with his or her primary caregiver in her theory of object relations. She maintained that the most crucial internal objects are those derived from the infant's parents. More specifically, it is the intimate

[1]By virtue of the diverse family structures that epitomise contemporary society and South African communities, this research report approaches the *caregiver* as an encompassing term for the individual who is primarily responsible for raising and caring for the infant or child. In a society where grandparents, older siblings or close adult kin are commonly responsible for child-rearing duties, the terms *parent*, *mother* or *father* are not always accurately descriptive (Ward, Makusha, & Bray, 2015).

relationship an infant has with the mother and her breasts that influences a child's emotional development (Brenman Pick, 1992). British psychoanalyst Donald Winnicott introduced the notion of the *good-enough mother* and further emphasised the necessity for consistent and repeated responsive caregiving toward the infant (Winnicott, 1960). John Bowlby, another early psychoanalyst, also placed prominence on the imperative role played by the primary caregiver with his theory of attachment. He stated that "young children, who for whatever reason are deprived of the continuous care and attention of a mother or a substitute-mother, are not only temporarily disturbed by such deprivation, but may in some cases suffer long-term effects which persist" (Bowlby, Ainsworth, Boston, & Rosenbluth, 1956, p. 211).

Bowlby (1973) held the view that the caregiver-infant relationship lays a strong foundation for future psychosocial, emotional and cognitive development. The eminent "secure attachment" will be fostered if the caregiver responds to the infant's emotional needs and signals, thus providing the infant with affectionate, intimate and constant care (Bowlby, 1969). In extension to Bowlby's work, other researchers maintain these findings in that responsive, dependable, sensitive and empathic care by the primary caregiver toward the infant facilitates secure attachment (Ainsworth, 1974; Beckwith, Rozga, & Sigman, 2002; Haza, Campa, & Gur-Yaish, 2006; Landman, 2009). In contrast, if caregivers fail to provide reliable and warm emotional receptions, the infant is at risk of forming disorganised and insecure attachments (Ainsworth, 1974; van IJzendoorn, Schuengel, & Bakermans-Kranenburg, 1999). Insecure and disorganised attachment patterns are associated with later socio-emotional regulation difficulties, aggressive conduct, and are predictors of both internalising and externalising behaviour symptoms (Beckwith et al., 2002; Groh, Roisman, van IJzendoorn, Bakermans-Kranenburg, & Fearon, 2012; Haza et al., 2006; Hesse & Main, 2006; Loeber & Hay, 1997).

Current research has been increasingly influenced by this school of thought from early psychoanalysts. The expansion of early childhood developmental literature recognises that investing in young people as early as conception will improve individuals' potential for life fulfilment and increase their prospect of contributing to society (Pinnock, 2016). Thus, fostering the earliest relationship between infant and caregiver is a form of personal and societal investment, and will have a profound effect on an individual's later development and throughout their life course.

Understanding and intervening in such relationships affects the work of educational psychologists. In his research, Donald (1991) places particular emphasis on the importance of an educational psychologist's mediating role within the parent-child relationship. Involving a child's family systems is crucial in an educational psychologist's scope of practice to effectively support the child. It is an educational psychologist's responsibility to psycho-educate families as to how positive and functional familial experiences influence healthy child development. Recent literature concurs and stresses the imperative role that educational psychologists play in child adjustment (Pillay, 2011; Theron & Donald, 2012; Toland & Carrigan, 2011). Educational psychologists working in South African communities, organisations and schools are in ideal positions to use their systemic connections to not only influence positive transformation, but to also implement preventative measures to avert later adversity (Donald, Lazarus, & Lolwana, 2010). Incorporating such strategies and measures into their work will support both the children whom they serve and the ecologies that affect them (Pillay, 2011). Thus, through integrating systemic and community-based approaches into their work, educational psychologists' scope of practice is considered to be significantly relevant for South African communities (Donald et al., 2010).

Since the relationship between the infant and caregiver shapes later development and learning, interventions that promote secure attachments and infiltrate into broader South

African communities are essential. Interventions such as these inform caregivers on effective caregiving and directly prevent adverse outcomes associated with insecure attachments.

The Baby Mat intervention, a caregiver-infant therapeutic service that is offered by a non-profit mental healthcare training community organisation in Johannesburg, South Africa, is an example of such a community-based approach. It is a learning centre that focuses on improving the emotional well-being and development of children under the age of seven, their parents and other caregivers (Ububele Educational and Psychotherapy Trust, 2016a). The three Umdlezane Parent-Infant Programme (UPIP) interventions offered at the community organisation include the Baby Mat intervention, Home Visiting and Parent-Infant Psychotherapy. *Umdlezane*, the programme's name, is an Nguni term referring to the indigenous post-partum period when family and friends attend to the mother's practical needs, allowing her to concentrate her attention on her infant (Frost, 2012). The UPIP programmes aim to mirror such support in its services.

Moreover, the aim of the Baby Mat intervention is to support caregivers by enhancing reflective functioning and, in turn, to promote secure attachment (Frost, 2012). The Baby Mat intervention is available at six primary healthcare clinics in and around Alexandra Township (Dawson, Richards & Frost, in press). Two practitioners are involved in the delivery of each Baby Mat therapeutic session. The coupled practitioners typically include a psychologist, an intern psychologist or a multi-lingual lay practitioner (who is referred to as a *home visitor*[2]). The practitioners begin each Baby Mat session with an introductory speech, referred to as the Baby Mat *talk*. During the talk, which is usually conducted in two to three African languages (Frost, 2012), the practitioners inform all the caregiver-infant dyads about the Baby Mat service. The practitioners then invite the caregiver and her infant on to the mat, which is

[2] The home visitors/lay practitioners are practitioners who reside in the Alexandra community. As the home visitors are involved in the UPIP Home-Visiting Programme *and* the Baby Mat intervention, they will visit the caregiver-infant dyads in their home environment, providing further support to caregivers and their infants (Ububele Educational and Psychotherapy Trust, 2016b).

placed on the floor of the waiting area of the immunisation and vaccination ward of the clinics. If the caregiver wishes, she and her infant may approach the mat for the therapeutic service while waiting for her appointment. The mat is used as a physical space where the caregiver can safely share her concerns or uncertainties, and be listened to. The feelings and anxieties expressed by the caregivers allow them to reflect on their own mental state as well as the mental state, needs and desires of the infant (Frost, 2012).

Furthermore, the Baby Mat intervention services are strategically offered in Alexandra Township, as the community organisation identified a need for a community-based mental healthcare preventative intervention in the area. The Baby Mat intervention with its aim to foster secure attachments was a response to this need. Urie Bronfenbrenner's bioecological model is valuable in understanding the *strategic* location of the Baby Mat service. The bioecological model recognises that child development is influenced by multi-systemic factors that are of varying proximity to him or her (Bronfenbrenner, 1977). He illustrated that the intrinsic qualities of a child (for example, a child's predispositions and demographics) are influenced by: (1) the microsystem – his or her home environment and familial dynamics; the school context including school ideologies, teachers and peers; the neighbourhood and community setting; as well as the child's religious affiliations; (2) the mesosystem – this is how the individual's home environment, school, neighbourhood and religious organisations interact, communicate and have interdependent relations; (3) the exosystem – the broader institutions, such as government policies, wider educational structures, social media and the caregiver's work environment and career opportunities, that indirectly influence the child; and (4) the macrosystem – this incorporates the socio-cultural factors that influence a child's beliefs systems, values, ideologies and attitudes (Bronfenbrenner, 1977). He also acknowledged how development may adjust over time (the chronosystem), thus recognising the importance of socio-historical conditions and life

changes that a child and family may have endured. Bronfenbrenner's theory conveys how contextual factors and socio-economic antecedents have a strong potential to affect the caregiver-infant relationship and influence later development.

Additionally, research shows that daily contextual stressors encountered by caregivers may impact their ability to parent effectively and meet the needs of their infant (Bray, Gooskens, Kahn, Moses, & Seekings, 2010; Pinderhughes, Nix, Foster, & Jones, 2001). More specifically, in South African communities and townships, parenting is often burdened with the stressors associated with impoverished living conditions, and as such becomes considerably more difficult (Bain & Richards, 2016; Ward et al., 2015). For example, poverty can burden caregivers' ability to provide for and protect their children in a stable and consistent way, undermining their capability to parent effectively. This increases the likelihood of inconsistent, emotionally distant and harsh parenting (Kotchick & Forehand, 2002). Furthermore, caregivers living in poverty are likely to be poorly educated and less able to provide an education for their children (Bray et al., 2010; Ward et al., 2015). Bromley (2010) found that caregivers perceived Alexandra to be a stressful place to live because they found the area to be threatening and dangerous. Stressful living circumstances correlate with caregivers who are less likely to consistently and effectively tend to their infants' needs, increasing the chances of forming disorganised or insecure attachment patterns (Long, 2009). Consequently, such contextual factors can hinder a caregiver's ability to parent effectively and act as a barrier to healthy child development.

Caregivers perceive the Baby Mat intervention to be a positive experience because they feel they are able to express their concerns, distress, emotions and experiences openly (Aspoas & Amod, 2014; Bromley, 2010). In light of this, a substantial amount of research has been conducted on the caregivers' perceptions of the Baby Mat intervention −including in other similar preventative intervention studies (for example: Aspoas & Amod, 2014;

Bromley, 2010; Frost, 2012; Landman, 2009; Tomlinson, Cooper, & Murray, 2005). However, very little documented research has explored the practitioners' perspective of such an intervention. In a study conducted by Landman (2009), the accounts of both mothers and counsellors of a parent-infant intervention in an informal settlement in the Western Cape, South Africa were explored. But these findings were based on the counsellors' process notes of how the mothers perceived the intervention and not on how the intervention was personally and professionally experienced by the counsellors themselves. Nevertheless, the research on such interventions noticeably highlights that the caregivers have a desire for a supportive ally and a need for acceptance from the therapists involved (Landman, 2009; Stern, 1995).

1.3 Rationale for the Study

The theoretical literature accentuates the value of secure attachment relationships between the caregiver and infant, and demonstrates how a preventative mental healthcare service, such as this one, is of significant importance. The positive correlations that secure attachments have for the development of socially competent and self-regulated individuals make it necessary to invest in interventions that foster quality attachments between caregivers and their infants (Frost, 2012). These services aspire to prevent adverse consequences using early intervention. Thus, it is not solely an individual preventative measure but a societal preventative service too.

What is more − since practitioners are perceived to play an imperative role in this therapeutic relationship −it is essential to understand the perceptions and perspectives of the practitioners concerned. Not only will this be helpful in understanding the various experiences of the practitioners, but this may also serve to inform future training for and application of the intervention in order to ensure that the needs of the caregiver-infant dyad can be met by the practitioners involved (Landman, 2009).

Therefore, this research study endeavoured to address this gap in the research and aimed to gain a deep understanding of the practitioners' lived experiences of their therapeutic work for the Baby Mat intervention. The findings of this study strived to shed light on the effectiveness and challenges of the implementation of the Baby Mat intervention, as perceived by the practitioners who deliver this service. This will further inform Baby Mat training and the optimal application of the intervention (Aspoas & Amod, 2014; Landman, 2009). Finally, as there is a critical need for mental healthcare support in South African communities, the findings will highlight the factors contributing to the efficacy of the intervention, and illuminate a path for the transferability of such a service into other contexts, similar to that of Alexandra Township.

1.4 Research Questions

In relation to the above aims and rationale, the specific research questions were as follows:

- What are the personal and lived experiences of the practitioners of the Baby Mat intervention?
- What are the practitioners' perceptions of the Baby Mat intervention in relation to the caregiver-infant relationship?
- What are the practitioners' perceptions of the Baby Mat intervention in relation to the quality of mothering?
- What are the practitioners' perceptions of the Baby Mat intervention in relation to infant development?
- What are the practitioners' perceptions of the Baby Mat intervention in relation to the therapeutic relationship shared between the practitioners and caregivers?

1.5 Demarcation of the Study

The chapter that follows will provide further detail on the theoretical underpinnings of the study. The Baby Mat intervention is described in greater detail, providing further

understanding of the practitioners' roles. The method used in conducting the study will be described in Chapter 3, followed by the presentation of the results of the study in Chapter 4. In Chapter 5, the findings of the study are discussed in relation to relevant literature. A summary of the research study and its implications as well as recommendations for future research are presented in the concluding chapter of the research report.

Chapter 2: Literature Review

Introduction

This chapter begins with an overview of the theoretical foundations of parent-infant psychotherapeutic interventions. The theoretical exploration traces the Baby Mat intervention's underpinnings of *attachment theory* – which influenced its conceptualisation – as postulated by John Bowlby (Bowlby, 1944, 1958, 1969, 1973) and, later, by Mary Ainsworth (Ainsworth, 1974). Next, the Baby Mat service is described as a psychodynamic-orientated intervention within a South African context. Thereafter, the origins and practices of the Baby Mat intervention are explored in detail. An introduction to the Baby Mat practitioners, the training procedures they undergo, the implementation of co-facilitation and the necessity of forming an adequate therapeutic alliance communicates the distinctive characteristics of the Baby Mat intervention. Following on from this is an exploration of attachment patterns in South Africa; this provides a rich understanding of why fostering secure attachments in community-based settings are important.

2.1 Theoretical Foundations of Parent-Infant Psychological Interventions

2.1.1 Attachment theory

As previously highlighted, John Bowlby was the pioneer of attachment theory and upheld the significance of the early relationship between caregivers and their infants. His attachment theory was derived after working with maladjusted and delinquent boys. He was profoundly interested in understanding how defiant behaviour developed in these children and adolescents. Consequently, the psychoanalyst turned to the ancestry of development by exploring the boys' relationship with their caregivers (Bowlby, 1944). From these explorations, Bowlby paid particular attention to understanding the attachment between the infant and caregiver, as he argued the profound effect it can have on later mental health functioning. It was from this work that Bowlby began to fully appreciate "the reality of the infant's close tie to his mother" and thus aimed to give this relationship the credit it deserved

in mental health literature (Bowlby, 1958, p. 351). In his work, he suggested that an infant needs to experience warmth and intimacy from a dependable mother in order for him or her to gain a sense of security and safety. Bowlby (1969, 1973) believed that such caregiving is essential for the optimal development of the child's mental well-being (Bowlby, 1969, 1973). Conversely, a mother who is unreliable and unaffectionate toward her infant communicates uncertainty to the developing child. This unpredictable caregiving puts a child at risk for the development of mental health problems (Bowlby, 1944).

Bowlby's work was further developed by Mary Ainsworth, a developmental psychologist. She formulated the well-known procedure of the *strange situation*, which focused on and emphasised the quality of attachment (Ainsworth, Blehar, Waters, & Wall, 1978). In her experiment-based research, a caregiver and her infant were placed in a playroom. The caregiver was then instructed to leave the infant in the unfamiliar room, with unfamiliar people, only uniting the infant with the caregiver at a later stage. It was originally hypothesised by Ainsworth that such a *separation* would cause an attachment reaction from the infant (for example, crying or following the mother as she left the room). Ainsworth's most renowned contribution to attachment theory was her recognition that it was the *quality* of attachment between caregiver and infant – not the separation – that influenced the infant's response pattern. Following from this, Ainsworth distinguished two types of attachment patterns that she termed as *secure attachment* and *insecure attachment*.

In the strange situation, the securely attached infant could explore the room when in the presence of his mother, as his mother served as his secure base. When separated from the mother, the infant became upset because of this provoked anxiety by the separation. However, upon her return, the mother was warmly greeted by her child because the baby was comforted by her presence (Ainsworth et al., 1978). The parenting style associated with the infant's reaction was sensitive and responsive caregiving, as the infant felt confident in his

mother's ability to comfort him. Haza et al. (2006, p. 190) summarised Ainsworth's secure attachment with the following:

> The securely attached infant stays close and continuously monitors [the caregiver's] whereabouts (*proximity maintenance*), retreats to her for comfort if needed (*safe haven*), resists and is distressed by separations from her (*separation distress*), and explores happily as long as she is present and attentive (*secure base*).

Ainsworth identified two types of insecure attachment patterns: insecure/resistant attachment and insecure/avoidant attachment. The former, also known as anxious/ambivalent attachment, is characterised by an infant who reacts with intense anxiety, resistance and uncertainty (Ainsworth et al., 1978). When the caregiver is present, the insecure/resistant infant avoids venturing and exploring. This is seemingly because the caregiver does not serve as a secure base for her infant. When separated from the caregiver, the infant becomes intensely distressed and displays signs of separation anxiety; perhaps this is because of the uncertainty as to whether the mother will return or not (Ainsworth et al., 1978). The baby resents being left and shows signs of ambivalence when reunited with the caregiver. The caregiver style associated with this attachment pattern is likely to be one of inconsistency, which initiates much uncertainty and anxiety in the infant.

The latter signifies an infant that presents with little distress when separated from the mother and appears to be indifferent when reunited with her. In the caregiver's presence, the infant is uninterested in exploring or venturing off, conveying a warped secure base (Ainsworth et al., 1978). The infant will distance himself from the caregiver as if he is avoiding his need for attention and affection. The infant has possibly acquired this behaviour because experience tells him that his emotional needs will not be responded to.

Mary Main and Judith Solomon (1990) added to the patterns of attachment literature, as they discovered that not all infants develop these ways of coping. In their research, they

acknowledged a fourth category of attachment, namely a disorganised attachment. Such infants have not been given an opportunity to devise a consistent coping strategy for regulating their negative emotions and anxieties. Infants classified with a disorganised attachment display a confused and abrupt response disposition. They are seemingly frightened of their caregivers; while they appear to seek contact from them, they then abruptly become avoidant as their caregivers approach them (Hesse & Main, 2006; Main & Solomon, 1990).

The disorganised attachment pattern is associated with abusive and neglectful parenting. Research has shown that such caregivers are more likely to present with a depressive disorder or a substance abuse problem (Beckwith et al., 2002), and as such are unlikely to meet the infants' needs because of their unpredictability. This communicates an unsafe environment to their babies, leading the infants to respond in a confused and erratic manner (Hesse & Main, 2006). Caregiver-infant dyads with such an attachment are often considered to be high-risk families, and these infants have been associated with later emotional concerns (Groh et al., 2012; van IJzendoorn et al., 1999).

2.1.2 Mentalisation and reflective functioning

Later research built on attachment theory posited that a caregiver, who is emotionally attuned to the infant, validates the infant's feelings and will provide the child with an accurate sense of self (Baradon et al., 2005). This process was postulated by Peter Fonagy (2001), a Hungarian clinical psychoanalyst, and became known as *mentalisation*: An individual who has the ability to mentalise will have the capability to recognise the thoughts and feelings of another (Fonagy, 2001; Slade, 2005). Mentalisation is theorised to be a skill that is acquired through learning and modelling, as opposed to an innate ability. Accordingly, a caregiver needs to understand her own mental state in order to process and translate such emotions to the infant. It is the role of the primary caregiver to receive unprocessed communications

expressed by the infant and to make sense of these communications. Subsequently, the caregiver's response to the infant will reflect this information back to the child as processed (Bion, 1962; Fonagy & Target, 2003). Consequently, a caregiver who interprets an infant's feelings, thoughts and desires gives the infant a platform to understand these mental processes. Recurring practice of this sensitive reflection supports the child's acquisition of mentalisation competencies (Fonagy & Target, 2003).

In order for the caregiver to empathise with the infant's intrinsic experiences, the caregiver requires an ability of *reflective functioning* (Fonagy, Gergely, Jurist & Target, 2004; Slade, 2005). Reflective functioning is an imperative human competency and process that is needed for a caregiver to effectively reflect and understand the mind and emotions of the infant, and thus mentalise (Aspoas & Amod, 2014; Slade, 2005). Acquiring and practising reflective functioning enhances the caregiver's ability to respond to her infant. It is this ability to appropriately reflect an infant's emotions that cultivates the development of a secure attachment.

Reflective functioning from caregiver to infant conveys emotional attunement to the child. In turn, these reflections facilitate the baby's internalised sense of self, and allows the baby's experiences and emotions to feel validated and seen (Baradon et al., 2005). Continual exposure to such experiences will promote skills that support the developing child to self-regulate emotional impulses (Fonagy & Target, 2003). This development occurs as the baby learns to connect the management of these emotional experiences with the affective mirroring and attunement of the caregiver. Inappropriate mirroring of the baby's emotional state may weaken the process of the infant learning to label his or her experience (Fonagy & Target, 2003). If the infant's emotional state is undermined, the caregiver communicates denial of the infant's emotions. This leads the baby to become overwhelmed by the anxieties attached to these affective experiences.

The implications that the quality of attachment has for later socio-emotional development makes this a significantly important theory. When secure attachments are formed, positive social skills of self-reliance, social competence and self-regulation are commonly developed in a child and adolescent (Sroufe, 2013). Individuals who display these positive behaviours are more likely to become socially responsible and are able to contribute toward society in adulthood (Landman, 2009). Conversely, caregiver-infant relationships that are insecure and disorganised in their attachment have considerable personal and social costs; externalising problem behaviours such as defiance and aggression are common consequences of an insecure and disorganised attachment (Loeber & Hay, 1997; Sroufe, 2013). Such behaviours have been found to be constant throughout one's life course and are strong predictors of antisocial and criminal behaviour in adolescence and adulthood (Farrington, 1988; Groh et al., 2012; Hutchings, Bywater, Davies, & Whitaker, 2006; Stormshak, Bierman, McMahon, & Lengua, 2000).

2.1.3 Holding

The process of reflective functioning necessitates a healthy emotional and psychological state within the caregiver. Donald Winnicott introduced the notion of *holding* in describing the optimal maternal care necessary for the infant (Winnicott, 1960). In his research on primary maternal preoccupation, Winnicott acknowledged the intensified sensitivity a caregiver has for the internal emotional experiences of the baby (Winnicott, 1958). He explained this heightened maternal care as an infant-mother *fusion*, whereby the infant is emotionally and psychologically dependable on the mother.

During this vulnerable and dependent period, Winnicott's *good-enough mother* will actively seek to hold the infant, insulating and safeguarding the infant's developing ego. In other words, the mother's main preoccupation is to consistently and reliably respond to her

infant's psychological, physical and emotional needs. In this way, the mother communicates that her baby's ego is safe from annihilation and impingements (Winnicott, 1960).

Winnicott (1960) strongly upheld the argument that it's highly probably an infant will develop into an insecure and anxious child if a caregiver fails to hold it. Whilst holding the baby is of utmost importance to ensure emotional safety, Winnicott importantly identified that to hold her infant optimally, the mother needs to feel held herself. Controversially, he did not believe that the skill of holding could be taught and suggested that a mother either has or does not have an instinctive ability to hold. However, later parent-infant psychotherapeutic interventions have rejected this, and proved that both holding and reflective functioning are skills that can, in fact, be imparted and applied (Baradon et al., 2005; Bromley, 2010; Chitty, 2015; Cooper et al., 2009; Frost, 2012; Thomson-Salo, 2007).

2.1.4 Acknowledgement of the infant

Critics of early attachment literature have argued against the portrayal of the infant as passive in the caregiver-infant relational dynamic (Lyons-Ruth et al., 1998; Thomson-Salo, 2007; Trevarthen & Aitken, 2001). This initiated a thinking transformation by acknowledging the infant's position in parent-infant psychotherapy. The Baby Mat intervention upholds this approach by recognising that the infant is an emotional being that has psychological capabilities extending beyond physiological instincts and reflexes. Trevarthen and Aitken (2001, p. 3) documented an infant's active development of the *self-and-other* in their relational theory of *inter-subjectivity*. The theory acknowledges an infant's intrinsic motivation and purposeful desire to socially engage with an environment of human factors. It understands "that the infant is born with awareness specifically receptive to subjective states in other persons" (Trevarthen & Aitken, 2001, p. 4). A caregiver, who successfully responds to the infant's motives for intersubjective communication (for example, his or her desire for social interaction), enables the baby to develop self-regulation skills and social proficiencies,

fostering pro-social engagements later in life. In contrast, mothers who neglect to do so, place their infant at risk of negatively impacting such developmental milestones (Trevarthen & Aitken, 2001). Therefore, the theory of inter-subjectivity does not disregard the infant or perceive the infant as passive, but rather that the baby is recognised as an active participant between all dynamics in his or her relational world.

Closely aligned with inter-subjectivity is the concept of *implicit relational knowing* (Lyons-Ruth et al., 1998). This is characterised by an individual's knowledge of how to behave in a socially and culturally appropriate manner. It is the ability to interpret social cues – how to show affection, when to laugh at a joke or how to approach and talk to individuals of different status and relation (Lyons-Ruth et al., 1998). The process of *knowing* is acquired at an unconscious level and begins to develop from infancy. Observing and modelling social behaviours and engagements, and understanding non-verbal communication and verbal interactions, as demonstrated by the caregiver, facilitates the infant's development of such skills. The caregiver is paramount in contributing to and mediating the repository of implicit relational knowing. Secure caregiver-infant attachments will promote this unconscious development and guide the child in learning socially acceptable responses and behaviours (Lyons-Ruth et al., 1998).

Therapeutic interventions that acknowledge the infant as a capable and active social participant nurture a foundation for the baby to develop appropriate ways of social engagement and interaction. Thomson-Salo (2007) maintains that the therapeutic process can be used as a tool to model – or remodel, if necessary – implicit relational knowing. The therapeutic space allows for a therapist to interact with the caregiver and infant, and model effective parenting behaviours as a result. Hence, the therapist becomes the mediator enabling such skills to be acquired, promoting this development to transpire (Thomson-Salo, 2007).

The aforementioned theories all commonly stress the importance of the caregiver's technique of responding to her infant. What is more, the research sheds light on acknowledging the infant's strong capacity for emotional reception. The literature conveys how crucial the caregiver-infant receptive relationship is in the formation of a secure attachment. Additionally, considering the positive implications secure attachment has for later pro-social development, fostering a caregiver's ability to communicate, respond and engage aptly with her infant is critical. Early intervention and support, therefore, needs to be a necessity. An example of an early preventative intervention in South Africa is the Baby Mat service that was developed by Katharine Frost in 2007 (Frost, 2007, 2012).

2.2 The Baby Mat Intervention

The Baby Mat intervention concept was based on the aforementioned theories, namely: attachment theory, mentalisation, reflective functioning, holding, inter-subjectivity and implicit relational knowing.

The parent-infant psychotherapeutic service is currently running in six primary healthcare clinics in Alexandra Township, where it has been on offer since July 2007 (Frost, 2012). The implementation of the Baby Mat intervention arose out of the need for primary preventative mental healthcare services in community settings, such as Alexandra Township. The principal aim of the intervention is to support the infant-caregiver dyad, based on the theoretical underpinning that nurturing a secure attachment will prevent later unfavourable outcomes. Equipping caregivers with skills of reflective functioning, and encouraging them to assimilate this way of connecting with the infant, is expected to foster the development of secure attachments (Frost, 2012). Furthermore, the Baby Mat intervention envisages that by therapeutically holding and containing the mother/caregiver, it will support her in becoming preoccupied with her infant and in turn, help her to hold her baby.

2.2.1 Origins of the Baby Mat intervention

The Baby Mat intervention was inspired by other outreach projects and interventions that value similar objectives and ideals. More specifically, the Anna Freud National Centre for Children and Families (Anna Freud: NCCF) community outreach project, conducted at the England's Lane Hostel in Camden, influenced the origins of the Baby Mat intervention (Frost, 2007, 2012). This outreach work offers parent-infant psychotherapy to marginalised communities and homeless families. The goal of the project is to reach high-risk families with babies who do not have access to mental healthcare institutions (Anna Freud NCCF, 2016). The outreach work supports parents to make sense of and understand their infant's needs, and respond to their baby sensitively. Simultaneously, parents have an opportunity to express their concerns in a safe and comfortable space. Experienced child and adult psychotherapists, with specialised competencies in early childhood interventions, conduct the service. The practitioners also acknowledge the adverse circumstances of these families and recognise the particular strain associated with their living conditions. Therefore, the practitioners are skilled in dealing with postnatal depression, socio-economic stress and domestic violence (Anna Freud NCCF, 2016). The project delivers psychotherapeutic services within the context of conventional healthcare clinics with the aim of removing the stigma associated with psychotherapeutic intervention. Thus, normalising the service for those in need is a primary aim (Anna Freud NCCF, 2016). Having parallel values in common, the Baby Mat founders saw relevance and transferability of this therapeutic service for South African communities.

Additionally, the Baby Mat intervention was also influenced by a mother-child community-based project that took place in Khayelitsha, Cape Town (Cooper et al., 2002). Khayelitsha is a socioeconomically deprived community that reflects many of the adverse conditions that individuals who live in Alexandra Township in Johannesburg experience. The

project was implemented to develop the quality of mother-infant relationships by visiting pregnant mothers twice during the later stages of their pregnancy and then for six months after birth on a weekly basis (Cooper et al., 2002). The practitioners in this study were trained in a mother-infant intervention programme whereby the mother's mood, her relationship with her infant and the infant's growth were the primary focus. The aim was to provide the mother with emotional support and encourage her to respond sensitively to her infant. Advice on how to manage her infant with regards to sleeping routines, crying and feeding concerns was also provided to the mother (Cooper et al., 2002).

In 2009, a few years after the implementation of the project, a randomised, controlled trial was conducted to assess whether the quality of mother-infant relationships as well as infant attachments had improved (Cooper et al., 2009). The outcomes of the study informed that mothers in the experimental group were more responsive and sensitive to their infants than the mothers in the control group (Cooper et al., 2009). The evidence led the researchers to postulate the effectiveness of this early childhood intervention programme.

Interestingly, further evaluative research on the project concluded that the mothers positively experienced the respect and acceptance that was provided by the practitioners involved. The mothers also expressed their need for a supportive and non-judgemental ally (Landman, 2009). Such findings served as additional evidence that the therapeutic relationship within psychotherapy plays a paramount role when connecting with parent-infant dyads (Stern, 1995; Landman, 2009).

2.2.2 Relevance of the psychodynamic approach

The Baby Mat intervention is "influenced by psychoanalytic parent-infant psycho-therapeutic principles" (Frost, 2012, p. 611) because of its inclusion of attachment theory (Bowlby, 1969), mentalisation and reflective functioning (Fonagy et al., 2004; Slade, 2005). However, upon reflection of how caregivers and practitioners have had to make use of the Baby Mat

service, in the here and now, it has become clear that the intervention is not a stringent psychotherapeutic space (Frost, 2012).

Considering that the majority of South Africans are not of European decent, a more progressive, less Westernised approach is often facilitated by practitioners. Consequently, the Baby Mat practitioners have tailored their facilitation to blend Western psychoanalytical ideas with that of indigenous African traditions, thus making the intervention more relevant to meet the needs of a diverse multicultural society (Aspoas & Amod, 2014). To supplement this, the community organisation forms part of the South African Psychoanalytic Confederation (SAPC). This confederation was created for the purposes of guiding psychoanalytic therapists in their practice and making psychoanalytic work more applicable to the South African context (South African Psychoanalytic Confederation, 2012).

2.3 The Baby Mat Practitioners

The following discussion introduces and illuminates the role of the Baby Mat practitioners. The explanation will highlight how this blended form of psychotherapeutic practice is applied.

2.3.1 Practitioner training

All Baby Mat practitioners are trained in parent-infant mental healthcare, which is based on the Anna Freud NCCF introductory course (Frost, 2012). The training course is aimed at lay people, community-based caregivers and practitioners who are interested in developing their skill set in working with infants, children and caregivers. The Baby Mat training involves eight sessions, which introduce parent-infant psychotherapy and working with caregivers and their infants. The course is experiential and includes both theory and parent-infant observations (Ububele Educational and Psychotherapy Trust, 2016b). The theory focuses on infant development and the infant's earliest relationships. Attachment theory is examined,

concentrating on the precursors and risk factors for insecure and disorganised attachment (Ububele Educational and Psychotherapy Trust, 2016b).

The process, procedures and skills needed for the practical application of the Baby Mat intervention are incorporated into the eight sessions of training. This is where competencies of reflective functioning, mentalisation and holding are fostered and practised. The trainees are skilled to work in pairs, consisting of a lay person and an intern psychologist or a registered psychologist. The coupled practitioners learn to work with what is presented on the mat, in the here and now (Frost, 2012). Together they are taught to observe the interactions between caregivers and their infants, as well as to attend to the presenting concerns of the caregivers. The training also includes role play and simulating case studies of the Baby Mat therapeutic service. The course is presented by the director of the community organisation and another counselling psychologist. The pair supervise the trainees during their theoretical learning and practical experiences. Thereafter, ongoing supervision and skills development takes place on a weekly basis, once practitioners are trained and are delivering the intervention.

2.3.2 Implementation of co-facilitation

A study was conducted in 2007 on the piloting of the Baby Mat intervention. It shed light on where improvements needed to be made in relation to the delivery of the service. In the first few months of implementation, the researchers were concerned about the slow response of the caregivers to what the Baby Mat intervention offered (Frost, 2012). Based on the findings of this study, a decision was made to include multilingual social auxiliary workers (the lay Baby Mat practitioners) who would partner with a psychologist in conducting the Baby Mat intervention (Frost, 2012). The lay practitioners are community-based caregivers from Alexandra Township who have an interest in working with caregivers and infants. They were recruited through the UPIP Home-Visiting project. The Baby Mat director approached trusted

organisations in the Alexandra community to recommend women who they felt were empathetic, warm and reflective caregivers. The women they recommended were then invited for selection interviews. Successful candidates portrayed skills of reflective functioning and mentalisation. Furthermore, the lay Baby Mat practitioners are familiar with the local knowledge, traditional beliefs and culture of the community. With their addition, the utilisation of the mat vastly improved. The coupled practitioners not only strengthened communication, but the dynamic between the two practitioners also aided the effectiveness of the intervention, as reported by Frost (2012).

In the 1950s and 1960s, co-facilitation or team therapy became a popular strategy in group psychotherapy as a way of managing and responding to larger group dynamics (Heilfron, 1969). Later, Tom Andersen's Reflecting Team Model (1987) in family therapy became a renowned form of teamwork therapy. Teamwork therapy is based on the notions of constructivism by upholding respect for the way in which individuals subjectively perceive the world (Willot, Hatton & Oyebode, 2012). Andersen (1987) acknowledges the strength of incorporating multiple perspectives, knowledge systems and differences of opinions into a therapeutic setting in order to effectively and ethically attend to clients' unique perceptions and experiences. He upheld that it is important to "share different versions of the same world" (Andersen, 1987, p. 2). Thus, Andersen's model views teamwork therapy as an approach that minimises power relations between the families served and the therapeutic team. The therapeutic team is believed to maintain ethical principles of justice, respect and fairness, as well as enhance feelings of client empowerment and inclusivity (Willot et al., 2012). The advantages of co-facilitation or teamwork therapy are combined therapeutic insights and technical abilities, different perspectives on the transference-countertransference relationship, the constitution of a two-way learning process, and alleviating isolation associated with private practice (Heilfron, 1969; Mintz, 1963; Willot et al., 2012).

Taking the rationale of co-facilitation and teamwork therapy into consideration, Saleebey (1994) further advocates that meaning-making is the basis for therapeutic and psychological services. In his research, he argues that psychological practice is where the meanings of the therapist (the theories in which the therapist basis his or her work) meets the client's narratives, culture, beliefs and rituals. Therefore, meaning-making becomes an imperative role of the practitioner in therapeutic work, as it enhances understanding of the client's subjective emotional world (Saleebey, 1994).

Therapists need to be mindful that individuals function in this world by creating meaning, and socio-cultural influences and belief systems provide meaning to individuals' actions, thoughts and feelings (Saleebey, 1994; Willot et al., 2012). Moreover, an individual's culture cannot be neglected in the process of therapeutic meaning-making, as culture and the associated value systems play a considerably influential role in an individual's development. Culture penetrates an individual's psychological development by influencing the way in which he or she perceives, feels, thinks and behaves (Bronfenbrenner, 1977; Huey, Tilley, Jones, & Smith, 2014; Saleebey, 1994).

Therefore, understanding traditional cultural beliefs is imperative to the work of the co-facilitators on the Baby Mat service. Bain and Richards (2016, p. 74) maintain that the "intermingling of diverse cultural beliefs, increased urbanisation and Westernisation, especially in South African cities, calls for an understanding of culture as a non-static, evolving phenomenon". Adopting a meaning-centred approach to therapy accommodates diverse understandings of health and well-being, thereby making the therapeutic process pertinent and culturally sensitive (Campbell-Hall et al., 2010). In a study conducted by Crawford and Lipsedge (2004) on seeking help for psychological distress in a South African setting, it was established that the majority of Black South African citizens make use of both traditional and Western systems of healing. Therefore, a system that blends these two models

will support a feasible and functional relationship between the two healing systems (Campbell-Hall et al., 2010; Saleebey, 1994).

Accordingly, including two practitioners on the Baby Mat who can combine their knowledge of traditional and Western mental healthcare not only aids understanding of the presenting concern, but is also necessary for cultural relevance and applicability of the service. The service then adopts a client-centred approach to mental healthcare and creates a forum that facilitates meaningful communication and respectful collaboration between the two systems of healing. This approach makes co-facilitation a highly recommended service for South African community-based mental healthcare interventions (Campbell-Hall et al., 2010; Dawson et al., in press; Saleebey, 1994).

2.3.3 Therapeutic alliance

During the therapeutic session, the practitioners "listen carefully to her [the caregiver], simultaneously responding to and reciprocating communications from the infant" (Frost, 2012, p. 610). Essentially, the practitioners demonstrate reflective functioning towards the caregiver in the likelihood that such behaviour will in turn be modelled by the latter toward the infant. Moreover, the therapeutic alliance offers the caregivers a platform for emotional relief and support (Bromley, 2010). The exploration conveys how the therapeutic alliance between the practitioners and the caregiver-infant dyad is instrumental in the effectiveness of the Baby Mat intervention.

2.3.3.1 Assessing the relational dynamic

The infant's communications are regarded as particularly fundamental in the assessment of the attachment development between the caregiver and infant. While simultaneously attending to the caregiver and her baby, the practitioners are observing the dyad's relational dynamic. Frost (2012) suggests that there are a number of questions that the practitioners remain mindful of when observing the dyad, including: Is eye contact between the baby and

caregiver made?; does the caregiver respond to her baby's communicated desires and needs?; what is the caregivers understanding of such communications?; and is the baby comforted by the caregiver's responses? The developmental accomplishments of the infant-caregiver relationship are qualitatively assessed by the Baby Mat practitioners. This is done by monitoring both the infant's development and the communication between the caregiver and the infant (Frost, 2012).

Additionally, the transference and countertransference relationship serves as supplementary evidence to evaluate the efficacy of the therapeutic process. Winnicott (1962) maintains that "the therapy that is needed involves the therapist personally" (p. 72). In other words, just as the scalpel is the tool for a surgeon, the therapist's mind, emotions and thoughts are the tools for therapy. The countertransference and transference of the therapeutic relationship, formed between the client and practitioner, are valuable sources that inform diagnostics (Lemma, 2008). According to Jones (2004), transference is used to gain further insights into the therapeutic process and relationship. The transference of clients highlight their unresolved anxieties, which may be projected onto the therapist. The countertransference is the living response and relationship to the transference – if the transference is silenced, the countertransference cannot reach its full potential and aid knowledge development (Racker, 2002). Countertransference events are a useful indicator of what is happening in the client's unconscious in relation to the therapist – it is an instrumental tool that fosters understanding of the transference of the client and therapeutic relationship (Racker, 2002). Bromley (2010) maintained that the transference-countertransference relationship provided the Baby Mat caregivers with a relational encounter and offered them a sense of oneness and joining.

2.3.3.2 Mhlawumbe: The notion of wondering

Furthermore, it has been found that caregivers communicate a variety of concerns on the Baby Mat (Aspoas & Amod, 2014; Bromley, 2010; Frost, 2012). Often the anxieties brought to the fore by the caregivers are concrete in nature. For instance, caregivers will voice their concerns about their infants' persistent crying, skin rashes, or sleep difficulties (Aspoas & Amod, 2014; Frost, 2012). Caregivers also reflect on their personal concerns, for example, painful remnants of their past or daily stressors that are compounded by their harsh living conditions frequently surface. The caregivers' anxieties are acknowledged and contained by the practitioners. The practitioners will use their clinical judgement to support the caregivers in exploring their concerns in a more symbolic and psychotherapeutic manner.

The symbolic exploration allows the caregiver to think of herself, her infant and the infant-caregiver relationship (Frost, 2012). In order to facilitate this, practitioners use *mhlawumbe,* an isiZulu term that directly translates into "perhaps" in English. *Mhlawumbe* facilitates the therapeutic strategy of *wondering*. In her work on reflective parenting programmes, Slade (2007) advocates a wondering of the presenting problem; wondering enables the therapeutic process to progress in a gentle manner and helps facilitate the caregiver to engage with the different possibilities of her concerns. It permits the caregiver to hypothesise and therapeutically fantasise about potential reasons for her distress and anxiety. In doing so, she is able to wonder about herself, her baby and their relationship in a safely facilitated space. Thus, "the Baby Mat aims to introduce a way of thinking about the infant that moves from the concrete to the symbolic; from the physical to the relational; and from the symptomatic to the psychological" (Frost, 2012, p. 612).

2.3.3.3 Umdlezane: A need for a supportive ally

Daniel Stern, the renowned American psychoanalyst and psychiatrist, acknowledged the anxiety provoked by the journey into motherhood, and described this as the *motherhood*

constellation (Stern, 1995, p. 172). His research invaluably explained that first-time mothers yearn for nurturing and support from an experienced mother or grandmother figure. Stern (1995) reflected that caregivers with absent maternal figures were responsive to parent-infant psychotherapy and compared the support from the therapist to that of a grandmother's. Moreover, his research also illuminated that parent-infant interventions needed to do more than hold and contain caregivers' anxiety. The new caregivers desired encouragement and recognition of their mothering abilities.

A prominent characteristic of the Baby Mat intervention is that of *umdlezane,* which mirrors the motherhood constellation postulated by Stern (1995). *Umdlezane* refers to the post-partum period when a caregiver can focus her energy on her infant's needs, while other women oversee practical duties in the home. The other women usually consist of relatives such as grandmothers, older sisters or female kin who support the caregiver in prioritising her baby during this time (Frost, 2012). The Baby Mat practitioners' guidance, holding and containment sets out to fulfil the role of *umdlezane* to those caregivers who so desire.

Studies conducted on caregivers' perceptions of the Baby Mat service suggest that a deficit/absence is felt during the period of *umdlezane* when caregivers' mothers or grandmothers are no longer present, due to distance or loss (Aspoas & Amod, 2014; Bromley, 2010; Frost, 2012). However, the research established that caregivers utilising the Baby Mat intervention "found comfort in the way that the facilitators tried to see things from their perspective and that they were not judgemental" (Aspoas & Amod, 2014, p. 587). The caregivers utilised the Baby Mat to obtain advice, and also perceived the practitioners to be sufficient replacements for absent mother and grandmother figures.

2.4 Attachment Patterns in South Africa

Subsequent to the above discussion, a closer inspection of attachment systems in South Africa will be considered. The following exploration emphasises the growing need for interventions such as the Baby Mat service in South Africa.

2.4.1 Investing in attachment systems in South Africa

There is a growing body of literature emphasising the necessity of investing in early childhood development as a solution to many social ills in South Africa (Barbarin & Richter, 2001; Pinnock, 2016; Richter et al., 2012). The *born-free* generation – the population of children born into democratic South Africa – are today's young adults, and encompass almost half of the country's population (Lefko-Everett, 2012). The term *youth bulge* is used to describe this group of young South Africans, referring to their window of opportunity to provide an economically productive future for South Africa (Cooper, De Lannoy, & Rule, 2015, p. 60). The reforms associated with democracy promised this cohort of children opportunities that their parents, grandparents and ancestors were denied.

Arguably, the post-1994 government made considerable democratic advances. Policies and legislation were created that gave primary obligation to young people and early childhood development (for example, the White Papers, the Children's Act, the Child Justice Act, and the Schools Act). However, in hindsight, there appears to be a gap between "plan, promulgation and enactment" (Pinnock, 2016, p. 226). The consequences of failing to effectively implement early childhood developmental policies have fed into South Africa's intergenerational cycle of poverty and social inequalities.

To an extent, this negligence has caused the youth to feel abandoned by the unfulfilled promises of post-apartheid policies. Exclusion is a reality for many young South Africans and the infuriation is palpable (Ward et al., 2015). The current tertiary education crisis in South Africa is a pertinent example of the "the ticking time bomb" of the aggravated

born-frees (Lefko-Everett, 2012, p. 9). The lack of educational opportunities, high levels of youth unemployment and continued social and economic deprivation are the reason for the youth's demoralisation and unrest, and has the potential to threaten the future of South Africa (National Planning Commission, 2012).

The importance of investing in early childhood development has never been so critical. Capitalising on these impressionable developmental years has the potential to reconstruct a new South Africa (Pinnock, 2016; Ward et al., 2015). Interventions aimed at targeting early childhood have the propensity to:

> Produce children who are healthy in every sense of the word and youths whose default does not have to be crime and violence. The resultant saving on policing costs alone would be significant. There would be savings in the budgets of prisons, the courts, healthcare services and private security. The resultant drop in crime rate would boost international investment and tourist confidence (Pinnock, 2016, p. 229).

Accordingly, the result of investing in early childhood would benefit individuals and society exponentially. As a result of acknowledging the crucial necessity of such interventions and programmes, an Early Childhood Development Policy (ECDP) draft was presented in 2015 (Republic of South Africa, 2015a). The objectives of the policy, which underscore the commitment to these fundamental early years, acknowledge the power of unlocking the potential of the youngest population to develop a future for South Africans. The ECDP has aligned its aims to children's constitutional rights by implementing measures that support their holistic well-being in order for them to maximise their cognitive, emotional, physical and psychological functioning (Republic of South Africa, 2015a).

More important, and pertinent to the Baby Mat intervention, the ECPD recognises the importance of attachment systems, thereby including the well-being of caregivers into its goals. For example, the policy proposes the implementation of interventions that will promote

the healthy pregnancy of mothers by providing psychological and social support. Moreover, parenting guidance and support will be encouraged to strengthen parents' capacity of early childhood stimulation (Republic of South Africa, 2015a).

2.4.2 Attachment-fostering interventions in South Africa

There is a lack of literature on attachment patterns in South Africa and it has only been in the last few years that studies on this area have been conducted. A 2005 study on mother-infant relationships and infant attachment in a South African peri-urban settlement found high levels of disorganised attachment patterns (25.8%) (Tomlinson et al., 2005, p. 1048). The high rate of disorganised attachment was considered to be indicative of maternal preoccupations, such as intimate partner violence, HIV/AIDS, rape and abuse. The psychosocial stress of living in such a community evidently impacted on caregiving capabilities.

In contrast, an unforeseen 61.9% of infants were found to have a secure attachment with their caregiver figure (Tomlinson et al., 2005, p. 1048). Considering the severity of social hardship and the adverse conditions of the impoverished setting, the high rate of secure attachments was unexpected. It was postulated by Tomlinson and colleagues (2005) that this positive conclusion may be indicative of *ubuntu*, whereby community members seek social support from one another. *Ubuntu* is also an Nguni term that roughly translates into "human kindness", which resonates with the values of *umdlezane.*

Further research on attachment surrounds the piloting and implementation of attachment-fostering interventions as well as evaluations of the mothers/caregivers' perceptions of these services (Aspoas & Amod, 2014; Bromley, 2010; Cooper et al., 2002; Cooper et al., 2009; Landman, 2009). Subsequently, there is a dearth of research that conveys the statistics and prevalence rates of attachment patterns in South African caregiver-infant dyads. Moreover, there is a shortage of empirical, longitudinal research conducted in South

African settings that explain the correlational affects between attachment patterns and later outcomes.

The Baby Mat is one of the few secure attachment-fostering interventions taking place within a community-based setting in South Africa. Consequently, the research generated from and expanded on the Baby Mat service may add to the small amount of literature.

2.4.3 Factors impeding secure attachment relationships in South Africa

The socio-economic and cultural climate in which caregivers find themselves may influence their ability to parent in terms of their responsiveness and sensitivity. As formerly established, in order for a mother to be able to provide a holding environment for her baby, she needs to feel held herself (Winnicott, 1960). Living in poverty is accompanied by daily challenges that often deprive a caregiver of feeling emotionally held, thus impeding her capacity to optimally hold her infant. To further explain how attachment formation is affected in South African communities, the stressors associated with impoverished communities will be explored in detail. Additionally, the stigma to seek therapeutic support indirectly places a further burden on the caregiver-infant dyad in relation to attachment; consideration will be given to how such factors impact the Baby Mat intervention.

2.4.3.1 The stressors associated with poverty

The discussion on Bronfenbrenner's (1977) bioecological model in the preceding section conveyed how contextual factors can affect relational, emotional, physical and mental functioning of an individual, and, thus, impact on the quality of the caregiver-infant relationship. According to Cooper and colleagues (2015), poverty undermines physical and mental health in all its dimensions. For instance, living in poverty is often characterised by inadequate shelter, poor nutrition and unhygienic environmental conditions. The economic and financial deprivation correlated with poverty often means limited access to a range of quality and accessible services, including primary healthcare services, mental healthcare

support, education and infrastructure such as electricity, water and transport. Furthermore, Foster (2012) identified that it is predominantly those living in townships that experience the majority of South Africa's violence, abuse and community disruptions. This implies that these citizens live in chronic fear of falling victim to criminal activity and delinquent conduct. Moreover, the lack of quality education results in limited information regarding child rearing, development and healthcare. What is more, these factors decrease the opportunity for children to escape such realities, and thereby perpetuate poverty from one generation to the next (Ward et al., 2015).

The hopelessness, pain and suffering of living in deprivation are immensely taxing on a caregiver's psyche. For example, the intensity of daily stressors associated with living in impoverished communities are often thought to be a precursor for postpartum depression (Barbarin & Richter, 2001; Donald et al., 2010; Ward et al., 2015). An infant subjected to the parenting of a depressed or emotionally unstable caregiver is believed to suffer traumatic experiences (Baradon, 2005). The infant's reaction has been described as the *dead baby complex*, where an infant is indifferent to the presence of the primary caregiver. The baby begins to cope through avoidance, by emotionally disengaging from the caregiver and forming a state of *derailed development* (Baradon, 2005, p.49). Therefore, as a result of the environment in which they live, depressed and distressed caregivers are more likely to put their infant at risk of developing a disorganised or insecure attachment (Beckwith et al., 2002; Bray et al., 2010).

Consequently, caregivers living in harsh contextual circumstances often become consumed with additional daily burdens, which may negatively impact their preoccupation with their infants. Thus, poverty tends to heighten parental distress and anxiety, and may potentially diminish a caregiver's ability to provide consistent, supportive and responsive caregiving (Bain & Richards, 2016; Cooper et al., 2015; Long, 2009; Ward et al., 2015).

Subsequently, forming a secure attachment between caregiver and infant becomes significantly more challenging. As a result, poverty substantially escalates the probability of initiating the development of a disorganised or insecure attachment, making it more likely that the child will experience unfavourable outcomes later in life (Bray et al., 2010; Kotchick & Forehand, 2002; Long, 2009; Pinderhughes et al., 2001; Ward et al., 2015). Unfavourable outcomes include a higher likelihood of dropping out of school and thereby limited youth employment opportunities, and increased risk-taking behaviours such as substance use, unprotected sex and defiant behaviour – all of which continue the cycle of intergenerational transmission of poverty (De Lannoy, Leibbrandt, & Frame, 2015; Moore, 2005). Not only does the cycle of poverty impact on the holistic well-being of the individual, it also jeopardises the future social and economic functioning of South Africa (National Planning Commission, 2012).

Such findings communicate the critical need for investing in mental healthcare support for caregivers living in impoverished communities, particularly during the vulnerable period of *umdlezane*. Interventions, such as the Baby Mat service, are fundamental and valuable contributors in disrupting this intergenerational transmission of poverty.

2.4.3.2 Stigma to seek help

It is important to explore the likelihood of caregivers responding to community-based interventions, such as the Baby Mat service. Community attitudes and beliefs, lack of knowledge and stigmatisation are known to prevent individuals in help-seeking behaviours (Hugo, Boshoff, Traut, Zungu-Dirwayi, & Stein, 2003). There is an assumption that individuals who seek mental healthcare support will be subjected to discrimination, leading to a resistance against therapeutic services (Quinn, Williams, & Weisz, 2015). As society perceives mental health to be an indication of weakness and abnormality, individuals anticipate that they will be stigmatised for engaging in help-seeking behaviours (Lucksted &

Drapalski, 2015). Globally, the negative connotation attached to a mental health disorder often leads to the discontinuation of treatment or, worse, avoiding support entirely. Stigma is perceived to yield harm in two ways: it weakens self-esteem and undermines individuals of social and economic opportunities (Corrigan, 2004; Quinn et al., 2015). Further research on the negative effects of stigma found that it reduces hope and a sense of recovery, and it exacerbates possible psychiatric mental health conditions, causing greater resistance to other support treatments (Lucksted & Drapalski, 2015).

The stigma attached to seeking support for child-rearing or child illness differs slightly in South African communities. The traditional cultural belief of *impundulu* – evil forces that have bewitched or invaded the infant – stigmatises the ill infant as well as the caregiver, making it distressing and humiliating to seek healthcare treatment (Berg, 2003, p. 269). *Impundulu* implies that ancestors are no longer guarding or protecting the baby, leaving the infant defenceless to these malevolent forces. Such beliefs leave caregivers vulnerable to judgements and discriminations, preventing them from seeking support for their infant or themselves.

Aspoas & Amod (2014) confirmed caregivers' trepidations associated with such beliefs. They found that caregivers accessing the Baby Mat intervention revealed that they were scared of approaching the service for fear of being judged. Consequently, this led to them masking their vulnerabilities and anxieties, resulting in their avoidance of approaching the service. In light of this, the stigma attached to help-seeking behaviours can be considered as a considerable barrier in attachment-fostering services, such as the Baby Mat intervention.

Conclusion

Chapter 2 explored the theoretical foundations that influenced the conceptualisation of the Baby Mat intervention. In light of the theoretical underpinnings, the rationale of the Baby Mat intervention was discussed and conveyed. The role of the practitioners delivering this

service was clarified. The following chapter, Chapter 3, examines the methods that were followed when conducting this research study.

Chapter 3: Method

Introduction

The methodological approach used and the research design adopted in conducting this study will be discussed in this chapter. The selection of participants and sampling method employed will be outlined, followed by a description of the procedure used in conducting this study. The data analysis procedure is also described. Ethical considerations are presented, as well as factors to ensure rigor of the study.

3.1 Methodological Paradigm

The research followed a qualitative mode of inquiry. Without the use of quantifying data, qualitative research aims to explore and explain social behaviours, contexts and human experiences (Fossey, Harvery, McDermott, & Davidson, 2002). The qualitative approach is suitable for this particular research study as it aimed to understand the perceptions and experiences of the practitioners who deliver the Baby Mat intervention.

The primary philosophical tradition that supports qualitative research is the interpretivist paradigm (Morgan & Sklar, 2012). An interpretivist paradigm involves understanding individuals' subjective human experiences and actions, which are interpreted by the researcher at hand (Terre Blanche, Durrheim, & Painter, 2006). Accordingly, the underpinnings of the interpretivist paradigm were adopted and utilised as a framework for this research study.

3.2 Research Design

Under the framework of the interpretivist paradigm, a qualitative-descriptive exploratory research design was applied to facilitate the collection, analysis and understanding of rich interpretative data (Hseih & Shannon, 2005). It is suggested that qualitative research is useful to fully understand poorly understood or complex aspects of health (Fossey et al., 2002; Hseih & Shannon, 2005). The adoption of this research design aided the exploration of the

perceptions and experiences of the practitioners who currently deliver the Baby Mat intervention. Furthermore, it allowed participants to reflect, in an in-depth manner, how they perceive the Baby Mat intervention in relation to: (a) the caregiver-infant relationship; (b) mothering; and (c) the infant's development. Lastly, the practitioners were able to explore and discuss their perceptions of the Baby Mat intervention in relation to the therapeutic relationship shared between themselves and the caregivers. The researcher facilitated the discussion and participants were given the opportunity to freely explore their experiences of these topics.

3.3 Context of the Study

As previously highlighted, the community organisation is situated on the outskirts of Alexandra Township, and the Baby Mat psychological support initiatives are aimed at its residents. Remaining cognisant as to how the community's dynamics may affect the practitioners' experiences, various factors of the setting of Alexandra are examined below.

3.3.1 Living conditions within South African townships

Article 27 of the United Nations Convention of the Rights of the Child stipulates that every child has the right to a standard of living for his or her development (Office of the High Commissioner of Human Rights, 1989). The social inequalities and impoverished living conditions that epitomised the apartheid regime have perpetuated into post-1994 democratic South Africa. The intergenerational cycle of poverty pre-determines the difficult living conditions that many South Africans experience (De Lannoy et al., 2015; Moore, 2005).

As previously amplified, more often than not the adversities of living within a lower socio-economic bracket are associated with the following: a limited opportunity to quality education; a lack of unemployment prospects due to a lack of skills; insufficient access to healthcare institutions; teenage pregnancy; child-headed households; inadequate nutrition; a higher likelihood of suffering from preventable infectious diseases (such as tuberculosis and

HIV/AIDS); geographically separated families; overcrowding; and the fight for limited resources causing violence and crime (Foster, 2012; Hall & Sambu, 2015; Kang'ethe & Itai, 2014; Pinnock, 2016). Such factors cyclically play a contributing role of deepening the anguish of those already suffering.

In 2013, approximately 54.3% of South African children lived below the poverty line, surviving on R21 a day (Hall & Sambu, 2015, p. 107). This indicates that a large percentage of the country's families remain uncertain as to when their next meal will be. Further, the high infant and child mortality rates in South Africa are a powerful indicator of the health of the country. What is more, it vividly emphasises the psychological pain and agony that many South African caregivers face. In 2013, almost a quarter of all infant and children under-five deaths were caused by preventable diseases (Statistics South Africa, 2014). With limited access to healthcare services, and thus a lack of immunisation and vaccination opportunities, infectious diseases such as pneumonia, HIV/AIDS, tuberculosis and intestinal infections can be held responsible for the deaths of many South African children. Coupled with this, the poor living conditions, the fight for primary resources and daily psychological distress have a ripple effect on other social ills. Violent neighbourhoods, domestic abuse and crime are common in such areas, because of the building frustration and desperation for basic resources (Foster, 2012).

3.3.2 Alexandra Township

In his autobiography, Nelson Mandela described the living conditions of Alexandra Township:

> It could fairly be described as a slum, living testimony to the neglect of authorities. The roads were unpaved and dirty, and filled with hungry, undernourished children scampering around half-naked… A single water tap served several houses. Pools of stinking, stagnant water full of maggots collected by the side of the road. Alexandra was known as the "Dark City" for its complete absence of electricity (Mandela, 1994, p. 88).

The peri-urban settlement of Alexandra was proclaimed a designated Black area or a "Native Township" in 1912 (Wilson, 2003). It is located in the north-eastern suburbs of Johannesburg, and neighbours some of the wealthiest areas of the city. Its infrastructure was built to accommodate a population of 70,000 during apartheid. The area was home to 20,000 shacks and was characterised by severe poverty, deprivation and neglect (Wilson, 2003). Today, the township carries the deep scars of apartheid and continues to epitomise the descriptions communicated by Mr Mandela.

Research findings recorded the population of Alexandra to now be over 470,000 (Mthembu, 2012). The immense growth is a result of migration from neighbouring countries in search of employment in South Africa (Dawson et al., in press). Subsequently, Alexandra is a densely populated area and overcrowding aggravates issues associated with the already inadequate resources (Wilson, 2003). Alexandra's level of unemployment is estimated to be 60%, which directly correlates with its poor standards of living and impoverished community (Wilson, 2003). Living within such a low economic bracket has been known to result in increased feelings of stress, violent offending, domestic abuse and higher rates of teenage pregnancy (Bromley, 2010; Dawson et al., in press; Easterbrooks, Chaudhuri, & Gestsdottir, 2005; Foster, 2012). As conveyed by the statistics, overcrowding, poverty, violence and crime evidently are not ruminations of apartheid, but remain firm characteristics of Alexandra in post-democratic South Africa (Alexandra Clinic Annual Report, 2009).

3.3.3 Alexandra Township clinics

While primary healthcare clinics in Alexandra are geographically accessible, the efficiency of the services provided is lacking (Roos & Banda, 2010). Statistics show that out of the total population of 470,000, 100,000 people, if not more, attend the clinics yearly (Statistics South Africa, 2014). Masses of patients waiting to be attended to and limited staff mean that the services provided by the clinic become unmanageable. Long queues are a frustrating

reality for South African caregivers and their infants, and being turned away happens more frequently than not. In their research study on the accessibility of primary healthcare services in Alexandra Township, individuals within the community conveyed their despondence, mistrust and despair towards the unreliable service delivery of primary healthcare clinics. The services that are provided were perceived to be inefficient and delivered in an unacceptable and inequitable manner (Roos & Banda, 2010).

3.3.4 The caregivers accessing the Baby Mat intervention

The caregiver-infant dyads, who potentially approach the Baby Mat intervention, attend the Alexandra primary healthcare clinics for their infants' routine immunisations (Frost, 2012). The caregivers are allocated to a clinic based on their address, and thus have little choice regarding the facility the caregiver-infant dyads visit and which practitioners will attend to them. The majority of the caregivers accessing the Baby Mat intervention are Alexandra residents. Accordingly, the caregiver-infant dyads are likely to be subjected to poor and unsanitary living conditions, have little income or be unemployed, and experience high levels of crime (Frost, 2012; Roos & Banda, 2010; Wilson, 2003). Moreover, approximately 30% of antenatal patients in South African clinics are HIV-positive (Republic of South Africa, 2015b, p. 26). Mirroring this, one in three caregivers who access the Baby Mat is HIV-positive (Frost, 2007, 2012).

Additionally, many of the caregivers who approach the service are teenage mothers in search of support from a maternal figure. From 2009 to 2014, the amount of infants that were born to teenage mothers declined from 30% to 7%, respectively (Statistics South Africa, 2015). While teenage pregnancy rates appear to be decreasing, young caregivers between the ages of 15 and 24 are still a vulnerable population and are at an increased risk of postpartum depression, repeat pregnancies, dropping out of school and having weak parental guidance (Ardington et al., 2012). Furthermore, many of the caregivers who attend the Baby Mat are

immigrants. Gauteng has the highest immigration rate in South Africa, of which the majority are from African countries, namely Zimbabwe, Nigeria, Democratic Republic of the Congo, Lesotho, Angola, Zambia, Congo and Malawi (Statistics South Africa, 2013, 2016). Many of the immigrants have come to South Africa seeking employment or for humanitarian reasons (such as asylum seekers and refugees) and reside in informal settlements (Statistics South Africa, 2013).

In light of such demographics, Frost (2012) maintains that the caregivers who approach the Baby Mat express a variety of concerns:

- Anxieties relating to their HIV infection. Alternatively, the caregiver is grieving the death of a loved one– be it a mother, child, spouse, family member or friend – due to an infectious disease.
- Stress of living within a poverty-stricken environment, for example, their inability to provide for their infants and families, experiences of having a shortage of food, inadequate housing, difficulties with transport and unemployment.
- Teenage caregivers seeking reassurance and guidance in relation to parenting.
- The conditions of being an immigrant, for example, the alienating consequences, xenophobia, and living far away from social and emotional support structures.

3.4 Participants and Sampling

The participants were selected through purposive sampling. Purposive sampling was chosen as the sampling method of choice because the participants were selected with a purpose based on specific criteria which were of interest to the researcher (Ritchie & Lewis, 2003). The Baby Mat practitioners were the participants selected in order to gain a detailed understanding of their perceptions and experiences of the current Baby Mat intervention. Considering their direct involvement with the intervention, it was assumed that these participants were likely to be knowledgeable and familiar with the Baby Mat intervention;

this facilitated a detailed exploration and discussion of the current practitioners' perceptions and experiences of the Baby Mat intervention.

The following sample inclusion criteria were used: (a) Participants had undergone infant mental health training at the community organisation; (b) they had delivered the Baby Mat intervention for at least one year; and (c) they attended their weekly scheduled Baby Mat sessions at the clinics in and around Alexandra Township. At the time of this study, the Baby Mat intervention was being delivered by 12 practitioners comprising registered psychologists and lay practitioners. The intern psychologists, who usually form part of the Baby Mat team, were undergoing Baby Mat training at the time of the data collection. Therefore, they were not able to participate in the research project. Table 1 provides the background details of the participants of the study.

Table 1

Description of Participants

Participant	Race	Training	Baby Mat Delivery (Years)	Language Spoken	Interview Type
1	Coloured	Psychologist	2	English	Focus Group 1
2	White	Psychologist	2	English	Focus Group 1
3	White	Psychologist	1	English	Focus Group 1
4	Black	Psychologist	4	Zulu; English	Focus Group 1
5	Black	Lay Practitioner	4	Sepedi; English	Focus Group 1; Individual Interview
6	Black	Lay Practitioner	1	Setswana; English	Focus Group 1; Individual Interview
7	Indian	Psychologist	2	English	Focus Group 1
8	Black	Lay Practitioner	5	Sepedi; Sesotho; English	Focus Group 2
9	Black	Lay Practitioner	2	Zulu; English	Focus Group 2
10	Black	Lay Practitioner	1	Sepedi; English	Focus Group 2
11	White	Psychologist	1	English	Focus Group 2
12	Black	Psychologist	2	English	Individual Interview

3.5 Data Collection

The methods of data collection applied in this research study were two focus group discussions and three individual interviews. Focus group discussions are valuable when trying to explore thoughts and feelings, because the interaction of the participants stimulates conversation as they share and compare their perceptions, desires and experiences (Greef, 2011; Terre Blanche et al., 2006). The two focus groups consisted of a mix of lay practitioners and registered psychologists. There were seven practitioners in the first focus group and four practitioners in the second focus group. The group sizes were originally planned to consist of seven practitioners in each focus group. However, considering that the

intern psychologists were no longer eligible to take part in the study, fewer practitioners were involved in the focus group sessions. Additionally, a practitioner who was scheduled for the second focus group cancelled for personal reasons, but was rescheduled for an individual interview at a later stage.

Ideally, it would have been best to have two focus groups consisting of six participants in each group. Krueger and Casey (2000) highlight that five to 10 individuals are typically appropriate for a focus group. However, considering the convenience and practical needs of some of the participants, the focus group sizes had to be modified.

Limitations during the focus group discussions were encountered during this study's data collection process. A known disadvantage of focus groups is that some participants may find a group situation intimidating and threatening to converse openly (Krueger & Casey, 2000). Furthermore, depending on the group dynamics, participants may feel pressurised into agreeing with the dominant view. These limitations in particular, became evident in the focus group sessions. As Table 1 portrayed, the participants varied in their socio-economic and cultural backgrounds, and they differed in their demographics, education and language. Their occupational status as well as their various roles and responsibilities within the community organisation was also different amongst the participants. Consequently, such factors influenced what was said, left unsaid, agreed and disagreed upon. Certain voices were more dominant in the discussions, while others found it more comfortable to remain quiet and agree with what was being raised and discussed.

In order to ensure a degree of triangulation, individual semi-structured interviews were also held with a lay counsellor and a registered psychologist. Since a member of the Baby Mat team was unable to make the second focus group, an additional individual interview was held. Individual interviews create an environment that is open and safe, where researchers can explore how participants authentically feel about their experiences (Greef,

2011; Terre Blanch et al., 2006). The succeeding individual interviews conveyed that certain participants felt that they were less able to share their thoughts in the focus group discussions, and found the one-to-one conversation more comfortable. Applying both data collection methods enhances a researcher's opportunity to gain a deeper comprehension of a phenomenon by understanding from different angles and perspectives (Terre Blanche et al., 2006).

3.5.1 Semi-structured interview schedule

A semi-structured interview schedule was utilised to facilitate the focus group interviews (see Appendix 6) and individual interview discussions (see Appendix 7). A semi-structured interview schedule ensures that the focal points of the research are addressed, whilst enabling an environment that flexibly permits open exploration of new ideas that are brought to the fore during the discussion by the participants (Ritchie & Lewis, 2003; Terre Blanche et al., 2006). Moreover, due to the specific research questions required and the exploratory nature of the research study, semi-structured interview schedules are recommended (Hseih & Shannon, 2005).

The schedules were developed after thorough review of the literature surrounding the topic and aims of the study. The questions considered the participants' experiences of the Baby Mat intervention, highlights of their work, limitations and drawbacks, and factors they perceived as important for the intervention to work productively. The one-to-one interview schedule was similar to that of the focus groups interview schedule, as some of the same topics needed to be probed further. However, the individual interview schedule was generated based on information and discussions that were raised in the previous focus group sessions. This element of flexibility is an advantage of the semi-structured interview schedule (Ritchie & Lewis, 2003).

The one-to-one interviewees were selected based on their participation in the focus group discussions, i.e. members who were significantly quieter or expressed different views in the focus groups were selected. Considering that the absent team member who had the individual interview is a registered psychologist, it was decided that the other two individual interviews would be conducted with lay practitioners. These one-to-one interviews were held with the selected participants to gain further insight into their perceptions and experiences, which could not be sufficiently explored during the focus group sessions.

3.6 Procedure of Data Collection

Written permission to conduct this research study was granted from the director of the community organisation. Ethical clearance to commence with the study was also obtained from the University of the Witwatersrand's Human Research Ethics Committee Non-Medical (Protocol number: MEDP/16/006 IH, see Appendix 8). Ethical procedures and considerations were rigorously followed (please refer to section 3.6 of the research report for a detailed discussion of these procedures).

Since the practitioners work at the community organisation, the researcher and the director coordinated a suitable time and date for data collection. It was suggested by the director that all the interviews could be conducted during the Baby Mat practitioners' supervision meeting that takes place every Tuesday afternoon for an hour. The participants were approached by the researcher at the first meeting. Once the necessary voluntary and written consent was obtained from all of the participants, the data collection process began, starting with the focus groups sessions. The focus groups preceded the individual interviews, as information from the two focus group discussions was used to illuminate the additional information required for the individual interviews. The individual interviews served to ensure that sufficient and quality data were collected. This is a technique employed in qualitative

research known as saturation, and confirms that the necessary data have been adequately collected to support the study (Walker, 2012).

The two focus groups were held for one hour each on two separate occasions during the practitioners' Baby Mat supervision periods. The three individual interviews were held a few weeks after the focus groups. All the data collection sessions were opened by a welcoming introduction, as well as an explanation of the research study, its rationale and context, from the researcher. It was explained that an understanding of the participants' perceptions and experiences of the Baby Mat intervention would be beneficial for adding to the current literature regarding interventions such as the Baby Mat service. The participants were informed that they would not suffer any negative consequences for not answering a question or requesting to leave the discussion.

As previously noted, one of the three individual interviewees could not participate in the previously scheduled focus group session. Thus, in this particular case, the original interview schedule that was used for the focus group discussion was utilised, as the participant could not reflect on the focus group experience.

3.7 Data Analysis

Once data were collected, the video and audio recordings were transcribed verbatim for data analysis to proceed. The data were analysed by means of thematic analysis, informed by Braun and Clarke (2006). This approach provides a six-phase process on how to conduct thematic analysis that is not specifically attached to a theoretical position. These phases include becoming familiar with the data, identifying codes within the data, searching for themes from the codes identified, refining the identified themes, naming the themes, and identifying verbatim extracts from the collected data to convey the essence of each theme (Braun & Clarke, 2006). The phases are not a dictated linear process – rather, the researcher interchanges between them.

The first phase required the researcher to become familiar with the data. This was achieved by listening to the interview audio recordings and watching the focus group video recordings multiple times. All the interviews were then transcribed verbatim. Reading the transcripts on multiple occasions also aided in developing familiarity with the data. Devoting time to this phase proved to be invaluable, as it supported the intricate analysis of the data.

Identifying codes within the data formed part of the second phase of thematic analysis. This phase included finding certain aspects within the data that were of interest to the researcher. In this step, poignant phrases and sentences are acknowledged and flagged. An example of such a statement from the study is: "Whether you come from a different background, whether you are educated or not, it just says we are here for you." This highlighted the supportive nature and non-judgemental disposition of the practitioners, which become prominent themes within the results.

Themes were then searched for from these codes that were identified, leading the researcher to the third phase. This was achieved by grouping and categorising the codes. For instance, the following were categorised under the umbrella of hopelessness: "…there is only so much we can do" and "I look up from the mat and just see the sheer masses that I won't reach." On some occasions, codes formed whole themes, while in other instances codes were applied as sub-themes.

The fourth phase comprised of the refinement of identified themes. In this step the researcher re-analysed the themes from the third stage by understanding how certain emerging themes fitted, or did not fit, with one another. For example, a common theme that emerged was that of the therapeutic alliance. However, after analysing the data further, it became evident that there were certain themes that fitted within this overarching banner. Consequently, the theme was refined and analysed in order to understand it fully.

The above phase was followed by naming themes that emerged from the data. The aim of this phase is to essentially label the themes as simplistically as possible (Braun & Clarke, 2006). Short phrases or words were given to each theme to encapsulate the narrative that the particular theme explores.

The final phase outlined by Braun & Clarke (2006) was to identify verbatim extracts from the collected data to convey the essence of each theme. This was a vital stage, as the choice of extract had to richly demonstrate each theme. Moreover, the extracts needed to enhance the argument of the research study in relation to the research questions and aims.

3.8 Ethical Procedures and Considerations

As previously noted, ethical approval to commence the research study was provided. Written permission to conduct this study was also requested and approved by the director of the community organisation who is responsible for the Baby Mat intervention. The community organisation's director initially provided verbal assurance that all the practitioners had voluntarily agreed to participate in this study. However, the researcher approached and personally asked the practitioners if they would voluntarily like to participate in the study at their first meeting.

Once the participants verbally confirmed their approval to willingly take part in the research study, they were provided with a Participant Information Sheet in the focus group (see Appendix 1) and a Participant Information Sheet in the individual interview (see Appendix 2). The information on these documents assured the participants' anonymity and described their voluntary participation. This explained the research study to the participants as well as highlighted all ethical considerations. The researcher illuminated the rationale and motivation behind the research study to contextualise their participation.

The Participant Information Sheet given to the participants in the focus group differed slightly from the Participant Information Sheet for the individual interview. By virtue of the

focus groups having up to seven participants, the focus group Participant Information Sheet needed to clarify that confidentiality could not be guaranteed. In order to communicate their understanding of this, participants of the focus groups were then requested to sign a form that respectfully requested them to keep the contents of the sessions private (see Appendix 3). All participants agreed to this and gave their written consent.

In order for all of the interviews to commence, the participants were requested to voluntarily sign two consent forms. The first form conveyed the participants' written consent to participate in the focus groups (see Appendix 1b) and the individual interviews (see Appendix 2b). The second was their written consent to be video recorded in the focus group (Appendix 4) and audio recorded in the individual interview (Appendix 5). The participants were assured that no identifying details or information would be used at any point of the study and pseudonyms would be utilised to replace their names. Further, it was highlighted that all information and recordings would be kept on a password-protected computer, and only the researcher and supervisor of the study would have access to the data. The participants were told that the data would be stored for a period of five years.

Terre Blanche and colleagues (2006) maintain that it is imperative that researchers ensure that no harm comes to the participants during the research study (non-maleficence) and researchers should always serve in the best interests of their participants (beneficence). If, for any reason, the participants did become distressed during or after the interviews, the contact details of free therapy services were provided in the Participant Information Sheets. It was clarified that this was merely a precautionary measure. During the interviews, the participants did reflect on certain Baby Mat cases and experiences that ignited emotional and anxiety-provoking responses. Consequently, it appeared that it was necessary to have the contact details available to inform the participants if they so needed.

Additionally, the Participant Information Sheet also emphasised that the participants did not have to answer any questions if they did not want to and had the right to withdraw from the study at any time, without facing negative consequences. Thereafter, participants were given an opportunity to ask any questions that they may have had regarding the study and their participation. Lastly, it was expressed that the relevant stakeholders would receive a detailed summary of the study's findings after the research had been conducted.

3.9 Considerations to Ensure Rigor of the Study

Rigor and trustworthiness of the study's research findings were assured by complying with the following criteria that are advocated by de Vos, Strydom, Fouche, and Delport (2011): *Credibility, dependability, authenticity, transferability* and *confirmability*.

3.9.1 Credibility

Credibility is characterised by the accuracy and legitimacy of the research findings. This was firstly ensured by selecting participants with first-hand experience and knowledge of the Baby Mat intervention through purposive sampling. Secondly, thorough engagement with the research data (recordings, notes and transcripts) demonstrated the clear links between the interpretations made from the data collected.

3.9.2 Dependability

Dependability is the stability and reliability of the research results over time. This was maintained through triangulation and cross-examination of the research findings. Including individual interviews ensured a degree of triangulation, so that the perceptions of the practitioners were understood from a variety of perspectives. Cross-examination of the research results conveyed that the findings of the research study were consistent, logical and dependable.

3.9.3 Authenticity

Authenticity was upheld through the application of Braun and Clarke's (2006) six-phase thematic content analysis. This process informed the researcher on how to generate accurate reflections of the experiences expressed by the participants. The process of supervision was also used to discuss and explore relevant themes. A reflective diary was utilised throughout the research study to guarantee this authenticity.

3.9.4 Transferability

Transferability includes the degree to which the findings can be applicably transferred to other contexts (de Vos et al., 2011). Considering the specific nature of the research study, the findings may not represent the broader community. The intention of this qualitative research study was to explore the topic of concern and elucidate the phenomenon being studied – not to generalise the findings to a population. Nevertheless, in order to maximise the transferability of the study, extensive descriptions of specific details from the research study are provided. Doing so enables transferability to contexts similar to those of this study. Furthermore, insights can be transferred and lessons can be learnt from the rich descriptions provided.

3.9.5 Confirmability

Leedy and Ormrod (2005) argue that the interpretation of qualitative data is often influenced by the researcher's biases and values. Confirmability is achieved by ensuring that the data collected and analysed are not biased or prejudiced by the researcher's subjective perspective. Confirmability of the research findings was maintained by using verbatim quotations and extracts from the participant's discussions. Additionally, probing and questions were used during data collection to make sure that interpretations, understanding and conclusions were accurate.

3.10 Position of the Researcher and Reflexivity

An additional strategy to ensure confirmability of the findings of the study was by acknowledging researcher reflexivity. Applying reflexivity to research requires the acknowledgement of how the researcher may influence the study's process, data collection and analysis, as well as the research findings (Willig, 2008). Qualitative research accepts the subjectivity of the researcher. Considering this, it is necessary for the researcher to recognise the differences in culture, social class, age and race between the participants and the researcher. The researcher of the study is a young White English-speaking middle-class female. As Table 1 portrayed, the participants in the study varied in their demographics. The lay practitioners are Black women who speak African languages, namely isiZulu, Setswana, Sepedi and Sesotho. They are residents of Alexandra Township, are mothers themselves and have many years of experience working as Baby Mat practitioners and on the Home-Visiting programme. The registered psychologists vary in race, including Coloured, Indian, Black and White. Their backgrounds vary from middle to upper class. The psychologists are trained in either educational or counselling psychology. Their years of professional experience as practising therapists vary, as do their years practising as Baby Mat practitioners.

In terms of South Africa's socio-political history, race, culture and socio-economic status need to be acknowledged as important factors because of their potential to influence what is spoken about and what is not openly expressed. These factors not only need to be considered in relation to the researcher, but also in relation to the interacting participants. Their demographic characteristics and their associated social status may affect the dynamics within the focus group.

In order to overcome these hurdles, reflexivity was applied with the aid of a reflective diary that was kept by the researcher. Supervision and guidance by the researcher's supervisor occurred throughout the research process. Additionally, the researcher aimed to

minimise such influential components from interfering with the research by attentively listening to and empathising with the participants. The researcher facilitated the focus groups and allowed for the flexible and open conversations. Constant engagement and reflection of the participants' communications were applied.

Conclusion

Chapter 3 outlined the measures that were taken in an ethical and responsible manner to support the data collection process and the data analysis of this study,. The methodological paradigm used and the research design were described. An outline of the procedure used for data collection and analysis was also given. The following chapter explores the findings of this research study. The results are discussed in relation to the themes that emerged from the data collection process.

Chapter 4: Results

The findings from the research study are explored in this chapter. Several themes emerged from the data collection process. The themes have been categorised into eight overarching domains. Within these predominant themes, relevant sub-themes that surfaced are also examined. Table 2 outlines subheadings of the themes and sub-themes that will be discussed in this chapter.

Table 2

Themes and Sub-Themes Emerging from the Results

Theme	Sub-Themes
Practitioners' lived experiences of the Baby Mat intervention	An occupation with meaning Feelings of hopelessness Ghosts of therapy
The therapeutic relationship	Formation of trust through consistency and availability Non-judgemental and unconditional positive regard Reflection of caregivers' childhood experiences The mothering role and *umdlezane* Co-facilitation The mat: A physical therapeutic frame
Practitioners' perceptions of developments made as a result of the Baby Mat intervention	Developmental achievements regarding the: • Quality of mothering • Infant development • Caregiver-infant relationship Practitioners' perceptions as to why progress transpires • The relevant application of theory • Reaching out: An opportunity for further support
Challenges experienced by the Baby Mat practitioners	The Baby Mat talk Resistance to approach the Baby Mat Language, race and culture Differences in experiences: • The lay practitioners' experiences • The psychologists' experiences
Baby Mat training	Experiential learning Innate qualities of being a Baby Mat practitioner
Personal implications of being a Baby Mat practitioner	
Necessity for supervision support	

The themes were identified within the data by employing an inductive approach. Instead of imposing a deductive framework whereby themes are deduced from a pre-existing framework, the researcher allowed themes to gradually emerge from the data that were

collected (Pope, Ziebland, & May, 2000). Considering this, it became evident that a few themes that emerged from data collection did not directly relate to the identified research questions. However, despite an inductive strategy being employed, it must be taken into account that the research questions were constantly held in mind during the data analysis process.

4.1 Practitioners' Lived Experiences of the Baby Mat Intervention

Sub-themes that illuminated the practitioners' experiences and perceptions of the Baby Mat intervention emerged from the collection of data. The sub-themes shed light on the practitioners' lived experiences and feelings of the service they provide. These are discussed in more detail below:

4.1.1 An occupation with meaning

The practitioners illuminated the meaningful nature of their work and conveyed how powerful the service is for the community it is geared toward. Participant 2 (Focus Group 1) expressed the following:

> The aim of the mat is so that you can go to people and connect… I think it really strengthens our observational skills and thinking symbolically. It's very meaningful work and creates thinking spaces. And you experience mothers in what's more of a natural setting for them.

Moreover, the practitioners pride themselves in offering the caregivers an experience within the clinic that is different from the treatment that they are accustomed to. It was expressed by the practitioners that the caregivers often feel disrespected and judged by the healthcare staff in the clinics. Participant 12 emphasised this in her individual interview: "A lot of the time, some of these moms wait for hours, and some of the nurses are really dismissive and cold and mean, and even that is something they [the caregivers] come to the mat for." In her individual interview, Participant 6 elaborated on this further:

> There was this mother, she had an underweight baby, and before she went to the mat, she was judged. You know that people thought she couldn't take care of her baby, and

> people were making her feel like not a good enough mother and she felt guilty. So we, as practitioners, are another picture from the nurses.

Providing a service that respects the rights of the caregiver and her infant upholds the practitioners' sense of gratification and job fulfilment: "It [the Baby Mat intervention] is so nice; we help her to contain, to see where she has come from and to talk with her in a polite way" (Participant 8; Focus Group 2).

4.1.2 Feelings of hopelessness

Whilst practitioners viewed their work as meaningful and indispensable, their experiences of working on the Baby Mat intervention were also perceived as overwhelming and demoralising. For example, Participant 7 (Focus Group 1) expressed:

> Although I am touching one life, or a few lives, I look up from the mat and just see the sheer masses that I won't reach and it's, um, it's so disheartening at times… I suppose I just feel that we could do more.

Thus, a prominent sense of hopelessness arose during data collection in relation to the practitioners' limited capacity to reach more caregivers who have a profound need of the Baby Mat service: "…at some point there is only so much that we can do. As hard as it is to wrap your mind around it, I think it is something that we have to do to protect ourselves from burning out' (Participant 11; Focus Group 2).

4.1.3 Ghosts of therapy

Following from this, it was frequently expressed by the practitioners that the caregivers' accounts of what they are exposed to when on the Baby Mat are emotionally provocative. For example, Participant 8 (Focus Group 2) said: "Sometimes you can just imagine yourself in that situation." Because of these accounts, the practitioners are often reminded of their own Baby Mat experiences. In her individual interview, Participant 5 added to this when conveying that she often finds herself reflecting on certain Baby Mat experiences:

> And I wondered how the mom was coping. Did she even have a bond with the baby? Maybe she is thinking, "If I wasn't raped, maybe your father will be here

> with us?" There were so many "maybes". But it is so hard. I felt, yoh, yeah, this is the core of the Baby Mat. Some are hard, uh, shocking. Some are, uh, you take with you. Some are just normal. Some are so difficult.

4.2 The Therapeutic Relationship

Forming a rapport with the caregiver-infant dyad is an aspect that the practitioners perceive to be pivotal for the functioning of the Baby Mat intervention. Participant 6 effectively explained the significance of the therapeutic alliance in her individual interview:

> The relationship with the mom is important, so that the mom will be free with me. She will see this person cares for me. If you don't have a relationship with the mom, it will make your work hard – you won't get through to mom. She won't even hear you. The mat for her won't matter.

Discussed below are factors that were perceived to aid the therapeutic relationship and, thus, the efficacy of the Baby Mat service.

4.2.1 Formation of trust through consistency and availability

Trust appears to be a considerably important factor within the therapeutic relationship. The practitioners maintained that their weekly presence at the various clinics in Alexandra provides the caregivers with an element of certainty and predictability. It communicates that the practitioners are reliable and committed to the service. Participant 7 (Focus Group 1) highlighted that it is: "The consistency of being there every week and that they know that you are there, which is the basis of forming a trusting rapport."

Furthermore, the non-committal nature of the Baby Mat service means that the caregivers can make the service work for them at their convenience. The caregivers have control as to when they would like to approach the Baby Mat; they are not expected to fit into a pre-scheduled appointment each week. Participant 2 (Focus Group 1) reflected:

> They're [the caregivers] not committed – it's not like you have an appointment and that they have to come. But they know you're there. They can pace themselves. They might hear the talk three times over, but might only come when the baby is a year old. Because that's when they actually feel that they can come into that space.

Consequently, the caregivers are able to manage their therapeutic experience. Furthermore, Participant 11 (Focus Group 2) also expressed that the consistent presence of the Baby Mat practitioners allows the caregivers to flexibly manage the unpredictability of motherhood:

> Like, this week, the caregiver will think she has a routine and then that changes. And if you are a mom and trying to plan things, it actually is so overwhelming for mothers. So, like this [the Baby Mat], you know if not this week, then next week.

4.2.2 Non-judgemental and unconditional positive regard

The practitioners maintained that the caregivers within this community often avoid openly communicating their negative feelings in fear of being criticised. Their apprehensions relate to not being good enough mothers or being prejudiced regarding their mothering abilities. In light of this, the practitioners elucidated that there is a traditional and cultural belief within the community that condemns caregivers from expressing their negative thoughts and affects. The superstition holds that caregivers should only speak positively of their motherhood experiences, as negative expressions may impinge on their developing infant. Participant 2 (Focus Group 1) clarified this by reporting:

> Some mothers have a real strong social pull to speak positively about their experiences and tend to not… And there is often an idea that negative experiences can affect your baby, and the rule that comes up for the mothers is then don't feel certain ways, and if you do, don't let yourself know that you do, and if you do know, don't let yourself talk about it.

Thus, according to the practitioners, what attracts caregivers into the therapeutic space is the non-judgemental disposition offered by the practitioners. To ease their trepidations, the Baby Mat practitioners' purpose is to adopt an unconditional positive regard toward the caregivers. This allows caregivers to acknowledge their experiences, positive or negative, as opposed to denying their feelings. Hence, the service is one that permits caregivers to converse authentically about their concerns of motherhood:

> There really isn't the opportunity for some new moms to process some of the difficult feelings. So, I think we give permission for that… it's a new kind of permission for them to engage in that kind of conversation (Participant 3; Focus Group 1).

This was further elaborated upon by Participant 12 in her individual interview: "I think, for some moms, it's almost their first experience of motherhood where they aren't judged."

4.2.3 Reflection of caregivers' childhood experiences

The practitioners maintained that caregivers often make use of the therapeutic space to reflect on their childhood antecedents. Participant 9 (Focus Group 2) suggested that, "You can kind of sense that something is there in their past." The practitioners hold that the Baby Mat intervention allows the caregivers to recognise how their past familial relationships may influence their parenting style. The caregivers' reflections of their histories encourage them to relate to their infants from a different perspective – from the infants' perspectives:

> I think it's also a combination of speaking about the babies' feelings, but also speaking about the moms' lives and their adolescence and their experiences. It is very powerful and adds to that linking of how they're raising the baby (Participant 4, Focus Group 1).

Furthermore, the safety of the therapeutic relationship supports caregivers through these vulnerabilities, as Participant 2 (Focus Group 1) expressed:

> I think there is something very powerful about them making a link between the here and now, about what they are struggling with, with their baby, and then connecting it to something that they can empathise with. For example, from their own experience when they were a child, like needing to feel looked after now.

4.2.4 The mothering role and *umdlezane*

The practitioners suggested that caregivers who have little social support utilise the therapeutic relationship as a substitute for maternal guidance and comfort. The practitioners often feel a responsibility to enact a maternal role for the caregivers. Participant 3 (Focus Group 1) conveyed this when stating the following: "You can see there is a mothering role,

especially with a lot [of the] younger mothers who lost their own mothers and you can see that pull on the mat." In consideration of this, it became apparent that maternal bereavement and grieving are common caregiver concerns that are brought to the Baby Mat. Participant 5 (Individual Interview) explained: "They [the caregivers] felt the void of not having their parents around." This was supported by Participant 6 (Individual Interview) when describing the caregivers' experiences of maternal loss: "They don't have anyone around them and they struggle 'cause they don't have the support anymore."

It was reported that caregivers will approach the Baby Mat service because they have a desire to be supported, much like their mother would do for them. Thus, the practitioners believe that such caregivers attend the Baby Mat because they are yearning for a sense of comfort and reassurance from a figure who offers support and guidance. Participant 1 (Focus Group 1) illuminated her perception on the supportive role that the practitioners play by stating: "Really, [what] she was coming to say is that, 'This is hard to do this on my own and it would be nice if someone could reassure [me].'" Participant 6 (Individual Interview) further elaborated on this:

> I think she wanted to tell us that she was struggling and to just say, "You know what, I can't do it on my own." She was on her own, no mom around, so she has to do it on her own.

4.2.5 Co-facilitators

A prominent theme that emerged during data collection was that of the co-facilitator relationship. All of the practitioners commented on the power of the Baby Mat service being a relational intervention. The participants perceived the implementation of co-facilitation as invaluable for supporting the development of a therapeutic relationship with the caregivers. What is more, the participants upheld that this, in turn, benefits the effectiveness of the Baby Mat intervention. The psychologists and lay practitioners value the different knowledge systems that each professional brings to the Baby Mat intervention. A crucial component of

their working relationship is how the two learn from and rely on one another to effectively deliver the Baby Mat service within this particular environment. This was explicitly substantiated by Participant 6 in her individual interview:

> I think it is best that you have a partner… My partner doesn't know about our culture, so she will bring her psychology part and I will bring my cultural part and together we will work it out.

Furthermore, the benefit of co-facilitation allows the practitioners to simultaneously attend to both the caregiver and the infant. Participant 8 (Focus Group 2) stressed the necessity of her co-facilitator by expressing: "Honestly, you can't cope without a partner. You can't manage it. While one is busy with the mom, the other is busy with the baby."

In addition, the participants conveyed that having a co-facilitator is not only beneficial for the therapeutic relationship, is also helpful for added emotional support. Participant 3 (Focus Group 1) emphasised the necessity of having a partner by stating: "As much as we are there to contain the mothers and the babies, we are also there to contain each other." Participant 1 (Focus Group 1) elaborated on this further: "Sometimes something does trigger in you and you are feeling paralysed. And that's what's nice – knowing that the other person can hold it, just while you gather yourself. When the mat empties, then you can discuss it." Thus, the reverence the practitioners have for one another was palpable. Participant 8 (Focus Group 2) supplemented this narrative:

> Well, there are many issues and sometimes, [when] it gets very emotional, is when you need your partner. It's like you don't know what direction to take and maybe your partner can contain the situation. It's where I see the importance of having a partner.

4.2.6 The mat: A physical therapeutic frame

The practitioners maintained that the Baby Mat intervention differs from traditional individual psychotherapy, because the mat is utilised as a representation of the therapeutic space and frame. The practitioners perceive that the mat attracts this particular population of

caregivers to the Baby Mat therapeutic service, suggesting that it supports the development of a therapeutic alliance. This was highlighted by Participant 4 (Focus Group 1) when expressing: "There is just this kind of power in this blanket in front of people." The practitioners held that the caregivers perceive the mat as approachable and comforting. Participant 10 (Focus Group 2) further substantiated this when stating, "It sort of says [to the caregivers], 'I am here for you.' Like, I am not here to judge you or be above you." Thus, the practitioners conveyed that the ritual of laying down the mat is believed to be welcoming and symbolises respect. This was illuminated by Participant 8 (Focus Group 2) when she expressed the following: "Whether you come from a different background, whether you are educated or not, it just says we are here with you – it is common ground."

4.3 Practitioners' Perceptions of Developments made in relation to the Baby Mat Intervention

In light of the sub-themes that emerged within the therapeutic alliance, the conversation during data collection transitioned into understanding the practitioners' perceptions of the effectiveness of the Baby Mat service in terms of the primary aims of the intervention. Remaining cognisant of the inconsistent and sporadic attendance of caregivers who utilise the Baby Mat intervention means that assessing the intervention's effectiveness is often difficult. Thus, the practitioners suggested that identifying developments in relation to the caregiver-infant attachment was challenging to regularly observe.

However, the practitioners maintained that the best opportunity to evaluate the caregiver and infant, as well as the relationship between them, was when caregivers revisit the Baby Mat. Additionally, the Baby Mat practitioners monitor positive adjustments when caregivers who previously accessed the Baby Mat are referred to the community organisation for further therapeutic support. Moreover, in some cases, the practitioners may recommend

caregivers to utilise the community organisation's Home-Visiting service. This serves as an added opportunity to observe the efficacy of the intervention.

The sub-themes below explore the practitioners' perceptions of caregiver-infant progress and the developments made because of the Baby Mat intervention. The three domains that were consistently conveyed, and are aligned to the research study's aims, included: (i) developments in terms of the quality of mothering; (ii) the infants' development; and (iii) the relationship development between the infant and caregiver.

4.3.1. Developments made in relation to the quality of mothering

Developments in terms of the caregivers' mothering were noted by the practitioners in two ways, namely: (i) caregivers showed an enhanced ability to think of the infant as an individual capable of emotional awareness and thought; and (ii) the liberation that comes from acknowledging and normalising the caregivers' concerns and anxieties.

With regards to the former, the practitioners believe that the emotions, feelings and cognitions of the infant are not fully considered very often. Rather, the caregivers appear to place an emphasis on the physiological well-being of their infants. The practitioners believed that an effective change in sensitive and responsive caregiving is achieved when the holistic health of the infant is understood by the caregiver. This is thought to be the initiating factor that enhances the potential to foster secure attachments. In essence, the process of reflective functioning generates an emotional solution to a concrete problem. Participant 11 (Focus Group 2) highlighted this: "Some of the mommies say my baby is vomiting or has a rash or has pink eye. So, they come with a physical thing but it's actually emotional." Thus, the goal for the practitioners is to communicate the caregiver's and her infant's true internal emotions. In her individual interview, Participant 12 also acknowledged this: "They [the caregivers] often bring something concrete… I like to acknowledge the concrete problem, then I say maybe we can try think about this in a different way."

The practitioners maintained that caregivers often experience a cathartic release when they recognise and comprehend that the infant is an emotional being. For example, Participant 5 (Focus Group 1) explained:

> The caregivers will say, "I didn't know that the way I treat my babies will affect them this way." Sometimes they will say [that] they are so grateful, because you know what the emotions was something I [the caregiver] was not aware of.

In relation to the latter, the practitioners felt that the caregivers utilise the therapeutic space because they have a yearning for reassurance and to be told "it is going to be okay" (Participant 1; Focus Group 1). This was further elaborated by Participant 4 (Focus Group 1) when explaining: "We acknowledge how stressful it is to be a mom and that there are so many things that make being a mom hard… And that we are here to support you if you are feeling stressed." Normalising the anxieties of motherhood appears to enhance the caregiver's parental efficacy. This then helps the caregiver to prioritise her infant. Participant 12 also expanded on this in her individual interview by sharing the following: "Just normalising those anxieties for her and just telling her that what she is doing is alright."

4.3.2 Improvements in infant development

The practitioners advocated that an infant's development is often mirrored by the caregiver's emotional state. Participant 11 (Focus Group 2) explained this:

> We were both very concerned about this particular baby. He had lots of scratch marks on his face, poor eye contact, and mom was very low and unresponsive to him. So, we encouraged her to come back to the mat. She had very limited support, so I think the fact that someone had taken an interest in her emotional well-being helped mom's and then baby's development. Every time she came for clinical check-ups, she would bring him to us. She was a mom who was really able to access the support… She was able to use what we gave her. The last time we saw him he was standing and smiling. She would then present him so proudly on the mat and say, "Look how he has grown."

4.3.3 Developments regarding the caregiver-infant relationship

The practitioners firmly upheld that much of the development and improvement that they witness occurs because the caregivers model their interaction with their infant on the way the practitioners interact with the infant. As Practitioner 2 (Focus Group 1) explains: "I think our hope is that through the way that we are with the baby, we're hoping that we are modelling something for the mom." The practitioners acknowledge the baby by greeting the infant and talking to him or her as an individual. They demonstrate to the caregiver that the infant is worthy of respect and recognition. Through the practitioners' enactments, the caregivers are able to learn a new way of interacting with the baby. Participant 12 (Individual Interview) further elaborated on this by emphasising the following:

> Through us talking to the baby, they [the caregivers] start thinking that, you know, this baby has a mind of its own and is able to understand more than what we give it credit for. So, I think those are the subtle changes that we see.

4.3.4 Practitioners' perceptions as to why progress transpires

The practitioners perceive that the reason for evident improvements is because of the application of mentalisation, reflective functioning, inter-subjectivity and implicit relational knowing techniques that are associated with the Baby Mat intervention. Moreover, the practitioners of the study highlighted that further developments are often noticed through the use of the Baby Mat intervention's efficient referral process.

4.3.4.1 The relevant application of theory

The practitioners suggested that the Baby Mat intervention supports the caregivers' emotional development and psychological growth, which in turn positively contribute towards the healthy development of the infants. Participant 10 (Focus Group 2) specifically highlighted that, "Making these moms aware of their babies – I think that's why we do see development." The practitioners hold that by mediating the caregivers' ability to think about and

acknowledge the infants' feelings and thoughts, the potential for secure attachment development is fostered. As Participant 7 (Focus Group 1) explored:

> Some of the moms laugh when I first say, "How do you think baby feels about that?" but then after a bit you can see that it gets them thinking about their baby in that way, which is quite different to the normal way they are used to speaking about their baby and caring for them.

Additionally, educating caregivers about the impact of caregiver-infant secure attachment was perceived as an invaluable psycho-educational tool employed by the practitioners. When delivering the intervention, the practitioners share how such attachments will lay a solid foundation for healthy holistic development later in life. They explain how the first 1 000 days of an infant's life are when the infant is most vulnerable and impressionable. This was illuminated by Participant 11 (Focus Group 2) when the following was shared: "Helping the mom think about that [the importance of the first 1 000 days], I think that's the one thing that hits home with the moms and makes a difference."

4.3.4.2 Reaching out: An opportunity for further support

Participant 7 (Focus Group 1) illuminated that a single Baby Mat session has the potential for positive caregiver-infant development to occur when expressing: "That once off can bring about so much change." However, despite this, the practitioners will recommend appropriate referral options to the caregivers in order to extend further support to the caregiver and her infant. Accordingly, the Baby Mat intervention serves as an opportunity for caregivers to learn about and gain awareness of additional resources and services that are available to them and their infant. Participant 5 (Individual Interview) shared her experiences of this:

> There are some referrals that, maybe we meet a person at the Baby Mat but maybe this person, they need an intervention, or if they are a "high-risk" kind of mom, sometimes I will go and give a home-visit.

Through these referrals, the practitioners are able to observe long-term accomplishments and additional improvements that would not have been possible if it were

not for the initial Baby Mat meeting. Participant 4 (Focus Group 1) described this by stating: "We get referrals from each other and then we can talk about it and see development from there." This was further emphasised by Participant 6 in her individual interview when expressing:

> When I first saw her [the infant], she was so tiny and just very small, you know? And on the mat the mom and baby were so uncontained; now [at home-visits] I saw her and she was so beautiful with a beautiful smile. It was so nice to see. They seemed so contained.

4.4 Challenges Experienced by the Baby Mat Practitioners

The data collection revealed the practitioners' experienced difficulties and drawbacks of the Baby Mat intervention. The introductory Baby Mat talk was reiterated as a profound challenge by the participants. Additionally, the practitioners' sense of despair and desperation surrounding the caregivers' resistance toward the Baby Mat service was evident. Furthermore, concerns about language, race and culture were additional strenuous components raised by the Baby Mat practitioners. Such difficulties will be explored below.

4.4.1 The Baby Mat talk

The Baby Mat introductory talk takes place at the beginning of each Baby Mat session. The practitioners believed that the talk is a vital component of the Baby Mat intervention and described it as an intervention, in and of itself. It is the first point of contact that the practitioners make with the caregivers. It is their chance to promote the service, to engage with the caregivers and to connect with them. However, the delivery of the talk was perceived as an intimidating component of the Baby Mat intervention. The practitioners shared their apprehensions that if the talk does not appropriately speak to their target population – the caregivers – it may threaten the uptake of the service. The practitioners perceived the talk as the most stressful and pressurised aspect of the intervention. In the focus

group sessions, this was frequently brought up by the practitioners. Participant 2 (Focus Group 1) explained:

> I think that's the anxiety that we hold about it [the talk]: "Will we be able to make a connection with the people? Will they respond? Will they be open?" And if you don't feel a connection with the bigger group of mothers, you kind of carry that on to the mat and worry about if anyone will feel that they can come and connect with you.

Furthermore, it was explained that caregivers attending the clinics are often subjected to a variety of announcements and proclamations by clinic staff that are largely undermining, dismissive and exploitive. Participant 11 (Focus Group 2) stressed: "I try not to be very lecturing and try and be more engaging. Also, because I think a lot of the people have so many talks that don't try to engage or connect with them." Thus, the practitioners clarified that the talk is an opportunity to communicate to caregivers that the Baby Mat service will be a different experience. Consequently, the practitioners' aim of their talk is to convey their respect and acceptance to the caregivers. They fear that the talk will be misconstrued and affect the caregivers' response to the service.

4.4.2 Resistance to approach the Baby Mat intervention

Following from this, the practitioners elaborated that, at times, they do experience resistance toward the mat by caregiver-infant dyads. Participant 4 (Focus Group 1) shared: "The mat, for some reason, has been very quiet and I am still trying to think why. Like, last week, we had no moms." In attempting to understand this further, the practitioners contemplated the various possibilities that may be causing this resistance. The privacy of the Baby Mat arose as a possibility. While the purpose of the Baby Mat is to lay down the mat in full view of the caregivers to eliminate isolation and stigmatisation, some of the practitioners perceived that this may be the reason for deterring the caregivers' uptake. Participant 5 (Individual Interview) suggested the following:

> I don't know, maybe [it's] the setting in the clinics. It's so difficult for us to see moms when the clinics are so full and we don't have some kind of privacy and the moms are feeling not so comfortable to talk about their issues.

Furthermore, the practitioners reflected that it is perhaps the caregivers' qualms of being judged by others that prevents them from utilising the Baby Mat service. This was expressed by Participant 1 when stating, "Sometimes it is hard for a mom to come and sit on the mat." Participant 10 (Focus Group 2) further illuminated this when expressing:

> Maybe they're not ready. I used to think maybe it was something that I said or something I didn't say, but then as you learn and grow at the end of the day [you realise that] it has to come from the moms as well. It's a partnership. You can't force people; they have to see the value.

4.4.3 Language, race and culture

Language concerns emerged as a common challenge during the data collection process. Participant 12 (Individual Interview) explained, "One of my biggest challenges is language. I worry that people will see me as not accessible." Communicating in a limited number of South African languages was perceived to negatively impact the practitioners' delivery of the service. Additionally, a few of the participants expressed that they feel a sense of isolation because of their inability to converse in an African language. For example, Participant 11 (Focus Group 2) conveyed, "For me, language is hard. You really want to be involved, but I often have to nudge my partner and say, 'Don't forget me,' or that I need a translation." Moreover, language issues experienced by the practitioners extend beyond South African languages. Many of the caregivers visiting the clinics in Alexandra are immigrants from neighbouring African countries, hindering translation and communication further. Participant 12 (Individual Interview) communicated the following: "A lot of them [the caregivers], because I am Black, expect me to speak their vernacular. I feel I have to justify why I can't speak their language."

In light of such difficulties, race and differences in culture were additional topics that were perceived as distressing for the practitioners. By virtue of her skin colour, Participant 1 (Focus Group 1) reflected, "I worry about the way they [the caregivers] perceive me." What is more, some practitioners shared their experiences of being intimidated, excluded or exploited because of their language, race and culture. In her individual interview, Participant 12 shared her experience: "I was walking out and went to sit on the mat when one mother grabbed me and said, 'Don't speak to us in the language of the White people.'

The practitioners also suggested that the race of the co-facilitators often functions as a determining factor of a caregiver's decision to approach the Baby Mat intervention. Participant 6 explained this in her individual interview:

> Sometimes, if there are two Black therapists, they [the caregivers] won't take us seriously. They will say, "Uh, these Blacks." But I have noticed [that] when I have a white partner, they will say, "Oh, this means this is very serious."

4.4.4 Experiences of the lay practitioners and the psychologists

During data collection, it became apparent that the lay practitioners and psychologists have experiences that are distinctive to their specific expertise and training. These perceptions will be explored below.

4.4.4.1 The lay practitioners' experiences

The lay practitioners maintained that language is more than just a vernacular concern for them. Becoming familiar with the psychological terminology was an area of difficulty for many of the lay practitioners. Participant 5 (Individual Interview) expressed that learning the psychological jargon was intimidating:

> Sometimes, the Baby Mat group, it's hard for me to find my voice. I just keep quiet. It is intimidating… the terms. Honestly, for me, it was hard hey: the transference and counter-transference. I was thinking, "What the heck is this?"

Furthermore, going beyond the physical nature of the caregiver's concern to a more emotional understanding is another challenge experienced by the lay practitioners. Participant 9 (Focus Group 2) described such an experience:

> It was a bit hard for me and some of the things, for me, even if a mom came to the mat, say the baby had a rash, for me it was simple – the mom must take the baby to the clinic and they must give the baby some ointment, but as time went by, I started understanding more and thinking, "Okay, this is how this is done."

Lastly, the lay practitioners conveyed the responsibility they feel because not only do they have to play the role of a Baby Mat practitioner, they also often have to liaise between the caregiver and the other practitioner.

> Sometimes I feel like I am in, like, two worlds. There is, like, the community and the mental health kind of thing. And I sometimes feel like I have to bring the two together to make it make sense for everybody. It's hard. (Participant 10; Focus Group 2)

4.4.4.2 The psychologists' experiences

The psychologists suggested that fully understanding the caregivers' socio-cultural norms and traditional beliefs is a challenging task. The psychologists maintained that the lay practitioners have an advantage over them because, as expressed by Participant 11 (Focus Group 2): "They know the community; they live in this community, so they can speak with the mothers on a level that they can understand – they have an 'in' with the community". However, the psychologists viewed this as an opportunity for growth. Participant 2 (Focus Group 1) explained: "The Baby Mat has become our access into the community in terms of learning about who they are and, um, how to, how to think about them and how to respond to them, and what their needs are."

In contrast to this, the psychologists reflected that they are concerned that there is a stigma attached to them as practitioners, because of the common misconceptions of the psychological profession. For example, individuals perceive that psychological work involves the diagnosis and treatment of weak, mentally unstable or *crazy*' individuals. In the past,

caregivers have expressed their anxieties about receiving support from a psychologist to the lay practitioners. Participant 6 (Individual Interview) explained the caregivers' apprehension toward psychologists when communicating that they are perceived as "people who work with brains" and that "they will think I [the caregiver] am mad".

4.5 Baby Mat Training

4.5.1. Experiential learning

The practitioners highlighted that their most profound lesson regarding the Baby Mat training was to learn to accept that the process necessitates experiential learning. Participant 11 (Focus Group 2) described her training experiences as "continual education". Reflecting on their Baby Mat training, the practitioners suggested that trainers should prepare trainees for the unpredictable nature of the cases that they may experience. As Participant 10 (Focus Group 2) explained, "I still feel like each mat is different. No two mats are the same."

The practitioners stressed that it takes self-reflection, flexibility and hours of hands-on learning that equips a practitioner for the demands of the intervention. Participant 7 (Focus Group 1) expressed, "It is about constantly, like just, evolving, that comes with the hours, the practice. But it honestly just feels like each week you [are] learning, about yourself, about the Baby Mat process, about your partner." Practitioners perceived that their most valuable learning occurred from their direct involvement with the community by gaining knowledge from the population for whom the service is intended. "It enables us to respond to them [the caregivers] in ways that are respectful and relevant and supportive of this population" (Participant 2; Focus Group 1).

4.5.2 Innate qualities of being a Baby Mat practitioner

The practitioners suggested that the Baby Mat intervention necessitates practitioners who possess intrinsic qualities in order to manage the multiple roles that the intervention demands. Participant 7 (Focus Group 1) passionately expressed: "I also think it needs to be something

you bring. Like you need to be able to connect with babies and think somehow in that way… I think that it is something that has to be quite natural." Additionally, it was suggested that practitioners need to exemplify the values and beliefs that fully embrace an infant's inter-subjectivity by acknowledging the infant's motives, feelings and desires. Participant 12 (Individual Interview) meaningfully shared, "I think it is quite powerful to start thinking about the mind of the baby even before they are born."

4.6 Personal Implications of being a Baby Mat Practitioner

Practitioners reported that the emotional nature of the caregiver-infant dyads that they experience inevitably have personal implications. Participant 4 (Focus Group 1) shared her feelings when stating the following: "Seeing the hardships of moms, you can't help but think about yourself being in that situation."

The practitioners who do not have children of their own reflect on what caregiving and motherhood may look like for them. For example, Participant 11 (Focus Group 2) questioned her desire of becoming a mother:

> Seeing how moms really struggle… I begin to question, like, oh my goodness, you have to put so much effort into having a baby. So, you start reflecting on such things. Like, what type of mom am I going to be and is it going to be so hard?

In contrast, the Baby Mat practitioners who balance motherhood reflected on how the Baby Mat has influenced their child-rearing capabilities and their relationships with their children. In her individual interview, Participant 5 conveyed how the Baby Mat intervention has affected her perceptions of motherhood: "I wish I could return back and start all over again… I know she has her own mind."

Additionally, the practitioners expressed that they cannot separate their Baby Mat skills of reflective functioning and mentalisation from their other work. They perceive these skills to be critical in understanding mental health. Participant 7 (Focus Group 1) maintained:

> I think once you get a taste of infant mental health, and once you start to think about babies in a different way, it's hard to ever stop doing that… Like when you work with children and therapy cases and adult therapy cases, it's, it's always there in your mind: the infantile, or thinking about the infant.

4.7 Necessity for Supervision and Support

In continuation of the personal and emotional implications of delivering the Baby Mat service, the practitioners emphasised the necessity for support from their colleagues, co-facilitators and supervisors. Participant 5 (Focus Group 1) stressed this when stating: "I thank God that the organisation that we are in is a little bit more containing for us." The weekly supervision meetings are utilised as a space for professional and personal growth as well as for emotional containment for the practitioners. The practitioners hold these sessions in high regard and believe it is during these periods when they can reflect on their transference-countertransference experiences. Participant 6 (Individual Interview) illuminated the openness and accessibility of supervision offered by the community organisation's team when sharing: "Anytime that we feel that we need to talk to someone, there is a space for us. Sometimes we are vulnerable on the Mat, but there is a space to come back to."

Conclusion

The aforementioned results portray the practitioners' narratives, conveying their shared and individual experiences of working with the caregiver-infant dyads that access the Baby Mat service. The chapter communicated the practitioners' highlights and drawbacks of working on the Baby Mat intervention. Moreover, the participants illuminated the factors that are perceived to make the intervention efficacious. The subsequent chapter will critically discuss the practitioners' experiences and insights in connection with pertinent theoretical findings.

Chapter 5: Discussion

Introduction

The themes and sub-themes highlighted in Chapter 4 explicitly conveyed the practitioners' perceptions and experiences of working on the Baby Mat intervention, as discussed in the focus group sessions and the individual interviews. In light of these, Chapter 5 will critically explore such findings in relation to the study's research aims and the literature background.

5.1 Aims and Findings of the Research Study

A specific aim of this research set out to understand the practitioners' lived experiences of the Baby May intervention. Aligned to this aim, the research findings conveyed the reality of working in the mental healthcare services within a South African context, which will be discussed. Additionally, the challenges and drawbacks perceived by the Baby Mat practitioners will be considered too. For instance, the stigma associated with seeking psychological and emotional support will be deliberated. The issues of language, culture and race that surfaced, despite the presence of the diverse co-facilitators, will be critically explored. In light of the challenges, the participants' perceptions of the necessity of vigorous Baby Mat training and supervision is also elucidated.

In addition, this research aimed to explore the practitioners' perceptions of the developments made as a result of the Baby Mat intervention in relation to: (i) infant development; (ii) improvements in the quality of mothering; and (iii) the developments observed within the caregiver-infant relationship. The Baby Mat practitioners in this study perceived that it is through their fostering of the caregivers' emotional awareness and insight that enhances developments in these domains. More specifically, the application of the theoretical concepts of reflective functioning and mentalisation will be discussed in relation to the Baby Mat practitioners' perceptions of these developments.

Lastly, this research study set out to explore the therapeutic relationship shared between the Baby Mat practitioners and caregivers. In correlation with this aim, the use of culturally sensitive co-facilitation and the physical frame of the mat are discussed as unique Baby Mat characteristics, which were perceived to enhance the therapeutic alliance by the participants of the current study. The therapeutic practices that the Baby Mat practitioners apply will also be examined. The practitioners' consistency and non-judgemental approach were deemed to draw caregivers to the service and promote the development of a working therapeutic relationship.

5.2 The Lived Experiences and Perceptions of the Baby Mat Practitioners

The following discussion explores the Baby Mat practitioners' perceptions of delivering a mental healthcare intervention in South African community clinics. Further, the participants' experienced challenges of working on the Baby Mat service are also critically deliberated. This discussion illuminates the necessity of the Baby Mat training and supervision, as per the findings from this research study.

5.2.1 The reality of therapeutic work within a South African context

The results of this study explicitly conveyed the Baby Mat practitioners' profound desire to support all caregiver-infant dyads that attend the Alexandra clinics. However, the practitioners in this study maintained that they frequently feel incapable of reaching the demand because of the limited time and human capital available. Considering this, a sense of hopelessness was professed by the participants during data collection. Knowing the benefits of the Baby Mat intervention, as well as the later positive effects of investing in secure attachment, the practitioners expressed their determination of reaching as many caregiver-infant dyads as possible. However, with only seven pairs of practitioners delivering the Baby Mat intervention, the participants explained that reaching all the caregivers and their infants is not always feasible. Their limited capacity in this regard is experienced as disheartening.

The Baby Mat intervention was a direct response to the lack of psychological services that are offered in primary healthcare institutions in Alexandra Township (Frost, 2012). It was previously highlighted that Alexandra Township is an overpopulated settlement, with very few resources to meet the needs of the population (Mthembu, 2012). The research contributions made by Wilson (2003) also illuminated how the limited resources, particularly healthcare and mental healthcare services, available in Alexandra are further aggravated by the dense overcrowding within the area. The cramped space of the Alexandra clinics and the endless queues of caregiver-infant dyads create an "overpowering awareness of need" that is experienced by the Baby Mat practitioners (Nortje, 2016). This literature contextualises the frustration and deflation that the Baby Mat practitioners emphasised in this current study.

Additionally, the Baby Mat practitioners suggested that they are confronted with unique problems and concerns that are context specific to working with this population group. The findings of the study elucidated that the practitioners are exposed to the accounts of caregivers who are subjected to trauma. Examples of the different traumas include: loss of an infant due to preventable causes; bereavement due to the loss of a loved one (for example, a husband or maternal figure); rape and domestic violence; hardships associated with unemployment and poverty; their own personal distress of living with diseases; and the stressors of living under harsh circumstances.

An extensive body of literature explores that such circumstances are not unique to the Baby Mat intervention, but are a reality of working in mental healthcare services in South African communities (Cooper at al., 2015; Kotchick & Forehand, 2002; Landman, 2009; Long, 2009; Moore, 2005; Tomlinson et al., 2005). The repercussions of apartheid mean that poverty is an intergenerational occurrence (De Lannoy et al., 2015; Moore, 2005). The living conditions that typified apartheid still epitomise the impoverished communities of South Africa today. In section 3.3 of Chapter 3, the socio-economic circumstances of caregivers

living in Alexandra Township were conveyed. The strain and distress the caregivers experience trying to provide for their family is a daily hardship. Meeting the basic physical needs of the infant – let alone his or her emotional, cognitive and social needs – becomes a near impossible task. Consistently responding to the infant's holistic needs becomes considerably fogged by the additional daily burdens associated with impoverished living circumstances (Bray et al., 2010; Ward et al., 2015).

Maslow's hierarchy of needs theory explains how individuals are motivated to achieve certain needs in a hierarchical manner, ranging from basic physiological needs to self-actualisation needs (Maslow, 1943, 1954). In order for a person to reach the level of self-actualisation (maximising one's holistic potential and seeking self-growth), a person's basic needs, need for safety and security, social needs of belonging, and self-esteem needs must be satisfied first (Maslow, 1943). While every individual is capable of moving up the hierarchy and achieving self-actualisation, Maslow conveyed that certain life circumstances may disrupt such opportunities (Maslow, 1954). Maslow's theory is pertinent in clarifying how harsh socio-economic living conditions and contextual stressors impede caregivers' potential for achieving the higher levels of Maslow's hierarchy. The difficulties that caregivers encounter daily inhibit the prospective for fulfilling their own and their infants' needs, even beyond their physical well-being. Obtaining food, water, shelter and warmth are, therefore, intuitively prioritised over their emotional and social health. Thus, the conditions associated with living in poor communities increase mental, emotional and physical distress, which can significantly hinder the ability to parent (Barbarin & Richter, 2001; Cooper et al., 2015; Pinderhughes et al., 2001).

Thus, the participants of the study reflected on their experiences of the traumatic accounts that caregivers bring to the Baby Mat service. They maintained that such narratives are a true reflection of the nature of psychological practice within South African

communities, and were reported to linger with and affect the practitioners, internally and interpersonally. Moreover, the participants' perceptions depict the accuracy of how a caregiver's context affects her capacity to reliably and consistently care for her infant. Accordingly, the Baby Mat practitioners reflected that working in such realities leaves them feeling hopeless because they are limited in their physical and emotional capacity.

5.2.2 Difficulties and challenges

In conjunction with the reality of working in the mental healthcare sector within South African communities, the practitioners' perceptions conveyed additional challenges that they often experience. The findings of this research portrayed the concern and distress felt by the Baby Mat practitioners in relation to race, language and cultural differences. Moreover, the Baby Mat practitioners in the study emphasised that the challenges they experience are often a result of the stigma associated with seeking mental health intervention.

5.2.2.1 Language, culture and race

Each Baby Mat practitioner in this research study perceived that their diverse personal demographics often affect their experiences on the Baby Mat intervention. Language, race and culture are often regarded as controversial topics, given South Africa's history of racial segregation. The legacy of the past has penetrated post-apartheid South Africa where differences are palpable and *othering* is not uncommon. The practitioners in the current study described their sense of alienation while on the Baby Mat.

The Black Baby Mat practitioners, particularly the lay practitioners, felt that caregivers often perceive their abilities and competencies to be inferior to that of their White counterparts. The lay practitioners shared the belief that the caregivers perceive the White practitioners as more professional. This frequently leaves the lay practitioners feeling subordinate, as previously described: "I don't think [the] mom will take us seriously if there are two Black people on the mat" (Participant 5; Individual Interview).

Understanding such perceptions and experiences is complex. Literature explains such prejudices through concepts of Black inferiority and Black consciousness. Frantz Fanon was a Black psychiatrist, revolutionary and philosopher of the mid-20th century. His activism has become influential in post-apartheid South African literature. Fanon was deeply distressed by the deep-rooted legacy of colonialism because of the paralysing inferiority complex of Blacks and their "abject idolisation of Whites as their role models" (Ranuga, 1986, p. 182). In response, Fanon had a priority to liberate Black people from this complex and help them retrieve their freedom and dignity. Later, Steve Biko (1978) concurred and argued that the oppression of apartheid led to self-denigration among Black South Africans. The glaring inequality between Blacks and Whites during apartheid times was thought to affect Black communities psychologically (Nobels, 2013). Indisputably, post-democracy has shaken psychological and emotional oppression, and Black consciousness, as posed by Biko, reinstated the pride and humanity of Black South Africans (Biko, 1978). However, the results of the current research study convey that such perceptions may still linger in South African communities.

Plausibly, the views of the caregivers may be related to the stereotype that is still attached to what it means to be Black and White in South Africa. For example, the impoverished setting of Alexandra Township directly neighbours the affluent area of predominantly White Sandton. The polarity of the area vividly illustrates the disparity between the rich and poor and, thus, White and Black in South Africa. Sandton is a neighbourhood primarily filled with affluent families who have access to quality education and live financially secure lives while reaping the benefits of such privilege. On the other hand, and as previously underscored, it is predominantly Black people who reside in the impoverished Alexandra Township. In comparison to their White neighbours, the daily frustrations and challenges are often psychologically disempowering for members of the

Alexandra community. This will undoubtedly impact on the psyche of township residents (Nduna & Jewkes, 2012). Consequently, the caregivers who access the Baby Mat service are living a reality that may fuel feelings of personal inferiority.

With the lay Baby Mat practitioners being Black women from the community, it may be difficult for some caregivers to relate to their empowerment and professional upliftment. Perhaps, to the caregivers, power and profession are still associated with *whiteness*. The lay practitioners suggested that they often feel subjected and victim to a possible inferiority complex, and frequently feel that they will not be perceived as competent professionals if a White practitioner does not accompany them to the Baby Mat. Conceivably, an inferiority complex may still be present in this community. It appears to have been projected onto the Baby Mat practitioners and it is powerfully felt in their countertransference experiences.

In addition, the White Baby Mat practitioners often expressed the alienation they feel because of their lacking proficiency in African languages. Without their African-language-speaking counterpart, they feel the intervention would not work as effectively. The White practitioners often rely on their partners' ability to converse with the caregivers and are frequently dependent on their co-facilitators' understanding of the traditional norms, beliefs and cultures within the community. Without being able to speak the language, the White practitioners are reliant on their therapeutic skills of observation and awareness of the non-verbal communications between caregiver and infant. While this was deemed as anxiety-provoking by the White practitioners, Frost (2012, p. 610) argues that such clinical observations are vital for the efficacy of the Baby Mat intervention as they aid in "responding to and reciprocating communication from the infant".

Regardless of such challenges, the culturally and racially diverse co-facilitators need to be aware of their demographic dynamics and utilise their personal insights and counter-transferences to aid the therapeutic journey. Dawson and colleagues (in press, p. 13) suggest

that the "projected interpersonal dynamics often play out between the couple, which can provide useful clues to the relationship and emotional experiences in the dyad." Such transference and countertransference experiences that manifest between the co-facilitators should be acknowledged and considered as an important source of diagnostic information on the Baby Mat (Baradon et al., 2005; Frost, 2012).

5.2.2.2 Stigmatisation associated with seeking psychological help

The Baby Mat practitioners in the current study conveyed their experiences of caregivers' resistance to the service that they offer. The participants' discussions suggested that this may be indicative of the stigma associated with mental healthcare intervention. The findings highlighted that there appears to be a negative connation attached to the Baby Mat practitioners' therapeutic work. According to the practitioners' perceptions, caregivers fear that they will be condemned as weak or incompetent parents if they seek psychological and emotional help.

Research suggests that there is a self-stigma that is imperative to consider as an influential factor in individuals' decisions to avoid seeking therapeutic support (Lucksted & Drapalski, 2015). Research has found that seeking psychological help or parental support is often misconstrued as an explicit sign of weakness in mothering abilities (Quinn et al., 2015). The anticipation of receiving a diagnostic label is perceived by caregivers to be a further deterrent (Corrigan, 2004; Edwards & Timmons, 2009). In light of this, Aspoas and Amod (2014) found that caregivers professed the Baby Mat talk to be a discouraging factor to approach the Baby Mat intervention. This is because the practitioners' introductory speech communicated that the service was for caregiver-infant dyads with problems or concerns. Caregivers reported feeling fearful about the judgements and discriminations of other caregivers if they sought support from the Baby Mat practitioners. In addressing the findings from Aspoas and Amod (2014), the practitioners have altered their talk by emphasising that

the Baby Mat is a space where caregivers can share their experiences, be it positive or negative.

However, as stated by the practitioners in the current study, the stigma associated with seeking psychological help still appears to be overpowering for some caregivers, continuing this resistance to the Baby Mat service. The participants suggested that the traditional African cultural belief of *impundulu* may be a reason for such resistance. As previously mentioned, *impundulu* is a negatively held belief that implies that an infant is unprotected against evil forces because his or her ancestors are no longer guarding the baby (Berg, 2003, p. 269). Seeking help may imply this to those who hold *impundulu* true. This leaves caregivers vulnerable to prejudices. Therefore, avoiding the Baby Mat service altogether appears to be more bearable for caregivers, rather than suffering prejudices when seeking help.

Nonetheless, dismissing her help-seeking urges and avoiding therapeutic support may place the caregiver-infant dyad at risk of forming an insecure/avoidant attachment. In this current study, this was perceived as a contributing factor to the Baby Mat practitioners' sense of hopelessness. The practitioners maintained that the Baby Mat intervention provides a platform for a caregiver to speak of and acknowledge her anxieties, stress and concerns. In doing so, this helps the caregiver to realign her preoccupation to her infant, fostering the potential for secure attachment. However, resisting the supportive space because of the misconceptions surrounding mental healthcare was often experienced as frustrating for the practitioners in the study. This is because circumventing such help may place the caregiver-infant attachment at risk, potentially causing future adverse consequences. The background literature provides justification for this by explaining that the caregiver may either project her unresolved anxieties onto the baby or communicate denial of the infant's emotions (Baradon et al., 2005; Fonagy & Target, 2003). Such transferences may convey to the infant that the caregiver is not able to tolerate anxieties of her own, and, therefore, cannot tolerate nor

comfort her infant's anxieties (Brenman Pick, 1992). This avoidant and neglectful parenting may lead to the formation of an insecure/avoidant attachment, which could lead to unfavourable later outcomes, as previously explored (Ainsworth, 1974; Haza et al., 2006; Sroufe, 2013).

5.2.3 Training and support

The Baby Mat practitioners professed that their experiences on the Baby Mat are frequently perceived as emotionally taxing, and are often carried into the practitioners' personal lives and other professional capacities. This led to an exploration of the participants' view of the necessity for vigorous training and supervision during the data collection process. Supervision and support from their colleagues was reiterated in the study's findings as essential for the Baby Mat practitioners' self-growth, reflection and awareness. The participants of the study believed that their group supervision sessions provide a containing space where they can feel held and supported.

Nortje (2016) suggested that the Baby Mat supervision group offers sustenance and a platform to explore the cultural and theoretical components of each Baby Mat case that is presented. In a study conducted by Landany, Mori and Mehr (2012) it was found that effective supervision and its offering of a supportive space encourages practitioner autonomy in the therapeutic setting, facilitates openness and self-reflection. The Baby Mat practitioners in the current study expressed that the emotionally charged experiences on the Baby Mat often leave them feeling vulnerable. The consistency of their weekly group supervision is experienced as comforting and indispensable.

Taking this into account, one practitioner highlighted during the data collection of this study that she would benefit from one-to-one supervision. "Just to hear our feelings… Because sometimes in that kind of a forum [group supervision], we don't usually say things" (Participant 6, Individual Interview). Personal therapy and self-care is essential in the mental

healthcare profession. Caring for others is a precious commodity, yet "by nature we are, as a species geared to needs of the self" (Skovholt & Trotter-Mathison, 2011, p. 4). Although personal therapy is not a requirement for the Baby Mat practitioners, it may provide the one-to-one support that some of the practitioners desire. In order to effectively care for the other, self-preservation is paramount. Self-care promotes resilience in practitioners and prevents burnout in emotionally taxing work (Skovholt & Trotter-Mathison, 2011).

Moreover, the Baby Mat training was perceived to prepare the practitioners adequately for the Baby Mat service. However, the experiential and continual learning component of the training was considered to be exceptionally beneficial by the current study's participants. The practitioners maintained that each Baby Mat encounter is unique, so remaining flexible and learning from the diverse experiences was perceived as imperative to the efficacy of their work. Kolb (2014) defines experiential learning as the process of learning through reflection of doing. He emphasised that engaging with real-life experiences nurtures the learning process and facilitates effective development and growth.

Working within South African communities requires this hands-on learning experience. Educational psychologists van der Merwe and Dunbar-Krige (2007) advise that in order for a community-based intervention to be successful, practitioners need to understand the context of their targeted community. The community's assets and resources need to be considered for the effective promotion of holistic well-being. Collaboration with the people of the community is vital (Donald et al., 2010). For example, the nurses, clinic administration staff, clinic stakeholders and community members need to be the Baby Mat practitioners' points of reference, and the people with whom they collaborate and unite. Importantly, the community members' indigenous knowledge needs to be valued and learned from, the expert-to-amateur dyad needs to be diminished, and co-learning and relationship building should be the focus (van der Merwe & Dunbar-Krige, 2007). The Baby Mat

practitioners in this study resonated with this theory, as they perceived that the fundamental reason for their professional development grew from immersing themselves in the culture of the community and learning from the people within the Alexandra context.

5.3 Developments Perceived by the Baby Mat Practitioners

While the perceived emotional challenges of their work were deemed as strenuous, the participants of the current research study highlighted that meaning and positivity are experienced, particularly when they observe the developmental gains as a result of the Baby Mat intervention. Being the individuals responsible for responding to the calamitous need for such an intervention often supersedes the Baby Mat practitioners' feelings of hopelessness and perceived drawbacks. Aligned to the aims of this study, the findings highlighted that there are various factors that contribute to the perceived developments made in relation to: (i) infant developments; (ii) the quality of mothering; and (iii) the caregiver-infant relationship. In their accounts, the participants of the current research study upheld that the primary developments that occur are a result of supporting the caregivers on a journey of emotional insight and awareness. The relevant application of the theory that underpins the Baby Mat intervention was experienced by the participants as valuable in achieving such developments.

5.3.1 Fostering awareness and insight

The participants in this study emphasised that it is through fostering the caregivers' emotional growth that often supports the development of (i) the infant; (ii) the quality of mothering; and (iii) the caregiver-infant relationship. The following factors were considered to be imperative in relation to the developments perceived, and will be critically discussed.

- Modelling skills of reflective functioning and mentalisation.
- Supporting the caregiver to move from a concrete to symbolic understanding of her infant.
- Offering additive support by means of referrals.

5.3.1.1 Modelling skills of reflective functioning and mentalisation

According to the practitioners of the study, the skills associated with reflective functioning and mentalisation are modelled from practitioner to caregiver, and are experienced as powerful transferences on the Baby Mat. The participants distinguished that significant growth and developments in terms of the quality of caregiving, the infants' development, and the infant-caregiver attachment occurs when such skills are assimilated by the caregivers. During the study's data collection, the participants explained that reflective functioning is modelled throughout the Baby Mat therapeutic process and develops systematically from: (i) co-facilitators to caregiver – in the way in which the practitioners hold, respond to and attentively listen to the caregiver; (ii) co-facilitators to baby – the practitioners interact with the baby acknowledging his or her intrinsic motives of inter-subjectivity; and (iii) caregiver to baby – the caregiver is emotionally contained by the practitioners, thereby enabling her to hold and sensitively respond to her infant.

Research theoretically supports the Baby Mat practitioners' perceptions of modelling reflective functioning skills to caregivers. Thomson-Salo (2007) advocated that the therapeutic space can be utilised as a modelling and demonstrative tool in parent-infant psychotherapy (Thomson-Salo, 2007). The Baby Mat intervention, along with the practices of the practitioners, is a working example of an effective modelling method that is efficacious in achieving the aims of reflective functioning. Baradon and colleagues (2005, p. 25) suggest that it is through this learning process that enables caregivers to "reflect upon the states of mind in themselves, in their infant and in the relationship between them." The therapeutic work of the Baby Mat practitioners promotes this positive development. They enhance a "proto-mentalisation, alerting the mother (when necessary) to the fact that her baby has feelings, is responsive and can try to protect itself" (Frost, 2012, p. 612). Supporting the caregiver on a journey of heightened emotional awareness facilitates her personal growth,

which directly affects her infant's development. Fonagy and colleagues (2004) further explain that reflective functioning encourages the caregiver's empathic capacities, facilitating her ability to respond to and reflect the baby's inner emotions, thoughts, feelings and desires.

In order for development to occur, the internal working models of change need to happen within all these relationship dynamics. The participants of the current study maintained that through the caregivers' therapeutic interaction and relationship with them [the co-facilitators], they learn, often for the first time, different ways of relating and caring for their infant. Lieberman & Pawl (1993) maintain that a therapist's empathetic responsiveness and attentiveness to the parent's needs are considered to be the "primary mutative factors in infant-parent psychotherapy" (p, 558). The relationship between the practitioner and caregiver, and the practitioner and infant, powerfully models a corrective relational experience whereby caregivers begin to practice protective and nurturing ways of relating to their infant (Lieberman & Pawl, 1993).

5.3.1.2 Moving from concrete to symbolic understanding

The results of this study indicated that the somatic health of the infant is a common concern expressed by caregivers who access the Baby Mat intervention. The Baby Mat practitioners upheld that they are psychoanalytically trained to recognise that emotional anxieties and distress of the infant frequently manifest psychosomatically. The participants of this study perceived that it is through the Baby Mat practitioners' therapeutic support that caregivers are able to shift from a concrete way of thinking about the infant to a more abstract, symbolic understanding of the baby. More specifically, the participants suggested that it is the notion of *mhlawumbe* ("perhaps" in English) that is used to support the caregiver to transcend her understanding of the baby from a physiological perspective by exploring the unconscious, emotional possibilities.

Furthermore, the practitioners in this study upheld that the technique of *mhlawumbe* permits the caregiver to reflect upon the unresolved conflicts from her past. According to the participants, this process was perceived to encourage the caregiver to reflect on her familial antecedents and acknowledge how these are possibly re-enacted in relation to her baby. The results of the study conveyed that the Baby Mat practitioners serve as a corrective emotional experience for the caregiver-infant relationship (as described in the above section, 5.3.1.1). They suggested that their role provides the opportunity to mutate the caregiver's concrete way of thinking about her infant by modelling empathetic behaviours and providing the caregiver with a space that gives her permission to experience and express her positive and negative emotions.

Essentially, the process of *mhlawumbe* can be aligned to the well-known psychotherapeutic research on *The Ghosts in the Nursery* (Frailberg, Adelson, & Shapiro, 1975). These are "the visitors from the unremembered past of the parents, the uninvited guests at the christening" (Frailberg et al., 1975, p. 387). In their research, Lieberman & Zeanah (1999) explain that the internalised early childhood experiences of the caregiver provide a structural framework that serves to encode current emotional events and responses. Providing a secure space for a caregiver to reflect on or *wonder* about her childhood may serve to inform her on how such past relational experiences can negatively or positively implicate her current child-rearing practices. Therefore, therapeutic intervention provides an opportunity for a caregiver to explore and acknowledge how her unconscious impulses may be projected from her past original objects to the current transference object of her baby (Lieberman & Pawl, 1993).

The participants of the study maintained that these psychotherapeutic techniques of reflective functioning, as described in the section above, as well as through the process of *mhlawumbe* on the Baby Mat, create a space within the caregiver for potential emotional

growth and psychological insight. The practitioners of the study upheld that it is the application of these psychotherapeutic notions that support the caregiver in recognising the infant as someone who is capable of emotional functioning and development. This, in turn, was believed by the Baby Mat practitioners to mirror evident progress in relation to the infant's emotional, psychological and physical development, the quality of caregiving and improvements in terms of the caregiver-infant attachment pattern.

5.3.1.3 Referrals

The results of this study conveyed that the identification of caregivers, infants and caregiver-infant dyads at risk is a paramount responsibility of the Baby Mat practitioners. In consideration of such, the Baby Mat practitioners upheld that they are trained to identify precursors of insecure or disorganised attachment as well as unhealthy infant development. Moreover, recognising the caregiver-infant relationships that require further therapeutic assistance was perceived by the participants to enhance further development opportunities of the caregivers and infants who visit the Baby Mat intervention.

The referral process is a primary characteristic of the Baby Mat intervention and was an original goal of the service (Frost, 2007, 2012). The results of this study, according to the practitioners' perceptions, portrayed that this component of the Baby Mat intervention evidently functions optimally. Literature argues that the facilitation of referrals is a crucial obligation of mental healthcare practitioners, particularly when working with vulnerable populations in community settings (Azzi-Lessing, 2010). Referrals ensure suitable case management and uphold professional ethical conduct by remaining within the limits of competency and practice (Health Professions Council of South Africa, 2008).

Furthermore, the participants in the study suggested that the referral process involves assisting caregiver-infant dyads to understand the value of engaging in external services that fit appropriately with their current needs. For example, the participants expressed that they

will often refer foreign caregivers to social workers as certain immigration concerns, such as social grants, are not within their scope of practice. Azzi-Lessing (2010) concurs with this good practice by maintaining that referrals should incorporate strategies to minimise further stress regarding economic, logistical and cultural barriers.

The practitioners of the study clarified that the Baby Mat intervention is often utilised as a short-term service by caregivers. Thus, the use of referrals was perceived by the participants to be highly beneficial for supporting caregiver-infant dyads on a long-term, consistent basis. According to the participants, the Baby Mat intervention exposes caregivers to external resources, which they were previously unaware of and that may be of benefit to them. For example, the community organisation's Home-Visiting programme was frequently highlighted by the participants as a common referral recommendation that they employ. They maintained that the Home-Visiting programme offers further support to the caregiver-infant dyad at the caregiver's convenience. This allows Baby Mat practitioners to assess the caregiver-infant dyad within their home environment and to develop long-term goals with the caregiver for optimum results. What is more, the practitioners communicated that such referrals allow them to observe the development gains made in terms of the caregiver-infant dyads attachment patterns. The long-term commitment also provides the opportunity for the practitioners to notice improvements in the infant's development, as well as progress in the quality of caregiving.

5.4 Factors Contributing to the Therapeutic Alliance

The research study aimed to understand the Baby Mat practitioners' perceptions in relation to the therapeutic alliance they share with the caregivers. The participants of the study advocated that a functional therapeutic relationship enhances the effectiveness of the Baby Mat community-based mental healthcare intervention. The findings from the data collection emphasised that the implementation of the co-facilitating pair was perceived to enhance the

Baby Mat's cultural sensitivity and, in turn, served to support a strong therapeutic rapport between the practitioners and caregivers. Furthermore, the results of the study identified the importance of showing mutual respect to the caregivers and their infants. The formation of trust through their consistent presence at the clinics and unconditional positive regard for the caregivers was also illuminated by the Baby Mat practitioners. It is these aspects of best practice that were deemed to support the development of a therapeutic alliance.

5.4.1. Culturally sensitive facilitation

During data collection, the participants perceived that the implementation of the diverse co-facilitating pair heightened the Baby Mat practitioners' opportunity to form a strong therapeutic alliance with the caregivers. Moreover, a consensus among the Baby Mat practitioners was the necessity of co-facilitation for the service to function optimally in the culturally diverse setting of Alexandra. Therefore, the findings of this research study made evident that the Baby Mat intervention strives to promote its cultural sensitivity. The Baby Mat practitioners explained how they value and benefit from their partners' knowledge systems and areas of expertise. With one Baby Mat practitioner having greater cultural knowledge and advanced acquisition of different African vernacular languages and the other practitioner having a well-established understanding of psychological theory, it is a service that was deemed to be culturally pertinent. The practitioners believe that the co-facilitation supports the development of a therapeutic relationship with the caregivers, creating a space for authentic and open therapy to transpire.

Cultural competence in therapeutic work is the belief that practitioners should not only acknowledge and appreciate other cultural groups, but also learn to effectively work with them (Huey et al., 2014; Sue, 1998). Culture is defined as a "historically transmitted pattern of meaning embodied in symbols, a system of inherited conceptions expressed in symbolic form by means of which [people] communicate, perpetuate, and develop their

knowledge and attitudes toward life" (Geertz, 1973, p. 89). Therefore, cultural competence is the ability to respect and understand the attitudes, values, beliefs and behaviours of culturally diverse populations. Consideration of sociocultural factors and backgrounds aids intervention strategies and optimal support of the client (Huey et al., 2014). Additionally, understanding traditional cultural beliefs and the meaning-making associated with them is vital for such a therapeutic intervention to serve its purpose (Campbell-Hall et al., 2010; Saleebey, 1994; Willot et al., 2012).

Paralleled to the participants' discussion regarding cultural competence was the practitioners' perceptions in relation to language differences. The findings of the study illuminated that proficient language translation skills are a necessity on the Baby Mat to enhance communication. The participants maintained that use of co-facilitation enables one practitioner to effectively translate, while the other practitioner can create psychological connotations and connections of the discourse involved. This was considered as an additional factor that fostered the therapeutic relationship, and thus the efficacy of the Baby Mat intervention.

In order to achieve communicative competence, Canale and Swain (1980) advise that the following competence levels need to be achieved: (i) linguistic competence – whereby the communicators share the same knowledge of the language code, including the language's grammatical rules, vocabulary and pronunciation; (ii) sociolinguistic competence – this incorporates the mastery of the sociocultural code of a language; communicators will appropriately judge the social context of the situation as well as assess the status of the person that they are talking to (for example, showing respect when talking to an elder or esteemed professional, and, thus, choosing an appropriate application of their vocabulary, politeness and content of speech); and (iii) strategic competence – this is knowledge of the verbal as

well as the non-verbal communication strategies that enable the communicators to assess the efficiency and goals of the communication at hand.

However, meaning-making extends beyond direct translation. African vernacular languages have distinctive socially and culturally constructed meanings that often cannot be directly translated into the English language. Burr (2015) maintains that there are numerous emotional states, recognised by individuals in non-Western cultures, which cannot translate into Western labels. Thus, it is the social constructivism of the African languages where the use of co-facilitation was perceived to be immensely supportive for the Baby Mat intervention. Social constructionism concerns the social and psychological meaning encoded within a language, and maintains that the inner and external worlds of an individual are fundamentally constructed in language (Burr, 2015; Terre Blanche et al., 2006). It promotes relevance and cultural sensitivity because it takes a more critical stand on analysing and understanding a vernacular language beyond its face value. Individuals are born into cultures with established conceptual frameworks and categories that inform the way in which they perceive and thus speak about the world (Burr, 2015).

Consequently, the assistance of the culturally attuned Baby Mat practitioner was professed to be instrumental in such instances by the participants of the study. For example, during data collection, the Baby Mat practitioners revealed that there is an African traditional belief that if a caregiver thinks or believes negative aspects about herself or her infant, it may manifest in reality. In their study on the caregivers' perceptions of the Baby Mat intervention, Aspoas and Amod (2014) confirmed such findings. They showed that caregivers "feared that action would be taken if the reality of their circumstances was revealed" (p. 65). Consequently, the culturally familiar co-facilitator is experienced to aid the therapeutic process through direct translation and is able to explain the culturally exclusive connotations,

beliefs, feelings, experiences and conceptual foundations associated with the social constructionism of an African language.

Moreover, the participants maintained that the two practitioners learn from one another and are better able to respond appropriately to the cultural concerns and issues of the caregiver and her infant. The Baby Mat practitioners of the study suggested that the two practitioners combine their experiences and knowledge of traditional African healing and Western methods of healing to allow the relational intervention to function optimally. Literature on co-facilitation advocates that collaboration between the traditional and the non-traditional facilitators enhances different knowledges, which help practitioners understand the meaning systems of the caregivers' and infants' emotional worlds, creating a meaningful and efficacious therapeutic space (Campbell-Hall et al., 2010; Saleebey, 1994).

5.4.2 Mutual respect

According to the practitioners' perceptions, the physical space of the mat is a symbolic sign of mutual respect. The practitioners in the study clarified that, at the beginning of every Baby Mat intervention, the mat is laid down in the immunisation ward of the clinics in full view of the other caregivers and infants. The reason for this is so that mothers and infants do not feel ostracised. The participants upheld that the mat dimensions serve as a physical frame for the therapeutic space, which conveys a message of comfort, security, trust and union. The utilisation of the mat for the Baby Mat intervention was supported by the Alexandra clinic's nursing sister, who believed that with the growing stigma of HIV, it would be best for the mat to be seen by all so as not be viewed as a service that would exclude the caregivers, thus creating suspicion and mistrust (Frost, 2012).

The perceptions of the practitioners revealed that the mat is a powerful symbol that diminishes status and emphasises equality between the infant, the caregiver and the practitioners. They suggested that it lays a common ground of communalism and oneness.

The mat is a distinctive therapeutic tool and has not been extensively explored in psychological literature. According to the experiences of the Baby Mat practitioners in the current study, the mat was identified as highly effective within this community setting. The characteristics that the mat symbolises are aligned to those of *ubuntu*. The notion of *ubuntu* highlights the importance of self in relation to others and speaks of the idea of a universal being (Tomlinson et al., 2005; Washington, 2010). Within African traditions of *ubuntu*, nature and the earth are said to sustain the lives of African people and acknowledge "that all things within the universe are connected" (Washington, 2010, p. 35). Indisputably, the Baby Mat practitioners perceived that the presence of the mat represents a communal space where individuals are interdependently and interrelatedly connected. The findings showed that the mat communicates that the practitioners are meeting the caregiver-infant dyads on their terms, in an environment of security, comfort and respect.

5.4.3 Consistency and reliability

During the data collection discussions, the Baby Mat practitioners emphasised the frustration and mistrust felt by caregivers toward the inadequate service delivery and inferior treatment at these clinics. As explained in section 3.3 of this research report, the inefficiency, disparaging treatment and disorganisation of the healthcare services in South Africa are a true reality for people seeking medical assistance. What is more, the healthcare institutions provide limited mental health support and appear to disregard the emotional well-being of new mothers, caregivers and their infants (Wilson, 2003).

In consideration of this, the Baby Mat practitioners of this study perceived that the consistency and predictability of the intervention provide caregivers with an incomparable experience amongst the chaos and uncertainty that epitomise the clinics. The participants illuminated that reliability and trust are conveyed by the Baby Mat practitioners through their stable and dependable presence at the institutions. With consideration of this, Epstein (1994)

highlights the importance of boundaries in therapeutic work. Violating boundaries of consistency and reliability may cause clients to lose confidence and trust in the process, impairing the ability for recovery.

Furthermore, as Frost (2012) conveyed, caregivers self-refer themselves to the Baby Mat, giving them independence to respond to the service offered. This was also explained by the participants of the study. However, the participants expanded on this and professed that it is their consistency and dependability that foster the development of trust and respect, even before caregivers decide to approach the Baby Mat service. The Baby Mat intervention is therefore portrayed as one of reliance and certainty, which will not exploit the rights of the caregivers and their infants, according to the practitioners' perceptions.

5.4.4 Unconditional positive regard

It was highlighted by the Baby Mat practitioners during the data collection process that treating the caregivers and infants with unconditional positive regard enhances the therapeutic relationship and enables the caregiver-infant dyad to utilise the Baby Mat therapeutic space optimally. According to this study's participants, acknowledging the caregivers' concerns and anxieties permits them to express their emotions in an accepting environment. The participants maintained that practising a non-judgemental approach is vital for the therapeutic alliance as well as for the efficacy of the Baby Mat intervention. For example, what strongly emerged out of the data collection were the participants explanations that caregivers fear acknowledging or expressing their negative emotions of motherhood. The participants suggested that caregivers have a social and cultural pull to speak highly of their maternal experiences in anticipation that any adverse thoughts or emotions will negatively impinge on the infants' development.

In their research on mothers' perinatal and infant mental health knowledge in a Johannesburg township setting, Bain and Richards (2016, p.89) similarly found that

caregivers have a rigid cultural prescription to perceive their infants as "blessings" and to minimise negative maternal affect. Their findings maintain that this prescription of how to experience motherhood means that negative emotions are often not permitted and are denied. The Baby Mat practitioners of this current study expressed that by normalising the caregivers fears and providing them with a non-judgemental space to express their feelings, be it positive or negative, often strengthens the therapeutic relationship. The Baby Mat practitioners explained that their unconditional positive regard permit the caregivers to acknowledge their affects which assists them in becoming aware of the potential influence that their feelings have on their infants development.

Following this, the results of this study also conveyed that the Baby Mat practitioners are presented with a variety of concerns. For instance, the anxieties and fears associated with HIV/AIDS were also suggested to be frequently brought to the Baby Mat practitioners' attention. The participants experienced that HIV-positive caregivers fear the stigmatisation and discrimination that they may endure because of their status. Furthermore, additional concerns that surface include: anxieties surrounding imminent death and loss of the infant, spouse, self or family member; distress in respect to opportunistic diseases; confusion regarding the virus; and not being a physically fit enough mother. Moreover, the practitioners of the study explained that many of the caregivers who attend the Baby Mat are immigrants seeking support. During the data collection, they reported that they receive many concerns from foreign caregivers surrounding xenophobic violence, resulting in experiences of extreme social isolation and victimisation.

As previously highlighted, one in three caregivers accessing the Baby Mat is HIV-positive (Frost, 2007, 2012). Prejudices and social misconceptions associated with HIV around concerns of breastfeeding, mother-to-child transmission, and reputation of the family are known to affect HIV-positive people psychologically (Seidel, Sewpaul, & Dano, 2000).

Furthermore, immigration means living far away from familial protective resources, limiting social support for many caregivers and their infants (Frost, 2012). Thus, according to the participants, caregivers who approach the Baby Mat are often yearning for social support, non-judgement and reassurance from maternal figures. Social support is known to be a significant moderator of stress. It has not only proven to help caregivers cope better with the demands of a new-born, it also promotes their parental efficacy (Elder, Eccles, Ardelt, & Lord, 1995; Lachman, Cluver, Boyes, Kuo, & Casale, 2014; Letourneau, Stewart, & Bamfather, 2004; Shumow & Lomax, 2002).

Thus, providing support and guidance to these caregivers was perceived to be of paramount importance by the Baby Mat practitioners in the current study. Living in conditions where stigmatisation and alienation is widespread, providing a non-judgemental space of safety and security was reported as essential. A primary aim of the Baby Mat intervention is to support the infant-caregiver dyad informed by the indigenous knowledge of *umdlezane* (Frost, 2012). This creates a space where the caregiver has the opportunity to prioritise her attention on her infant, free of the anxiety associated with the prejudices and bigotries of others. Caregivers perceive the unconditional positive regard and the ability of the practitioners to understand the world from their perspective as supportive (Aspoas & Amod, 2014; Bromley, 2010). The caregivers felt that the practitioners created an environment for them to release their pent-up feelings and showed them that they were not alone (Aspoas & Amod, 2014).

The participants of the study viewed their role as a mothering one, especially in cases where caregivers explicitly yearn for maternal guidance and support. The practitioners believed that the Baby Mat service fills the void of caregivers' absent social support or maternal deprivation. By comforting the caregivers and providing them with the suitable empathy that they need, the practitioners of the study suggested that they offer a holding

space for the caregivers' vulnerable emotions. In alignment with Winnicott's (1962) theory of holding, the social support substituted by the Baby Mat practitioners was maintained as a containment mechanism for the caregivers, which was perceived to reinforce the caregivers' parental efficacy.

Furthermore, without undermining their experiences, the practitioners of the study also upheld that normalising the caregivers' experiences of motherhood and childrearing is invaluable. For example, normalising the common anxieties of caregiving (such as infant milestone development, breastfeeding distress or the uncertainties of child-rearing) reassures the caregivers that their apprehensions and concerns are appropriate for their experiences. In his research, Stern (1995) found that acknowledging the mother figure and her responsibilities of motherhood is an effectual supportive component in parent-infant psychotherapy. The results of the study showed that the practitioners' perceptions concur with this, and that the participants strongly reinforced the significance of offering the caregivers the recognition, guidance and encouragement they are longing for from a supportive figure.

Conclusion

In summary, it is evident from the discussion that the practitioners value the work they do and perceive their therapeutic practice on the Baby Mat to be a meaningful one. The unique characteristics of the Baby Mat intervention make the practitioners' work pertinent and powerful for the Alexandra community. Following Chapter 5, Chapter 6 draws the research report to a close. A summary and overview of the study's research findings in relation to the aims are concisely described. Thereafter, the chapter will explore future recommendations and examine the limitations of the research study.

Chapter 6: Conclusion

Following a summary of the research findings, the implications of the results will be explored in this chapter. Recommendations are made based on the results of the study. The limitations of the study are discussed and suggestions for further research are considered.

6.1 Summary and Overview of the Study

This research study set out to explore the perceptions and experiences of the practitioners who deliver the Baby Mat intervention. The caregiver-infant intervention is a community-based mental healthcare service that is offered at five primary healthcare clinics in Alexandra Township in Johannesburg. The predominant aim of the Baby Mat intervention is to therapeutically support caregivers and their infants with the goal of fostering secure infant-caregiver attachments. As the focus of the intervention is to serve caregiver-infant relationships to promote the holistic well-being, learning and development of children, as well as the prevention of later adverse outcomes for children and adolescents, the scope of this research falls within the domain of educational psychology.

Paralleled to the research aims, the participants of this study explored their perceptions in relation to their work on the Baby Mat intervention. The results of the study conveyed the Baby Mat practitioners' lived experiences and challenges of working within community-based mental healthcare clinics in South Africa. The practitioners highlighted their concerns regarding language, race and cultural differences, which they have experienced on the Baby Mat intervention. They also explored the stigma that is attached to seeking psychological support and showed how this often causes caregivers to resist the Baby Mat service. Considering such difficulties, the participants elucidated their perceptions of the importance of the training and supervision they receive.

Furthermore, the findings illuminated the Baby Mat practitioners' perceptions of the developments and improvements made as a result of their work on the Baby Mat service.

Progressions in terms of infant development, the quality of caregiving and caregiver-infant attachment were explored. The practitioners professed that developments are often apparent when the practitioners' modelled skills of reflective functioning are appropriately applied by caregivers. Enhancing caregivers' mentalisation capabilities was perceived to encourage them to acknowledge the infant as an emotionally adept individual with his or her own thoughts, feelings and needs. The participants upheld that they frequently experience developments in the quality of caregiving when they normalise the caregivers' anxieties of motherhood. It was suggested that through the recognition of caregivers' parental capabilities, it often serves to enhance the caregivers' parental efficacy and, in turn, is likely to have a positive influence on the infants' development, both physically and emotionally. The practitioners perceived that these combined factors increased the likelihood of the development of secure caregiver-infant attachments.

Furthermore, the Baby Mat practitioners also perceived that the screening of caregivers, who may be at risk, facilitates an efficient and feasible referral process. The referral process was considered as an integral part of the Baby Mat practitioners' duties, as it presents caregivers with an opportunity to receive home-visits or attend other therapeutic services that are offered in Alexandra by the community organisation. Moreover, the Baby Mat practitioners perceived that a referral plan provides additional opportunities for them to assess the caregiver-infant dyad developments.

In addition to the perceived developments, the Baby Mat practitioners described the significance of a solid therapeutic alliance shared between the caregivers and themselves. Importantly, the participants maintained that the formation of a therapeutic rapport is necessary for the efficacious delivery of the intervention. The practitioners' perceived consistency and non-judgemental approach were deemed to draw caregivers to the service and promote the development of a working therapeutic relationship. Moreover, the findings

accentuated the role of the mat as a powerful intervention tool utilised in the Baby Mat service. The frame of the mat was believed to eliminate social status by creating a common ground and communalism within the therapeutic space.

Expansion on the practitioners' discussion of the therapeutic alliance led to an exploration of the benefits of co-facilitation. While understanding the dynamics of co-facilitation was not an initial aim of this research study, the data collection and analysis showed that the implementation of co-facilitators was perceived to enhance the Baby Mat intervention's cultural sensitivity and relevance for the Alexandra community. The practitioners suggested that the culturally diverse co-facilitation pair enables them to share their different skill sets, knowledge systems and expertise, permitting them to support the caregiver-infant dyad in a valuable and meaningful way. This was deemed as an invaluable characteristic of the Baby Mat intervention as it supports the development of a therapeutic relationship with the caregivers and promotes the effective delivery of Baby Mat intervention.

6.2 Implications of the Results and Recommendations Based on the Findings

The focus group and individual interview discussions explored the highlights and challenges that the practitioners experience when delivering the Baby Mat intervention. Thought was given to potential recommendations and suggestions to improve the difficulties that are currently perceived, as well as to acknowledge and maintain the strengths that enhance the intervention. The Baby Mat talk surfaced as a contested component of the intervention. Although the talk has been revised to make the introductory speech of the Baby Mat service more accessible, it became evident that there is still an element of resistance to approach the Baby Mat service. The stigma and humiliation associated with seeking psychotherapeutic support as well as the fear of diagnostic labelling are factors described by the participants to be the cause of the caregivers' resistance.

In elaboration of the above concern, the practitioners also indicated that the immunisation area of the clinic, where the Baby Mat intervention is held, often lacks in privacy. As described in preceding sections, the mat is laid down in full view of the other caregivers to add a dynamic of comfort and combat feelings of suspicion and alienation. However, considering the caregivers' apprehension of approaching the Baby Mat service, the practitioners suggested that creating a more private space may put the caregivers at ease. Negotiating an area that is slightly more secluded may promote an explicit sense of confidentiality and discretion, thus alleviating the caregivers' anxiety about judgements when utilising the intervention.

The hopelessness felt by the practitioners because of their limited ability to reach the demand of caregiver-infant dyads at the clinics was particularly evident. A way to possibly reach more caregiver-infant dyads is to expand the service by adding additional Baby Mat interventions to the clinics where the service is currently offered. Having more than one Baby Mat laid down might also aid the above recommendation, in that there will be several caregiver-infant dyads receiving the intervention concurrently. Adding multiple Baby Mats may convey a sense of togetherness and empowerment between caregivers who have similar experiences of motherhood. Yet, with the lack of space, this may also raise the concern of a lack of privacy.

The practitioners highlighted the diverse concerns they are presented with when delivering the Baby Mat intervention. However, it became apparent that some concerns raised by the caregivers are beyond the practitioners' scope of practice. For example, practitioners are limited in their ability to help with social grant distress expressed by foreign caregivers. While these caregivers are referred to social workers, it might be valuable to have social workers on site to assist the practitioners with these encounters. Hence, the involvement of the Department of Health and the Department of Social Development is recommended.

Furthermore, many Baby Mat caregiver-infant dyads present with emotionally taxing accounts, making it difficult for the practitioners to separate their therapeutic practice from their personal lives. In relation to this, one-to-one supervision was suggested by the participants. Their group supervision was perceived as beneficial in relation to case formulation of the caregiver-infant dyads in which they serve. However, the practitioners maintained that additional one-to-one supervision may be advantageous for self-preservation support and for self-growth purposes. Perhaps personal psychotherapy should be considered as a requirement for the practitioners because of the sensitive nature of the Baby Mat cases. Relational therapies such as family and group therapy are additional modes of support that can be considered if required by practitioners. Additionally, humanistic and behavioural therapies may be useful for self-development and solution-focused strategies if needed by the Baby Mat practitioners.

Despite the inclusion of co-facilitators, the challenges surrounding race, language and culture were expressed as common anxieties by the practitioners. In response to such difficulties and challenges, the co-facilitators have aptly adapted their practice by learning from the community that they are in, collaborating with the caregiver-infant dyads, and forming mutual respect in the clinics. What is more, the culturally diverse co-facilitation pair assist one another for the intervention to appropriately support their clients from the Alexandra community. Arguably, these demographic challenges are consequences of broader systemic problems in South African society, which have socio-historical roots attached to the inequalities of apartheid. Thus, they are social challenges that extend beyond the control of the practitioners and directors of the Baby Mat service. Addressing such issues requires revisiting existing policy frameworks and addressing the cyclical structural disparities in South Africa.

Lastly, while attachment theory has been found to have universal applicability, the theoretical implications of working in culturally diverse settings cannot be neglected. Chapter 2 of this research report highlighted the relevance of the psychodynamic approach that is applied during the delivery of the Baby Mat intervention. Western psychoanalytical ideas are blended with indigenous African traditions, thus aiding a culturally-informed facilitation of the Baby Mat service. Moreover, this research report findings emphasized that the co-facilitators give great consideration as to how cultural diversity influences their practice. In order to effectively blend the two paradigms, the co-facilitators are evidently reliant on the diverse therapeutic pair. While one practitioner has expertise in diverse cultural knowledge and is proficient in a number of languages, the other practitioner draws upon techniques of psychodynamic theory. Additionally, the co-facilitators adapt their psychodynamic approach to meaning-making by exploring subjective experiences of multiple meaning systems, which is mindful of cultural diversity. The combination of the co-facilitators' skillsets allows for effective interpretation and therapeutic support of the relational, emotional and physiological concerns that are brought to the Baby Mat service.

6.3 Limitations of the Research

The results and discussion of the study should be understood in relation to the following limitations. The initial intention of data collection aimed to include all the Baby Mat practitioners in the two focus group discussions – this would have encompassed all 14 of the practising Baby Mat practitioners (the registered psychologists, intern psychologists and the lay practitioners). Due to the changes of the community organisation's internship programme, the interns were not included in the data collection process. Inclusion of such practitioners would have allowed for an even deeper understanding of the practitioners' perceptions and experiences of delivering the Baby Mat intervention. Additionally, it would have been ideal

for the focus groups to have contained an equal number of participants. However, due to unforeseen predicaments, this was not possible.

An additional limitation evident during the focus group discussions was that some practitioners were more vocal and open to sharing, while others resisted sharing their perceptions and experiences. Reasons for this may be because they may not have always had an opportunity to speak during the discussions or perhaps they are naturally more introverted and may have been reluctant to share in a group setting. It became evident that these participants were more comfortable sharing in a one-to-one forum.

Finally, the results of the research study are limited by the qualitative nature of the design of the research study. Since the sample of the study was purposively selected and relatively small, the findings cannot be generalised or inferred to other populations. Thus, the results of the study may not be representative of the practitioners who deliver similar interventions in different settings.

6.4 Suggestions for Further Research

There is a lack of literature that conveys the prevalence rates of attachment patterns between caregiver-infant dyads in South Africa. There is also limited documented research in South African settings, which explains the correlational affects between attachment patterns and later outcomes. Most research to date has been cross-sectional or limited to short-term longitudinal follow-ups. Thus, further research may endeavour to bridge this gap in literature. Perhaps going forward, longitudinal studies should be conducted to understand the later outcomes of community-based interventions that foster secure attachments, such as the Baby Mat intervention.

Furthermore, the practitioners' perspectives and perceptions of the Baby Mat intervention had not been explored prior to this study. Since the practitioners are core contributors to the effectiveness of the service, their role needed to be acknowledged. This

study not only conveyed their importance within the therapeutic alliance, but also revealed the necessity of the relationship between the therapeutic couple. Therefore, further research should be done on the effectiveness of culturally and racially diverse co-facilitators as a feasible solution to offering relevant and applicable mental healthcare interventions in diverse South African communities. The Baby Mat intervention, with its inclusion of diverse co-facilitators, may be the pioneer for developing and expanding much-needed mental healthcare services in South Africa.

6.5 Concluding Remarks

The relationships and mental and emotional well-being of caregiver-infant dyads are currently not a primary concern in South African public healthcare services. The Baby Mat caregivers encounter daily pressures and harsh challenges distinctive to South African communities and townships. Alexandra Township is characterised by poverty, violence, xenophobia and unemployment. Consequently, caregivers are navigating their way through motherhood in isolation and are yearning for reassurance and social support. The Baby Mat intervention was implemented as a response to a dire need for parent-infant mental health support in Alexandra Township.

As Winnicott (1960) illuminated, caregivers are better able to emotionally hold their infants' anxieties when the caregivers feel emotionally held themselves. The Baby Mat practitioners are the individuals responsible for holding to transpire. Therefore, this study acknowledges the necessity and importance of the practitioners' contribution for the success of the Baby Mat intervention. The practitioners nurture the micro-systemic influence of child development by supporting the primary caregiver and her infant. Pairing a culturally accustomed practitioner with a psychotherapist effectively provides caregivers with the relevant guidance, modelling, containment and *umdlezane* that they seek. Moreover, the co-facilitators' mediation functions as a way of helping the caregiver prioritise her infant. This

enhances the caregiver's capacity to reliably and stably attend to her infant. The interaction provides an opportunity for meaningful engagement between the caregiver and infant, thereby fostering a secure attachment, which, in turn, attempts to prevent later adverse outcomes.

Considering the positive effect secure attachments have for later development, supporting caregiver-infant relationships needs to become an urgent priority in South Africa. The therapeutic work done by the Baby Mat practitioners promotes the holistic well-being of the developing child and adolescent, and serves as an investment for the healthy functioning of future South Africa. The findings from the study highlight the efficacious factors of the Baby Mat service, illuminating a path for possible expansion and transferability of such interventions into broader contexts, similar to that of Alexandra Township. In light of such, the words of Urie Bronfenbrenner are pertinent in understanding the critical role the Baby Mat practitioners play in supporting early childhood attachment systems:

> If the children and youth of a nation are afforded opportunity to develop their capacities to the fullest, if they are given the knowledge to understand the world and the wisdom to change it, then the prospects for the future are bright. In contrast, a society which neglects its children, however well it may function in other respects, risks eventual disorganisation and demise (Bronfenbrenner, 1970, p. 216).

References

Ainsworth, M. D. S. (1974). *The development of infant-mother attachment.* Washington, DC, USA: Office of Child Development.

Ainsworth, M. D. S., Blehar, M., Waters, E., & Wall, S. (1978). *Patterns of attachment.* Hillsdale, NJ: Erlbaum.

Alexandra Clinic Annual Report. (2009). *Alexandra Health Centre and University Clinic: 80 years.* Johannesburg, South Africa: Alan Frank and Associates.

Andersen, T. (1987). The reflecting team: Dialogue and meta-dialogue in clinical work. *Family Process*, *26*, 415–428.

Anna Freud National Centre for Children and Families. (2016). Parent Infant Projects. Retrieved 01 November 2016 from http://www.annafreud.org/services-schools/services-for-children-young-people-families/parent-infant-project/

Ardington, C., Branson, N., Lam, D., Leibbrandt, M., Marteleto, L., Menendez, A.,… & Ranchhod, V. (2012). *Revisiting the 'crisis' in teen births: What is the impact of teen births on young mothers and their children?* A SALDRU Policy Brief. Cape Town: SALDRU, UCT.

Aspoas, B., & Amod, Z. (2014). A South African study on caregiver perceptions of a parent-infant intervention implemented to foster secure attachment. *Infant Mental Health Journal*, *35*(6), 580–590.

Azzi-Lessing, L. (2010). Meeting the mental health needs of poor and vulnerable children in early care and education programs. *Early Childhood Research and Practice*, *12*(1), 1–20.

Bain, K., & Richards, J. (2016). Mothers' perinatal and infant mental health knowledge in a Johannesburg township setting. *Journal of Child and Adolescent Mental Health, 28*(2), 71-95.

Baradon, T. (2005). What is genuine maternal life? Clinical considerations and techniques in parent-infant psychotherapy. *Psychoanalytic Study of the Child, 60,* 47–73.

Baradon, T., Broughton, C., Gibbs, I., James, J., Joyce, A., & Woodhead, J. (2005). *The practice of psychoanalytic parent-infant psychotherapy – Claiming the Baby.* London, England: Routledge.

Barbarin, O. A., & Richter, L. M. (2001). *Mandela's children: Growing up in post-apartheid South Africa.* New York: Routledge.

Beckwith, L., Rozga, A., & Sigman, M. (2002). Maternal sensitivity during infancy and subsequent life events relate to attachment representation at early adulthood. *Developmental Psychology, 35,* 693–700.

Berg, A. (2003). Parent-infant psychotherapy in South Africa. *Infant Mental Health Journal, 24*(3), 265–277.

Biko, S. (1978). *I write what I like.* London, England: Heinemann.

Bion, W. (1962). *Learning from experience.* London, England: Heinemann.

Bowlby, J. (1944). Forty-four juvenile thieves: Their characters and home life. *International Journal of Psycho-Analysis, 25,* 19–52.

Bowlby, J. (1958). The nature of the child's tie to his mother. *International Journal of Psycho-Analysis, 39,* 350–373.

Bowlby, J. (1969). *Attachment and loss: Vol. 1. Attachment*. New York: Basic Books.

Bowlby, J. (1973). *Attachment and loss: Vol. 2. Separation*. New York: Basic Books.

Bowlby, J., Ainsworth, M., Boston, M., & Rosenbluth, D. (1956). The effects of mother-child separation: A follow-up study. *British Journal of Medical Psychology, 29,* 211-249.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3,* 77–101.

Bray, R., Gooskens, I., Kahn, L., Moses, S., & Seekings, J. (2010). *Growing up in the new South Africa: Childhood and adolescence in post-apartheid Cape Town.* Cape Town, South Africa: HSRC Press.

Brenman Pick, I. (1992). The emergence of early object relations in the psychoanalytic setting. In R. Anderson (Ed.), *Clinical lectures on Klein and Bion* (pp. 24–34). London, England: Routledge.

Bromley, K. (2010). *Ububele Baby Mat Project: Caregivers' experiences and perceptions*. (Master's thesis, University of the Witwatersrand). Retrieved from http://146.141.12.21/bitstream/handle/10539/11427/KatieBromley_MAThesis.pdf?sequence=1

Bronfenbrenner, U. (1970). *Two worlds of childhood: U/S and U.S.S.R.* New York: Pocket Books.

Bronfenbrenner, U. (1977). Toward an experimental ecology of human development. [Electronic version]. *American Psychologist, 32,* 513–531.

Burr, V. (2015*). Social constructionism* (3rd ed.). London, England: Routledge.

Campbell-Hall, V., Petersen, I., Bhana, A., Mjadu, S., Hosegood, V., Flisher, A. J. (2010). Collaboration between traditional practitioners and primary healthcare staff in South Africa: Developing a workable partnership for community mental health services. *Transcultural Psychiatry, 47*(4), 610–628.

Canale, M., & Swain, M. (1980). Theoretical bases of communicative approaches to second language teaching and testing. *Applied Linguistics, 1*(1), 1–47.

Chitty, A. (2015). Infant mental health: Health visitors as key partners. *Community Practitioner, 88*(10), 29–30.

Cooper, D., De Lannoy, A., & Rule, C. (2015). Youth health and well-being: Why it matters. In A. De Lannoy, S. Swartz, L. Lake & C. Smith (Eds.), *South African Child Gauge*

2015 (pp. 60–69). Cape Town, South Africa: Children's Institute, University of Cape Town.

Cooper, P. J., Landmand, M., Tomlinson, M., Molteno, C., Swartz, L., Murray, L. (2002). The impact of a mother-infant intervention in an indigent peri-urban South African context: Pilot study. *British Journal of Psychiatry, 80,* 76–81.

Cooper, P. J., Tomlinson, M., Swartz, L., Landman, M., Molteno, C., Stein, A.,… & Murray, L. (2009). Improving quality of mother-infant relationship and infant attachment in socioeconomically deprived community in South Africa: Randomised controlled trial. *British Journal of Psychiatry, 9,* 974–982. doi: 10.1136/bmj.b974.

Corrigan, P. (2004). How stigma interferes with mental healthcare. *American Psychologist, 59*(7), 614–625.

Crawford, T. A., & Lipsedge, M. (2004). Seeking help for psychological distress: The interface of Zulu traditional healing and Western biomedicine. *Mental Health, Religion and Culture, 7*(2), 131–148.

Dawson, N., Richards, J., & Frost, K. (in press). *The Baby Mat Intervention – A primary preventative mental health intervention in a culturally diverse setting*.

De Lannoy, A., Leibbrandt, M., & Frame, E. (2015). A focus on youth: An opportunity to disrupt the intergenerational transmission of poverty. In A. De Lannoy, S. Swartz, L. Lake & C. Smith (Eds.), *South African Child Gauge 2015* (pp. 22–33). Cape Town, South Africa: Children's Institute, University of Cape Town.

de Vos, A., Strydom, H., Fouche, C., & Delport, C. (2011). *Research at grassroots: For the social sciences and human service professions* (4th ed.). Pretoria, South Africa: Van Schaik.

Donald, D. R. (1991). Training needs in educational psychology for South African social and educational conditions. *Psychological Society of South Africa, 21*(1), 38–44.

Donald, D., Lazarus, S., & Lolwana, P. (2010). *Educational Psychology in social context: Ecosystemic applications in South Africa.* South Africa: Oxford University Press.

Easterbrooks, M., Chaudhuri, J. H., & Gestsdottir, S. (2005). Patterns of emotional availability among mothers and their infants: A relationship, contextual analysis. *Infant Mental Health Journal, 26*(4), 309–326.

Edwards, E., & Timmons, S. (2009). A qualitative study of stigma among women suffering postnatal illness. *Journal of Mental Health, 14*(5), 471–481.

Elder, G.H., Eccles, J.S., Ardelt, M., & Lord, S. (1995). Inner-city parents under economic pressure: Perspectives on the strategies of parenting. *Journal of Marriage and the Family, 57,* 771–784.

Epstein, R. S. (1994). *Keeping boundaries: Maintaining safety and integrity in the psychotherapeutic process.* Washington, DC: American Psychiatric Press.

Farrington, D. P. (1988). Childhood aggression and adult violence: Early precursors and later-life outcomes. In D. J. Pepler & K. H. Rubin (Eds.), *The development and treatment of childhood aggression* (pp. 5–25). New Jersey: Lawrence Erlbaum Associates.

Fonagy, P. (2001). *Attachment theory and psychoanalysis.* New York: Other Press.

Fonagy, P., & Target, M. (2003). *Psychoanalytic theories: Perspectives from development pathology.* New York: Routledge Taylor & Francis Group.

Fonagy, P., Gergely, G., Jurist, E. L., & Target, M. (2004). *Affective regulation, mentalisation and the development of the self.* New York: Other Press.

Fossey, E., Harvey, C., McDermott, F., & Davidson, L. (2002). Understanding and evaluating qualitative research. *Australian and New Zealand Journal of Psychiatry, 38,* 717–731.

Foster, D. (2012). Gender, class, 'race' and violence. In C. L. Ward, A. Dawes & R. Matzopolous (Eds.), *Youth violence in South Africa: Sources and solutions in South Africa* (pp. 23–51). Cape Town, South Africa: UCT Press.

Frailberg, S., Adelson, E., & Shapiro, V. (1975). Ghosts in the nursery: A psychoanalytic approach to impaired infant-mother relationships. *Journal of the American Academy of Child Psychiatry, 14*, 387–421.

Frost, K. (2007). The Baby Mat Project (part of the Ububele Umdlezane Parent-Infant Project). *Psychoanalytic Newsletter*.

Frost, K. (2012). The Ububele Baby Mat Intervention: A community-based parent-infant intervention at primary healthcare clincs in Alexandra Township, Johannesburg, South Africa. *Journal of Psychology, 42*(4), 608–616.

Geertz, C. (1973). *The interpretation of cultures.* New York: Basic Books.

Greef, M. (2011). Information collection: Interviewing. In A. S. De Vos, H. Strydom, C. B. Fouche & C. S. L. Delport (Eds.), *Research at grassroots: For the social sciences and human service professions* (4th ed.) (pp. 286–313). Pretoria, South Africa: Van Schaik.

Groh, A. M., Roisman, G. I., van IJzendoorn, M. H., Bakermans-Kranenburg, M. J., & Fearon, R. (2012). The significance of insecure and disorganised attachment for children's internalizing symptoms: A meta-analystic study. *Child Development, 83*, 591–610.

Hall, K., & Sambu, W. (2015). Income poverty, unemployment and social grants. In A. De Lannoy, S. Swartz, L. Lake & C. Smith (Eds.), *South African Child Gauge 2015* (pp. 107–113). Cape Town, South Africa: Children's Institute, University of Cape Town.

Haza, C., Campa, M., & Gur-Yaish, N. (2006). Attachment across the lifespan. In P. Noller & J. A. Feeney (Eds.), *Close relationships: Functions, forms, and processes.* New York: Psychology Press.

Health Professions Council of South Africa (2008). *Guidelines for good practice in the healthcare professions – Seeking patients' informed consent: The ethical considerations (Booklet 9).* Pretoria, South Africa: HPCSA.

Heilfron, M. (1969). Co-therapy: The relationship between therapists. *International Journal of Group Psychotherapy, 19*(3), 366–381.

Hesse, E., & Main, M. (2006). Frightened, threatening, and dissociative parental behaviour in low-risk sample: Description, discussion, and interpretations. *Development and Psychopathology, 18,* 309–343.

Hseih, H.F., & Shannon, S.E. (2005). Three approaches to qualitative content analysis. *Qualitative Health Research, 15*(9), 1277–1288.

Huey, S. J., Tilley, J. L., Jones, E. O., & Smith, C. A. (2014). The contribution of cultural competence to evidence-based care for ethnically diverse populations. *Annual Review of Clinical Psychology, 10,* 305–338.

Hugo, C. J., Boshoff, D. E. L., Traut, A., Zungu-Dirwayi, N., & Stein, D. J. (2003). Community attitudes toward and knowledge of mental illness in South Africa. *Social Psychiatry and Psychiatric Epidemiology, 38*(12), 715–719.

Hutchings, J., Bywater, T., Davies, C., & Whitaker, C. (2006). Do crime rates predict the outcome of parenting programmes for parents of 'high-risk' preschool children. *Educational and Child Psychology, 23*(2), 15–24.

Jones, A. C. (2004). Transference and countertransference. *Perspectives in Psychiatric Care, 40*(1), 13–19.

Kang'ethe, S. M., & Itai, M. (2014). Exploring the South African post-apartheid poverty situation and proposing measures to mitigate the status: A literature review. *Mediterranean Journal of Social Sciences, 5*(15), 449–457.

Kolb, D.A. (2014). *Experiential learning: Experience as the source of learning and development* (2nd ed.). New Jersey: Pearson Education.

Kotchick, B. A., & Forehand, R. (2002). Putting parenting into perspective: A discussion on the contextual factors that shape parenting practices. *Journal of Child and Family Studies, 11,* 255–269.

Krueger, R. A., & Casey, M. A. (2000). *Focus groups: A practical guide for applied research.* London, England: Sage Publications, Inc.

Lachman, J. M., Cluver, L. D., Boyes, M. E., Kuo, C., & Casale, M. (2014). Positive parenting for positive parents: HIV/AIDS, poverty, caregiver depression, child behaviour, and parenting in South Africa. *AIDS Care: Psychological and Socio-Medical Aspects of AIDS/HIV, 26*(3), 304–313.

Ladany, N., Mori, Y., & Mehr, K. E. (2012). Effective and ineffective supervision. *The Counselling Psychologist, 41*(1), 28–47.

Landman, M. (2009). *Inside the black box of a successful parent-infant intervention in a South African informal settlement: Mothers' and counsellors' accounts of the process.* (Doctoral dissertation, Stellenbosch University). Retrieved from http://scholar.sun.ac.za/bitstream/handle/10019.1/1165/landman_inside_209.pdf?sequence=1.

Leedy, P. D., & Ormrod, J. E. (2005). *Practical research: Planning and design* (8th ed.). Cape Town, South Africa: University of Cape Town Press.

Lefko-Everett, K. (2012). Ticking time bomb or demographic dividend? Youth and reconciliation in South Africa. *South African Reconciliation Barometer Survey: 2012 Report.* Cape Town, South Africa: Centre for Justice & Reconciliation.

Lemma, A. (2008). Transference and countertransference. In A. Lemma (Ed.), *Introduction to the practice of psychoanalytic psychotherapy* (pp. 230–271). London, England: Wiley & Sons.

Letourneau, N. L., Stewart, M. J., & Bamfather, A. K. (2004). Adolescent mothers: Support needs, resources, and support-education interventions. *Journal of Adolescent Health, 35*(6), 509–525.

Lieberman, A. F., & Pawl, J. (1993). Infant-parent psychotherapy. In C. H. Zeanah (Ed.), *Handbook of infant mental health* (pp. 427–442). New York: Guilford Press.

Lieberman, A. F., & Zeanah, C. H. (1999). Contributions of attachment theory to infant-parent psychotherapy and other interventions with infants and young children. *Handbook of attachment: Theory, research, and clinical applications* (pp. 555–574). New York: Guilford Press.

Loeber, R., & Hay, D. (1997). Key issues in the development of aggression and violence from childhood to early adulthood. *Annual Review of Psychology, 48,* 371–410.

Long, C. (2009). *Contradicting maternity: HIV-positive motherhood.* South Africa: The University of Witwatersrand Press.

Lucksted, A., & Drapalski, A. L. (2015). Self-stigma regarding mental illness: Definition, impact and relationship to societal stigma. *Psychiatric Rehabilitation Journal, 38*(2), 99–102.

Lyons-Ruth, K., Bruschweiler-Stern, N., Harrison, A., Morgan, A. C., Nahum, J. P., Sandler, L.,… & Tronick, E.Z. (1998). Implicit relational knowing: Its role in

development and psychoanalytic treatment. *Infant Mental Health Journal, 19*(3), 282–289.

Main, M., & Solomon, J. (1990). Procedures for identifying infants as disorganised/disorientated during the Ainsworth strange situation. In M.T. Greenberg, D. Cicchetti & E.M. Cummings (Eds.), *Attachment in the preschool years: Theory, research, and intervention* (pp. 121–160). Chicago: University of Chicago Press.

Mandela, N. (1994). *Long walk to freedom: The autobiography of Nelson Mandela.* London, England: Abacus.

Maslow, A. H. (1943). A theory of human motivation. *Psychological Review, 50*(4), 370–396.

Maslow, A. H. (1954). *Motivation and personality.* New York: Harper and Row.

Mintz, E. E. (1963). Special values of co-therapists in group psychotherapy. *International Journal of Group Psychotherapy, 13,* 127–132.

Moore, K. (2005). *Thinking about youth poverty through the lenses of chronic poverty, life-course poverty and intergenerational poverty.* Manchester, England: Institute for Development Policy and Management, University of Manchester.

Morgan, B., & Sklar, R. (2012). Sampling and research paradigms. In J. Maree (Ed.), *Complete your thesis or dissertation successfully: Practical guidelines.* Cape Town, South Africa: Juta.

Mthembu, J. (2012, September). ANC statement on the Centenary of Alexandra Township. [ANC Press Release]. Retrieved from http://www.anc.org.za/show.php?id=9887

National Planning Commission. (2012). *National Development Plan 2030. Our future: Make it work.* Pretoria, South Africa: The Presidency. P. 24.

Nduna, M. & Jewkes, R. J. (2012). Disempowerment and psychological distress in the lives of young people in Eastern Cape, South Africa. *Child and Family Studies, 21,* 1018–1027.

Nobels, W.W. (2013). Shattered consciousness, fractured identify: Black Psychology and the restoration of the African psyche. *Journal of Black Psychology, 39*(3), 232-242.

Nortje, M. (2016). The Ububele Baby Mat intervention: Facilitating meaning in a multi-cultural context. *Journal of Child and Adolescent Mental Health, 28*(2), 97-107.

Office of the High Commissioner of Human Rights. (1989). *Convention on the Rights of the Child, UN General Assembly resolution 44/25.* Geneva, Switzerland: United Nations.

Pillay, J. (2011). Experiences of learners from child-headed households in a vulnerable school that makes a difference: Lessons for school psychologists. *School Psychology International, 33*(1), 3–21.

Pinderhughes, E.E., Nix, R., Foster, E.M., & Jones, D. (2001). Parenting in context: Impact of neighbourhood poverty, residential stability, public services, social networks, and danger on parental behaviours. [Electronic version]. *Journal of Marriage and Family, 63*, 941–953.

Pinnock, D. (2016). *Gang Town.* Cape Town, South Africa: Tafelberg.

Pope, C., Ziebland, S., & May, N. (2000). Qualitative research in healthcare: Analysing qualitative data. *British Medical Journal, 320*, 114–116.

Quinn, D. M., Williams, M. K., & Weisz, B.M. (2015). From discrimination to internalised mental illness stigma: The mediating roles of anticipated discrimination and anticipated stigma. *Psychiatric Rehabilitation Journal, 38,* 103–108.

Racker, H. (2002). *Transference and countertransference.* London, England: Karnac Books.

Ranuga, T. K. (1986). Frantz Fanon and Black Consciousness in Azania (South Africa). *Phylon (1960-), 47*(3), 182–191.

Republic of South Africa (2015a). *Draft National Early Childhood Development Policy.* Republic of South Africa: Department of Social Development. Retrieved from http://www.dsd.gov.za/index.php?option=com_docman&task=Cat_view&itemid=39&gid=121

Republic of South Africa (2015b). *The 2013 National Antenatal Sentinel HIV Prevalence Survey South Africa.* Republic of South Africa: The National Department of Health. Retrieved from https://www.health-e.org.za/wp-content/uploads/2016/03/Dept-Health-HIV-High-Res-7102015.pdf

Richter, L., Biersterker, L., Burns, J., Desmond, C., Feze, N., Harrison, D.,… & Slemming, W. (2012). *Diagnostic review of early childhood development.* Pretoria, South Africa: Department of Performance, Monitoring and Evaluation & Inter-Departmental Steering Committee on ECD.

Ritchie, J., & Lewis, J. (2003). *Qualitative research practice: A guide for social science students and researchers.* London, England: Sage.

Roos, S., & Banda, E. C. (2010). *Accessibility of primary healthcare services in Alexandra township* (Magister Curationis dissertation). University of Johannesburg, Johannesburg.

Saleebey, D. (1994). Culture, theory, and narrative: The intersection of meanings in practice. *Social Work, 39*(4), 351–359.

Seidel, G., Sewpaul, V., & Dano, B. (2000). Experiences of breastfeeding and vulnerability among a group of HIV-positive women in Durban, South Africa. *Health Policy and Planning, 15*(1), 24–33.

Shumow, L., & Lomax, R. (2002). Parental efficacy: Predictor of parenting behaviour and adolescent outcomes. *Parenting: Science and Practice, 2*(2), 127–150.

Skovholt & Trotter-Mathison (2011). *The resilient practitioner: Burnout, prevention and self-care strategies for counsellors, therapists, teachers, and health professionals* (2nd ed.). New York: Routledge.

Slade, A. (2005). Parental reflective functioning: An introduction. *Attachment & Human Development, 7*(3), 269–281.

Slade, A. (2007). Reflective parenting programs: Theory and development. *Psychoanalysis Inquiry, 26,* 640–659.

South African Psychoanalytic Confederation. (2012). *Pocket directory: Communicating our commitment to national mental health.* Cape Town, South Africa: Frances Williams.

Sroufe, L.A. (2013). Attachment and development: A prospective, longitudinal study from birth to adulthood. *Attachment & Human Development, 7*(4), 349–367.

Statistics South Africa. (2013). *Documented immigrants in South Africa, 2013. Statistical release, Report No: P0351.4.* Pretoria, South Africa: Stats SA.

Statistics South Africa. (2014). *Mortality and morbidity patterns among the youth of South Africa, 2013, Report No. 03-08-12.* Pretoria, South Africa: Stats SA.

Statistics South Africa. (2015). *General Household Survey 2009-2014, Report No: P0318.* Pretoria, South Africa: Stats SA.

Statistics South Africa (2016). *Community survey 2016, Statistical release, Report No: P0301.* Pretoria, South Africa: Stats SA.

Stern, D.N. (1995). *The motherhood constellation: A unified view of parent-infant psychotherapy.* New York: Basic Books.

Stormshak, E. A., Bierman, K. L., McMahon, R. L., & Lengua, L. J. (2000). Parenting practices and child disruptive behaviour problems in early elementary school. *Journal of Clinical Child Psychology, 29*(1), 17–29.

Sue, S. (1998). In search of cultural competence in psychotherapy and counselling. *American Psychologist, 53,* 440–448.

Terre Blanche, M., Durrheim, K., & Painter, D. (2006). *Research in practice* (2nd ed.). Cape Town, South Africa: University of Cape Town Press.

Theron, L. C., & Donald, D. R. (2012). Educational psychology and resilience in developing contexts: A rejoinder to Toland and Carrigan (2011). *School Psychology International, 34*(1), 51–66.

Thomson-Salo, F. (2007). Recognising the infant as subject in infant-parent psychotherapy. *International Journal of Psychotherapy, 88,* 1–18.

Toland, J., & Carrigan, D. (2011). Educational psychology and resilience: New concept, new opportunities. *School Psychology International, 32*(1), 95–106.

Tomlinson, M., Cooper, P., & Murray, L. (2005). The mother-infant relationship and infant attachment in a South African peri-urban settlement. *Child Development, 76*(5), 1044–1054.

Trevarthen, C., & Aitken, K. J. (2001). Infant inter-subjectivity: Research, theory, and clinical applications. *Journal of Child Psychology and Psychiatry, 42*(1), 3–48.

Ububele Educational and Psychotherapy Trust (2016a). About Ububele. [Organisation Website]. Retrieved from http://www.ububele.org/about.html

Ububele Educational and Psychotherapy Trust (2016b). Courses: Parent Infant Psychotherapy. [Organisation Website]. Retrieved from http://www.ububele.org/parent.html

van der Merwe, M., & Dunbar-Krige, H. (2007). Action: Learning in community psychology. In N. Duncan, B. Bowman, A. Naidoo & V. Roos (Eds.), *Community Psychology: Analysis, Context and Action* (pp. 293–309). Cape Town, South Africa: UCT Press.

van IJzendoorn, M. H., Schuengel, C., & Bakermans-Kranenburg, M. J. (1999). Disorganised attachment in early childhood: Meta-analysis of precursors, concomitants, and sequelae. *Development and Psychopathology, 11,* 225–249.

Walker, J. L. (2012). Research column: The use of saturation in qualitative research. *Canadian Journal of Cardiovascular Nursing, 22*(2), 37–41.

Ward, C., Makusha, T., & Bray, R. (2015). Parenting, poverty and young people in South Africa: What are the connections? In A. De Lannoy, S. Swartz, L. Lake & C. Smith (Eds.), *South African Child Gauge 2015* (pp. 69–73). Cape Town, South Africa: Children's Institute, University of Cape Town.

Washington, K. (2010). Zulu traditional healing, Africa worldview and the practice of Ubuntu: Deep thought for African/Black psychology. *The Journal of Pan African Studies, 3*(8), 24–39.

Willig, C. (2008). *Introducing qualitative research psychology*. London, England: Mcgraw-Hill International.

Willot, S., Hatton. T., & Oyebode, J. (2012). Reflecting team process in family therapy: A search for research. *Journal of Family Therapy, 34,* 180–203.

Wilson, M. (2003). *Alexandra Township and the Alexsan Kopano Resource Centre.* South Africa: University of the Witwatersrand.

Winnicott, D. W. (1958). Primary maternal preoccupation. In *Collected papers: Through Paediatrics to Psycho-Analysis* (pp. 300–305). London, England: Tavistock Publications.

Winnicott, D. W. (1960). The theory of the parent-infant relationship. In M. M. Khan (Ed.), *The maturational processes and the facilitating environment: Studies in the theory of emotional development* (pp. 37–55). London, England: The Hogarth Press and the Institute of Psycho-Analysis.

Winnicott, D. W. (1962). Providing for the child in health and crisis. In M. M. Khan (Ed.), *The maturational processes and the facilitating environment* (pp. 64–73). London, England: Hogarth Press.

PSYCHOLOGY
THE SCHOOL OF HUMAN AND COMMUNITY DEVELOPMENT (SHCD)

Private Bag 3, Wits, 2050 – Tel: 011 717 4541 – Fax: 011 717 4559 – Email: psych.SHCD@wits.ac.za

Appendices

Appendix 1: Participant Information Sheet (Focus Group)

The Practitioners' Perceptions and Experiences of the Baby Mat Mental Healthcare Intervention

Dear Madam/Sir,

My name is Nikki Preston and I am an Educational Psychology master's student studying at the University of the Witwatersrand. I am required to conduct research as part of the requirements for the completion of my degree.

I would like to conduct my research on the practitioners' perceptions and experiences of the Baby Mat intervention offered at the community organisation. Much research on the caregivers' perceptions of the Baby Mat intervention, and other interventions alike, has been conducted; however, there appears to be relatively little documented research on the practitioners' perceptions of the intervention. Since the therapeutic alliance forms a considerable part of the intervention, it is important to understand and explore how the practitioners perceive the intervention. This understanding could make a further contribution to the practitioners' training and the application of the intervention. The primary aim of the research is therefore to gain insight into the perceptions and experiences of the practitioners who facilitate the Baby Mat intervention.

I would like to formally invite you to take part in my research study. Should you agree to participate in this study, I will require approximately 60 minutes of your time to partake in

one of two focus group sessions with six of your colleagues. Please note, in addition to the focus group session, a psychologist, intern psychologist and lay counsellor may be asked to partake in a one-to-one, face-to-face, semi-structured interview at a later date. The duration of the one-to-one interview will be approximately 60 minutes each. These one-to-one interviews will be held with the participants to gain further insight into their perceptions and experiences that could not be fully explored during the focus group sessions.

Participation in this study is entirely voluntary and no one will be disadvantaged or advantaged for choosing to participate or choosing not to participate in this study. Due to the nature of this study, there are no inherent risks or dangers to you, the other practitioners' or the community organisation. There are also no inherent benefits. Participants may choose to withdraw from the study at any time or choose not to answer specific questions without negative consequences. Although, no harm is anticipated to occur during the focus group session, the contact details of free counselling and support services offered in Johannesburg are provided below. This information is given to you if you feel that the focus group discussion does elicit any sensitive emotions in you. The following free therapy services may offer you the necessary help:

- Lifeline Johannesburg– 011 728 1347
- Lifeline Alexandra – 011 443 5026
- Childline – 011 484 0771
- South African Depression and Anxiety Group (SADAG) – 011 234 4837 (Mental Healthcare Line)

Confidentiality cannot be fully assured due to the discursive nature of focus groups. However, all participants will be asked to sign a contract requesting them to remain confidential of all information discussed between participants during the focus group sessions.

The results of the research study will be processed by myself (the researcher) and my supervisor. If direct quotes are used from the responses, no identifying information will accompany that quote. Any identifying information will be safeguarded in a password protected computer. Anonymity will be respected in handling of all data related to the participants and my supervisor and I will only have access to such information and data. The

research results will be reported in the form of a research report and will be made available on the university web. The study may also be published in the form of a journal article.
With your consent, the focus group interviews will be video-recorded for data analysis reasons. However, only my supervisor and I will have access to these videos and they will be safeguarded in password protected computers. Your name and direct quotes will be replaced with pseudonyms (for example 'Participant A) to ensure anonymity. Once the information of the interview has been transcribed verbatim, the videos and transcripts will be destroyed at a later stage.

General feedback from the results of the study will be presented in a summary and will be sent to the community organisation once the research is completed. A copy of the final report will be sent to the Director of The community organisation. If you have any concerns and questions about the research study, you are welcome to contact myself or my supervisor.

Yours sincerely,

Nikki Preston

079 493 0897
nlpreston91@gmail.com

Zaytoon Amod (Supervisor)

011 717 8326
zaytoon.amod@wits.ac.za

PSYCHOLOGY
THE SCHOOL OF HUMAN AND COMMUNITY DEVELOPMENT (SHCD)

Private Bag 3, Wits, 2050 – Tel: 011 717 4541 – Fax: 011 717 4559 – Email: psych.SHCD@wits.ac.za

Appendix 1b: Participant Consent Form (Focus Group)

Participant Consent Form

Focus Group

I _____ consent to participation for the proposed study on; *Practitioners' perceptions and experiences of the Baby Mat mental healthcare intervention*, conducted by Nikki Preston.

As a participant in her study, I understand that:

- My participation is voluntary.
- I am able to withdraw from the study at any time without negative consequences.
- I do not have to answer any question(s) I do not wish to without negative consequences.
- Any identifying and personal information of mine will remain anonymous in the final research report, although my quotations may be used in the research study.
- If my quotations should be used, I understand that no identifying information of mine will be revealed.
- I understand that confidentiality is not guaranteed due to the nature of focus group discussions.
- I am aware that the results of this study will be reported in the form of a research report for the partial completion of the degree, Master of Educational Psychology, and may be published in a scientific journal.

PSYCHOLOGY
THE SCHOOL OF HUMAN AND COMMUNITY DEVELOPMENT (SHCD)

Private Bag 3, Wits, 2050 – Tel: 011 717 4541 – Fax: 011 717 4559 – Email: psych.SHCD@wits.ac.za

Appendix 2: Participant Information Sheet (Individual Interview)

The Practitioners' Perceptions and Experiences of the Baby Mat Mental Healthcare Intervention

Dear Madam/Sir,

My name is Nikki Preston and I am an Educational Psychology master's student studying at the University of the Witwatersrand. I am required to conduct research as part of the requirements for the completion of my degree.

I would like to conduct my research on the practitioners' perceptions and experiences of the Baby Mat intervention offered at the community organisation. Much research on the caregivers' perceptions of the Baby Mat intervention, and other interventions alike, has been conducted; however, there appears to be relatively little documented research on the practitioners' perceptions of the intervention. Since the therapeutic alliance forms a considerable part of the intervention, it is important to understand and explore how the practitioners perceive the intervention. This understanding could make a further contribution to the practitioners' training and the application of the intervention. The primary aim of the research is therefore to gain insight into the perceptions and experiences of the practitioners who facilitate the Baby Mat intervention.

I would like to formally invite you to take part in my research study. Should you agree to participate in this study, I will require approximately 60 minutes of your time to partake in a one-to-one, face to face, semi-structured interview. The duration of the one-to-one interview will be approximately 60 minutes. This interview is to gain further insight into your perceptions and experiences that could not be fully explored during the focus group sessions.

Participation in this study is entirely voluntary and no one will be disadvantaged or advantaged for choosing to participate or choosing not to participate in this study. Due to the nature of this study, there are no inherent risks or dangers to you, the other practitioners' or the community organisation. There are also no inherent benefits. Participants may choose to withdraw from the study at any time or choose not to answer specific questions without negative consequences. Although, no harm is anticipated to occur during the individual interview, the contact details of free counselling and support services offered in Johannesburg are provided below. This information is given to you if you feel that the individual interview elicits any sensitive emotions in you. The following free therapy services may offer you the necessary help:

- Lifeline Johannesburg– 011 728 1347
- Lifeline Alexandra – 011 443 5026
- Childline – 011 484 0771
- South African Depression and Anxiety Group (SADAG) – 011 234 4837 (Mental Healthcare Line)

The results of the research study will be processed by myself (the researcher) and my supervisor. If direct quotes are used from the responses, no identifying information will accompany that quote. Any identifying information will be safeguarded in a password protected computer. Anonymity and confidentiality will be respected in handling of all data related to the participants and my supervisor and I will only have access to such information and data. The research results will be reported in the form of a research report and will be made available on the university web. The study may also be published in the form of a journal article.

With your consent, the individual interview will be audio-recorded for data analysis reasons. However, only my supervisor and I will have access to these audio recordings and they will be safeguarded in password protected computers. Your name and direct quotes will be replaced with pseudonyms (for example 'Participant A) to ensure anonymity. Once the information of the interview has been transcribed verbatim, the audio recordings and transcripts will be destroyed at a later stage. General feedback from the results of the study will be

presented in a summary and will be sent to the community organisation once the research is completed.

A copy of the final report will be sent to the Director of The community organisation. If you have any concerns and questions about the research study, you are welcome to contact myself or my supervisor.

Yours sincerely,

Nikki Preston
_____
079 493 0897
nlpreston91@gmail.com

Zaytoon Amod (Supervisor)
_____
011 717 8326
zaytoon.amod@wits.ac.za

PSYCHOLOGY
THE SCHOOL OF HUMAN AND COMMUNITY DEVELOPMENT (SHCD)

Private Bag 3, Wits, 2050 – Tel: 011 717 4541 – Fax: 011 717 4559 – Email: psych.SHCD@wits.ac.za

Appendix 2b: Participant Consent Form (Individual Interview)

Participant Consent Form

Individual Interview

I, _____ consent to participation for the proposed study on; *Practitioners' perceptions and experiences of the Baby Mat mental healthcare intervention*, conducted by Nikki Preston.

As a participant in her study, I understand that:

- My participation is voluntary.
- I am able to withdraw from the study at any time without negative consequences.
- I do not have to answer any question(s) I do not wish to without negative consequences.
- Any identifying and personal information of mine will remain anonymous in the final research report, although my quotations may be used in the research study.
- If my quotations should be used, I understand that no identifying information of mine will be revealed.
- I am aware that the results of this study will be reported in the form of a research report for the partial completion of the degree, Master of Educational Psychology, and may be published in a scientific journal.

PSYCHOLOGY
THE SCHOOL OF HUMAN AND COMMUNITY DEVELOPMENT (SHCD)

Private Bag 3, Wits, 2050 – Tel: 011 717 4541 – Fax: 011 717 4559 – Email: psych.SHCD@wits.ac.za

Appendix 3: Focus Group Confidentiality Request

The Practitioners' Perceptions and Experiences of the Baby Mat Mental Healthcare Intervention

Dear Madam/Sir,

Focus groups cannot guarantee full confidentiality and privacy of information because there will be more than one participant present during the focus group discussion. In this case the focus group will contain seven participants, including yourself.

However, it is important to aim for as much confidentiality as possible so that all participants' privacy is ensured.
This letter is requesting you maintain confidentiality after the focus group discussion has taken place.

Sign: _____

Date: _____

PSYCHOLOGY
THE SCHOOL OF HUMAN AND COMMUNITY DEVELOPMENT (SHCD)

Private Bag 3, Wits, 2050 – Tel: 011 717 4541 – Fax: 011 717 4559 – Email: psych.SHCD@wits.ac.za

Appendix 4: Participant Consent Form (Video Recording of the Focus Group)

The Practitioners' Perceptions and Experiences of the Baby Mat Mental Healthcare Intervention

I, _____, have read the participant information sheet, and consent to have my interview video recorded by Nikki Preston. In doing so I understand that:

- My interview will be video recorded
- My interview video recording will be subject to analysis
- No identifying information from the video recordings will be used in the transcripts or the research report
- My video recorded interview will only be accessed and heard by the researcher and her supervisor
- My video recorded interview will be kept in a safe place (a password protected computer)
- Video recordings will be destroyed after the stipulated length of time of five years is met

Signed: _____

Date: _____

PSYCHOLOGY
THE SCHOOL OF HUMAN AND COMMUNITY DEVELOPMENT (SHCD)

Private Bag 3, Wits, 2050 – Tel: 011 717 4541 – Fax: 011 717 4559 – Email: psych.SHCD@wits.ac.za

Appendix 5: Participant Consent Form (Audio Recording of the One-to-One Interview)

I, _____, have read the participant information sheet, and consent to have my interview audio recorded by Nikki Preston. In doing so I understand that:

- My interview will be audio recorded
- My interview audio recording will be subject to analysis
- No identifying information from the audio recordings will be used in the transcripts or the research report
- My audio recorded interview will only be accessed and heard by the researcher and her supervisor
- My audio recorded interview will be kept in a safe place (a password protected computer)
- Audio recordings will be destroyed after the stipulated length of time, of five years, is met

Signed: _____

Date: _____

Appendix 6: Focus Group Semi-Structured Interview Schedule

(Preamble: My name is Nikki Preston and I am currently completing my masters in Educational Psychology at the University of the Witwatersrand (Wits). Part of the requirement of the completion of my degree is the submission of a research report. For my research I would like to explore and understand your opinions and experiences of the Baby Mat intervention. In this focus group I will ask everyone a few questions to guide the discussion. Please remember that there are no right or wrong answers. Everyone's opinion is of value whether you agree or disagree. I would also like to emphasize that you not be disadvantaged in any way if there are negative aspects or challenges that you would like to express. I would really like to hear what you really feel and not what you think I would like to hear. At no time will you be forced to answer any questions. It will be your decision to respond as and when you wish. Before the group discussion begins, I would like to please ask each of you to agree not to talk about aspects discussed with other people after the focus group session. From my side, I would like to reassure you that your names will be kept confidential. When I write up the details of this discussion, I will replace your names with pseudonyms. Our focus group will be an hour).

**The questions below may need to be probed further, which is why they are included in the schedule. However, the interview will also be guided by topics discussed during the focus group sessions.*

<u>Demographics and Personal context</u>

- Could you please introduce yourself?
    - What qualifications do you have?
    - What type of practitioner are you (psychologist, intern psychologist or lay counsellor)?
    - How long have you been a practitioner?
    - How long have you been a Baby Mat practitioner?

<u>Perceptions of the Baby Mat intervention</u>

- What are your personal experiences of the Baby Mat intervention?
- What are some of the highlights of your work?
- What are the limitations or drawbacks experienced?
- What do you think is important in order for the Baby Mat intervention to work effectively?

<u>Experiences of the effectiveness of the intervention</u>

- What are your perceptions of the Baby Mat intervention in relation to the caregiver-infant relationship? Please elaborate.
- What are your perceptions of the Baby Mat intervention in relation to mothering? Please elaborate.
- What are your perceptions of the Baby Mat intervention in relation to the infant's development? Please elaborate.

Therapeutic relationship

- How do you feel about your interaction with the caregiver when delivering the intervention? Please elaborate.

Suggestions for the intervention

- Do you have any suggestions for improvement of how the intervention is conducted?
- Do you have any suggestions for improvement of the intervention training?

Personal feelings toward the intervention

- How does the intervention relate or influence the other work that you do?
- How does the intervention affect your life personally?
- What support is available to you? (For example: Supervision; personal therapy; peer discussions).
    - What role does supervision and containment play for you, in this field of work?

Other

- Do you have any additional thoughts or comments?

Appendix 7: Semi-Structured Interview Schedule

(Preamble: Just to remind you: My name is Nikki Preston and I am currently completing my masters in Educational Psychology at the University of the Witwatersrand (Wits). Part of the requirement of the completion of my degree is the submission of a research report. For my research I would like to explore and understand your opinions and experiences of the Baby Mat intervention. In the focus group we had a discussion with the other practitioners about all of your experiences about the Baby Mat intervention. In our discussion today we can discuss how you felt the focus group went and what other information you would like to share about your feelings toward the intervention. We can explore aspects in light of what was discussed in our previous group conversation.

I would also like to re-emphasize that you not be disadvantaged in any way if there are negative aspects or challenges that you would like to express. I would really like to hear what you really feel and not what you think I would like to hear. At no time will you be forced to answer any questions. It will be your decision to respond as and when you wish. From my side, I would like to reassure you that your name will be kept confidential. When I write up the details of this discussion, I will replace your name with pseudonyms. Our discussion together will be approximately 60 minutes.

<u>Demographics and Personal context:</u>

- What qualifications do you have?
- What type of practitioner are you (psychologist, intern psychologist or lay counsellor)?
- How long have you been a practitioner?
- How long have you been a Baby Mat practitioner?
- Which focus group were you in?

<u>Experiences of the focus group:</u>

- How did you experience the focus group?
- Is there any additional information that you would like to share about your experiences of the Baby Mat intervention that you never had a chance to talk about in the focus group?

<u>Perceptions of the Baby Mat intervention:</u>

Is there anything else you would like to share regarding:

- Your personal experiences of the Baby Mat intervention?
- The highlights of your work?

- The limitations or drawbacks experienced?
- The important factors in order for the Baby Mat intervention to work effectively?

Experiences of the effectiveness of the intervention:

Is there anything else you would like to share regarding:

- Your perceptions of the Baby Mat intervention in relation to the caregiver-infant relationship? Please elaborate.
- Your perceptions of the Baby Mat intervention in relation to mothering? Please elaborate.
- Your perceptions of the Baby Mat intervention in relation to the infant's development? Please elaborate.

Therapeutic relationship:

Is there anything else you would like to share regarding:

- How you feel about your interaction with the caregiver when delivering the intervention? Please elaborate.

Suggestions for the intervention:

Is there anything else you would like to share regarding:

- Suggestions for improvement of how the intervention is conducted?
- Suggestions for improvement of the intervention training?

Personal feelings toward the intervention:

Is there anything else you would like to share regarding:

- How the intervention relates or influences the other work that you do?
- How the intervention affects your life personally?
- The support that is available to you? (For example: Supervision; personal therapy; peer discussions).
    - What role does supervision and containment play for you, in this field of work?

Further comments:

Appendix 8: Human Research Ethics Committee (HREC Non-Medical): Clearance Certificate

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

HUMAN RESEARCH ETHICS COMMITTEE (SCHOOL OF HUMAN & COMMUNITY DEVELOPMENT

CLEARANCE CERTIFICATE	**PROTOCOL NUMBER: MEDP/16/006 IH**
PROJECT TITLE:	Practitioners' perceptions and experiences of the Baby Mat Mental Health Intervention
INVESTIGATORS **DEPARTMENT**	Preston Nikki Psychology
DATE CONSIDERED	30/05/16
DECISION OF COMMITTEE*	Approved

This ethical clearance is valid for 2 years and may be renewed upon application

DATE: 30 May 2016

CHAIRPERSON
(Prof. Brett Bowman)

cc Supervisor:

Dr Zaytoon Amod
Psychology

DECLARATION OF INVESTIGATOR (S)

To be completed in duplicate and **one copy** returned to the Secretary, Room 100015, 10th floor, Senate House, University.

I/we fully understand the conditions under which I am/we are authorized to carry out the abovementioned research and I/we guarantee to ensure compliance with these conditions. Should any departure be contemplated from the research procedure, as approved, I/we undertake to submit a revised protocol to the Committee.

This ethical clearance will expire on 31 December 2018

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES