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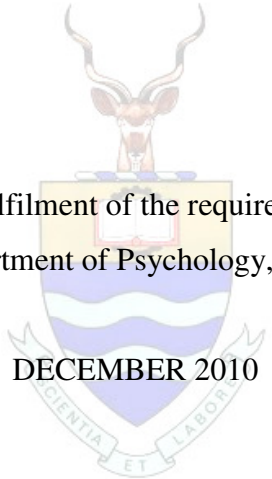
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Ububele Baby Mat Project: Caregivers' experiences and perceptions

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Supervisor: Katherine Bain

DECLARATION

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

Signature:..... Date:.....

ABSTRACT

Extensive research and literature exists emphasising that the quality of the early infant attachment style and psychic structure developments are dependent on the quality of maternal care received by an infant. Infants' who experience consistent, sensitive, and reliable care are more likely to develop secure attachments and healthy psychic structures which will positively influence their future abilities to function healthily in their environments and to experience healthy interpersonal relationships. The importance, therefore, for the development and assessment of parent-infant interventions focused on improving the quality of maternal care available to infants, is clear. The Ububele Baby Mat Project, implemented at the Alexandra Health Care Clinic in Johannesburg, is one such intervention and no evaluation of this intervention has been conducted. It was deemed necessary by the team providing the service for them to gain some idea of the way in which their service is being received in the community it is serving as well as to assist them in developing their intervention further. The current research aimed to get insight into the mothers' experiences and perceptions of the Baby mat. The form of data included 8 semi-structured in-depth interviews of women who had accessed the Baby mat and thematic content analysis was used to interpret the results. The findings indicated that overall the mothers received the Baby mat very positively and spoke of the service being invaluable to them, especially in the face of the adverse conditions in which they live. Suggestions for the Ububele Baby Mat Project team are also provided.

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CHAPTER 1: INTRODUCTION

1.1 Research Aim

Winnicott (1960) stated that: "There is no such thing as an infant, meaning that whenever one finds an infant one finds maternal care, and without maternal care there would be no infant" (p 39). This statement highlights the role of maternal care in healthy infant development. Maternal care can be provided by anyone who takes on the primary responsibility for ensuring that the infant's needs are met. In the context of the current research the individuals providing primary care to the infants are often the infant's grandmothers and so the term caregiver is typically used to denote this role (Frost, 2007); however in the current study the term mother will be used to denote the primary caregiver[1].

The aim of this research was to explore the experiences and perceptions of mothers who accessed Ububele[2]'s Baby Mat Project service at the Alexandra Health Care Clinic (AHCC) in Alexandra Township, Johannesburg. The Ububele Baby Mat Project (UBMP) is run by an educational psychologist and a multi-lingual auxiliary social worker/co-therapist every Thursday morning in the Well Baby clinic at AHCC (Frost, 2007; Frost & van der Walt, 2010). It is based primarily on the Lane Hostel Project (the outreach section of the Anna Freud Centre in England) and involves placing a mat on the floor of the clinic to allow a designated space for mothers to work with the psychologist (The Anna Freud Centre, 2010). Further information regarding the development of the UBMP as well as the purpose/function and theoretical underpinnings of the project is within Chapter 2.

The exploration of the mothers' experiences and perceptions began with conducting semi-structured in-depth interviews with the mothers after they had accessed the Baby mat. A thematic content analysis was then used to analyse the interviews. The analysis was inductive

[1] In the current research these maternal caregivers are referred to as mothers because, despite their biological or non-biological connection to their infants, they fulfil the role of 'mother', identify themselves as mothers, and should be recognised as such. At the time of the research proposal the mothers were referred to as caregivers, as stipulated in the title, however, after conducting the research the researcher felt that describing the women as mothers was the most respectful way in which to refer to them and the role they fulfil in their infants' lives.

[2] Ububele, the African Psychotherapy Resource Centre is situated in Kew on the border of Alexandra Township. The centre aims to address the drastic shortage of specifically trained mental health workers who can communicate with their clients appropriately. In order to meet their goals of providing such help the centre provides training, clinical, and research services.

in nature in that a prescribed theoretical interest did not inform the themes that were identified; however, the analysis did go beyond just the surface-level description of the mothers' experiences. In addition to the important exploration of their ideas, assumptions and conceptualisations of the Baby mat and their experience of it, space was also allowed for the mothers' unconscious feelings, fears, and wishes to emerge as well as for clinical impressions to be incorporated in the analysis. In doing this it was hoped that the mothers' authentic experiences of the intervention and its effectiveness would emerge.

1.2 Rationale

In developmental psychology there is a well established literature base focused on attachment which emphasises the negative effects insecure attachment styles have on an infant's future emotional, behavioural and cognitive development (Berlin, Cassidy, & Belsky, 1995; Thompson, 2008). As a result, research focused on identifying parent-infant relationships indicative of insecure attachment styles, as well as studies focused on parent-infant interventions have become of particular importance in the field of attachment theory. Several researchers have stressed the importance of evaluating the effectiveness of interventions that are implemented (Murray, Fiori-Cowley, Hooper, & Cooper, 1996); especially those implemented in developing countries due to the perceived differences that cultural ideas have on parenting styles and subsequent attachment development (Minde, Minde, & Vogel, 2006).

Of the research evaluating such interventions, many have focused on outcome measures rather than on the subjective experiences and perceptions of the mothers who receive such interventions (Bakermans-Kranenburg, Van Ijzendoorn, & Juffer, 2005; Baradon, 2002; Murray et al., 1996; Tomlinson, Cooper, & Murray, 2005; Wendland-Carro, Piccini, & Millar, 1999). Three studies were found which look at mothers' experiences and perceptions of the interventions they received. Buultjens, Robinson and Liamputton (2008) conducted a pilot study which looked at mothers' perceptions of the intervention they experienced. This study was conducted in Australia and focused specifically on mothers suffering from postpartum depression. The intervention was focused on trying to alleviate the effects of the depression on the mothers' interactions with their infants as well as the subsequent effects on the attachment formed (Buultjens, et al, 2008). Cooper et al. (2002) used a four point interview scale to assess 449 mothers' perceptions of a mother-infant intervention they had received in a peri-urban settlement in Khayelitsha, Cape Town. Landman (2009) also conducted a study in Khayelitsha, which looked at the personal experiences of the

counsellors, the project and counsellor supervisor (author) and 17 mothers who had been involved in what was already considered to be a successful mother-infant intervention programme. This intervention had been conducted from a point in time within the mothers' antenatal periods to the infants being 6 months of age (Cooper et al., 2009). The current study is unique in that it comprised of 8 in-depth interviews with women who received a short-term intervention in the South African context. In analysing the mothers' experiences and perceptions of the Baby mat it was hoped that a culturally appropriate assessment could be made of a) the relevance of the intervention, b) the ease of accessibility of the intervention and c) any necessary adjustments that need to be made to the intervention to better suit the community it is serving. The current study is also adding to the parent-infant psychotherapy body of literature, especially with regard to cross-cultural experiences and perceptions of this type of intervention.

1.3 Context of Alexandra Health Care Clinic and the Ububele Baby Mat Project

The AHCC is located on the outskirts of Alexandra, a peri-urban settlement in Johannesburg, South Africa. Historically it was created as part of the group areas act of 1923 during the apartheid regime for black South Africans. Today the deprivation and severe poverty experienced in Alexandra stands it in stark contrast to the wealthy suburbs, such as Sandton, which are just 3 kilometres away. It is estimated that there are approximately 750 000 people inhabiting the roughly 7.6 square kilometre area which holds around 20 000 shacks (Alexandra Clinic Annual Report, 2009; Alexandra Renewal Project, 2006; The World Bank Group, 1999). Mothers and infants living in these adverse conditions are highly susceptible to having compromised secure attachment developments, due to issues such as poverty, domestic violence and relationship problems as well as what has been hypothesised as the negative effects high rates of HIV have in this community (Tomlinson et al., 2005).

The clinic began in 1929 as a missionary mother-and-child clinic which served the community of 20 000 people. Today it serves the still impoverished community as a welfare organisation surviving on the support of The Gauteng Department of Health as well as many donor companies and organisations in and around the community. The clinic's mission statement is, "... to strengthen the health status of individuals and families in Alexandra and the surrounding communities through the provision of user-friendly primary health care services" (Alexandra Clinic Annual Report, 2009).

While the clinic provides much needed medical treatment to the community it serves, there is little help and support with regard to emotional difficulties or concerns that mothers may experience either in relation to themselves or in relation to their infants. Despite no dedicated service being provided directly by the clinic, there are very stressful demands on the limited number of nursing staff in the Well Baby clinic and so the emotional difficulties of the mothers are most probably overlooked (Jewkes, Abrahams, & Mvo, 1998).

The UBMP therefore holds a special place in the Well Baby clinic as it offers the mothers an opportunity to express their concerns and furthermore offers one form of mental health facility, which is not easily available in Alexandra, to the mothers and infants. The UBMP has been running for 3 years and it was felt necessary by the UBMP team for there to be an evaluation of whether the project is meeting the needs of the mothers and infants accessing it. These needs have informed the current study's research questions which are discussed in the methodology section.

CHAPTER 2: LITERATURE REVIEW

2.1 Attachment theory

Attachment theory is of significant importance for understanding our personality development and interpersonal functioning (Senior, 2009). Its development began with the clinical observations of John Bowlby who developed an understanding of the significance of mother-infant interactions and the importance of these interactions for future infant development (1969, 1973, and 1980). Bowlby theorised that attachment serves an evolutionary purpose in that it is a natural progressive process which allows for the continued existence of the human species. The evolutionary-adapted behaviour system, on which he based the theory of attachment, allows for the infant to safely and effectively explore his environment, without the threat of anticipated dangers, by maintaining a close proximity to his mother and thus ensuring the infant's successful psychological and physical survival (Senior, 2009).

This behaviour system is understood as developing through the innate behaviours expressed by the infant within the first few months after birth as well as the maternal behaviours which the primary caregiver displays (Smith & Pederson, 1988). The new born infant is highly skilled in being able to signal for the primary caregiver to initiate interactive behaviour as well as being able to signal for the primary caregiver to stop aversive experiences such as hunger (Senior, 2009). Bowlby described the 0 to 2 month infant as being pre-attached as he is unable to discriminate between social responsiveness. Between 3 to 6 months the infant is able to make discriminating social responses and Bowlby describes this as attachment in the making. Certain cognitive, physical and psychological developments need to occur in the infant before clear-cut attachment can be formed, and this typically occurs between 7 months to 3 years of age. From 3 years and onwards the child is able to make goal-corrected attachment where he begins to understand the needs and wants of others, is able to make inferences about the mother's behaviour and can begin to interact in more complex relationships which reach further than the mother-infant relationship (Senior, 2009; Zeanah, Mammen, & Lieberman, 1993).

The type of clear-cut attachment style which develops is dependent on the quality of the interpersonal relationship the infant experiences with his primary caregiver(s) (Bretherton & Munholland, 2008). A healthy attachment style is described as secure and develops if the needs of the infant are met and the infant experiences the primary caregiver as being a

reliable, supportive and predictable figure who is emotionally accessible and responsive. Conversely an unhealthy attachment style is described as insecure and develops if the above mentioned aspects of mother-infant interactions are not met (Bretherton & Munholland, 2008).

These interpersonal relationships become internalised by the infant as internal working models which influence the way in which the infant predicts a) how his primary caregiver(s) will behave in different situations, b) how he will behave and c) the interaction between the two (Bowlby, 1973). Internal working models are continually constructed and updated according to the infant's communicative, social and cognitive development. These models can also be reconstructed by what Bowlby (1973) described as affective discontinuity. If a secure infant begins to experience his mother as unreliable and unpredictable the previously secure attachment can change to one of insecurity as the infant no longer knows how to match his external experiences with his previously constructed internal working model. This is not to say that infrequent lapses in mother sensitivity will result in the shattering of the secure internal working model or that if circumstances improve the mother will not become more sensitive to the infant's needs. Bowlby does stress, however, that once an insecure internal working model has been constructed it is a lot more difficult for these defences to be reconstructed positively (Bowlby, 1973, 1980, 1988).

Bowlby's theory was later elaborated upon by his colleague Mary Ainsworth who was instrumental in developing a classification system which evaluates the quality of mother-infant attachments (Senior, 2009). The differences in the quality of these attachments are assessed using the Strange Situation procedure (Ainsworth, Blehar, Waters & Wall, 1978). The procedure is used to assess the infant's behavioural responses to gradually increasing stressful experiences with regard to the presence of a stranger and the departure and return of the mother (Ainsworth, 1985). The behavioural responses observed, as well as the mother's abilities or inabilities in meeting the infant's needs, are categorised into one of the following four attachment styles: secure, resistant/ ambivalent, avoidant, and disorganised/ dissociated (Fonagy, 2001; Senior, 2009; Sigelman & Rider, 2003; Zeanah et al., 1993).

An infant with a secure attachment style freely explores his environment in the presence of his mother and a stranger and is distressed when the mother departs from the room but is reassured when she re-enters. It is thought that the developing internal working model of the secure infant confidently represents the mother as being a reliable source of comfort. An

infant with a resistant/ ambivalent attachment style is highly distressed when the mother departs from the room but shows little comfort upon her re-entry. The developing internal working model of infants with this style of attachment is thought to be unsure of the mother's abilities to meet the infant's needs and as a result exaggerates the infant's emotional responses in an attempt to ensure a comforting response. An infant with an avoidant attachment style is thought to hold a developing internal working model of the mother as unreliable in meeting his needs and as such the infant tries to control his emotional arousal by attempting to minimise the separation anxiety evoked in the Strange Situation procedure. An infant with this attachment style approaches the stranger in the room quite a lot quicker than the infant with a secure attachment style and does not appear to be too distressed when the mother departs from the room and is definitely disinterested in acknowledging her re-entry (Ainsworth et al., 1978). An infant with a disorganised/ dissociated attachment style displays no coherent strategy for coping with the presence of a stranger or the departure and re-entry of the mother (Main & Soloman, 1986). It is known that these infants have generally been exposed to physical abuse or neglect (Crittenden, 1985) and as such they develop an internal working model which is fearful and confused and in which the mother is perceived as the source of comfort but at the same time the perceived threat of annihilation (Lyons-Ruth & Jocobvitz, 2008; Fonagy, 2001).

2.2 Mothers' experiences of attachment

The quality of the mother-infant relationship is a central premise to attachment theory and highlights that both the mother and the infant have an influence on the development of the attachment relationship as well as their own individual experiences of it (Wendland-Carro et al., 1999). Much literature has focused on the infant's experience of the attachment relationship and his internal working model of the self in relationship to the attachment figure, while there is little literature focused on the mother's experiences of the attachment relationship and her internal working model of the self as an attachment figure in relationship to a certain child (Bretherton et al., 1989). Knowledge of this area is vital in assessing the development and maintenance of the attachment relationship as the mother forms an integral part of the process.

Bowlby (1969) describes the mother as experiencing a maternal retrieving behaviour which has as its purpose the protection of the infant. The mother, much like the infant keeps a watchful eye on the other. The mother who is focused on the infant's behaviours intervenes

when the infant is thought to be in danger, becomes alarmed and action oriented when the whereabouts of the infant is unknown and experiences relief when the infant is found (Bretherton et al., 1989). According to Bowlby (1969) the mother experiences a strong pull towards being close to and keeping the infant safe, "(w)hether they submit to the pull, or stand against it depends on a hundred variables, personal, cultural and economic" (Bowlby, 1969, p. 241).

Mothers who provide sufficient and appropriate sensitivity and responsiveness affect the infant's ability to form a secure attachment (Wendland-Carro et al., 1999). The capacity for a mother to provide such an environment has been found to be dependent on their awareness of their own childhood attachment relationship (Wendland-Carro et al., 1999). Significant evidence has been found in two non-biological studies conducted on a sample of adoptive parents and their previously maltreated adopted children which illustrated the unique influence parental states of mind regarding attachment can have on newly forming relationships (Hodges et al., 2003; Steele et al., 2003). They assessed 63 parent-infant relationships. One month before the placement the parents' styles of attachment were assessed using the Adult Attachment Interview. Within 3 months of placement the parents were administered the Parent Development Interview to assess their representations of their child and the children were administered the Story Stem Assessment Profile to assess their attachment representations (Hodges et al, 2003; Steele, et al., 2003). The researchers found that parents who were rated as 'secure' on the Adult Attachment Interview perceived their relationship with their adoptive child as more joyful, reported feeling more competent as mothers, reported feeling less angry and more hopeful of the child, provided fuller and richer descriptions of their child, and were more child-focused in their motivations for facilitating child development and the new relationship, than parents who were rated as insecure-dismissing in their Adult Attachment Interview (Hodges et al., 2003; Steele et al., 2003). These results provide evidence for the powerful influence parents' evaluations of their personal childhood experiences can have on their ability to facilitate and maintain new attachment relationships.

Two predominant risk factors which are seen to negatively influence mothers' capabilities to provide appropriate and sufficient sensitivity and responsiveness are, 1) young mothers still needing to require mothering skills (Jacobson & Frye, 1991, Seitz, Rosenbaum, & Apfel, 1985) and, 2) mothers in low-income environments who experience adverse social conditions (Speiker & Booth, 1988). Many mothers in the current study were typically new young

mothers who are experiencing adverse social conditions, as this is the population that predominantly accesses the clinic (Frost, 2007). The Baby mat has as one of its functions to provide a physical space in which practical as well as therapeutic discussions around parenting can be facilitated. This is important as it provides an opportunity for the two predominant risk factors to be ameliorated to a small extent.

2.3 Effects of attachment style on development

Many longitudinal studies have looked at the long term effects attachment style has on development (see Green and Goldwyn (2002), Lyons-Ruth and Jacobwits (2008) and Thompson (2008) for reviews). While infant attachment style is not deterministic of later development there is research which shows that insecurely attached infants have more cognitive, emotional, behavioural and psychopathological problems through their development than infants described as securely attached (Ainsworth, 1985; Fonagy, Target, & Gergely, 2000; Murray & Cooper, 2010; Senior, 2009; Thompson, 2008). This highlights the importance for early interventions, such as the UBMP, in populations where the quality of the attachment is threatened, as it is in Alexandra where one study reported forty-two percent of assessed infants as insecurely attached (Minde, et al., 2006).

Tomlinson, et al. (2005) found that early difficulties in mother-infant interactions, measured at 2 months, were associated with adverse attachment relationships at eighteen months, despite accounting for current maternal circumstances and interaction patterns. Early negative experiences have been found to impact on later development and these can be at great cost to the individual as well as to the community. At the individual level they tend to have more negative life experiences and at the community level more resources are required to deal with health and economic issues. These points highlight the need for interventions focused on improving mother-infant interactions in order to prevent insecure attachments developing and subsequent difficulties in reversing the pattern of attachment.

Insecure attachment styles have been found to be reinforced by the recurring negative and stressful life events which tend to occur during one's life and reinforce and maintain the insecure parent-infant relationship (Hamilton, 2000). The mothers who were interviewed in this study may have been experiencing extreme life stressors which are common when living in poverty; such as increased levels of stress, HIV and Aids, other illnesses, poor living conditions, violence, and loneliness. It is therefore important that the Baby mat is as effective as possible in order to make the mother-infant relationship as resistant as possible to these

adverse conditions. This study was therefore necessary in order to assess the effectiveness of the Baby mat intervention as it is the only mother-infant intervention that these mothers are known to access.

Psychopathology from an attachment perspective may be influenced by an individual's ability to deal with stressful life experiences (Senior, 2009). Insecure attachments have been shown to affect children negatively as they report feeling more lonely and develop less adaptive social skills and negative self-perceptions as well as having difficulty forming healthy peer relationships, more specifically close relationships than children with secure infant attachments (Berlin, et al., 1995; Schneider, Atkinson, & Tardif, 2001). It is thought that a secure attachment style allows an individual to be more resilient to life stressors as well as to physical or psychological threats (Mikulincer, Horesh, Eilati, & Kotler, 1999). This is because their coping strategies are adaptive; they are developed on their abilities to experience their negative emotional responses in a contained manner (Mikulincer, et al., 1999). Individuals with insecure attachments are thought to be more vulnerable to such stressful life experiences as their coping strategies are less adaptive. These individuals tend to be unable to remain constructively connected in social relationships (Carlson & Sroufe, 1995), and as a result become more socially isolated, have reduced social support, and subsequent relationship dysfunction (Kobak & Shaver, 1987, cited in Senior, 2009). Adolescents and adults who have insecure attachment styles and experience significant separation, the loss of a parent, or a disturbance to the parent-infant relationship are more vulnerable to depression and anxiety (Senior, 2009).

While the development of secure attachment is ideal it is important to note that the enduring effects of secure attachment on the development of the child are also thought to be contingent on the continued experience of sensitive care from the attachment figures (Ainsworth, 1985). The child becomes more receptive to parental influences and socialisation incentives as they identify with goals that are more acceptable within their environment (Kochanska, 2002). Children who develop secure attachments with their mother as infants develop a harmonious mother-infant relationship which highlights the roles of both the infant and the mother in working together to reinforce positive reciprocal interactions and maintain them (Thompson, 2008). There is clear evidence that this type of relationship is persistent over the short-term (at least until the second year), however it appears that family life stressors and changing circumstances have more of a mediating role over the long term development of mother-infant relationships than the initial attachment formed (Thompson, 2008). The Baby mat is

accessible on more than one occasion to mothers who bring their infants to the clinic. While the main goal of the UBMP is to bring to the mother's awareness her infant's individual personality and needs, it is hoped that these mothers will access the mat on more than one occasion and as such to facilitate that the good enough mother-infant relationship be maintained.

2.4 Patterns of attachment seen in the South African context

Research on attachment styles in the South African context have been conducted primarily in impoverished peri-urban settlements (Minde, et al., 2006; Tomlinson et al., 2005). These contexts are wrought with poverty which impact the mothers' capacities to provide "good enough parenting" and in which there are high rates of reported maternal postnatal depression (Patel, Rodrigues and DeSouza, 2002).

Tomlinson et al. (2005) studied 147 Black mother-infant attachment pairs in Khayelitsha, Cape Town. The researchers used the Strange Situation procedure, developed by Ainsworth et al. (1978), to assess infant attachment styles. Despite the extreme adverse conditions in which the mothers and infants were living in, the majority of infants were securely attached (61.9%) at 18 months. While this result was unexpected due to the conditions of the postnatal environment, it was found to be similar to other cross-cultural rates which range from 55% (Van IJzendoorn, Goldberg, Kroonenberg, & Frenkel, 1992) to 67% (Van Ijzendoorn & Kroonenberg, 1988) for secure attachment. Twenty-five point eight percent of the infants were rated as having a disorganised attachment (Tomlinson et al., 2005). The researchers highlight the importance of preventative intervention programmes in that a disorganised attachment style can possibly have longer-term undesirable consequences for the infant and his community (Tomlinson et al., 2005).

Minde et al. (2006) assessed the cultural sensitivity of attachment measures in Alexandra, Johannesburg. The researchers used a maternal interview (Working Model of the Child Interview, WMCI) to assess the attachment styles of 46 Northern Sotho speaking mothers and their children aged between 18 and 40 months. The WMCI assesses the parents' subjective experiences and perceptions of their relationship with their children. The researchers note that while the attachment classifications determined by the WMCI are highly correlated with those of the Strange Situation procedure, the classifications are highly dependent on the rater's judgement which is based on western cultural norms. The purpose of their study was to administer the WMCI and to compare the attachment styles described when using the

western cultural norms provided with the interview in comparison to using culturally significant Northern Sotho norms (Minde et al. 2006). They found that when using the original testing norms (western) the rates of securely (31%) and insecurely (69%) attached children were highly underestimated and overestimated respectively in comparison to the rates described using the culturally sensitive norms (58% securely attached and 42% insecurely attached) (Minde et al., 2006). While this study shows the importance of culturally sensitive assessments of attachment, it also shows that there is a high rate of insecurely attached infants in the Alexandra community (Minde et al., 2006). This is the community in which the current studies population is being drawn from and as such highlights the importance of the UBMP in this context.

2.5 The Ububele Baby Mat Project

The UBMP, developed in 2007, was conceptualised in a brainstorming session with Tessa Baradon from the Anna Freud Centre. The aim was to develop a community-based mother-infant intervention and as such three techniques were considered; Dilys Daws' "Standing next to the weighing scales", London (Daws, 1985), Astrid Berg's "Talking with infants", Cape Town (Berg, 2002), and England's Lane Hostel Project (one of the Anna Freud Centre's outreach parent-infant programmes) (The Anna Freud Centre, 2010). The UBMP is based primarily on the Lane Hostel Project (Frost, 2007, Frost & van der Walt, 2010) which offers support to developing parent-infant relationships in homeless families (The Anna Freud Centre, 2010). Play on the mat between parents and their infant is encouraged while they wait for the health care visitor. This focused time of play on the mat has been described as offering a welcomed contrast to the practical concerns which predominantly preoccupy the parents (The Anna Freud Centre, 2010). The mat provides a space in which encouragement of healthy parent-infant interactions can be received and modelling of these interactions can be observed. This space also allows parents to begin thinking about and reflecting on their children as individuals with their own desires and needs (The Anna Freud Centre, 2010).

The UBMP is concerned with merging Western knowledge systems and concepts of attachment with local knowledge systems that reinforce indigenous practices in order to improve attachment between mothers (or primary caregiver/s) and their infants (Frost & van der Walt, 2010). A discussion of local and western knowledge systems regarding pregnancy and early attachment will now be discussed to try and understand how the mothers' may be

experiencing their role as a mother and how the western knowledge systems may be appropriate for the current context

It is expected that the Baby mat may play a similar role for the mothers who access it to the traditional process of illness disclosure. When one falls ill it is important for one to report their physical, physiological and even cognitive changes to a family member. Its purpose is to help the person understand his or her symptoms. Traditionally the mother is the person who is reported to, as she has been the closest to the ill person since birth. It is also believed that older figures will know more about disease and can therefore be of more helpful support (Pillay, 2003). Many of the mothers who access the Baby mat are refugees who often do not have family support structures around them and report feeling isolated and lonely (Frost & van der Walt, 2010). There is also some contention between the nurses and the patients in the clinic and so there is limited opportunity for such women to access emotional and supportive help (Frost & van der Walt, 2010). It is therefore necessary in the current study to see how the therapist and co-therapist are experienced and perceived.

2.6 Purpose/ functions of the Baby mat as well as some theoretical underpinnings

The purpose/ functions of the Baby mat in its specific context have unfolded as the project has developed over the last 3 years and continue to emerge as the project continues (Frost & van der Walt, 2010). Psychoanalytic attachment theory was used in the developing phases of the UBMP. The importance of the quality of early infant experiences is well established in both the attachment and psychoanalytic literature (Fonagy, 2001). Attachment theory and psychoanalytic theory were originally thought of as being highly incompatible. Attachment theory, as critiqued by psychoanalysts was seen as being highly mechanistic and non-dynamic in that it rejected many of the primary components of psychoanalytic theory in early development, for example; innate drives, unconscious processes, biological vulnerabilities, and the ego state of the developing infant (Fonagy, 2001). However, literature comparing these two theories has found them to have several points of contact (see Fonagy, 2001 for a review). Psychoanalytic theory and attachment theory (psychoanalytic attachment theory) are now viewed as being highly compatible and complementary (Fonagy, 2001). While attachment theory provides a clear explanation of what happens between the mother and the infant, it lacks a description of what happens intrapsychically and this is what psychoanalytic theory is able to provide. Hence, the theoretical underpinnings of the UBMP tend to incorporate concepts from both psychoanalytic and attachment theories, however, the

project does not specifically provide a psychoanalytic therapeutic space. Following is a discussion of several aspects to the UBMP with regard to certain theoretical concepts.

1) The identification of mothers and infants at risk of insecure attachment.

   The developmental consequences of insecure attachment styles and the need for early identification of such attachment styles were discussed earlier. Berg (2002) has inferred from her South African research that infants who develop insecure attachment styles tend to develop a 'failure to thrive'. Failure to thrive is seen in infants who have difficulty gaining weight as well as infants who display disturbed emotional and physical states (Benoit, Zeanah, & Barton, 1989; Berg, 2007a, 2007b). These phenomena tend to be seen in infants whose mothers either suffer from postnatal depression, struggle with feeding, and/or are incapable of reflective thinking (Berg, 2002).

2) To model to the mother a way of being with her infant.

   The Baby mat provides a moment in which mentalisation can be developed in the mother in that her attention is brought (when necessary) to her infants' individual experiences of feelings and responsiveness. This is enhanced by the therapists talking to the infant as an individual, allowing the mother to reflect upon her infant's mental state. Baradon et al. (2005) describe how one of the primary principles for parent-infant psychotherapy is that the mother acknowledges that the infant has a sense of self and is a separate person capable of independent mental states. This has been described by Fonagy (1989) as the process of mentalisation. The assumptions made under mentalisation include; the belief that an individual's behaviour is meaningful and intentional, understanding one's own thoughts and feelings as well as those of others, open-mindedness in recognising the limits to knowing the other and an appreciation of the defensive processes employed and the reluctances to change (Fonagy, 1989).

3) The promotion of a coherent sense of self for the infant.

   This is closely related to mentalisation and is considered to be an integral part of mother-infant work (Baradon et al., 2005). The infant's coherent sense of self is promoted through the therapist speaking directly to and attributing possible states of mind for the infant (Frost & van der Walt, 2010).

4) To encourage a movement from concrete to symbolic thinking.

   Many of the mothers who access the mat bring a description of the infant's physical illness as the presenting concern. Through discussion with the mother, the therapists aim to create a fuller picture of the infant's state by highlighting possible emotional concerns of the infant and thus moving thinking from a concrete to a more abstract construct (Frost & van der Walt, 2010). Freud's (1949) concept of a 'body ego' describes how the infant ego is a body ego and that the emotional difficulties of the infant as well as emotional difficulties of the maternal figures are expressed through the soma of the infant.

5) To facilitate practical discussions around parenting.

   The Baby mat provides a physical space on the mat, away from the chaos of the clinic. The space wards off external impingements to create a space for the mother-infant dyad to feel safe enough to talk openly. This is based on Winnicott's holding (Winnicott, 1990) – an integral aspect of Winnicott's holding phase of maternal care is environmental provision.

CHAPTER 3: METHODOLOGY

3.1 Research design

The aim of this research was to explore the experiences and perceptions of mothers who had accessed the Baby mat at the AHCC. While mothers' experiences and perceptions of mother-infant interventions have been reported on (Buultjens et al., 2008; Cooper et al., 2002; Landman, 2009), this research is the first evaluation to be conducted on the UBMP. It is hoped that the findings will provide an initial look at the way this service is being experienced and perceived in the community that it is serving, in order to assist the UBMP team to evaluate their service and to help inform further quantitative research, which is their aim.

When evaluating phenomena about which little is known, Elliot (1999) suggests that qualitative research is best suited. This is because qualitative methods allow for research to be "more explanatory than confirmatory; more descriptive than explanatory; more interpretive than positivistic" (Rennie, Watson, & Monteiro, 2002, p. 179). It was decided that a qualitative research design which utilised the mothers' words, language, descriptions and responses would best suit the aim of the current research (Whitley, 2002). In order to enable the researcher[3] to access and interpret the subjective meanings offered by the mothers a thematic content analysis of extensively transcribed interviews was the chosen form of data analysis (Fossey, Harvey, McDermott, & Davidson, 2002). The interpretation of the interviews entailed decisive analysis, interpretation, reflection and conceptualisation (Parker, 2003). The influence of the researcher's assumptions, understanding and interpretations are also acknowledged in order to lend some authenticity to the mothers' recorded views (Fossey et al., 2002).

3.2 Participants

The sample consisted of 8 mothers who accessed the Baby mat, with their infants, at the AHCC. Permission from the AHCC to attain access to the participant group was obtained (Appendix A). Participant recruitment only began once ethics clearance was attained from the University of the Witwatersrand medical ethics committee (Appendix B). The criterion for participation was that the mothers could converse in English, as had been experienced by the

[3] For this section of the research the terms researcher and interviewer will be used inter-changeably as it was the same person.

therapists during the Baby mat sessions. While this was not an ideal criterion as it excluded mothers who did not speak English, it was decided that because of the restraints of the research project as well as the preliminary nature of the research that this criterion assisted in maximising the time available to the researcher and the mothers.

Through discussions with the Ububele team it was decided that in order to try and prevent selection bias, the therapists would offer the opportunity for participation to all mothers who were able to converse in English. This method of selection for participation was therefore independent of issues such as; the order in which the mother approached the Baby mat, the problem the mother brought with her or the way they in which she was experienced on the Baby mat. It was also decided that the mothers would be introduced to the research by the therapists after the mother's 'session' had ended. This was thought to be the best way of introducing the mothers to the research as it provided a link between the therapists and the researcher in the minds of the mothers and it was thought that by introducing the research at the end of the session, that the interaction between the mothers and the therapists during the session would not be affected by knowledge of the research. Having the therapists introduce the idea of the research and the brief time delay between the Baby mat session and the approach by the researcher also allowed the mothers a little time to prepare themselves for the approach of the researcher and to decide if they wished to participate or not.

On days of data collection three to four mothers would be offered the opportunity to participate in the research, however, due to many different factors, a maximum of two mothers were interviewed on the day of their having accessed the Baby mat. For the other mothers the opportunity was offered for them to return to the clinic within a few days of their Baby mat experience. Five mothers were interviewed on the same day as having been on the Baby mat and 3 were interviewed within a few days of their experience. No mothers refused to be interviewed when approached by the interviewer, however, during data collection, one mother did not answer her phone when the interviewer called to set up an interview time and another mother did not arrive for her interview time and could not be contacted.

Additional interviews were not conducted because evaluations of the collected and transcribed interviews indicated that no new information was emerging and that data saturation had occurred (Fossey et al., 2002; Kelly, 2006). The content of the 8 interviews conducted was thought to provide enough material in order to identify and explore important aspects of the mothers' experiences and perceptions of the Baby mat (Fossey, et al., 2002). In

other words, ‘sampling to redundancy’ was believed to have occurred after 8 interviews had been conducted (Kelly, 2006, p. 289).

While the mothers’ anonymity could not be protected due to the nature of the data collection, their confidentiality was protected to the best of the researcher’s abilities in writing this research report. It is important to keep in mind that although pseudonyms were chosen for the mothers (Dulani ,Ebony, Farai, Inertia, Joy, Mosima, Nolwasi, and Palesa), the Baby mat therapists may be able to identify the mothers through extracts used in the analysis because of their knowledge of the mothers’ personal histories and problems presented. After discussion with the researcher’s supervisor and the UBMP team around this unavoidable possibility, it was felt that this did not represent a risk to the mothers’ rights to confidentiality as the therapists being aware of specific mothers’ opinions or feelings about the Baby mat service would not lead to any negative or punitive reactions on the part of the therapists towards the mothers. Much like the process of therapy, it was felt that any negative countertransferential feelings experienced by the therapists upon reading the report could be worked through within the UBMP supervisory team to prevent these feelings from being expressed either verbally or non-verbally towards mothers accessing the mat.

3.3 Interview procedure

3.3.1 Developing the research questions

This research is the first evaluation to be conducted on the UBMP and so the exploratory nature of this research and the possibility of this research assisting Ububele in a) evaluating their service and b) developing further studies, influenced the development of the research questions. In order to provide a sense of context, it felt important for the focus of the research to be on both the mothers’ personal experiences as well as their experiences and perceptions of the Baby mat and its therapist and co-therapist. The following 4 research questions were developed to focus the structure of the interview schedule:

1. How do the mothers experience the Baby mat and the Baby mat therapist and co-therapist?
2. Do the mothers’ personal circumstances influence their experience?
3. What do the mothers walk away with after having been on the Baby mat?
4. How does the context of the Baby mat impact on the mothers’ experiences?

3.3.2 Developing the research interview schedule

Interviews have been described as being conversations with questions; however, in contrast to daily conversations, the focus of the interview is predetermined by the interviewer (Parker, 2005). The formulation of the interview questions guides the frame for the interview set up as well as the degree to which something new will be produced through conversation (Parker, 2005). Parker (2005) describes three questions being essential to formulating the interview schedule. He states that it is important to consider a) what does the researcher want to focus on, b) what might possibly emerge, and c) what might be surprising about the interviews? He describes these questions as being very important in influencing how rapport will be able to develop between interviewer and interviewee, the extent to which the interviewee is able to develop her own narrative, as well as the security felt by the interviewee in speaking about her experiences (Parker, 2005).

A semi-structured interview schedule (Appendix C) was developed in order to allow for flexibility during the interview process (Kerlinger, 1986). The qualitative research interview characteristics as described by Briggs, 1986; Denzin, 1989; Douglas, 1985; Mishier, 1986; Spradley, 1979 (cited in Neuman, 1997), were used in relation to their relevance for the current research in informing the interview structure. While it was suggested that the beginning and end of the interview not be defined, for the current research there was a predefined open-ended opening question which was used in order to begin the interview and a predefined debriefing question which was used at the end to check how the participant was feeling. The end question was felt to be an ethical responsibility.

The semi-structured nature of the interview also allowed for a deeper understanding of the mothers' experiences and perceptions of the Baby mat as it allowed for the interview to be conducted in an exploratory manner (Liamputtong & Ezzy, 2005). The non-directive open-ended questions used at the beginning of the interview encouraged the mothers' to speak about what was most important for them. This also helped in developing rapport between the interviewer and interviewee. Some open ended questions were used throughout the interview as they stopped the interviewee being led by the interviewer and allowed the interviewer to pay attention to and gain insight and knowledge from the interviewee (Liamputtong & Ezzy, 2005). More specific questions were added into the interview schedule to allow for some consistency with regard to topics discussed across the interviews. The order of the questions was dependent on the way in which the participant told her story and they were asked during

each interview at times that felt appropriate. Some of the questions were asked either near the end of the interview if an opportunity had not arisen earlier or were not asked if the participant's interview material was rich enough. 'Prompt responses' were also developed in order for the flow of the interview to continue without being stopped by the interviewer asking more questions (Parker, 2005, p.60). Prompt response included: 'That is interesting, tell me more', 'What do you mean by...?', 'What is your understanding of...?', and 'Could you give me an example?' While exploring the mothers' personal stories the interviewer used questions and prompts which allowed for her to try and understand what it means for this woman to be a mother at this time in her life with this baby. This focus was suggested in supervision and helped to enhance the exploratory nature of this research.

Keeping in mind the above mentioned formulations about developing interview questions the researcher considered the interview schedules of other research which were similarly focused on mothers' experiences of having been involved in mother-infant intervention programmes. The structure of the interview schedule and some of the interview questions used in the current research were informed by the interview schedule used by Buultjens et al. (2008). They looked at the perceptions of mothers suffering from postnatal depression who had participated in a holistic intervention programme focused on alleviating the effects of the depression on the mothers' interactions with their infants as well as to assess the subsequent effects on the attachment (Buultjens et al., 2008). Landman's (2009) interview schedule used in her study of mothers' and counsellors' accounts of a successful parent-infant intervention in a South African informal settlement was considered, as well as a Likert scale used by Cooper et al. (2002) in their pilot study. Their study assessed the effectiveness of a mother-infant intervention in an indigent peri-urban South African context. Certain questions from the Landman (2009) and Cooper et al. (2002) studies were adapted to suit the needs of the current research and others helped to inform the development of many interview questions.

In addition to the interview schedules used in previous research, previous articles written by the UBMP therapist were referred to. Certain difficulties and concerns previously expressed by the therapist with regard to the project were kept in mind (Frost, 2007). These reported difficulties and concerns, and together with further discussions had with the Baby mat therapist, helped the researcher to include questions which the therapist (and Ububele) would like answered. This approach felt necessary as it would allow for the UBMP's team to gain a

greater understanding of what impact their project is having in the community that it is serving.

Two pilot interviews were conducted in order for the original interview schedule to be tested. These interviews were transcribed and worked through by the researcher and her supervisor. Through discussions about the two interviews some questions were reframed, new questions were included and further prompting responses formulated.

3.3.3 Interviews

The interviewer attended the AHCC with the Baby mat therapist for seven mornings. The first two mornings were used as observation periods, in which the interviewer sat, from what was thought to be an unimposing position, observing the happenings in the clinic and on the Baby mat. This was very useful as it allowed for the interviewer to become aware of her own thoughts, feelings, reactions and fantasies with regard to being in the clinic, as well as for the researcher to begin to familiarise herself with the clinic context. The third morning was used for pilot interviews and the subsequent four mornings consisted of the interviewer approaching mothers to participate in the research. On these mornings the interviewer sat in the same unimposing position from which she was able to wait and watch the happenings in the clinic as well as those on the Baby mat.

Once the mother left the Baby mat, one of the therapists would indicate to the interviewer whether she should approach that particular mother. The interviewer noted where the mother sat with her infant and approached her once she felt as though the mother had had some time to sit with and possibly think about her experience on the mat. The interviewer introduced herself as being the person whom the therapists had spoken about and asked if it would be ok for her to sit with the mother for a few minutes to explain the research and for the mother to ask any questions. At this stage of recruitment the participant information sheet (Appendix D) was briefly discussed with the mothers due to the very busy and distractible nature of the clinic context. It was felt that the parameters of the research could be better and more fully explored outside of the clinic context. Each mother was then asked if she would be willing to participate in the research. If the mothers agreed to be interviewed the interviewer set up a convenient time for them to participate; either on the same day as having accessed the mat or within a few days following.

Participation drop-out was anticipated for mothers who were asked to make a special trip to return for their interview and therefore R20 compensation was offered for their travelling expenses. This was only spoken about once the mother had agreed to participate in the research and was only paid to the mother on the day of her return. A returning form and remuneration agreement was signed on the day of recruitment (Appendix E). For mothers returning to the clinic a copy of the participant information sheet was given to them to take home and read before coming for their interview.

Due to the demands of the resources in the clinic there was no room available for the interviewing process and so the interviews generally took place in available spaces, which tended to be on a blanket under a shaded tree on the clinic grounds. The participant information sheet, which detailed the purpose of the research and what the interview would entail, was discussed in length with the mothers before beginning the interview. The mothers were informed that participation was voluntary and that they would not receive any benefits or money for participating in the research. It was explained that they may choose not to answer any questions that they did not want to, that there were no right or wrong answers, and that they may stop the interview at any time with no negative consequences. The efforts which were going to be made to keep their personal information confidential were described and they were also informed that absolute confidentiality could not be guaranteed (such as an instance in which the disclosure of their personal information would be required by law). The need for recording the interview, what would happen to their recording and their transcript, and the efforts made to protect the security of their recordings and transcripts were explained. The mothers were informed that no identifying information would be included, but that direct quotes would be used in the report and that the quotes would be used with those from other interviews. It was also explained who the report would be made available to as well as that the clinic CEO would receive a general feedback letter. The mothers were also offered the opportunity for feedback, however, at the time of writing this report none of the mothers had made use of this opportunity. The contact details of the researcher and her supervisor were made available to the mothers in case they had any questions or concerns and the number for the university ethics committee was provided in case any of the mothers had any complaints against the researcher. Before beginning the interview the consent forms for the interview (Appendix F) and recording (Appendix G) were read to the participants, to ensure that they had been understood, and were signed. All of the mothers agreed for their interview to be recorded.

During the interview the interviewer tried to keep the interview exchange as friendly and conversational as possible (typical conversational practices such as jokes, diversions, and anecdotes, etcetera were allowed for) (Neuman, 1997). The interviewer remained interested in the mother's story and also encouraged the participant to elaborate on certain aspects of her story through the use of frequent prompt responses as described above (Neuman, 1997). At times the interviewer attempted to clarify with the participant any meanings which were unclear, thereby establishing the credibility of the study (Stiles, 1993). Throughout the interview the interviewer tried to remain aware of the social context, the participants' norms, and language usage (Neuman, 1997). Any significant information was recorded in order to better inform the analysing process.

It is important to note that the narrated experiences which were collected during the interviews are thought about by the researcher as not necessarily being the participants' true experiences but rather their accounts of their experiences which have been affected by factors such as perceptions and memories (Parker, 2005). The recordings of the interviews were transcribed verbatim by the researcher and further notes were made during this process. While this process was felt at times to be very tedious, it did allow for the researcher to become familiar with and immersed in the interview data and helped with thinking about and analysing this data through a closer and what was felt to be a more informed perspective.

3.3.4 Position of the researcher

Self-reflexivity is important on the part of the researcher as it creates an awareness of potential bias (Parker, 1994) and forms a crucial aspect of any genuine scientific study (Harré, 2004). The subjective experience of the researcher during the qualitative research process is thus significant (Terre Blanche, Durrheim, & Kelly, 2006). A report written on the UBMP highlighted the obvious effect a white psychologist had in the clinic (Frost, 2007). While the projections (humiliation, isolation and helplessness) were reported to have subsided over time (Frost, 2007), the researcher is aware that her presence may have an impact on the processes occurring in the clinic as well as in her interviews with the mothers. It was important for the researcher to be aware of her social-status, race (Caucasian) and cultural background and the effect that these had on the interview process. At certain points in the interview process the researcher's cultural and racial difference was spoken about by the mothers. It seemed as though there was a need for the interviewer to reflect on this

difference and to be curious about what it meant for the mother and also how this difference influenced what the mother felt able to inform the researcher about, with regard to her cultural beliefs and practices. While for some mothers there may have been a degree of feeling that the interviewer would not fully understand their experiences, the interviewer tried to assure each mother through her body language, tone, and reflective responses that she was interested in and focused on their individual experiences.

During the interview process the interviewer was aware of being positioned as a knowing therapist by some of the mothers despite their having been informed of the research purpose of the interview. It was therefore difficult at times for the interviewer to balance the focus of the interview between the aims of the research and allowing the mothers to lead the process. When it was felt that this was balance was not being maintained, the interviewer reiterated her position and purpose for the interview and stated that the mothers' needs for a therapeutic space would be discussed with the UBMP team and that this would then be made available to them, if they so wanted.

It felt important for the mothers to know that the researcher was not working for the UBMP team but rather as a separate individual who was evaluating their service and primarily interested in the mothers' experiences and perceptions. At times it felt as though the researcher was being linked with the Baby mat therapists because the introduction had been done through them and the researcher was concerned that this would impact the degree to which the mothers would feel free to be honest about their Baby mat experience. However, through transcribing, reading and re-reading the interviews it seemed as though the mothers felt able to respond freely as many suggested changes for the project, however, the researcher is aware that certain negative comments may have been excluded due to the possible associations made by mothers between the researcher and the UBMP team.

Self-reflexivity was also encouraged during the analysis stage of the research through supervision. The researcher's understandings and analyses of the interview data was considered in relationship to what was said by the mothers and in instances where possible misunderstandings were found they were noted and reflected upon. For instance when one mother discussed being involved in her cultural practice of attending a virginity clinic from age ten, the researcher included this in her analysis as forming part of an impingement experienced by this mother. Through supervision, however, this understanding was discussed

in relation to the mother's story and the words she used and it was evident that she had not experienced this practice as an impingement but rather as a caring and positive experience she had had with her grandmother. It is important for the interviewer to have had opportunities in which her cultural understandings, viewpoints, values and beliefs and the impact they had on the research could be discussed (Bantjes, 2010). The supervision sessions held with the researcher's supervisor as well as a meeting held with the UBMP team allowed the researcher the space to openly discuss and reflect upon her fantasies, fears and assumptions of the clinic and the mothers accessing the mat. These were then thought about in relation to the analysis.

3.4 Data analysis

3.4.1 Thematic content analysis

Thematic content analysis was conducted on the transcribed and anonymised interviews. In using thematic content analysis the researcher was able to identify, analyse and report themes which occurred in the mothers' interviews. The flexibility of thematic content analysis allowed for rich and detailed themes to be identified (Braun & Clarke, 2006; Fossey, et al., 2002). An inductive approach to identifying the themes was utilised so that the themes were driven by the data rather than being prescribed by the researcher's theoretical interest (Ezzy, 2002). The categories into which the themes were sorted were therefore not decided on before coding the data (Ezzy, 2002). The analysis occurred in a relatively systematic manner which allowed for unanticipated ideas, issues and themes to surface (Babbie & Mouton, 2005). The themes were identified at a latent level; the researcher was interested in the underlying ideas, assumptions, and conceptualisations the mothers' are made about the Baby mat and their experience of it (Braun & Clarke, 2006). These were all further developed through the researcher's interpretations and the written report focuses on providing a rich overall description of the entire dataset. While some depth and complexity may have been lost, it is suggested that this form of analysis is most effective for an area of research which has not been explored before (Braun & Clarke, 2006).

Braun and Clarke's (2006) six phases of thematic analysis were used: familiarising yourself with the data, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and producing the report. Terre Blanche, Durrheim and Kelly (2006) described the process of qualitative data analysis as being a cyclical process in which the data

is returned to on numerous occasions. Throughout the thematic analysis, the steps, as described by Braun and Clarke (2006), were revisited. This type of process in which the analysis is worked and reworked has also been described as being a process of 'trial and error', which is common in thematic content analyses (Wimmer & Dominick, 1983).

The researcher identified herself as playing an active role in the identification of themes, in that she selected themes which were of interest to the current research and is discussing them in this report (Braun & Clarke, 2006). The analysis used in this research has as its aim to report on the experiences, meanings and personal realities of the participants.

3.4.2 Process of analysis

The process of analysis for the current research is discussed under Braun and Clarke's (2006) six phases of analysis. The first phase is *familiarising oneself with one's data*: data collection – which included interviewing and transcribing the interviews – was conducted by the researcher, which therefore means that the researcher actively engaged with and had prior knowledge of the data before beginning the analysis (Braun & Clarke, 2006). The researcher immersed herself in the data by reading and re-reading the transcribed interviews and by beginning to formulate ideas of meanings and patterns present in them. This part of the process is known as the bedrock of the analysis (Braun & Clarke, 2006). This phase was also useful in that it allowed the researcher time to take notes which were consulted later on in the analysis process.

In the second phase, that of *generating initial codes*, the researcher looked for what was in the data. Through the process of manual coding the researcher spent time with each transcribed interview looking for as many points of interest as possible. Gradually the researcher was able to build up a collection of codes which represented the transcribed data. Each transcript was assigned a colour so that in the next phase, when joining codes into themes, it was evident which extracts belonged to which mother.

In the third phase the researcher began *searching for themes*. Codes, which were similar in meaning or represented data extracts which were variations of similar content, were grouped together. Preliminary themes were then generated by looking at the broader level which the codes represented. Overarching themes were developed in order for different codes to be joined together. Subthemes were also developed so that the organisation of the data extracts

within each overarching theme was more fluid. Data extracts or codes which were felt to be unnecessary were discarded. This was the beginning of being able to make sense of what was significant in the data.

In the next phase of *reviewing themes*, the researcher focused on ensuring the coherence of extracts within themes as well as for there to be differences between themes. The dataset was reviewed to determine if the themes represented the content of the data set and any additional abstracts which then suited the themes were added in. The process of this stage was stopped when it was felt that nothing substantial was being added from the dataset.

Defining and naming themes was what constituted the fifth phase. The researcher focused on what each theme represented about the data and attempted to combine the data extracts within each theme, or subtheme, in a coherent and consistent manner with the use of a narrative. It was important to ascertain what aspect of the data each theme or subtheme was representing and to name the themes accordingly. They were then read through and analysed to ensure that there was no repetition between themes and that what was being written about was focused on answering the research questions.

In general the analytic process was conducted with the help of supervision and the themes were confirmed by the research supervisor, thereby establishing the stability of the study (Stiles, 1993). This allowed for the researcher to feel confident in *producing this report* in that the themes and sub themes, identified and written about, were felt to represent the narratives of the women interviewed and would be helpful in answering the research questions.

3.5 Ethical considerations

The inclusion of the primary health care clinic's name in the research was not considered unethical as there are only four clinics in which the UBMP is run, with the project at the AHCC being the founding project. Many readers of this research would be aware of the clinic names at which the project is run and it is believed that because so many mothers access this clinic every week that the confidentiality of the mothers would not jeopardised.

Permission to conduct the research at the AHCC was obtained from the clinic CEO, in collaboration with the UBMP manager. A letter with the findings from the study will be made

available to the CEO and the full report will be provided to the UBMP manager. Permission to conduct this research was obtained from the university's medical ethics board.

There was an ethical responsibility to ensure the safety of the researcher in entering Alexandra and accessing the AHCC. This responsibility was taken on by the researcher as well as the Ububele organisation who themselves use a specific safety procedure. The researcher was included in the Ububele's safety procedure and felt her safety was provided for.

Written consent for the interviews and the recordings of the interviews was also obtained. The participants were informed that participation was voluntary and that there were no expected adverse consequences from withdrawing from the study at any stage. They were assured of their confidentiality with regard to their interviews and anonymity with regard to transcribing and reporting of the interview content. They were informed that direct quotes may be used from their interviews but that no identifying information would be revealed. The participants were made aware of their having access to a letter with the findings of the research, however, at the time of writing this report none of the mothers had requested this. The mothers who returned for their interviews were compensated for their travelling expenses. They signed a remuneration and return agreement form on the day of recruitment. Compensation was not thought to constitute any form of influence in their decision to join the research as it was only offered once the mother has agreed to participate in the interview. It was deemed a necessary form of compensation as these mothers do not typically have any money for extra expenses and it was thought that it increased the possibility of the mother's return for her interview, therefore decreasing participant drop-out rates.

The nature of the study and the interview schedule were not expected to harm or distress the participants in any way. A short debriefing session was included at the end of the interview schedule to ascertain if the mother was feeling any distress, however, none of the mothers expressed such. The numbers for free counselling services were provided on the information sheet for all of the mothers and they were informed of the nature of these services.

During the data collection period one mother was felt by the interviewer to be of danger to herself and her infant. After consultation in supervision it was decided that I would phone the mother and ask her if it would be alright for me to contact the Ububele therapist, whom she had spoken to on the Baby mat, and to see if they could arrange for a social worker to come and see her. This mother had spoken about her need for someone to speak to and so it was

thought that she would be comfortable with this decision. After phoning the mother and receiving permission to contact the Ububele therapist, a social worker was referred to her through their organisation.

CHAPTER 4: RESULTS

As described in the previous chapter the analysis of the interviews was inductive in nature and was influenced by the examination of personal and supervision notes. While keeping in mind the five research questions needing answering, the analysis was based primarily on the core themes and ideas which emerged in the interviews themselves as the analysis was conducted. These core themes and ideas were grouped under three overarching areas of focus; The Baby mat, Being a mother in Alexandra, and Experiences of general health care services. Despite the analysis having been based on thematic content analysis the researcher noticed trends which seemed to be occurring between the different environments the mothers were living in and their reasons for accessing the Baby mat, or their experiences had on the Baby mat. As such an additional section on the trends noticed has been included. The overarching areas of focus and the trends noticed are discussed in this section.

4.1 "They take everything in their minds": The Baby mat

Overall, all the mothers felt that going to sit on the mat to talk to the therapists was a positive experience. Nolwasi stated that: "It was good", and Ebony said that she received: "Everything that I needed to know". Farai stated: "I feel better" and Joy expressed that: "it was fine".

Inertia was seen hitting her toddler in the Well Baby clinic and was invited by the therapists to sit with them. She described herself as initially having negative expectations of the experience which she expected to have on the mat, but spoke then about how positive it was for her:

> It was quite embarrassing the first time when they first called me...it was a little bit scary...I thought maybe they were going to ask me, ask me, why I beat the baby? Why I do such harsh things to my baby? Why do I always take the anger out on her? So ugh, that was the thing that made me scared to talk...I was thinking maybe they were going to tell the nurses that I smack the baby or something. Something else that was also going to make me feel bad...I thought maybe she was strict. I thought maybe first, to shout at me...then I tell her my problems...It was fine...after going there I felt much better...I think what they did yesterday was right. They were right to call me and have a talk. I think it was right...It made me feel much better.

Dulani was invited to join the therapists on the mat after approaching them to ask a question about a service in the clinic. She described her experience as fine and that even though she was "so happy to go" she was also "feeling nervous". Farai also commented that although the experience was worthwhile, that: "It was not that easy...it is difficult to talk about some stuff". However, she felt that she would still advise others to sit on the mat, as did all the other mothers.

Analysis of the mothers' comments regarding their experiences revealed that the mothers felt that they had received something from the mat. Ebony stated that: "...she did offer me some information". For many of the mothers who were concerned about the health of their babies or their babies' eating patterns, concrete advice was found useful and usable. Nolwasi stated: "I like their advice...they say to me the other people I need to see". For Mosima it seemed that the advice she received helped her gain some understanding of her infant as an autonomous individual person, she stated that: "after talking...I gain something...I learnt that like he is old now, two years. So, like, he can just decide". Inertia experienced the practical advice given to her about how to respond differently to her toddler's behaviour as helpful, she recalled that: "They ask me why do I have to smack her? Then I told them, she bit, she bite the baby. Then they told me I was wrong to beat her. I had to call her and talk to her, not to smack her. It was wrong for me to smack". Joy, who had presented for a red mark on her child's head, which she was concerned may be a form of bewitchment, felt satisfied with the advice she understood was given to her: "And advised me to ask both families of my, of this child. To make sure that this thing is, to know about it. And to know if it is dangerous or if it is just a thing". Some of the mothers also expressed satisfaction with more general advice that was given concerning the relationship between mother and child. Joy stated:

> And if, she, she, she even advised us to, to sing, to use the language. To not use any other, to use the one that we talk to children, the mother tongue...She said something about connection and that your, and so your baby will know whose, whose him mum is. And to just know you, know your voice.

For some of the mothers the fact that the Baby mat therapists had listened to their accounts of experiences from their own childhoods that were distressing them now, perhaps re-evoked by having had their own babies, felt good. More abstract links made by the therapists between the mothers' distress and their infants' problems were also taken by the mothers. This is evident in the following comment from Farai:

> It was like. I had um, a good advice...He is doing ok. There is no problem. The only problem I have is that one. So they think because I did explain to them my, how it was now. They think maybe, and how I grew up and being abused so. Maybe I am thinking too much, I'm giving too much. They think maybe it is that. That's why I see the little things like the baby not eating. They think I am giving too much 'cos I, I've never grown up with love and when I explain to them. They think that maybe I am giving too much, so I should think of other stuff not think too much about nothings happening...I think what they told me helped because they said I must keep on giving, even if he eats a spoon or three spoons, he will get used to it. He will eat in his own time. Maybe after, a year, I should start reducing the milk. They giving too much milk, then reduce maybe four bottles.

Although advice was valued, the general sense gained from the mothers who were interviewed was that they felt that they had been given something, whether it was an idea, reassurance, encouragement or containment. Feelings of reassurance typically came from the mothers' experiences of their own as well as of their infants' behaviours being normalised. Mosima stated that: "...they helped me...Like another mum may ask her, 'Why my baby do things like this?' She say, 'No, every baby has their things, your baby has this, my baby has this'". Dulani stated: "...like she was telling me I am ok and then I must not worry, even the child he ok, I must not worry". For Farai, the therapists' acknowledgement that: "...everything is normal to my child" seemed to give her reassurance for her concerns about her baby. Ebony also received advice that reassured her that there was nothing to worry about and this seemed to leave her knowing what to do next: "...it is important for me to go to the doctor or any, to go anywhere where I can find the information where I will be satisfied, or something". Joy explained that she had been given encouragement to seek out further answers for herself: "And because that she gave me the idea to research more...Ya, she gave me something because she even encouraged me to research about this, about this if I think it is dangerous". Farai seemed to have understood her experience of the Baby mat as an encounter with trained professionals who can take all the relevant information and help her make sense of it:

> And then the, the way they are trained, I can see they can even see, in their. Like when they talk to you they take everything in their minds and it, they

> imagine it and have the solutions by them. And when they take it out to you, it builds you, then you feel it. This is what have to be done.

Overall, the mothers seemed to experience the Baby mat as helpful and as a space where mothering and its related fears or concerns could be thought about. Ebony stated: "Well it was very helpful...she managed to help me...So she told me that it is normal...She told me that some of the things that I am experiencing are normal, well, well every mother should experience that things...they are very helpful". It also seemed that this experience was felt to be beneficial for the relationship between mother and infant. This can be confirmed by Inertia's statement: "It can help me have a good relationship with my daughter".

4.1.1 "She can tell you the way that you feel it": Relationship

The relationship developed between the mothers and the therapists was spoken about often and appeared to be of great importance to the women interviewed. In general, this relationship seemed to strongly influence their experiences on and perceptions of the Baby mat. These relational experiences allowed for the mothers to feel a sense of joining and an opportunity for openness, as well as feelings of relief. For most of the mothers this was a unique relational experience which was expressed further in their experience of the therapists, as well as in their perceptions of the therapists as being trustworthy. Another strong positive aspect of the relationship was the offer for it to be ongoing and all of the mothers felt passionately about the necessity of the Baby mat service in their clinic. These important aspects of the mother-therapists relationship are discussed below.

4.1.1.1 "You won't be scared to take out whatever is in you": Joining and openness

When discussing what happened on the mat, most of the mothers spoke about themselves as having joined with the therapists, to think about and in some instances find solutions for their infants' problems. Many of the mothers described a collaborative relationship which had developed between themselves and the therapists. Nolwasi stated that: "...we were working together, I was working, saying it may, it might be". It seems as though the therapists encouraged the mothers to work with them to think about their infant's problems, which was experienced by some mothers as the therapists considering the mothers being equally capable of thinking about their babies' difficulties. Mosima recalls one of the therapists asking her: "You don't think if it is that?" and Inertia stated that: "They talk to me the same and equal way...So that if they are having a solution that you might like, or you might agree to. To solve the problem with them, then I think your problem will be solved".

Further support for the joining aspect of the relationship was evident in the mothers' common usage of the word 'we' when speaking about the mother-therapists relationship. Joy stated that: "We talk about my customs and what she know...we were just combining everything, because we all don't know anything about this, ya". For Joy it seems as though the relational dynamic which developed was helpful despite her not finding a solution for her infant's problem. Mosima stated more generally that: "We were talking about babies". For Dulani, the most important part of her experience on the mat was that: "We were talking about the tale about, the stories of the child".

For some mothers this joining experience was described as having been acknowledged on both a physiological and a psychological level. When Farai spoke about the therapists she recalled that: "She can tell you the way that you feel it, that feeling, that can talk to you and that is not very good for me. It is very good. She feels very good...You feel it, when she talks, you feel that thing".

Encouragement was felt by most of the mothers with regard to thinking about their infants and their experiences. Most also felt comfortable to approach the therapists. Joy stated that: "Ya, because she, she said, she said that we must come and ask anything. Anything about the children. And anything, just anything about the motherhood and your baby, ya." and Farai felt that: "They can just go and talk about anything that is suspicious to you". There seemed to be an overall feeling that anything could be spoken about, and this encouraged the mothers to feel open as well as to experience the therapists as being open. Palesa stated that: "Because when you are open, you, you won't be scared to take out whatever is in you. You will be open, you talk at that thing that maybe hurt me". Inertia said: "I saw them as people I can have serious, show something with them" and Mosima commented that: "They are open, like, they are open". This encouragement seemed to fill the mothers with courage to speak about what was troubling them.

In general there seemed to be a need for the mothers to be able access a space in which they could feel comfortable to speak about their experiences. This is evident in Inertia's expression of her need: "And it made me feel, because I did needed somebody to talk to about this relationship and her. Even sometimes we don't say, 'I have this thing of taking out my stress on my child'". The need for this space is also evident in their comments relating to the possibility of being involved in an ongoing relationship similar to that which occurred on the Baby mat. Palesa stated that: "She took the numbers and my address and she told me that

they are in Kew and that they will call me. So that I could see the psychologist, for the child and me and my problem". For Nolwasi, the possibility of receiving more professional help was comforting; she stated that: "They tell me the other people I need to see, to go back to the therapists for therapy. This is what I liked". Similarly Inertia liked the help offered to her as well as the help offered for her daughter; she stated that:

> "Then they told me, if I am having a problem, not scared to talk to them. They can write down my numbers and write down my name and details and my address. So that they can keep my information and I can go to the therapy...I liked the, I like the nursery thing about my child. Taking my child to the nursery. Getting to learn more things that she is not able to learn when she is around the loxion[4]".

Overall there was a sense that for the mothers who felt they needed more help, the experience had on the Baby mat was the beginning of something positive for both them and their infants.

4.1.1.2 "They make you to feel free": Relief

Many of the mothers felt that their experience on the mat left them with a sense of relief. For some mothers the information they received gave them this sense of relief. Ebony stated that: "I am relieved now, mmm, I am relieved knowing that it happens to everything. 'Cos that worries me...I felt relieved 'cos they explain everything I needed to know". There was a sense that for some mothers their unsure feelings about themselves as mothers contributed primarily to their worries and so in gaining confirmation about the health of their infant, relief was experienced. Mosima stated that: "I'm relieved, 'cos ya...I was not noticing that it was alright...I feel good". For many mothers it was also the relational experience they had on the Baby mat that offered them relief. Commonly this relief was described as feeling free. Joy stated that: "Ya, um, they make you to feel free. To just think whatever". For Inertia the experience of going to the mat in itself made her feel relieved: "It was, I guess it made feel much freer...I can say I am relieved because I got somebody to talk to". Overall the mothers' experiences of being able to express their feelings and speak about their personal experiences were what allowed for them to feel relieved. This is confirmed by Dulani's statement that: "Because the first day when I was with her, and then I was crying and now I am fine, I am so happy", and Mosima's statement that: "Even if you are stressed neh, like the way I saw them, if you are stressed and if you can talk to them, you can be very much relieved."

[4] This is a local slang term used by some community members meaning location.

4.1.1.3 "And I went there": A unique relationship

For most of the mothers, the relational experience they had on the mat was in contrast to relational experiences they have had in their personal lives. Many of the mothers described their personal experiences of asking for advice in their environments as being a space in which they felt unimportant and which they found to be unhelpful. Joy stated that: "They [people who she has spoken to in her personal life] just talk and talk and talk. Making more, um, confused you don't know anything". Palesa also spoke about her experiences that: "Maybe she [someone who she has spoken to in her personal life] speaks, she talks, talks, talks, then after, then maybe when you want to raise a question, then they will say, no, no, no, you know what". It seemed as though these experiences had left many of the mothers feeling unheard, unacknowledged and disrespected and had therefore influenced many of them to not ask for advice from people in their environments. Joy stated that: "Others just tell me what to do, don't know, don't care about what I believe or what I think or what I want" and Farai stated that: "Because you just can't talk to anybody".

Issues around trust also emerged as influencing the mothers' feelings of not being able to speak to people in their lives about their concerns. Inertia stated that: "Anybody, I don't trust anyone, even around me". For some mothers this mistrust had developed out of previous experiences of being ridiculed or not having their experiences respected. Inertia spoke about her previous experiences and how she feels that the people around her are not safe:

> The people I am living with there, they, I don't know how to say. They are non secretive, they are non secretive. Because they can't keep somebody's secrets or somebody's things. They can't keep those things... Because you can talk, you can go to somebody and talk to that person. The next day, the following day you can have that talked by somebody else, "Ooh, I heard this thing, this rumour about I she is like this and that, this and that". They are not safe. You hear, you hear me phone somebody else, then neh, just like that... It has happened a long time, it happens a long time.

Many mothers spoke about feeling that the people they had spoken with were not the right people. Joy stated that: "People can say ridiculous things, not um, not, not true things". For one mother her experience of not having grown up with her own mother prevented her from trusting in her mother's advice. Ebony stated that:

> The reason why I went to the mat baby there, I thought maybe that what my mom is telling me is not true ‘cos my mom never raised a child. We were raised by my grandmother and my grandmother is no longer there to tell if everything is ok or something like that.

Ebony explained how this had influenced her ability to trust in people advising her: “I don’t easily believe people, you know, especially if you are not a pro, if you are not a professional or something”. Farai spoke about how she had realised that the medical staff at the clinic were not the right people to talk to about her concerns, she stated that: “...maybe talking to the doctor it is just like asking a policeman about something for a clinic. So everything have to go to the right person, then you get help”. Palesa also spoke about her hesitation to speak to other people in the clinic, she stated: “...you know, you see, here it is cold”.

As a result many of these mothers have not spoken to anyone about their concerns and their experiences. While for some mothers there was a sense that they could receive the necessary advice from professionals for others there was a belief that they would not experience the space and relationship they wanted and felt they needed. This is evident in the following comments from Inertia:

> ...that is why I am, I am deciding to always keep things inside myself...That is why I am always keeping, deciding to keep my things in my chest...I never thought that there would be people...I thought that is the first one I am having...Because some things I told them [the Baby mat therapists] yesterday I have never talked with somebody, like even my own family...my secrets can be safe with them.

It therefore seemed as though the relational experience available to the mothers on the Baby mat was unique for all of them. When speaking of the therapists the mothers spoke only of positive things. Analysis of the mothers’ comments regarding their thoughts about the therapists revealed that the mothers thought that they were good. Mosima stated that: “Two of them, they are good...They are comfortable...They are good”. For most of the mothers this goodness was felt in the way in which the therapists were with the mothers. For Nolwasi, “...the way the therapists told me” was what she said she liked most about her Baby mat experience. Similarly Dulani stated that: “She was so nice...Oh, the, the way she talks and the way she explains you”. Palesa stated that: “...you know, she is so calm. She does have this, what do you call, a patience”. It seems as though the therapists were able to create a space in which some mothers felt that exploring their concerns would be bearable. Farai stated that: “I

love the way she speaks...She gives courage. She gives you courage. Even, like when she talks, all the things are happening out there".

For many mothers, the experience of the therapists showing interest in their personal experiences, both past and present, was positive. Dulani stated that: "I talk to her, then I tell her my problems, and all that and so I'm fine...I just told them about my story". Palesa stated that: "I told her about my little boy, and I told her about my, my life. That it is not happy" and Inertia also felt that: "...they talked of things I battle with".

Many of the mothers felt listened to, which seemed to be in contrast to how many experienced interactions in their personal lives. Palesa stated: "Even when you ask her a question, she does listen to your question". Mosima felt that: "The therapists on the mat, they listening". In conjunction with this is the positive impact the therapists questioning had on the mothers' sense of being listened to. Mosima stated that: "Ya they ask me. They ask me", and Joy reiterated that:

> They ask me about what I thought...Mmm, because they even ask you, what, what, what you instincts tell you, ya. What are your beliefs? What do you, what do you, what do your culture say about this? What are your instincts?

This style of interaction possibly allowed some mothers to feel safe and seemed to provide an opportunity for them to open up in ways which they had not done before. Farai stated that: "So I do talk to them about it...And I went there. And I tell them what's happening". This feeling of safety allowed some mothers to be able to reflect on difficult personal experiences and on themselves as mothers. Inertia stated that:

> Then they ask me about my history, then I had to tell them my history...They said to me. Oh they ask me question, oh, why do I have to treat my daughter like that? So I told them, then they ask me, 'Do I, do I have a, do I have parents?' Then I said, 'Yes I am having a single parent'. Then they ask me, 'Where is my dad?' Then I told them, 'I don't know my dad'. Then they ask my daughter, her. Then I said, 'He is there but not by my side. He's having a wife and a child outside. And he is married to another woman'. So, they ask me, 'How does that affect me, affect me so that I treat my daughter so harsh?'.

When asked whether they trust the advice the therapists had offered them and if so, why, many mothers spoke about the therapists being professionals and that they believe that they

work professionally for the mothers and their infants. Nolwasi stated that: “They will do other things that they promised they will do for the baby”. For other mothers, the fact that the therapists were unknown and/or perceived to be from outside the community made it easier for them to trust the therapists with their personal information. It also seemed to make it easier to trust the advice they offered. Inertia stated that:

> The thing that makes me trust them is that I don’t know them, they don’t know me. And, when they don’t know me, they come separate...I see that, I see it much different to talking to somebody who is living nearby my. Those people I know them. I don’t know these people and I don’t know what kind of people they are...I thought they are people from, they are outsiders so I think it is much better, for them, for me to tell them – so that my secrets can be safe with them.

Dulani stated that: “Yes. I do. Yes. I do...Because, me, I trust them. They are the two people who doesn’t know you and then you tell them the story with her and then she give you an answer, what you must do, what you mustn’t”. Mosima described how the therapists had previously helped her and that this experience is what made her trust them now:

> Last of, he was six months then. He was crying, he was crying. Like ok, I went to them, then they advised me that if a baby like is crying, like I was not like to talk the baby. I was just, if he was crying I was just feeding, breast feeding. So like they teach me how to communicate the baby; touch her, singing for him like different stuff...Because when he was six months they help me, they help me a lot. So like...if they can help me again.

Another mother seemed to develop trust in the therapists through their honesty and acknowledgement of not knowing. Joy stated that: “I found that she doesn’t know anything about it”. This honesty as well as the clearly defined boundaries set up around what the therapists can and cannot, as well as will and will not do, helped Joy feel a genuine connection with the therapists and then allowed her to trust what they offered her. Having presented at the mat for a red dot on her infant’s head, she stated that:

> She even told me that she won’t advise me with anything medi, medi, with um, with this thing, medication, medication for the dot because she is not doing anything medical...Because she don’t know anything about this and she doesn’t, she, she’s never heard anything, um, concerning this dot. On what to, on how to heal or what.

Joy also felt that, because so many mothers accessed the mat that the therapists were trustworthy. Joy stated that: “Many people go...Once they just um, enter the room and announce that they are here, many people, you see the line is growing much longer. So I believe many people trust...and that is even why I went there”.

Overall, the relational experience had by most of the mothers on the mat was different to those that they have experienced in their personal lives and it was this uniqueness that offered them a needed space to voice their concerns. Many mothers spoke of feeling appreciative of the way the therapists were with them. Inertia stated that: “Because they are never rude, they are both the same to me and they were both sweet to me...They never, there was never any harsh words between me and them”. Dulani had spoken to a friend about her experience on the mat and recalled her friend saying that: “I am so lucky to have someone to share something with”. This uniqueness therefore seems best described as a different relational experience.

4.1.2 “There’s your hope”: The Baby mat service

All the mothers stated that they would suggest to another mother to access the Baby mat if they had anything concerning them. Inertia stated that: “That is where we getting chances to go and try to talk to them, if we are having problems”. While all the mothers felt the mat was useful for them, some focused on the way in which they believe the experience is helpful with issues of motherhood while others focused on the way in which they believe the experience is helpful for personal struggles. Joy stated that: “Many moms are confused like me. They don’t know what to do, what to expect, what to, what to do. So it helps you”, while Inertia stated that:

> I think it is a clever idea because most of us, mothers, it’s where, it’s where we get a chance to see, to see things. I think it is fine because some of us get to see things, that is where we get a chance to do things that are allowing you to learn how to, to, to learn things about situations around us.

For two mothers, their experience was expressed to be something needed. Farai stated that: “And going to the mat today, I realise that I have to talk. Not to take everything inside me. To make everything inside me”, and Inertia stated that: “I felt oh, that was the talk I needed to talk”. Whatever the mothers’ needs, all the mothers who had been on the mat believed in the usefulness of the experience. Palesa stated that: “Then they can help them. I can see that they

can help them". This offered the mothers a sense of hope in that there is a valuable service available for them. Nolwasi stated that: "They are there for moms" and Inertia stated that she would tell another mother to go because she believes: "There's your hope".

4.1.2.1 "It's just that...": Limitations of the Baby mat

Despite the overwhelmingly positive response expressed by the mothers about their experience on the Baby mat, most of the mothers felt that there was at least one thing that influenced their experience negatively. Many mothers spoke about the clinic environment as negatively impacting their experience. Farai spoke of the environment of the interview as being in contrast to that of being on the Baby mat in that while on the Baby mat she did not feel able to express herself fully. She stated that: "I didn't explain with her...With what I am doing now". It seemed as though the private space provided for Farai, during the research interview, allowed her to feel more comfortable to express the pain she was feeling, possibly because there were no other mothers around to witness this.

Ebony felt that the crowdedness of the room made her feel uncomfortable; she stated that: "No it is not comfortable, it is not hey. The place is too crowded". It seem as though this made it difficult for her to take in what the therapists were offering her. She stated that she was unsure of whether the therapists had answered her questions: "And she didn't answer I think. I didn't remember what did she say...I don't know but she didn't give me the answer". Dulani also spoke about not remembering what the therapists had specifically spoken with her about, however, she attributed this to the fact that: "I just forget a lot of things".

Palesa also spoke about how she could not concentrate on what the therapists were saying because she was concerned about missing her name being called in the clinic. She stated that: "You know it was too noisy here, then I didn't concentrate because I was listening to my name, that they will call me here. So I didn't concentrate on much... I don't remember well because I was concentrating on this". It may be that the context within which the Baby mat is situated negatively impacts on the amount of information the mothers take in. It also seemed as though Ebony perceived the therapists as knowing a lot but felt that she was unable to take everything in; she stated that: "I don't really know what she say, she says a lot of things hey".

One mother commented on the physical positioning of the mat. Ebony stated that:

> Everything turns out very fine. It is just that maybe some mothers, I don't know, they won't feel comfortable, it is not a comfortable place. I don't know...You know like we

> don't like sitting down, down in the floor. Maybe if they could bring some chairs or something, mmm, ya.

However, other mothers stated that they were happy with the mat's positioning because of the familiarity of the space provided. Dulani commented that: "It is fine, yes. 'Cos we are used to it, sometimes when there wasn't a bed we are used to sleep on the floor. It was fine", and Farai stated that: "I think we are used to being relaxed and free and all that". Inertia also expressed that: "I think it's com, it's comfortable for me". Inertia went on to comment on the appropriateness of the Baby mat in the Well Baby clinic, she stated that:

> No, I don't think that there is anything that should be changed. I think it is fine. The way it is because it is helping some of, we as parent, as single mums to get over things that stress. Get over things like being a single parent. Getting over problems and trying to solve things with the children. You are a single mum with a child. I think it is fine. The mat is helping us... because this way we, you see, you even saw yesterday, we were many there by the hall. That is where we getting chances to go and try to talk to them, if we are having problems.

Limitations surrounding ease of accessibility were brought up by two mothers. The first seemed to be a reflection of one of the mother's personal anxieties with regards to being understood. Palesa stated that:

> Like, especially if you are a person who didn't go to school at all. You don't know English at all. English, you don't, ok, when the therapist, maybe she comes here and explain to you, to the mums. And ok, I want to go there, but, I can't speak, you see, I can't express myself. And, ok, then what am I going to do? But I have got a problem. But then what am I going to do now.

The reason why this fear was understood as being this mother's personal anxiety is that on the Baby mat, the co-therapist is also the interpreter who is fluent in many South African languages and works as translator between the mother and the therapist when necessary. This co-therapist introduces the Mat to the room of mothers using African languages.

Mosima also commented on a limitation with regard to accessibility in that mothers are not able to access the mat more than once a week. She said: "Ai, ya they can make like something, they can give them room somewhere so that every time you have problem you can go there. Here in the clinic. On Mondays, they don't come? Any problem, you can come

anytime". This limitation, however, provides evidence for the need for this service within this context.

4.1.2.2 "I said to me, you know what? I was supposed to see those women": Previous knowledge of the Baby mat service

Most of the mothers had previous knowledge of the Baby mat service available in the clinic. This knowledge ranged from having either heard about or seen the therapists in the clinic on previous occasions to having previously accessed the mat when bringing their children for immunisation. Word of mouth informed two mothers of the service offered. Inertia stated that: "I also heard them talking at the Alex fm radio. Talking about these things where a mother, a mother, a mother and a child relationship so, I had to listen to them and then after listening they gave some addresses and I never go to this address." For another mother, hearing from her sister about the Baby mat service made her come to the clinic. Nolwasi stated that:

> My sister told me. I normally discuss my problems with my sister. She told me to come to the clinic. My sister told me that she knows that there is, there are two ladies who speak to mums and that they normally talk to mums but she has never come to sit. I think she has seen the ladies in the immunisation when she has brought her children.

Joy stated that: "I've seen them when I was there, when I have come before". Farai also explained that she had seen the therapists in the clinic previously but that her own anxieties had stopped her from approaching the therapists. She stated: "Last Thursday I was here. I was not there for immunisation I was there and I saw them there and I think of going there but eish. I am afraid maybe they will ask big questions and questions". Palesa spoke about her journey from hearing about the service available by listening to the co-therapist's introductory speech to the day she actually felt able to approach the mat. She stated that:

> I've been thinking about my child, eh this one, is so naughty. Last time when I was here, Brenda, she did speak to the women in here, then I didn't go. Because my child is, I mean he was one year six but he was the way he is. Then I thought, when I was at home, I said to me, you now what, I was supposed to see those women because my child now, maybe when he goes to school then he will be naughty, he won't listen to the teachers. Doing maybe somethings, you see. Then I was supposed to go to that

> lady there. Then I, I, came another, there was another month, after one year six. Then when I, I was there I didn't see anybody, she was not here. And I, I said, you know what? I don't know when am I going to see that woman so I can speak to her about this child... I thought of going but I thought no. Maybe it is because he is still young, he is still naughty, he is still young he will be fine.

Mosima was the mother who had accessed the mat previously and she stated that: "Ya, I was like. They used to come chat to me. Last of, he was six months then. He was crying, he was crying... they helped me".

4.1.2.3 "Then I realised, these people are the right people to talk to": Introductory talk

Most of the mothers felt that the introductory talk was an invitation to come and speak about any problems they were experiencing themselves or noticing with their child. Joy stated that: "Ya, because she, she said, she said that we must come and ask anything. Anything about the children. And anything, just anything about the motherhood and your baby". For Palesa the invitation was particularly focused on speaking about one's child. She stated that:

> ...oh she said to us, I don't know she is coming from where. Then she helps children, if you have got maybe a sick child, or like abusing, abusive child, blah, blah, blah, everything. Then you can come and sit there.

For two mothers the invitation seemed to feel like an opportunity for them to ask questions about things of which they were unsure. Nolwasi stated that: "They told me about me about the child, that if the child has a something that a mother doesn't understand or a problem then we must go and sit with them", and Mosima stated that:

> Ya, she was saying like, uh, if like, uh, if you have problem with your baby, you have to come tell us. We will try to help you, you know, these things. If you have problem with the baby you can come to me... they say, if your baby, if you have problem with your baby and you don't know, you don't understand, you can come, you can talk to us.

For one mother the invitation to come and talk fed into her concerns about not knowing as a mother and it felt quite scary for her. Her feeling scared was evident on reflection. Ebony stated that:

> She said that if we don't ask questions there might be complications about our child, even if it is not now, so I decided yo, if my child is doing this, then maybe after 5 years there might be difficulties, or something.

Overall there was a sense, from listening to the introductory talk, that the therapists on the Baby mat were the people the mothers needed to see if they had concerns about motherhood or their children. This is evident in Farai's description of what she heard and remembers thinking:

> So few things like give your child love. Uh, you have to do this and that and that to your child so that your child could...So when I heard Brenda talking about the thing. I knew the word psychology but I still didn't know what like do they specialise. So, since Brenda was coming and talking about that thing, then I realised. These people are the right people to talk to.

4.1.2.4 "For me it was a problem with my child": Feelings about accessing the Baby mat

Feelings about accessing the baby mat included a combination of both positive and negative feelings. A sense of initial anxiety seemed to relax into feeling completely comfortable. Dulani stated that: "I was so happy to go... I was feeling nervous... No, I was going to ask there...so I meet them there, to talk to them". Mosima, who had previously accessed the Baby mat, stated that she had faith in the process and this allowed her to feel positive about approaching the Baby mat service. She stated that: "Ya, I didn't have a problem, because like I know, 6 months, like the time he was 6 months, they help me, just, even now they can help me". For Ebony, her need to find information to help her made her decision to access the Baby mat service quite easy. She stated that: "No, not at all. I needed to know something. I think. What can I say? I was not nervous, I was not thinking anything. I just went there to get some information that is all".

Despite the introductory talk and the openness of the Baby mat process in the Well Baby clinic, fear of stigmatisation about accessing the Baby mat is prevalent. It seems as though there is sensitivity in the clinic towards HIV and towards difference. This may be connected to patients' sensitivity about other patients accessing services which are either different or extra. A few of the mothers expressed feeling nervous about accessing the Baby mat because of their concern about what this would mean in the minds of the other mothers about themselves. Nolwasi stated: "I think that when you come, that other mums, when other

people see you come to sit with the Baby mat, they think that they help people who have AIDS". These reactions may also be in part due to previous experiences of rejection as a result of their HIV status. Dulani spoke about a personal experience she had had which left her feeling hurt and rejected:

> Hmmm, I just found a job and then the problem, the lady, I was working with, that one she bring me here to Johannesburg. And then she tell that lady, so I am not good, my status is not good, that is why I haven't got the job... The old lady, she just explain this lady. That is why she is not giving me the job. She said my status is not good. Because I am HIV positive. That is why I lose the job after I found the job... It was sad. It was so sad... Because I work with the other, I worked with that lady for 20, 21 years. She bring me here to Johannesburg.

Two mothers spoke about overcoming their fears of stigmatisation because their concern for their infant's problem felt more pressing. Nolwasi, whose 5 year old son suffers with encopresis, stated: "It was fine because I knew I wanted to come to the mat this week and I didn't care about other people. I have a problem and I wanted to come to the Baby mat to talk about it. I didn't care about other people because they wouldn't help me". There was a sense of desperation in Nolwasi's need for accessing the mat, she stated again that: "For me it was a problem with my child, my child had a problem and so I didn't care what was happening, I didn't mind. I just wanted to come and access the Baby mat". For Joy, it seems as though her fear of stigmatisation was linked to her ability as a mother rather than of having HIV. She stated that: "I didn't care what they think. I just went there and did what I wanted". It seemed as though her perception of the Baby mat service as being popular with other mothers, helped her to overcome her fears of accessing it. She stated that: "Once they just um, enter the room and announce that they are here, many people, you see the line is growing much longer".

For one mother whose HIV status is positive there was a fear that she would have to talk about her status and that the therapists would blame her for the problems she perceived her son to be having. She spoke about overcoming her fear:

> I think of going there but eish. I am afraid, maybe they will ask big questions and questions... And what makes me afraid sometimes is, telling, like maybe talking to someone. I talk until I have to talk about my status, then it's...'Cos I think sometimes some of the things, they are not good because of that...Maybe they will blame me. Maybe not. But today I just told myself, 'No I will go there'.

One mother spoke about her concern about being able to express herself properly. However, again it seems as though her need to access the Baby mat service was enough to help her overcome her fears of not being able to either express herself or understand the therapists properly. She stated that

> It depends... You see 'cos others they are scared, others they are shy, they are very shy, you see. You know 'cos we, we blacks, English is not our first language so sometimes ok, you want to go there and see them but when coming to talk English, you, you can't express yourself, you know. Even me, I'm not good in English, like you can't. Sometimes you want to express yourself and you think, how am I going to express myself to the therapists? It is better, maybe it becomes better if she does the translation, she do the translation. Then, ok, you can understand. You can talk on things... and we don't know what to say. You want to, to, to, speak but how am I going to start that, you know. I can't know even the language, what am I going to do now?

4.2 "So I even wake up at night thinking": Being a mother in Alexandra

When interviewing the mothers who accessed the Baby mat, exploring their experiences as mothers as well as the factors influencing their experiences were considered crucial. It was thought that their social and/or personal context would affect their experiences of the Baby mat. It felt important to put the Baby mat into the context of not only the clinic but of the mothers' social and personal environments as these women who access the Baby mat are mostly from this environment, that of Alexandra.

4.2.1 "...we are living there...I'm so afraid": The environment

Most of the mothers did not speak about problems that they experience in their environment, however, one mother gave very vivid examples about how she experiences living in Alexandra. Inertia described her environment as feeling unsafe for her and her daughter and stated that:

> "We are living with people who are too rude. Rude, rude, rude, rude...They are so rude. Even they are rude to children, very rude...'Cos the people living there, beat them, they are rough, they are alcoholics. They are up to no good...They do smack other people's children...they don't understand that a kid is a kid".

She recalled an incident in another area in Alexandra where a man had shot a three year old child dead because he had sworn at him. Inertia expressed feeling acutely aware that: "...it might happen to my baby". It is evident that Inertia is consumed by the very dangerous and pervasive threats in her environment and concerned about protecting her daughter from them. She stated that:

> "I am trying to protect her because some, some people out there, they are so rude and they will, the child there by the yard was once raped. She was maybe 8 or 9 months. Raped by this guy, and he was drunk and living there, and we are living there...that is why I always try and take her away. I'm so afraid...next year I don't want her to be by the location, I want her to be in school. I don't like her around the environment. I don't want her there. They are rough. The people drink. I don't like that".

While these concerns were only expressed by one mother, and it is important to keep in mind that this is probably not the same experience had by the other mothers, it is also important to think about the probability of many mothers and infants living in Alexandra experiencing circumstances very similar to those Inertia was speaking about.

Farai also spoke of her concerns about raising her elder daughter in Alexandra. She stated that: "Because now, living in a township. You know those fourteen, from fourteen years old they do teenage things. This and that, bad things they do...[Like] dating at an early age, having sex at an early age, smoking, drinking, partying, not going to school, hmmm, being stubborn". This worry was further expressed by Inertia who showed concern about there being a lack of boundaries practiced in the community with regards to children having sex. She said that:

> They don't think of them as children because they are having sex. They all think, 'Oo, this one, this one she is old, she knows a man. She is even having a baby. At the younger age of ten. Agh, she's old. She can, I can also make her a wife. I can also make her something down there'.

4.2.2 "It's not enough": Mothers struggling to survive

Most of the mothers were either students or not working and therefore depended on external sources for financial support. This support ranged from receiving money from family members, the infant's father, their partner, and/or a social grant. Joy, a seventeen year old student living at home with her parents, described how her infant's father supports her

financially: “Ya he is around...he takes the responsibilities...like the child support...[he] is going to pay for the school fees”. Mosima, who left her partner and father of her child because he was abusive towards her, lives with her sister and is supported by her. She described her experience of depending on her sister and her desire to be financially independent:

> I fell pregnant in school so I didn’t go, my sister was taking me to job. So there was nobody to take the baby, to take care of the baby when I am going to school...I was know exactly that if I have a baby I can’t afford to take her to the crèche...I’m trying, like, even now like with my sister, sometimes she is taking to my baby to the crèche so like I am looking for a piece job so that I will take myself to school or finish...I’m not working. But now at least like, with my sister taking him to crèche, I am wake up in the morning, and go to the market looking for job. Like I am trying, like I hope that I will get something...Like if I had my own money, I can maintain my babies without bothering anybody.

Inertia, who also dropped out of school because of her pregnancy, spoke of her experience:

> After I had the baby I had to sit for five months from January last year, I had to go and get a job and I get a job from Spar. That is where I was working as a cleaner. And that is where I got this kind of treatment there by my manager. Then I had to quit and leave. And that was it I never got another job again. I went, this year I went to search for a job. Even to search for the job in the internet, there was no job there. It was hard; it was too late for me to go back to school. Next year if I am having much money, and much time I am deciding to go back to school. To go back to school for an education, so that I might have a better future.

Inertia described herself as coping financially, “I am coping with the money my baby’s father gives for his baby. Because she is eating everything I eat, she can eat pap, she can eat gravy, she can eat meat. She can eat soup, she can eat anything, apples, anything. She eats” and she stated that, “I am having the child grant”. Her comment about wanting a better future and her descriptions of how she is coping, however, provide evidence that she is struggling financially and that this is impacting on the quality of physical care her child is experiencing. Below is a description of how she copes:

> It is difficult financially because it is not enough. Because...she is having one jacket...even yesterday you saw her – she wasn't wearing any jersey. Because...all of the jerseys are dirty...sometimes...after bathing she wants to stay there by the soil, playing with the soil and I dislike that. She doesn't have enough clothes and I dislike her being dirty...The nappies she wear...when I put her nappies, maybe early in the morning...And if it is wet, maybe I can change her even tomorrow. That is where I can save things. Because even now, Mon, Monday the 26th, she was 2 year that day. I was not able to buy her a cake, even a cake. All I had to say, it was happy birthday. Even the dress she was wearing yesterday, she was, that was bought by somebody outside who I know.

Ebony fell pregnant during her last year of her BTech diploma and was intending on going back after the technikon's holidays to complete it so that she could get a job. She was aware of needing to support herself financially, despite living at home with her mother who was working: "...he will go to the crèche...I have already started for finding a job...And there are these people, they called me on Tuesday. To know if I am still available...What can I say? I do need a job hey, really I do need a job".

Dulani, an unemployed elderly lady, who had recently become guardian to her niece's baby and had only just applied for a social grant stated that, "Now, because I am not working it is difficult. When I was working it was fine because I was buying [food]. When I buy piece of meat I know I have to share all those pieces [between three children] and then I share some...it's not enough". Even the two mothers who were working expressed similar sentiments. Farai, who is helped financially by her partner and who works as a room attendant in a hotel, stated that: "I am not happy about the salary but every second [I] do something with what I get. Half a thing is better than nothing". Farai described how difficult her circumstances can be for her and her children if something unplanned occurs. She explained how her work schedule is based on a 5 days on and 2 days off rotational system. According to Farai her son had recently been sick and so she had to take her 'off days' early so she could stay home and look after him. As a result, she said: "So I won't be off for four weeks because I took those days".

Palesa described herself as, "...the bread winner at home" and spoke about the financial difficulties she experiences despite having a permanent job. She described a history of

borrowing money from the bank to support her sick mother and pay for the funeral services for her mother and brother. She described her current financial situation as follows:

> Things are bad. Things are difficult now. This month we don't have food, we don't have nothing...It is so stressful...Until now, I am trying to cover things but I can't...at the end of the month I have nothing, because my bank deduct their money. And on last month, in the house we didn't have food to eat. I didn't know what to give my child and they were crying, 'Mummy I want food', and there was nothing...The thing is, even if we ask some money, steal some money, it is like that and I can't cope anymore...Because now I am thinking that with this money that I have with me, I wanted to buy some cabbage because I only have a little bit of mielie meal in the house and a little bit of cabbage and a little bit of carrots, so that we can eat until the weekend...I took a leave for now until Monday so maybe Monday I will have money to go to work...I am owing maybe R2000 for the transport and the school fees, since the year start I didn't pay...It is so stressful...I was so stressed. I am stressed. So I even wake up at night thinking, what am I going to do from now on? Like I am trying to do things but everything it seems like I am doing nothing.

Overall the mothers experience themselves as financially struggling, despite receiving external support or working themselves. These mothers' accounts of their struggles within an extremely financially deprived environment highlight the high levels of stress that these mothers are exposed to on a daily basis. In addition to this it seemed as though in circumstances where there was so little financial provision that the mothers struggled to provide a space in which they could allow themselves and their infants' some release from the strain of their environment. Palesa stated: "Because I want to make them happy. You know it is so nice sometimes if maybe I take them away, to play there, take them for the day. Take them to whatever, it is so nice. And the naughty ones, then they become trouble free".

4.2.3 "Mommy, you know what, it will be ok": Support

Other than financial support, many mothers spoke about the quality of their support systems. These support systems included family, social and relational support as well as previous and current support through their cultural and religious practices. The mothers' experiences were by no means homogenous and seemed to fall on a continuum between feeling supported and feeling isolated and let down. Most mothers spoke about experiencing support which represented a mixture of supportive experiences in different areas of their lives.

4.2.3.1 Familial, social and relational support

Many mothers spoke about the quality of the support structures they experience as a mother. Joy stated that: “I’m just, I’m just surrounded; I’m just surrounded with support. And so around me is so positive. So I just, I’m fine”. Ebony spoke about her mother being really helpful. She said that: “My mother she does help me when she know...Mmm, she does tell me if he is sick, what I must give him, the food, everything, everything that is happening about the child she does help me”. Ebony, however, spoke of her mother not being there to support her when she was growing up and so she struggles to take in the advice and help her mother offers her. She stated that: “My mom did tell me but I didn’t trust her...Every time she says something, it turns out like that, so I think I will...I think I will start trusting her...She tells me, it’s just that I am the one that has the problem”.

Farai stated that she receives financial support from her partner and that he is supportive of all her children, despite being father only to her youngest child only. She stated that: “I think he is very supportive...Those other girls are not his kids. Their father passed away. So he is very supportive of all of them. He give them love. And an outsider can’t see it is not his child...with the kids he is good”. She did not speak of a broader support network and it seemed as though she has not experienced supportive relationships in which she has been able to express herself. She said that: “But personal problems. I don’t talk about them. ‘Cos sometimes it is hard to say something...It is too difficult to talk about. But I do feel I should talk...I don’t have friends and I am not used to talk about my things”. It seemed as though for Farai accessing the medical services available at the clinic was her way of managing her concerns, however, it is evident that she wants more. She stated: “Most of the time I come here to the clinic to ask questions during the week about something I don’t understand...I didn’t know after the doctors, who was left to talk to”. Farai described how she speaks to her daughters, aged fourteen and 8, and that it seems as though to some extent they offer her support. She spoke of them saying: “‘Mommy, hey, everything is too serious with you’, like, ‘Mommy, you treat us well’”. Similarly, Palesa’s children offer her support. She stated that:

> You know, they love me so much...And that older one, he can understand. He can, if, like, if he ask me. If I don’t have money, he do understand because he knows that if I do have money then I do something for them. The, the smaller one, that one, he can’t understand...That one, the older one. He will tell me, ‘Mommy, you know what, it will be ok. It will be ok’. Sometimes when we, when we didn’t have money, then ok

> I've got maybe a bread. Bread, then with that bread, maybe later on there must [be] some slices. He does share with me, 'You know what mommy, take two there. I'll take two there'.

Inertia expressed having no emotional support. She stated that she received financial support from the father of her child but that he was not accessible to her emotionally or to help her raise their child. She said that:

> He does give the child support money and that is it. He doesn't have the time. When you are calling him telling him that the baby is sick, he doesn't want to know. He tell you, 'What am I going to do? Do you tell me to come and cry over you so that sometimes he or she might, she might get better if I cry with you'.

Many mothers reported feeling isolated in their environment as well as in their experience as a mother. Inertia stated that: "I always face things alone...I could say it is being lonely...I don't have anybody...nobody is bothered...I don't have people so I keep to myself". Palesa said: "Um, for, for now my family I will say that they don't support me because the first time, at the time when my mother was sick, they were not there for us. And my mother, when she dies, they were not there. We stood on our own". Dulani, who had removed her niece's child from his mother's care two months ago, was troubled by the disinterest of the mother in her child. She stated that: "Even now since I have had [my niece's child], the mother she didn't phone to ask how is [he], because she knows [he] was sick". Her main support structure is a friend with whom she lives about whom Dulani said: "The family friend at home...she just advise me what I must do, what I do and then she tells me".

Mosima stated that she was living with her sister in Alexandra and that her parents lived far away. When asked about what it may be like for her to be a mother without having her own mother around she struggled to answer the question and responded by stating how she came to be in Johannesburg. She said: "Like, ok. Hmm. My mom like, I, I, I came in Joburg for coming to school for five, six years. So I got pregnant in Grade 11 that's why I am this side". While it could be that Mosima misunderstood the question as having been asking her why she is in Alexandra without her mother, it is also possible that her resistance towards speaking about her feelings (as evident in the question being reframed and asked in different ways) could possibly indicate that her experience as a mother, without the close physical and/or emotional support from her own mother, has been difficult.

Although Nolwazi did not speak specifically about her support structure, she said that her sister had advised her to come to the clinic to speak to the therapists on the Baby mat. Even though one is unable to ascertain the quality of the support she does receive at home, it would appear that she is able to access information from her sister which then helps her to some extent.

4.2.3.2 Cultural and religious practices

Most of these mothers have grown up and lived in a transitional society in which there has been a merging of both traditional and western cultural practices. When speaking about the way in which they think their culture impacts them as mothers or in their own lives, many mothers spoke about themselves as being separate from their culture. Dulani said that: "I don't think my culture impacts me. Not that much because I am removed from the cultures. I am doing my own thing". She spoke more specifically about her own experience with HIV and thinking about traditional medicinal practices. She said that: "I was scared to take those things. Those medicine, those Zulu medicine...I just unsure sometimes, I don't believe it with, in those things too much. 'Cos I believe myself and God and I say 'Oh God help me. When you give me this [HIV], let me pull through this and then I will be ok'".

Some mothers spoke about their culture as letting them down. Nolwasi, spoke about feeling that her ancestors had let her son down. She stated that she and the father of her child had followed cultural practices but that her son was still suffering. As a result she stated that: "I am thinking that our culture, I am thinking about it, that it is not good because he had the ceremony and he still has the problem and so it must be something else". It seemed as though this had influenced the extent to which she associates herself with her culture. She said: "I believe in culture, but not too much in culture. I am not deep in my culture".

Similarly Palesa spoke about feeling let down by her culture and how she had moved away from it. She stated that:

> ...we suffered a lot, a lot, a lot. Especially on my mother, she suffered a lot...You know I do believe in God...But me neh, my mother, she was doing that but we grow out of it. That ancestor thing. But since my mother passed away, me, I don't do that. I don't do that anymore because I do believe in God. I know God, he is the one who grows me and he will protect me and he will do everything...I know that, ok, the ancestors, they are there, But I don't believe in them anymore.

As mentioned by Palesa and Dulani above, religion was spoken of as offering support for some of the mothers. It seemed as if the support offered to them through religion gave them hope for their own and their children's futures. Palesa shared that: "I mustn't say I am struggling. I must be strong. I must just talk to God. You know what, God knows what you want, what is your future, then, you see. You just have to believe in him and then he will do everything for you". For Farai, asking for a son from God and receiving one provided evidence for her that he was listening to her. She said: "Because I believe in that what you ask from God, he just give you. You won't ask bread and he give you a biscuit. If you ask a biscuit he will give you a biscuit".

4.2.4 "I think I am a heartless mom, very heartless": Experience as mother

Overall the mothers spoke about their mothering experiences as being difficult and acknowledged that being a mother was trying. Ebony stated: "I am tired... It has been challenging in a way...you can't do anything", and Palesa said: 'Ya, to be a mother it is not easy. It is not easy. You must make effort...it is not easy at all". She also made reference to struggling to meet her own needs because she could only manage to meet the needs of her children. She said:

> I have to sacrifice a lot, a lot, a lot...I used to buy myself anything that I wanted, anything I can buy, anything. But now when I think, I think of myself, my children don't have things. And I have to make sure my child has things, like shoes, or must have clothes first, before I make myself happy.

Other mothers spoke about parts of their experiences as mothers as being difficult. Inertia said: "Sometimes it is hard, sometimes it's, I can tell myself sometimes it is hard for me to be a mom". She went further to describe the struggle she experiences in her interactions with her infant by saying that: "I sometimes do give her love. I sometimes get bored of giving her love". It seemed as though Mosima's experience of mothering had initially been difficult, although she did not explicitly state this. She said: "Like now I'm, like now, for now I am starting to enjoy him very much because even if he is going to play, he wants me there".

4.2.4.1 Experiences of not knowing

A prominent theme for these mothers was their experiences of themselves as not knowing. Most of the mothers felt that they were unable to make sense of their infants' behaviours which meant that as a result they were not able to meet their infant's needs. In other words,

opportunities were lost for the infants to have their experiences acknowledged. Ebony explained:

> ...well my child has this thing, sometimes he does some moves, so I didn't understand why he does that. So I thought maybe it is this thing, his umbilical cord thing [which is hurting him]...Sometimes he will make some noise, as if he wants to, he wants to like, as if he is in the toilet he will do, 'Mmm', something like that. Then the moves, he all of a sudden crying. So I didn't understand why he is doing that. I thought maybe he is hungry or something.

Mosima spoke about not understanding why her 18 month old son would not eat the food she prepared for him. She said:

> It's about, uh, a problem with my baby, not eating, he don't like, like baby food, like soft porridge. He only likes polony, banana and orange. If I make like soft porridge, [he says] 'No I want'. I was not knowing what to do anymore because I was doing this for him, he don't want. 'No, I don't want this, I want that.' I was, I was not knowing what to do.

Farai was also concerned about her 18 month old son not eating, as well as with the fact that she could not understand why. She said: "So I thought, mine doesn't want to eat food. He doesn't want to. Then I should know why. But the weight is normal, but the baby is not eating so what makes his weight [normal]"? Overall it seemed as though the mothers, while concerned about their infants' behaviours, struggled to think about possible causes for them.

Joy, a new mother of a 2 month old infant, spoke about being unsure of whether to be concerned, "...about the red dot at the back of [her infant's] head". She said: "...some black people told me that it is dangerous, some told me it is just a thing. Now I am confused because I can't agree or disagree with anyone. This is my first child and I don't know and I have never seen it before".

While Palesa was able to identify that her 2 year old son's aggression was a problem she was unable to understand why he was aggressive. She said: "He is so naughty. He fight with other children... I don't know, even that anger. I don't know what is happening, what is wrong with my child". Similarly, Nolwasi was able to identify that her 5 year old son's encopresis was atypical but only expressed that: "Maybe there is something wrong with my son... I don't know. I am not ok with it".

For one mother her experience of not knowing was related to her self experience. Despite Inertia speaking about the abuse she suffered at the hands of her mother and being able to identify what happens within her when she hits her daughter, she seemed unable to make sense of her behaviour. She stated that she feels: "...a little bit nervous about the way I am...the minute I get stressed, it's the minute I cry, and the minute I cry is the minute I get more angry. The minute I get angry, I feel it. I smack her. I find something I can hurt, so I can see that, I can see that thing hurt". Her inability to understand her behaviour was reflected in her question: "Why can't I get it that I beat? ...Because I don't know why, what is it that make me smack...Why am I angry? Why is this anger hurting me? Why am I feeling like this"?

It seemed as though for Dulani her struggle with not knowing was in relation to trying to understand her niece's behaviour. She had adopted her niece's son 2 months prior and her niece had made no contact with her since then. She questioned: "How can you do that to a child? Because even the mother, she doesn't know what is happening with the child now".

4.2.4.2 Impact of not knowing

As a result of not knowing, most of the mothers felt distressed about the health of their infants. For some of the mothers their distress was expressed as worry. Ebony stated that: "Ya, there are parts that are strange in a way. I become scared, afraid, or something...Maybe like, maybe he is sick. You become worried because you don't understand what is going on...what will happen...I was thinking that it happens only to my child". Mosima also seemed concerned about the physical health of her infant: "I was just worried...I was just worried about why he don't want, like food...I was just like, I was thinking, maybe there was something wrong with him. If he is sick or something". Joy feared the possible consequences the red dot on the back of her infant's head might have. She stated: "It is dangerous...The baby will cry and maybe end up dying".

For Inertia it seemed as though her inability to control herself around her infant is what made her fearful. Inertia admitted that she smacks her daughter a lot, that: "When she does a little bit of things wrong, I have to smack. Always smacking...I could say maybe twenty [times a day]". She spoke of an incident in which she lost control and burnt her daughter: "Sometimes I, I don't know what happened that day, I burnt her...I put her on top of the stove. I put her, on top of the stove. Right like that. I don't know what was wrong with me". It is probable

that Inertia has a poor capacity for coping with stress. She said that she: "...sit[s] alone and think[s], 'What if? What happens one time I smack her and she dies. What will I do?'".

For some mothers the distress felt in relation to the health and well-being of their infants was that they had done something to contribute towards what they perceived to be their infant's problem. Farai expressed that: "Maybe there is a problem to my child, who is affected in some way...I just keep on blaming myself. Maybe my child was affected...Because sometimes you think maybe you are the wrong one. You didn't do right things for your child". Farai seemed concerned that in not knowing she would miss something that would affect her child. She said: "Even if you think it is small. To you it can be small but it can do damage". Palesa reflected on the anger she felt and experienced in relationship to her son's father, at the time during her pregnancy and at the time of delivering her son. She seemed to attribute her child's anger to those experiences. She said:

> There's a thing that I see that cause the child to be like that. It was on my pregnancy. I've never been happy because me and his father. It was like we were fighting, neh. And the other thing we, I didn't be happy at all because it was like for me. When I was, I was, after, after delivery...Then he came to the, to the ward. Then he told me that he was, in the, in, because they, they did put the child in the incubator because they didn't know how to help him. And he came to me then he told me that, 'You know what, uh, this child is not mine'. Then I was stressed because he was the one who told me that he wanted the child and suddenly he is telling me that the child is not his.

While Farai and Palesa seemed able to think about themselves as possibly having influenced their infants' behaviours, it seemed difficult for Nolwasi to think about her inability to help her son in that she stated emphatically, "I know how to help my child", despite having expressed not knowing.

For two mothers, their inability to make sense of their infant's behaviours left them feeling impotent with regards to helping their children. Palesa stated that: "What can I do? There is nothing I can do" and Nolwasi said that: "...it will just go and go and go and be worse and he will end up disabiliting the child". Feeling helpless was also experienced by one mother who wanted to protect her infant but was unsure of how to do so. Joy spoke about not being able to know what advice she should trust. She stated that: "...people told me stories. I don't know which one to believe. And I can't disagree or agree with anyone. 'Cos maybe some of them

might be right, you know. I just don't know...It is not nice, because you always have to rely on other people". In general it seemed as though not knowing created frightening experiences for these mothers.

4.2.4.3 "Oo, I love myself": Reflections of self as mother

The mothers' reflections on themselves as mothers ranged from very negative to very positive. Inertia stated that: "I think I am a heartless mom, very heartless", whereas Farai said: "Oo, I love myself. I think I am a good mother to my kids". For both Farai and Mosima their perceptions of themselves as mothers were strongly influenced by their children's responses to them. Farai said of her fourteen year old daughter: "...she does tell me [that I am a good mom]", and Mosima stated that: "If he was crying, maybe I will think I am a bad mom...Like, the things that make me feel I am a good mom because he want me here with him". For one mother the extent of her personal and social struggles was difficult for her to separate out from her experience of herself as a mother. This was evident in her response to being asked to reflect on herself as a mother, Palesa commented: "Other than the problems".

4.2.5 "...'cos she never had a baby": Experience of own mother

It seemed as though for some mothers their experiences as mothers re-evoked distressing childhood experiences that they had had. Faria, whose mother passed away and whom she spoke of never knowing, stated with a high level of emotionality that she wants to give her children the best she never had, "'Cos I know the pain of not having a mother. Not getting that love...I just want to grow up my babies with love. So no one can love them but me".

For Palesa, her experience as a mother seemed to be a constant reminder of her mother not having provided for her and the suffering she has endured as a result. She said: "Because as time goes on, when you grow old, then, there must be a day when God will take you. Then your children must have something, you see...Because now, me, I am struggling a lot. I am struggling a lot."

Two mothers spoke about feeling unable to trust their mothers because of experiences they had with them while growing up. It seemed as though Ebony struggled to trust her mother's advice on mothering because of the negative emotions she held towards her for not having mothered her. She said:

> I thought maybe that what my mom is telling me is not true 'cos my mom never raised a child. We were raised by my grandmother and my grandmother is no longer

> there to tell if everything is ok or something like that...even if she tells me that it is normal, I don't believe her 'cos she didn't have a baby.

Inertia commented on her inability to trust people, especially her mother. She said: "No I don't want to feel the pain on me...here I am today, suffering just because of her. If it wasn't by her, maybe I would've been a better person. Maybe I wouldn't have a child by now". She described her mother as a "rude and hardened" woman. She spoke about being rejected by her mother at the age of fifteen for sleeping with men, despite her grandmother proving to her mother that she was still a virgin. The following extract shows the different experiences Inertia had with her mother, at the hands of whom she believed she suffered, and her grandmother, whom she believed loved and cared for her. Inertia described how:

> ...my mom told me that, 'well, because you started dating I think you have even slept with many people. So I am no longer going to buy things for you. Starting from today you are going to know what things you need, you must buy everything you need, food, clothing, cosmetics. Everything you need. Hair, from hair to toe, from body to everything. Everything that you need you must learn that you are a woman now if you are sleeping with old men'. But when I said, 'No, I am single' but after I had to have a first relationship, I had to get money...Because even having a child I was trying to, to cover things for me...I even went to the virginity test...By my grandmother's house...Because every time when I was home my grandmother took that Monday off going to the virginity clinic. I went there, do the virginity test, and I, I, I, I, I, was proved that I am still a virgin. Then my grandmother could show the certificate to my mum that I am still a virgin. And I have a certificate in my grandmother's house, some of them she framed them...I started when I was ten.

It seems as though Inertia's experience as a mother is a constant reminder of her experience of her own mother which she feels was very uncaring and destructive for her. It seems plausible to state that while she struggles to deal with the environment her mother created for her, that she is recreating a similar environment for her own daughter. Her story illustrates the intergenerational transmission of abuse and the negative cyclical process poor mothering can have on future generations.

4.3 "I don't think they are people who are supposed to work with people because they are heartless": Experiences of general health care services

Three of the mothers spoke candidly about their experiences of health care received at the Alexandra clinic and of health care services in general. There seemed to be consensus between the women of the health care services available to them. Palesa stated that: "You know, especially here in the clinic. Whether you can go to the clinic, whether you can go to the hospital. I don't know, maybe they are the same... As I told you, in the clinic, in the hospitals they are the same". Farai spoke about the Alexandra clinic as offering better services to those offered at other clinics, and that that was why, "You can see they are full now. Most of the people are from east of Alexandra and west, and the staff are from other clinics...They are here for good service". It seemed as though Farai understood the health care service at Alexandra clinic as being better because, "At the end of the day they do what they are supposed to do". Emphasis of good healthcare was not on the quality of the care but that you had received the service that was required. Farai stated that: "They don't even care...but at the end of the day they help you". It seems as though through past experiences of poor health care services the mothers have lowered their expectations and are happy with just being seen on the day that they attend the clinic. Farai stated that: "As long as at the end of the day, what we are here, we are done". Palesa described it as being an experience that needs to be survived. She stated that: "Afterwards I know, ok, I am finished with them...afterwards then we go home". For many of these mothers this meant waiting the whole day. In general the mothers spoke about their negative experiences of the nurses, as well as their having to meet the nurses' needs.

4.3.1 "The approach": Negative experiences of nurses

All three mothers spoke about the nurses as being confrontational. As Palesa stated: "It is just that, it, it, it comes from, like let's say a person, what kind of a person that person is. The approach". It seems as though the nurses are often experienced as shouting, screaming and being rude towards the patients. Palesa stated that: "Because sometimes if you can talk to them...then they shout you...and sometimes you will, you will, you always feel scared of them asking or scared of...you just want to listen to what they are saying". Farai stated that: 'They scream and scream...They just come if they feel like saying whatever they do, they just say...And maybe the baby is not well...Ya, they do scream actually. 'You are not looking after your baby? What, Why your baby is like this? You have to do this, this, and this, and

that. Why are you not doing this and this and that? Because we told you to do that and that'". Inertia stated that:

> They are very, very rude...I can say, you can come here. Have an appointment. Maybe like sick things. They ask you, 'Why do you come this time?' You tell them what. 'Why do you do this things? Why do you have to go?' Ooh. 'Why do you have to get sick?' Can you answer the questions – why did you get sick? Because you don't know why.

Her perception was of the nurses feeling angry with the patients, "For making them work". Her irritation and anger towards the nurses was felt in how she stated that: "They are supposed to work because if it wasn't for the people who are sick they wouldn't be able to work, they were not able to earn something".

There was also evidence that the mothers have experienced the nurses as being dismissive and unempathic. Palesa recalled an incident in hospital after giving birth to her same son in which a health care nurse ignored her request for pain medication. She spoke of:

> After the ceasar, then they take you to the ward, then after taking me to the ward...I had the child at the night...at night they didn't want to give us anything. The following day I was having like pains. After you have a ceasar you having pain, very bad pain....I asked her, 'Uh sister, I am asking for the pain pills. Can you please give me the pain pills?' Uh, she ignored me, and I ask her again because I didn't, I was having those pains, it was so hard. Then she doesn't even wanted to give it to me.

In speaking about nurses from another clinic, Farai expressed how they were unempathic towards the mothers and their infants. She stated that:

> They count the number. After maybe ten o clock they tell you to go to the other clinic...Yes they just cut, 'From here, you others, you may go'. Sometimes it is really bad because you have been there early. You see they should just tell you early, so you can see what you can do.

For many of the mothers this confrontational style of interacting makes it a) difficult for them to approach the nurses because they are scared to ask anything, and b) difficult to take in what the nurses are saying because the experience is so negative. Inertia stated quite

emphatically that: “I don’t think they are people who are supposed to work with people because they are heartless”.

4.3.2 “I make sure...I know, maybe ok they want this”: Mothers meeting the nurses needs

Two of the mothers expressed feeling a sense of responsibility for the behaviours of the nursing staff. They seemed to be highly aware of themselves within the practitioner-patient relationship and saw themselves as needing to maintain a harmonious balance. Farai stated that: “...it is my duty to be patient for my child to get what’s right for him. So I have to wait”. Palesa stated that: “I make sure that when I come here, I, like I know maybe, ok they want this. And I do the way they want, and so that I mustn’t have any arguments with anyone. I mustn’t fight with anyone. Then afterwards then we go home”. Farai also spoke about the relationship as being conditional: “They do give good favours. When I am good to them because once you bring attitude then they will act badly to you”. Palesa stated that: “You know me, I make sure that when I come here, I, like I know maybe, ok they want this, and I do the way they want”.

Palesa spoke about fearing being perceived as disrespecting the health care nurses and the consequences that would have for her and her child:

> Ya, because sometimes you concentrating, maybe they call you. Then when you are standing, you stand up there, you try to watch for your name there if they did call you. Then they will say, ‘How many times did we call you? And you didn’t know. We were calling you and you didn’t come then what do you expect us to do now?’...Maybe they will tell you that we will help you after that one because you didn’t want to come, you see.

The poverty of investment, felt by the mothers, of the nurses’ interests in meeting the needs of the mothers and their infants, is evident in how Farai described her experience of the nurses: “They do what they have to do”.

4.4 In summary

From the accounts given of being a mother in Alexandra it seemed as though many of the mothers struggled to survive in their daily lives, despite stating that they feel that they are coping. Threats experienced in the physical environment were spoken about as being dangerous and pervasive. Many mothers described themselves as being financially dependent

on others and that financially there never seemed to be enough. This deprivation was also experienced by some mothers with regard to their support structures in that they felt like they were on their own. Familial, social, and personal relationships as well as cultural and religious practices offered each mother a different combination of supportive experiences or lack thereof. Most mothers described themselves as being unable to make sense of their infants' behaviours and spoke about experiencing distress and feeling powerless as a result. Some mothers struggled to make sense of their own experiences or those of others and this also concerned them. These struggles left some mothers feeling isolated. In general the mothers' reflections about themselves as mothers ranged from being very positive to very negative. The mothers' accounts of their experiences of their own mothers seemed to influence how they mothered and wanted to mother their own children as well as the degree to which they trusted their mothers in helping them mother.

The mothers' responses to their experiences and perceptions of the Baby mat were overwhelming positive. For many mothers the experience they had was in complete contrast to the experiences they have had in their daily lives. This was particularly evident in the way that they described the relationship which they felt has developed between themselves and the two Baby mat therapists. Many mothers reported feeling as though they had gained something from their experiences despite feeling initially nervous, or even scared, of using the service. The Baby mat seemed to offer many of the mothers a space in which they could think about their experiences as mothers and their concerns about motherhood. All of the mothers reported either receiving an idea, reassurance, encouragement or containment and many spoke about feeling relieved as a result. From analysing the way in which the mothers spoke about and were thinking about their infants at the time of the interview, it seemed as though at least two of the mothers were able to think of their infants as separate human beings with their own internal worlds. Comments made about the Baby mat service indicated that the introductory talk was felt to be an invitation for the mothers to access the Baby mat, that many mothers had previous knowledge of the service available at the clinic and that their experiences had been overwhelmingly positive. Despite some limitations being mentioned by a few mothers, all the mothers stated that they would recommend the service to other mothers and it seemed evident that this service is perceived as being needed in the community it serves.

Three mothers spoke candidly about their experiences of the general health care services at both public hospitals and clinics. Analysis of their descriptions indicated that they had come

to expect little with regard to the quality of health care service received. From these mothers' reports it seems as though nurses, in general, respond negatively to the vulnerabilities expressed by the patients. They are often experienced as being confrontational, aggressive and unempathic. The mothers expressed feeling highly aware of themselves in the mother-practitioner relationship in which they had to be mindful of themselves in relation to the nurses. It seemed as though the mothers experience themselves as having to meet the needs of the nurses rather than feeling able to have their own needs met without condition.

In the following chapter the results will be consolidated in order to provide some understanding of how these mothers experienced and perceived the Baby mat service. Links will be made, between the core themes and ideas spoken about by the mothers, the trends noticed and theory, in order to answer the research the questions which have been identified. It is hoped that the discussion of these results will help to create a concise picture of the mothers' experiences and perceptions of the Baby mat and that the discussion will prove fruitful for and provide useful information to the UBMP team.

CHAPTER 5: DISCUSSION

The aim of conducting this research was to provide an initial look at the way the UBMP service is being experienced and perceived in the community that it is serving. This was done by interviewing 8 mothers who had accessed the Baby mat at the AHCC. The population who typically accesses the Baby mat are mothers who live in Alexandra Township; the majority of whom are black South Africans. All the mothers interviewed in this research were black South Africans and therefore while the sample represents the majority of mothers living in Alexandra Township, it does not does not demographically represent the population who accesses the Baby mat. The in-depth interviews were focused on looking at their experiences and perceptions and answering the following questions: How do the mothers experience the Baby mat and the Baby mat therapist and co-therapist?; Do their personal circumstances influence their experience?; What do the mothers walk away with after having been on the Baby mat?; and How does the context of the Baby mat impact on the mothers' experience?

In the following discussion the results from the interview analyses have been consolidated in order to present the ways in which the mothers experienced and perceived the Baby mat. To begin with, a discussion is presented regarding the mothers' personal experiences of their environment, including their personal relationships and experiences of health care services in general, in order for the Baby mat to be placed into context. The rest of the findings will be discussed under each of the four research questions in order to attempt to answer them.

5.1 Putting the Baby mat into context

Alexandra is an impoverished community in which there are approximately 750 000 people inhabiting the roughly 7.6 square kilometre area which holds around 20 000 shacks (Alexandra Renewal Project, 2006; The World Bank Group, 1999). This is the community of mothers and infants which the UBMP serves every Thursday at the Alexandra Clinic. Personal accounts of living in such impoverished conditions were provided by some of the mothers interviewed.

5.1.1 Experiences of being a mother

Being a mother can be one of life's most positive experiences, however, some distress is always involved – especially in the first few years of the child's development (Cowan & Cowan, 1995). These levels of distress have been shown to increase markedly if mothers are raising their children in poverty, especially if they are single mothers (Olsen & Banyard,

1993). From the reports given by the mothers, it is evident that they experience much stress and distress being a mother in Alexandra. One mother spoke vividly about her experience of her environment as being pervasively dangerous and threatening as well as about the marked distress this causes her. While this experience may not account for all the mothers' experiences of their environments it is probable that many of the mothers who access the Baby mat do experience such distress as a result of living in Alexandra.

Many mothers reported that they were struggling financially; most were dependent on external sources of support, such as family members, partners, the infants' fathers, or social grants. This is not uncommon for mothers living in poverty whose well-being is dependent on the reliability of their support networks (Blalock, Tiller, & Monroe, 2004). Even mothers who were working and financially supporting themselves and their children, spoke about their own difficulties in being able to survive financially. The lack of economic resources seemed to be impacting on many of the mothers' abilities to provide for their infants' basic needs. It has been stated that, the lack of economic resources available to families living in poverty impacts on the parents' abilities to offer opportunities which are necessary for healthy physical, cognitive and emotional growth to their infant (Orthner, Jones-Sanpei, & Williamson, 2004). Additionally, it seemed as though for many of these mothers, their economic struggles preoccupied their thoughts and remained a constant reminder of the difficulty of their situation and the deprivation in which they live. Tomlinson et al. (2005) found that, mothers who lived in adverse conditions but were still able to provide a sufficiently good personal environment, were mothers to securely attached infants. Factors which seemingly assist mothers in being able to provide a sufficiently good personal environment tended to be absent for many of the mothers interviewed for this research.

Deprivation was also experienced by many mothers with regard to their experiences of familial and social support. Only one mother stated with conviction that she felt supported. For the other mothers there seemed to be varying degrees of support offered by different sources with the majority of mothers not having positive and/or consistent supportive experiences. This is concerning as positive supportive experiences have been found to help buffer mothers against the very demanding and stressful experiences associated with motherhood (Voight, Hans, & Bernstein, 1996). Mothers who have positive supportive relationships have been found to provide emotional consistency, responsiveness and sensitivity towards their infants' behaviours (Colletta, 1981; Levitt, Weber, & Clarke, 1986). Support has also been found to be negatively correlated to angry, punitive and restrictive

maternal behaviour (Colletta, 1981). Most of the mothers interviewed in this research are therefore at risk for negative mother-infant experiences.

Having said this it is also necessary to state that for many mothers, familial support, from mothers, grandmothers, siblings, and partners, can often be a source of both support and stress (Voight et al., 1996). This was stated by many of the mothers in the current research in that, despite having access to different – yet limited – familial support sources, many mothers spoke about the difficulties involved in their relationships with such individuals.

Social support, as offered by a friendship group, was spoken about by one mother. Other mothers commented on their feelings of social isolation. This is therefore an area in which many mothers are not able to experience self-affirming interactions, or receive positive feedback and advice, which have been found to be offered by friendship groups in studies looking at support networks (Voight et al., 1996). Two mothers also reported that they received emotional support from their children and it seemed as though, to some extent, the children took on responsibility for their mothers' emotional well being. This highlights a possible inability for such mothers to think about the impact of their experiences on their infants and to provide them with an experience in which their own emotional well being is thought about, made sense of and made survivable.

Cultural beliefs and practices which would offer mothers a way of thinking, about themselves and their infants, were spoken about as no longer being incorporated in many of the mothers' lives. This trend was also noted by Long (2009) who stated that while traditional practices and cultural beliefs are still valued among many South African mothers, the degree to which these mothers engage with them varies. Some mothers seemed to draw support from their religious beliefs – which were spoken of as providing them with hope and a way of surviving their circumstances, however, not all the mothers who stated that they had moved away from their cultural beliefs stated that they had managed to find support elsewhere. It is therefore possible that for some of these mothers there may be a lack of opportunity or lack of a supportive framework within which to think about and understand themselves and their infants' behaviours.

One mother, who stated that she had not spoken to anyone regarding personal issues, commented on how difficult it was for her to speak about things which are important to her. She stated that: "...it is hard to say something...It is too difficult to talk about". While she may have experienced difficulty in using a space that is meant for thinking because it is

unfamiliar, it may also be difficult because in not having experienced such a space, she may have experienced fear in relation to overwhelming emotions and thus found it difficult to articulate her thoughts and emotions.

There also seemed to be a sense that no room was available for the mothers to talk about their concerns regarding motherhood and their infants. Some of the mothers spoke about feeling as though they were bothering others and that in previous experiences their attempts to seek help had been rejected. It seemed that many mothers were not given opportunities in which to think about the problems they were experiencing and as such "...stood on [their] own", as stated by one mother, with their uncertainty.

In general, the mothers expressed that parts of their experiences of being mothers were difficult and that they had had to sacrifice things for themselves in order to meet the needs of their infants. For all the mothers their experiences of not knowing were coloured by feelings of worry, distress, guilt, impotence, and helplessness. Many of the mothers were concerned with fantasies of their own destructive potential and feeling that they were alone in their experience. While some mothers spoke about their needing reassurance from others, other mothers spoke about feeling uncertain in needing to rely on the other for reassurance, especially when what they were receiving was different from varying sources.

Reflections of the self as mother ranged from very positive to very negative. Two mothers felt reassured of themselves as mothers because of how their children responded to them, whereas another mother stated emphatically that she was heartless. One mother seemed to struggle to think about herself as a mother as being separate from the stress which she was experiencing because she was consumed and preoccupied by it.

For some mothers, their experiences as mothers re-evoked distressing childhood experiences that they had had. One mother was highly concerned about correcting the mistakes of her past which made her extremely sensitive to and over-involved in focusing on negative experiences of her child. She was therefore very worried and stressed about the good her infant was receiving. In South Africa there has been a history, because of the Apartheid system, of mothers sending her children away to their grandmothers to be looked after. For one mother this created issues around trust for her with her own mother and she seemed to struggle to take the good in from her mother. There was also evidence that intergenerational patterns of parenting were evident. One mother spoke vividly about her own negative experiences of her

own mother, and spoke about her own abusive behaviour towards her daughter. However, there seemed to be very little conscious linking between the two experiences.

5.1.2 Experience and expectations of health care professionals

The AHCC is a welfare organisation surviving on The Gauteng Department of Health as well as many donor companies and organisations in and around the community and as such, there are limited resources available (Alexandra Clinic Annual Report, 2009; Jewkes et al., 1998). This was evident in the Thursday Well Baby clinic as there was a limited number of nursing staff available in relation to the very high number of caregivers and infants accessing the clinic. In the weekly observations conducted by the researcher approximately 100 mother-infant dyads and a maximum of 5 nursing staff were counted in the clinic. It became evident, to the researcher, over the course of conducting the interviews and attending the clinic each week that the system placed very stressful demands on the nursing staff, the mothers and the infants. It was noticed that there appeared to be little consistency and predictability in the behaviour of the nursing staff each week despite the same nursing staff being involved in the process. For example, on one Thursday morning when the researcher and the therapist arrived at 09h00 am, the clinic was seemingly running smoothly; whereas on another Thursday morning, the mothers – some of whom had been waiting with their infants since 05h30 am – were still waiting for the nurses to begin the clinic at 10h00 am.

Three mothers spoke about their experiences of general health care services as being of very poor quality and that their expectation of good service was to be seen on the same day as accessing the clinic and not much more. In describing their experiences of nursing staff, the mothers described them as being confrontational, scary, dismissive and unempathic. It also seemed that for two mothers they felt a sense of responsibility for meeting the needs of the nursing staff. They were highly aware of themselves as being part of a practitioner-patient relationship and that there were negative consequences for themselves and their infants, such as not being served, not receiving medication, or being shouted at and embarrassed in front of the other mothers, if they did not meet the conditions set up by the nurses. It was also felt that the nurses had little investment in the mothers and their infants' wellbeing. It must be noted that one mother described the nursing staff at the Alexandra Clinic as being better than the nursing staff at other clinics; however, it seemed as though her experience of better service and treatment did not necessarily mean service and treatment of a good quality and caring nature. Gubb (2010) described how mothers accessing healthcare systems in Johannesburg

are not 'held' or assisted by the medical staff who are supposed to offer support. This is clear in the current research from the descriptions given above as well as by one mother's very candid description of nurses as being heartless.

Winnicott (1958) stated that there is such a thing as a not good enough environment and that such an environment negatively impacts on the infant's development. Gubb (2010) suggests that there is also such a thing as a not good enough society which negatively impacts on mothers' abilities to function successfully in order to meet the needs of their infants. From the descriptions made available by the mothers in the current research it seems evident that support systems that are typically thought of as offering sufficient support are not readily available to most mothers accessing the Baby mat at Alexandra clinic. It will become evident through the following sections that one of the major impacts the Baby mat has on the mothers who access it is that it is experienced as being in contrast to their personal and general medical support systems.

5.2 How do the mothers experience the Baby mat and the therapist and co-therapist?

Overall the mothers experienced the Baby mat very positively. The introductory talk, given by the co-therapist, was influential for most mothers in their decision to access the Baby mat. The one aspect of the talk which was referred to most often was the opportunity for the mothers to speak about anything concerning them with regard to mothering or their infant. The way in which the mothers spoke about what was offered to them in the introductory talk, suggested that they were able to attach their own fears and concerns to the open invitation they received, which made them feel drawn to engaging with such a process. The offer to receive help and possibly to understand what was troubling them seemed to feed into most of the mothers' experiences of feeling isolated and struggling as well as their experiences of not knowing. Crumidy & Jacobziner (1966) stated that programmes which offer a sincere willingness to help and opportunities for empathy and understanding are more successful at reaching "unreachable" populations, such as their work with young unmarried mothers.

Many mothers had previous knowledge of the Baby mat service either through word of mouth or having seen the therapists[5] in the clinic before, however, for most of these mothers they had only accessed the Baby mat for the first time on the day of their being invited to

[5] This term refers to the therapist and co-therapist who were present on the Baby mat for all of the mothers' experiences

participate in the research. The way in which the mothers spoke about their feelings regarding accessing the mat suggested that there are many different factors which make it difficult for them to do so. These included; fear of stigmatisation regarding being perceived as being HIV positive or of being a bad or incompetent mother, fear of not being able to express oneself properly, fear of being asked questions which would be too difficult to answer, and fear of being blamed for their infant's problems or difficulties. There seemed to be an overarching theme of a fear of rejection either by the other mothers in the clinic or by the therapists on the Baby mat. This may be linked into previous experiences in the mothers' lives in which they have experienced rejection by their familial, social and health service support structures. For some mothers their desperation to receive help, because other avenues had proved not helpful, is what allowed them to overcome their fears of going to the Baby mat, whereas for others their witnessing other mothers access the Baby mat made it easier for them to do so.

The way in which the mothers spoke about their experiences of the therapists made it evident that in many ways the relationship that was established was the most important aspect of their time on the Baby mat. The importance of the relationship in facilitating therapeutic change is described by Winnicott (1965) who placed a lot of emphasis on the therapist creating a 'facilitating environment' in which 'holding' and 'management' of the patient were seen as being more important than interpreting to the patient (Winnicott, 1988). He stated that: "...the therapy that is needed involves the therapist personally" (Winnicott, 1962b, p. 72). In the current study the relationship was spoken about as being unique and in contrast to the relationships experienced in their daily lives. Typically, the interactions the mothers spoke about in their personal lives were ones in which they felt unheard and where opportunities for them to think were closed down. The mothers tended to view the therapists as open, honest and trustworthy. For one mother her trust in the one therapist developed out of the therapist admitting that she did not know about something around which the mother was concerned. It seemed as though this showed the mother that the therapist was being honest and genuine with her, which was in contrast to how she has experienced others in her life.

Another mother perceived the therapists as being outsiders to her community and this made it easier for her to trust in them because she experienced them as being different to the people in her own life whom she felt unable to trust. Other mothers perceived them as being professionals and that they treated and spoke with the mothers. They were described as being patient, as listening, and as including the mothers as equals in a conversation about their own and/or their infants' problems. The importance of being treated like an equal can be equated

to Winnicott's (1960) idea of the father holding or supporting the mother psychologically – a part of which may be about allowing her to feel confident in her abilities as a mother.

From some mothers' accounts of their time on the Baby mat it seemed as though they experienced the therapists as being able to speak about the bad stuff or the stuff that had previously been unspoken. One mother stated: "And I went there" which feels like an experience of being able to go to, to think about and ultimately survive the 'unknown'. All of these factors seemed to make it possible for mothers to speak with the therapists about things concerning them. One mother stated beautifully that: "You won't be scared to take out whatever is in you". Bion's theory of containment and his function of the containing mind are appropriate in describing the function which the therapists seem to play in relation to the mothers. The therapists seem to create a 'mental skin' which is able to withstand the contents of the mother's internal worlds and is able to give meaning to their experience (Ivey, 2009).

The mothers went to the Baby mat for different reasons, however, all of the mothers found their experiences to be useful. Their reasons ranged from personal struggles to concerns about their infants, and despite the reason given for accessing the Baby mat, it was spoken about as being something which was valuable and offered the mothers hope.

5.3 Do the mothers' personal circumstances influence their experience on the Baby mat?

The above descriptions regarding being a mother in Alexandra suggest that deprived holding experiences and a lack of containment are offered by the community and the health care clinics for mothers and their infants. These are in stark contrast to those provided by the Baby mat, according to the participants' reports of their experiences on the Baby mat, and it therefore seems as though mothers in these types of communities need the service offered by such interventions as the UBMP because of the difficult communities in which they live. It is important to keep in mind that the mothers' experiences of their physical and emotional environments were of differing degrees along a continuum of feeling supported and not feeling support at all. In the current research it seemed as though the mothers who experience the least containment within their social environments needed the containment offered by the mat for themselves first, whereas those with more support were able to access the mat for their infants. This trend is discussed below.

When thinking about the types of problems the mothers brought to the Baby mat, how they spoke about their past and current personal experiences and circumstances, what they seemed to remember about the mat and how they were experienced in their interviews, it seemed as though a trend was occurring. The following is not based on a thematic content analysis, but is rather based on what was noticed by the researcher, and it was felt that it was important to include it in the discussion as it may help to answer the second research question which is: Do the mothers' personal circumstances influence their experiences on the Baby mat?

Mosima, who presented to the mat with concerns regarding her son's eating behaviour, spoke about the therapists helping her to see that he is old enough to decide what he wants to eat. This information seemed to reassure her that her son was not sick but that he had the capacity to decide what he wanted. Later on in her interview when asked about how she thinks about herself as a mother Mosima spoke about viewing herself in response to how her son reacts to her. She described how she thinks she is a good mother because her son chooses to have her around him and that if she was not a good mother he would not want her around. It felt as though Mosima had been able to take in the idea that her son was an autonomous individual with his own mind. This linked back beautifully to what she had heard the therapists inform her of on the mat.

Joy, who presented to the mat with concerns about bewitchment regarding a red dot on the back of her infant's head, presented herself as feeling very unsure about her abilities to be a good mother. She spoke about having really appreciated the therapists admitting that they did not know about the red dot but that they had encouraged her to seek information until she was satisfied with what she knew. Joy also spoke about how the co-therapist had encouraged her to sing and speak to her infant in her traditional language so that he would learn to know his mother. There seemed to be a sense of Joy also being able to hold in her mind her infant's ability to know. In other words, that her infant also has his own mind.

The way in which these two mothers were experienced in their interviews was in complete contrast to how two other mothers were experienced. While Mosima and Joy spoke mainly about their infants, Inertia and Palesa spoke predominantly about their own personal struggles. During both Inertia and Palesa's interviews the interviewer struggled to keep the focus of the interview on the research topic as both of these mothers were experienced as needing a space in which they could speak about their own experiences. Inertia spoke about the Baby mat as being a place for mothers to go to speak about their struggles and that the

therapists were there to help mothers. It seemed as though she was not able to think about her infant's experience because she was preoccupied with her own. Palesa, on the other hand, was not able to remember what the therapists spoke to her about which she attributed to her inability to focus on what the therapists were saying. While part of her inability to take in what the therapists were saying may be due to the fact that she was listening for her son's name to be called in the clinic, it also seemed as though she was struggling so much in her personal life that she was not able to focus on what had been spoken about with regard to her infant. While she was concerned about her son's behaviour she seemed preoccupied with the suffering she was experiencing and it seemed as though she had appreciated the opportunity offered by the Baby mat for her to speak about her own struggles.

After noticing these different experiences had by these four women, the researcher wondered about their personal circumstances and how these may have impacted on their experiences on the mat. It seemed as though the two mothers who were able to access the mat primarily for their concerns about their infants (and about themselves as mothers) felt supported emotionally in their family environment. Mosima spoke about how helpful her sister had been in helping her with her infant and Joy spoke about the support she received from her parents, her infant's father, as well as her friends and teachers. On the other hand, Inertia and Palesa spoke about how socially isolated they were and how neither of them felt supported. Palesa did state however that God was very influential in her life and it seemed as though believing in him offered her hope.

It appears to be a really important and valued aspect of the Baby mat that the therapists are able to 'meet the mother where she is' or attune to the mother's needs and attend to the most pressing issue first, for example, if the mother needs her cries to be heard first by the therapists, so that she can then hear the cries of her baby (Fraiberg, Adelson, & Shapiro, 1975). Perhaps the therapists are able to provide these mothers with experiences, which allow them to focus on their infants, that are not being experienced in their personal lives. According to Winnicott (1960) the father of the infant has an important role in supporting the mother which then allows her to become primarily preoccupied with her infant. Or, in African culture, it is often deemed the older women's job, of holding the mother and warding off impingements so that she can create a good enough holding environment for her baby. Perhaps, in addition to a therapeutic function, it is this role that the Baby mat also fulfils for many of the mothers who do not have the necessary support from the father of the infant or their extended family. According to the literature, part of this holding role entails emotional

regulation of the infant (Shore, 2010). This study suggests that the role of the Baby mat therapists is also, at times, regulation of the mother's emotions, so that she can in turn regulate her baby's emotions. This regulatory function is reminiscent of Bion's concept of containment, where both the mother and the therapist's role is to act as a container for unprocessed emotion, through which this emotion is thought about, made meaningful and tolerable and then returned (Bion, 1970).

With regard to the four remaining mothers such a strong correlation between 'reason' for accessing the mat and degree of personal support experienced were not noticed. To some extent Farai, who spoke about not speaking about personal concerns with anyone, experienced the Baby mat as creating a space in which she could think about her personal experiences and how they were affecting her as a mother. Dolly, who was invited to join the therapists on the Baby mat and who reported only speaking about the 'stories of the infant', spoke about appreciating the space created by the Baby mat therapists in which she felt heard, despite speaking very positively about emotional support she received from a personal friend. Ebony, who spoke about struggling to trust the support offered to her by her mother, seemed to experience the Baby mat as both offering her reassurance and encouragement as a mother as well as providing proof for her that she can trust her mother as the advice offered was similar. Nolwasi, who was experienced as being extremely concerned about the health of her 5 year old son who was suffering with encopresis, seemed defended against exploring her experience as a mother and was preoccupied with helping her son medically and so she really appreciated the offer for an appropriate referral offered by the Baby mat therapists.

In general it seemed as though the extent of support experienced by the mothers in their personal environments allowed them to access the Baby mat either for concerns about their infants or for concerns about themselves, either as a mother or independent of their mother-role. Mothers who accessed the Baby mat for concerns about themselves, typically did not experience good familial and/or social support and therefore can be thought of as experiencing a 'not good enough' environment. These mothers tended to be anxious and fearful of issues in a variety of areas of their lives and their thoughts seemed to be strongly influenced by these emotions.

Winnicott (1958) stated that there is such a thing as a not good enough environment and that such an environment negatively impacts on the infant's development. Gubb (2010) suggests that there is also such a thing as a not good enough society which negatively impacts on

mothers' abilities to function successfully in order to meet the needs of their infants. From the descriptions made available by the mothers in the current research it seems evident that support systems that are typically thought of as offering sufficient support are not readily available to most mothers accessing the Baby mat at Alexandra clinic. It will become evident through the following sections that one of the major impacts the Baby mat has on the mothers who access it is that it is experienced as being in contrast to their personal and general medical support systems.

5.4 What do the mothers walk away with after having been on the Baby mat?

It seemed as though for all of the mothers that they walked away from the Baby mat with some recognition that the interaction that they had experienced was different to many of those that they have experienced in their familial, social, and/or health care service structures. Many mothers reported that they felt listened to, and it seemed as though some mothers were able to speak about things which they may not have necessarily spoken about before. One mother stated that she felt her secrets would be safe with the therapists; this highlights the possible extent to which some mothers may have felt that they could speak about their experiences, thoughts or feelings. The mothers seemed therefore to leave the Baby mat feeling as though they had interacted with two people who were there for, interested in, and focused on them and their infants. In a Winnicotian sense this may have offered some mothers with a true self experience in which they felt known (Winnicott, 1962); which is possibly in contrast to their everyday highly developed false self experiences, which allow them to survive their very difficult physical and personal environments. Bion (1977) also states that the purpose of psychotherapy is "to introduce the person to his 'real' self" (p. 44) and that truth and compassion are qualities that people need to be able to feel in the attitudes of others towards them (Bion, 1992).

Many mothers spoke about the Baby mat therapists as having provided them with space in which mothering and its related concerns could be thought about. This is in contrast to many mothers' previous experiences in which they had not been encouraged to think about such things by either being rejected in their attempts at wanting to think or by being told how to think, respond or behave. Whereas these previous experiences were spoken about as not being helpful, the interaction experienced with the Baby mat therapists was deemed helpful. One mother stated: "...they take everything in their minds...they imagine it...And when they take it out to you, it builds you, then you feel it". This creates a wonderful image representing

Bion's theory of the container and the contained (Britton, 1992; Casement, 1985). This mother described her experience of the therapists' abilities: being able to keep in mind, think about, make meaning of and then give back to the mother in a manageable way, an understanding of her emotional experience, which could then be used by her. The container (the therapists) had been able to provide this mother with a containing mind (a mind in which one's emotional experience can be kept safe and given meaning), which had therefore created a space for her to feel temporarily contained (Britton, 1992; Casement, 1985). This provides the mother with a momentary good-containing experience in place of a bad-rejecting/ judgemental/ uncontaining experience which seems to colour many mothers' everyday interactions (Ivey, 2009).

Many mothers spoke about feeling as though they had received something from being on the Baby mat. For some mothers this included either practical advice, an idea which they perceived to be helpful or an offer for a suitable referral. While the majority of psychoanalytically driven therapies refrain from offering advice to the patient because of the idea that it may be experienced, by the patient, as imposing or disempowering, Landman (2009) showed in her research that mothers in similarly deprived communities experienced receiving advice positively. In such historically deprived environments there is an absence of knowledge accessible to communities such as Alexandra Township, and as such many older women would not have had access to knowledge regarding infant care, and similarly today many mothers do not have the same abilities to access information as mothers living in more affluent communities. Foucault argued that for a community to become empowered it needs knowledge (Landman, 2009) and this is highlighted in the current research in the many mothers' desires to know about themselves and their infants. On a more intrapsychic level, for one to have their psychic experience known to the self and to feel that they are known by others can also be very empowering.

The therapists' manner of being with the mothers and including them in the discussions around the presented problems was stated as being an important part of the experience by many mothers. This joint product of interaction between the therapists (container) and the mothers (contained) is another aspect essential in the process of providing a containing experience (Ivey, 2009). In addition to this, many mothers spoke about having been encouraged to act further or to believe in their abilities as mothers and this seemed to leave them with a sense of potency.

One mother had been to the Baby mat once before and many other mothers stated that they would either refer other mothers to the mat or return themselves if they needed help in the future. It seemed as though the mothers' perceptions of the accessibility of support from the therapists on the Baby mat provided them to some extent with their self-regulation of distress. This finding has also been found in social support research (Priel & Besser, 2002), which also states that the mothers' psychological and physical health, and their coping abilities were positively influenced by similar perceptions (Hobful, Nadler, & Lieberman, 1986; Wethington & Kessler, 1986). Overall, it was evident that all the mothers had, to some degree, been positively influenced by their experience on the mat.

For the mothers to walk away with such positive responses it seems plausible to infer that the mothers felt the therapist and co-therapist to be empathic. Kohut (1981) stated that empathy is an essential therapeutic tool which assists therapists in being able to help their patients. He stated that it is through empathy that one is able to come to know another person (Kohut, 1981); and it is possible that through the empathic behaviour of the therapist and co-therapist that the mothers felt that they had become known. Empathy is also essential for mothers to "know" the experiences of their babies (Schore, 2010). Perhaps through being empathised with, the mothers can come to empathise more with their babies.

5.5 How does the context of the Baby mat impact on the mothers' experience?

One of the aims of the UBMP is to provide a space that is separate from the chaos which occurs in the clinic, in which parents and infants can be held and in which impingements can be warded off (Frost & van der Walt, 2010). Despite most mothers stating that they felt safe in the relational space which was created on the Baby mat; the physical space of the clinic was felt to be impinging. These impingements included the crowdedness of the room, the noise in the room, and the need to listen intensely to the nurses in case their infant's name was called. To some extent these impingements distracted the mothers from what was happening on the mat and seemed to impact on how much the mothers were able to take in from their experiences.

During the establishment of the service and in collaboration with the health care providers in the clinic, it was decided that the Baby mat would be placed on the floor in the clinic. It was thought to be important for the Baby mat to be visible to all the mothers in order to ward off the fears many mothers may have regarding stigmatisation (Frost, 2007). Despite this provision, two mothers spoke about HIV in relation to their accessing the mat. This highlights

the prevalence and fear of HIV-related stigma in the society. On a more practical level, one mother stated that she felt uncomfortable sitting on the floor and suggested that chairs be made available. Perhaps the lack of physical provision, with regard to resources, made the service feel make-shift or of poor quality, which may be linked to many mothers' experiences of poor quality services provided in the clinic and a history of deprivation. It may be that the perceived lack of investment in the physical context of the Baby mat may concretely represent the lack of investment or emptiness felt by many mothers internally. Other mothers, however, stated that they felt comfortable with sitting on the floor because it was what they were used to and made them feel free.

CHAPTER 6: CONCLUSION

6.1 Findings of the research

This research aimed to explore the experiences and perceptions of mothers who accessed the Baby mat and found that that overall it was experienced and perceived as being a valuable service in the Well Baby clinic. Most mothers had previous knowledge of the Baby mat service, however many of them spoke about experiencing difficult emotions in accessing the Baby mat. The introductory talk offered by the co-therapist and the quality of the relationship established between the therapists and the mothers seemed to be very influential in helping the mothers to overcome their fears of accessing the mat and of speaking about things which were, for some mothers, very difficult to speak about. Fear of stigmatisation, either relating to HIV or towards being perceived as a not good enough mother, were spoken about by many mothers as making it difficult to access the service.

It seemed as though the mothers' experienced the Baby mat therapists as being able to provide them with a space in which mothering and its related concerns could be thought about and that this experience was unique for many of them. Therapeutic qualities such as listening, empathy and encouraging thought were very highly regarded and spoken about as being helpful in that many mothers walked away feeling as though their problems had been made more manageable. It is possible that some mothers were then able to walk away from their Baby mat experience feeling more capable of being able to self-regulate their distress; however, it is also possible that some mothers were not able to do so. Some mothers may have found it difficult to trust in their experiences on the mat, despite speaking of it as being very positive, in that it is something which is unknown to them and possibly threatens the defensive structures which have been established in response to their environments which appeared to be very threatening and pervasive for most of the mothers interviewed. It did seem as though the way in which the therapists included the mothers as equally knowing and important contributors in trying to thinking about, understand and possibly solve the presenting problem, allowed for many mothers to take in the good which was offered by the service.

To some degree the mothers' personal circumstances influenced their experiences on the Baby mat as well. It seemed as though a more efficient, reliable and caring support network allowed some mothers to access the Baby mat regarding concerns for their infants whereas mothers who were not as well supported accessed the Baby mat regarding concerns about

themselves, which was to some degree separate from their concerns about mothering. Whatever the reason for each mother accessing the Baby mat service it was evident throughout all the interviews that the mothers had positive experiences and perceived the service as something beneficial for themselves as well as others.

Some points were raised, however, about the context of the Baby mat which seemed to hinder some mothers' experiences of the service. These mainly concerned factors in the clinic which were experienced as being impinging, such as the crowdedness, the noisiness, and the actual service being provided by the Well Baby clinic nurses. It also seemed that HIV-related stigma was present and that possibly the service was perceived as being make-shift or of poor quality because of the lack of physical resources made available to the mothers. Some mothers also spoke about being left feeling that they weren't able to get enough from their Baby mat experience or that they were left wanting more, which seemed to be a combination of the placement of the mat in the clinic where some mothers felt impinged upon, and other mothers possibly being made aware of their neediness and feeling as though what they received was not enough. In a context in which there is no space made available for the mothers' and infants' emotional health and well-being to be focused on, it can be stated that the UBMP service provides the mothers and infants with hope.

6.2 Suggestions for Ububele Baby Mat Project team

The following points are suggestions for the UBMP team for possible areas of consideration:

- To maybe spend some more time thinking about how to make the service more easily accessible in light of what many of the mothers said with regard to their struggles with accessing the mat. For instance it may be helpful for some mothers to hear what some perceived fears may be, in order to normalise their responses to thinking about and wanting to go on the Baby mat, which may then make it easier for them to access the mat knowing that what they are experiencing is normal.

- For more thought to possibly be given towards the impact of the impingements of the physical context of the clinic on the mothers experiences of their time on the Baby mat as these were the only negatives which were spoken about in relation to the service.

- Some mothers spoke about being unsure of when or where they would be able to access the Baby mat in future. Despite possibly being told on the mat of the

designated times, some mothers spoke about struggling to take in everything which was said. Perhaps something more concrete, which the mothers could take away with them, such as an information card stating the times of the service accessibility would assist the mothers in being able to continue to think about and/or possibly remember their Baby mat experience. It may also make it easier for them to refer other mothers to the service.

- Despite all the aspects of the aims of the Baby mat project possibly not being met it is important for the Ububele team to remain positive in the knowledge that their service is offering the mothers accessing it a positive experience. Winnicott (1967a, p. 166) stated that "...in my clinic the motto is: how little need be done?", and it seems as though what the Ububele team is able to provide, in a context which seems to be difficult for everyone involved, is an invaluable service which is meeting very important needs of most of the mothers accessing it.

6.3 Limitations of the current research

Two limitations have been identified for the current research. The first is that only eight mothers were interviewed. Despite data saturation having been reached with regard to the themes analysed, the experiences spoken about were specific to the eight mothers interviewed and this makes the results not generalisable. The second is that the extent to which mothers expressed their criticisms of the service may have been negatively impacted upon because of possible associations having been made in the mothers' minds between the researcher and the therapist, despite the researcher stating that she was working independently.

6.4 Suggestions for future research

Future research evaluating the UBMP could involve interviewing mothers who do not access the Baby mat, in order for more insight to be gained into what prevents mothers from accessing the service. This may help the UBMP team in being able to encourage more mothers to access the Baby mat.

Another suggestion is for mothers, who have accessed the Baby mat, to be interviewed over several time periods (such as on the same day, one week later, and one month later), in order for more insight to be gained into whether any long lasting effects of the mothers' having accessed the Baby mat exist.

A further suggestion would be to conduct quantitative research regarding the efficacy of the Baby mat. Various measures that assess the quality of the mother-infant relationship, the infants' responsiveness and the mother's sensitivity and ability to reflect on the mind of her baby could be utilised in order to examine the outcomes of the service offered on the mat.

There is a sparse amount of literature available regarding mothers' (and their infants') experiences in adverse conditions in South Africa, and the factors which either help or hinder these mothers. While early mother-infant interventions are important and vital for the healthy development of infants in our society, it also seems essential for more information to be made available regarding the adverse life conditions in which these mothers and infants live. One benefit of this would be to provide health care practitioners with a greater understanding of the society which has helped develop this individual whom they are treating. Another would be for health practitioners to be able to assist mothers in utilising factors within their personal environments which may assist their development rather than hinder them.

REFERENCES

Ainsworth, M. D. S. (1985). Patterns of infant-mother attachments and effects on development. *Bulletin of the New York Academy of Medicine*, *61*, 771-791.

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: Alan Frank and Associates.

Alexandra Renewal Project. (2006). *Alexandra township: Status in the year 2000*. Accessed March 02, 2010, from http://www.alexandra.co.za/01_about/status.htm.

Babbie, E., & Mouton, J. (1998). *The practice of social research*. Oxford: Oxford University Press.

Bantjes, M. (2010). *Working with interpreters in psychological interventions*. Paper presented in the SPP orientation week, Johannesburg, South Africa: University of the Witwatersrand.

Bakersmans-Kranenburg, M. J., Van Ijzendoorn, M., & Juffer, F. (2005). Disorganized infant attachment and preventative interventions: A review and meta-analysis. *Infant Mental Health Journal*, *26*, 191-216.

Baradon, T. (2002). Psychotherapeutic work with parents and infants – psychoanalytic and attachment perspectives. *Attachment and Human Development*, *4*, 25-38.

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

Benoit, D., Zeanah, C. H., & Barton, M. L. (1989). Maternal attachment disturbances in failure to thrive. *Infant Mental Health Journal*, *10*, 185-202.

Berg, A. (2002). Talking with infants: A bridge to cross-cultural intervention. *Journal of Child and Adolescent Mental Health*, *14*, 5-14.

Berlin, L. J., Cassidy, J., & Belsky, J. (1995). Loneliness in young children and infant-mother attachment: A longitudinal study. *Merrill-Palmer Quarterly*, *41*, 91-103.

Bion, W.R. (1970). *Attention and interpretation*. London: Tavistock.

Bion, W.R. (1977). *Seven servants: Four works by Wilfred R. Bion.* New York, NY: Aronson.

Bion, W. R. (1992). *Cogitations*. London: Karnac Books.

Bowlby, J. (1969). *Attachment and loss. Volume 1: Attachment*. London: Hogarth Press.

Bolwby, J. (1973). *Attachment and loss. Volume 2: Seperation: Anxiety and anger*. London: Hogarth press.

Bowlby, J. (1980). *Attachment and loss. Volume 3: Loss, sadness and depression*. London. Hogarth Press.

Bowlby, J. (1988). *A secure base*. New York, NY: Basic Books.

Blalock, L. L., Tiller, V. R., & Monroe, P. A. (2004). "They get you out of courage": Persistent deep poverty among former welfare reliant women. *Family* Relations, *53*, 127–137.

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

Bretherton, I., Biringen, Z., Ridgeway, D., Maslin, D., & Sherman, M. (1989). Attachment: The parental perspective. *Infant Mental Health Journal*, *10*, 203-221.

Bretherton, I., & Munholland, K. A. (2008). Internal working models in attachment relationships: Elaborating a central construct in attachment theory. In J. Cassidy & P. R. Shaver (Eds.), *Handbook of attachment: Theory, research and clinical applications* (pp. 102-127). New York, NY: The Guilford Press.

Britton, R. (1992). Keeping things in mind. In R. Anderson (Ed.), *Clinical Lectures on Bion and Klein* (Chapter 8). London: Routledge.

Buultjens, M., Robinson, P., & Liamputtong, P. (2008). A holistic programme for mothers with postnatal depression: Pilot study. *Journal of Advanced Nursing*, *63*, 181-188.

Carlson, E. A., & Sroufe, L. A. (1995). Contribution of attachment theory to developmental psychopathology. In D. Cicchetti & D. J. Cohen (Eds), *Developmetal psychopathology*. New York, NY: John Wiley.

Casement, P. (1985). Key dynamics of containment. In *On Learning from the Patient* (Chapter 6). London: Routledge.

Colletta, N. D. (1981). Social support and the risk of maternal rejection by adolescent mothers. *Journal of Psychology*, *109*, 191-197.

Cooper, P. J., Landman, M., Tomlinson, M., Molteno, C., Swartz, L., & Murray, L. (2002). Impact of a mother-infant intervention in an indigent peri-urban South African context. *British Journal of Psychiatry*, *180*, 76-81.

Cooper, P. J., Tomlinson, M., Swartz, L., Landman, M., Molteno, C., Stein, A., McPherson, K., & Murray, L. (2009). Improving the quality of mother-infant relationship and infant attachment in socioeconomically deprived community in South Africa: Randomised control trial. *British Medical Journal*, *338*, 1-8.

Cowan, C. P., & Cowan, P. A. (1995). Interventions to ease the transition into parenthood: Why they are needed and what they can do. *Family Relations*, *44*, 412-423.

Crittenden, S. B. (1985). Social networks, quality of child rearing, and child development. *Child Development*, *52*, 857-865.

Crumidy, P. M., & Jacobziner, H. (1966). A study of young unmarried mothers who kept their babies. *American Journal of Public Health*, *56*, 1242-1251.

Daws, D. (1985). Standing next to the weighing scales. *Journal of Child Psychotherapy*, *11*, 77-85.

Fonagy, P. (1989). On tolerating mental states: Theory of mind in borderline personality. *Bulletin of the Anna Freud Centre*, *12*, 91-115.

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

Fonagy, P., Target, M., & Gergely, G. (2000). Attachment and borderline personality disorder: A theory and some evidence. *The Psychiatric Clinics of North America*, *23*, 103-119.

Fossey, E., Harvey, C., McDermott, F., & Davidson, L. (2002). Understanding and evaluating qualitative research. *Australian and New Zealand Journal of Psychiatry*, *36*, 717-732.

Fraiberg, S., Adelson, E., & Shapiro, V. (1975). Ghosts in the nursery. *American Academy of Child and Adolescent Psychology*, *14*, 387-421.

Freud, S. (1949). *Ego and the id*. London: The Hogarth Press.

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

Frost, K., & van der Walt, C. M. (2010). The Baby Mat Project – a community attachment based intervention at a primary health care centre in Johannesburg, South Africa. (unpublished).

Elliot, R. (1999). Editor's introduction to special issue on qualitative psychotherapy research: Definitions, themes and discoveries. *Psychotherapy Research*, *9*, 251-257.

Ezzy, D. (2002). *Qualitative analysis: Practice and innovation*. London: Routledge

Green, J., & Goldwyn, R. (2002). Annotation: Attachment disorganisation and psychopathology: New findings in attachment research and their potential implications for developmental psychopathology in childhood. *Journal of Child Psychology and Psychiatry*, *43*, 835-846.

Gubb, K. (2010). Reflections on society as borderline mother. *Psycho-analytic Psychotherapy in South Africa*, *18*, 40-57.

Hamilton, C. E. (2000). Continuity and Discontinuity of attachment from infancy through

adolescence. *Child Development*, *71*, 690-694.

Harré, R. (2004). Staking our claim for qualitative psychology as science. *Qualitative Research in Psychology*, *1*, 3-14.

Hobful, S. A., Nadler, A., & Lieberman, J. (1986). Satisfaction with social support during crisis: Intimacy and self-esteem as critical determinants. *Journal of Personality and Social Psychology*, *51*, 296-304.

Hodges, J., Steele, M., Hillman, S., Henderson, K., & Kanuik, J. (2003). Changes in attachment representations over the first year of adoptive placement; narratives of maltreated children. *Journal of Child Clinical Psychology*, *8*, 351-368.

Ivey, G. (2009). Wilfred Bion: Thinking, feeling and the search for truth. In J. Watts, K. Cockroft, & N. Duncan (Eds.), *Developmental psychology* (2nd ed.) (pp. 112-137). Cape Town: UCT Press.

Jacobson, S. W., & Frye, K. F. (1991). Effect of maternal social support on attachment: Experimental evidence. *Child Development*, *62*, 572-582.

Jewkes, R., Abrahams, N., & Mvo, Z. (1998). Why do nurses abuse patients? Reflections from South African obstetric services. *Social Science and Medicine, 47*, 1781-1795.

Kelly, K. (2006). From encounter to text: Collecting data in qualitative research. In M. Terre Blanche, K. Durrheim, & D. Painter (Eds.), *Research in practice: Applied methods for the social sciences* (pp. 285-319). Cape Town: UCT Press.

Kerlinger, F. N. (1986). *Foundations of behavioral research* (3rd ed.). Fort Worth: Holt, Rinehart and Winston.

Kochanska, G. (2002). Mutually responsive orientation between mothers and their young children: A context for the early development of conscience. *Current Directions in Psychological Science*, *11*, 191-195.

Kohut, H. (1981). *Reflections on empathy*. Paper presented at the 1981 Self Psychology Conference in Berkeley, California. Retrieved November 12, 2010, from http://www.yourtube.com/watch?v=ZQ6Y3hoKI8U.

Landman, M. F. G. (2009). *Inside the black box of a successful parent-infant intervention in a South African informal settlement: Mothers' and counsellors' accounts of the process.* Dissertation presented for the degree of Doctor of Philosophy. Stellenbosch University: Department of Psychology.

Levitt, M., J., Weber, R. A., & Clarke, M. C. (1986). Social network relationships as sources of maternal support and well-being. *Developmental Psychology*, *22*, 310-316.

Liamputtong P. & Ezzy D. (2005). *Qualitative Research Methods* (2nd ed). Melbourne,

Victoria: Oxford University Press.

Long, C. (2009). The joys of motherhood. In *Contradicting Maternity* (pp. 54-80). Johannesburg: Wits University Press.

Lyons-Ruth, K., & Jacobvitz, D. (2008). Attachment disorganization: Genetic factors, parenting contexts, and developmental transformation from infancy to adulthood. In J. Cassidy & P. R. Shaver (Eds.), *Handbook of attachment: Theory, research and clinical applications* (pp. 666-697). New York, NY: The Guilford Press.

Main, M., & Soloman, J. (1986). Discovery of an insecure disorganised/disorientated attachment pattern. In T.B. Brazelton & M. W. Yogman (Eds.), *Affective development in infancy* (pp. 95-124). Norwood, NJ: Ablex.

Mertesacker, B., Bade, U., Haverkock, A., & Pauli-Pott, U. (2004). Predicting maternal reactivity/sensitivity: The role of infant emotionality, maternal depressiveness/anxiety, and social support. *Infant Mental Health Journal*, *25*, 47-61.

Mikulincer, M., Horesh, N., Eilati, I., & Kotler, M. (1999). The association between adult attachment style and mental health in extreme life-endangering conditions. *Personality and Individual Difference*, *27*, 831-842.

Minde, K., Minde, R., & Vogel, W. (2006). Culturally sensitive assessment of attachment in children 18 – 40 months in a South African township. *Infant Mental Health*, *27*, 544-558.

Murray, L., & Cooper, P. J. (1997). Effects of postnatal depression on infant development. *Archives of Disease in Childhood*, *77*, 99-101.

Murray, L., Fiori-Cowley, A., Hooper, R., & Cooper, P. (1996). The impact of postnatal depression and associated adversity on early mother-infant interactions and later infant outcome. *Child Development*, *67*, 2515-2526.

Neuman, W. (1997). *Social research methods: Qualitative and quantitative approaches*. New York: Allan & Bacon.

Olsen, S. L., & Banyard, V. (1993). “Stop the world so I can get off for a while”: Sources of daily stress in the lives of low-income single mothers of young children. *Family Relations*, *42*, 50-56.

Orthner, D. K., Jones-Sanpei, H., & Williamson, S. (2004). The resilience and strengths of low-income families. *Family Relations*, *53*, 159-167.

Parker, I. (1994). Qualitative research. In P. Banister, E. Burman, I. Parker, M. Taylor, & C. Tindall (Eds.), *Qualitative methods in psychology: A research guide* (pp. 1-16). Buckingham: Open University Press.

Parker, I. (2003). *Qualitative research in psychology*. Retrieved March 01, 2010, from http://www.uel.ac.uk/cnr/documents/Parker.doc

Parker, I. (2005). Interviewing. In I. Parker (Ed.), *Qualitative psychology: Introducing radical research* (pp. 53-70). New York, N.Y.: Open University Press.

Patel, V., Rodrigues, M., & DeSouza, N. (2002). Gender, poverty and postnatal depression: A study of mothers in Goa, India. *American Journal of Psychiatry*, *159*, 43-47.

Pillay, B.J. (1993). A study of the relation between health attitudes, values and beliefs and help-seeking behaviour with special reference to a representative sample of black patients attending a general hospital. Unpublished dissertation (pp.1-254). University of Natal.

Priel, B, & Besser, A. (2002). Perceptions of early relationships during the transition to motherhood: The mediating role of social support. *Infant Mental Health Journal*, *23*, 343-360.

Rennie, D. L., Watson, K. D., & Monteiro, A. M. (2002). The rise of qualitative research in psychology. *Canadian Psychology*, *43*, 179-189.

Schore, A. N. (2010). Relational trauma and the developing right brain: The neurobiology of broken attachment bonds. In T. Baradon (Ed.), *Relational trauma in infancy: Psychoanalytic attachment and neuropsychological contributions to parent-infant psychotherapy* (pp. 19-47). London: Routledge

Seitz, V., Rosenbaum, L. K., & Apfel, N. H., (1985). Effects of family support intervention: A 10-year follow-up. *Child Development*, *56*, 376-391.

Senior, L. (2009). Attachment theory. In J. Watts, K. Cockcroft & N. Duncan (Eds.), *Developmental psychology* (2nd ed.) (pp. 215-233). Cape Town: UCT Press.

Sigelman, C. K., & Rider, E. A. (2003). *Life-span: Human development* (4th ed). Belmont, CA.: Wadsworth/Thomson Learning.

Smith, P. B., & Pederson, D. R. (1988). Maternal sensitivity and patterns of infant-mother attachment. *Child Development*, *59*, 1097-1101.

Schneider, B., Atkinson, L., & Tardif, C. (2001). Child-parent attachment and children's peer relationships. *Child Development*, *37*, 86-100.

Spieker, S., & Booth, C. (1988). Maternal antecedents of attachment quality. In J. Belsky & T Nerworski (Eds.), *Clinical implications of attachment* (pp. 95-135). Hillside, NJ: Erlbaum.

Steele, M., Hodges, J., Kanuik, J., Hillman, S., & Henderson, K. (2003). Attachment

representations in newly adopted maltreated children and their adoptive parents: Implications for placement and support. *Journal of Child Psychotherapy*, *29*, 187-205.

Stiles, W. B. (1993). Quality control in qualitative research. *Clinical Psychology Review, 13*, 593-618.

The Anna Freud Centre. (2010). *England's Lane Hospital: Supporting homeless families with babies*. Accessed March 08, 2010, from http://www.annafreud.org/pip_outreach.htm.

The World Bank Group. (1999). *Upgrading urban communities: A resource framework.* Accessed March 02, 2010, from http://web.mit.edu/urbanupgrading/upgrading/case-examples/overview-africa/alexandra.html.

Terre Blanche, M., Durrheim, K., & Kelly, K. (2006). First steps in qualitative analysis. In M. Terre Blanche, K. Durrheim, & D. Painter (Eds.), *Research in practice: Applied methods for the social sciences* (pp. 320-344). Cape Town: UCT Press.

Thompson, R. A. (2008). Early attachment and later development: Familiar questions, new answers. In J. Cassidy & P. R. Shaver (Eds.), *Handbook of attachment: Theory, research and clinical applications* (pp 348-365). New York, NY: The Guilford Press.

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

Van Ijzendoorn, M., & Kroonenberg, P. M. (1988). Cross-cultural patterns of attachment: A meta-analysis of the Strange Situation. *Child Development*, *59*, 147-156.

Van Ijzendoorn, M., Goldberg, S., Kroonenberg, P. M., & Frenkel, O. J. (1992). The relative effects of maternal and child problems on the quality of attachment: A meta-analysis of attachment in clinical samples. *Child Development*, *63*, 840-858.

Voight, J. D., Hans, S. L., & Bernstein, V. J. (1996). Support networks of adolescent mothers: Effects on parenting experience and behaviour. *Infant Mental Health Journal*, *17*, 58-73.

Wendland-Carro, J., Piccinini, C. A., & Millar, W. S. (1999). The role of an early intervention on enhancing the quality of mother-infant interaction. *Child Development*, *70*, 713-721.

Wethington, E., & Kessler, R. C. (1986). Perceived support, received support and adjustment to stressful life events. *Journal of Health and social Behavior*, *27*, 78-98.

Whitley, Jr., B. E. (2002). *Principles of research in behavioural science* (2nd ed.). New York, NY: McGraw-Hill

Wimmer, R. D., & Dominick, J. R. (1983). *Mass media research: An introduction*. Belmont: Wadsworth Publishing Company.

Winnicott, D. W. (1958). Primary maternal preoccupation. In *Collected papers: Through paediatrics to psycho-analysis* (pp. 300-305). London: 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: The Hogarth Press and the Institute of Psycho-Analysis.

Winnicott, D. W. (1962a). Ego integration in child development. In M. M. Khan (Ed.), *The maturational processes and the facilitating environment: Studies in the theory of emotional development* (pp. 56-63). London: The Hogarth Press and the Institute of Psycho-Analysis.

Winnicott, D. W. (1962b). Providing for the child in health and crisis. In M. M. Khan (Ed.), *The maturational processes and the facilitating environment: Studies in the theory of emotional development* (pp. 64-72). London: The Hogarth Press and the Institute of Psycho-Analysis.

Winnicott, D. W. (1965). *The maturational processes and the facilitating environment: Studies in the theory of emotional development.* London: The Hogarth Press and the Institute of Psycho-Analysis.

Winnicott, D. W. (1976). The aims of psycho-analytic treatment. In M. M. Khan (Ed.), *The maturational processes and the facilitating environment: Studies in the theory of emotional development* (pp. 166-170). London: Hogarth Press and the Institute of Psycho-Analysis.

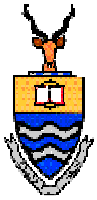
Winnicott, D. W. (1988). *Holding and interpretation*. London: The Hogarth Press.

Winnicott, D. W. (1990). The theory of the parent-infant relationship (1960). In D. W. Winnicott (Ed.),*The maturational process and the facilitating environment: studies in the theory of emotional development* (pp. 37-55). London: Karnac.

Zeanah, C. H., Mammen, O. K., & Lieberman, A. F. (1993). Disorders of attachment. In C. H. Zeanan (Ed.), *Handbook of Infant Mental Health* (pp. 332-346). New York, NY: Guilford.

APPENDIX A

Letter of permission from Alexandra Health Centre CEO



UNIVERSITY
OF THE
WITWATERSRAND,
JOHANNESBURG

School of Human and Community Development
Private Bag 3, Wits 2050, Johannesburg, South Africa
Tel: (011) 717-4500 Fax: (011) 717-4559
Email: 018lucy@muse.wits.ac.za

Dear Mr. Labane Maluleke

My name is Katie Bromley. I am studying a Masters degree in Clinical Psychology at the University of the Witwatersrand. I would like your permission to conduct research as part of my degree at the Alexandra Health Centre and University Clinic. I am interested in interviewing ten caregivers who access the Baby Mat on Thursdays at the Well Baby Clinic. The interviews will be carried out in the Ububele Umdlezane Parent Infant Project (UUPIP) room. Katherine Frost has given permission for this which is conditional on your permission being granted. The interviews will last between 30 minutes and 1 hour and will be conducted by myself and a translator. The interviews will be audio recorded, however only the translator and I will have access to them. The interviews and transcripts will be kept in a secure file on a computer which only I will have access to. The transcripts and the final report will not contain any identifying information of the caregivers involved in the study and as such their rights to confidentiality and anonymity are respected. After the report is finished the caregivers' interview recordings and transcripts will be kept in password-protected file on a computer for 6 years before it is destroyed. Please see the attached participation sheet and the two consent forms for more information.

The interviews will be focused on trying to gain insight into the caregivers' experiences and perceptions of being on the Baby Mat and how it is received by them. It is hoped that this insight will allow me to assess to some extent the effectiveness of this project in your clinic.

On completion of the study you will be informed of the findings through a letter and the research report can be made available to you if so required. My contact details and those of my supervisor are attached to this form in the event that you may have any further questions or concerns.

Kind regards

Ms. Katie Bromley
(Clinical Psychology Student)
082 344 3498
Email: katierachael@gmail.com

Ms. Katherine Bain
(Research Supervisor)
011 717 4558
Email: Katherine.Bain@wits.ac.za

I LARANE TOALLERG have read the attached information letter and give my permission for Katie Bromley to conduct her research at the Alexander Health Centre between the period of the beginning of June to the end of August 2010.

Signed on this day the 07/July/2010 May 2010



Signature

APPENDIX B

Ethics clearance from the University of the Witwatersrand medical ethics committee

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG
Division of the Deputy Registrar (Research)

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)
R14/49 Miss Katie R Bromley

CLEARANCE CERTIFICATE	**M10437**
PROJECT	Ububele Baby Mat Project: Caregivers' Experiences and Perceptions
INVESTIGATORS	Miss Katie R Bromley.
DEPARTMENT	Department of Psychology
DATE CONSIDERED	30/04/2010
DECISION OF THE COMMITTEE*	Approved unconditionally

Unless otherwise specified this ethical clearance is valid for 5 years and may be renewed upon application.

DATE 03/05/2010 **CHAIRPERSON** .....
(Professor PE Cleaton-Jones)

*Guidelines for written 'informed consent' attached where applicable
cc: Supervisor : K Bain

DECLARATION OF INVESTIGATOR(S)

To be completed in duplicate and **ONE COPY** returned to the Secretary at Room 10004, 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 to be contemplated from the research procedure as approved I/we undertake to resubmit the protocol to the Committee. **I agree to a completion of a yearly progress report.**

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES...

APPENDIX C

Interview Schedule

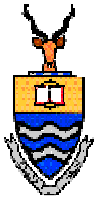
(Preamble: I would like to discuss with you your experience of having been on the Baby mat as well as you thoughts and feelings around the therapists on the mat and about your baby. If you do not understand any of the questions you may ask for them to be explained differently and if there are any questions you do not want to answer, that is also OK, we will carry on to talk about something else. You can take your time in answering the questions and please try to answer in as much detail as possible because I would like to learn from you so that we can make the Baby mat as good as possible).

1. What was it like for you to go on the Baby mat?
2. What question did you take with you onto the mat?
3. What were you thinking about your baby's problem?
4. What information did you receive?
5. Have you spoken to anyone about your baby's problem before?
6. What did they say?
7. What did you think about what they said?
8. Was what Katharine and Brenda offered the same/ different? If so how – for both.
9. What do you think about what they said?
10. What do you think about Katharine?
11. What do you think about Brenda?
12. Was there anything that you heard Brenda say that made you feel as though you wanted to go and talk to Katharine and Brenda?
13. What do you think the relationship is between Katharine, Brenda and the nursing staff in the clinic?
14. How are you thinking now about your baby's problem?
15. What does it feel like for you if you feel like you can't help your baby?

16. What is it like to feel scared or helpless or incompetent?
17. Has it made you think about your baby differently? To think about what the baby is thinking or feeling?
18. Can you describe your baby to me? What is he/ she like?
19. What has it been like for you being a mommy? What things make it easy, what makes it hard?
20. How has your life changed since you have had baby?
21. What is it like for you if you can't really do anything else now? What does it feel like?
22. What kind of support structure so you have at home?
23. What kind of relationship do you have with the baby's daddy?
24. How are you able to cope financially?
25. Can you tell me a little about how your culture impacts you as a mommy?
26. Do you think the mat is good or bad for the moms?
27. What did you like about the mat or about being on the mat?
28. What would be the best thing to change about the mat?
29. How did you feel about where the mat is in the clinic?
30. What was it like sitting on the floor?
31. How are you feeling now?

APPENDIX D

Participant Information Sheet



UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

School of Human and Community Development
Private Bag 3, Wits 2050, Johannesburg, South Africa
Tel: (011) 717-4500 Fax: (011) 717-4559
Email: 018lucy@muse.wits.ac.za

Hello.

My name is Katie Bromley. I am studying a Masters degree in Clinical Psychology at the University of the Witwatersrand. I would like your permission to conduct research as part of my degree and am inviting you to take part in this study. I am doing research on the Ububele Baby Mat Project. Research is something that is done to find out more about a question. In this study I want to find out what your experience is of being on the Baby mat and your thoughts about your baby. I am also interested in your opinions of the Baby mat and the therapists. This research is being done so that the effectiveness and appropriateness of the Baby mat in the clinic can begin to be explored.

I am inviting you to take part in this research study. There will be 12 caregivers who will be asked to take part; they will all have been on the Baby mat like you and may be of different nationalities. If you decide to take part you will be interviewed in a separate room in the clinic by the researcher. I understand that you want to get your baby seen by the nurses and do not want to lose you place in the queue and therefore I can, or you can, ask another caregiver in the queue to come and call you from the interview if your baby's name is called out. If this happens you may stop the interview but it would be important for you to return afterwards to finish it. The interview will take between 30 minutes and 1 hour and will be done by me with the help of the translator. You may choose not to answer any questions that you do not want to, there are no right or wrong answers and you may stop the interview at any time with no negative consequences. Participation is voluntary and you will not get any benefits or money for participating in the study.

Efforts will be made to keep your personal information confidential, however, absolute confidentiality cannot be guaranteed. Personal information will not be included in any part of the research, except possibly on the interview tape; however, personal information may be

disclosed if required by law. It is necessary for me to record the interview in order for me to remember as much detail as possible. Your interview will not be heard by anyone else other than the translator and me. I will write up your interview (transcript), all your identifying information will be removed, and use it with all the other interviews to help me write my report. The digital interviews and transcripts will be kept in a password-protected file on a computer which only I will have access to. The printed out transcripts will only be seen by my research supervisor and me and will be kept safely in a locked cupboard. My supervisor will not know any of your personal information and will only be reading the interviews to help me write my report. It is possible that direct quotes from your interview will be used in the report, however, no identifying information will be included and they will be used with quotes from other interviews. After the report is finished your interview recording and transcript (both digital and printed out) will be kept in their secure places for 2 years, if the research is published in a journal, or for 6 years, if it is not published, before it is destroyed. General feedback will be given in the form of a letter to the CEO of Alexandra Clinic, and the finished report will be seen by the therapists who run the Baby mat, the people who mark my report and a copy will be kept in the library at the University if the Witwatersrand. Feedback can also be given to you in the form of a letter and if you would like more feedback I will give it to you with pleasure. My contact details and those of my supervisors are attached to this form.

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

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

Kind regards

Ms. Katie Bromley
(Clinical Psychology Student)
082 344 3498
Email: katierachael@gmail.com

Ms. Katherine Bain
(Research Supervisor)
011 717 4558
Email: Katherine.Bain@wits.ac.za

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

Counselling services

We do not expect that the interview will harm you in any way but if you feel that you are having difficulties after having participated you may access one of the following free therapy services.

Ububele Umdelzane Parent Infant Psychotherapy service	011 786 5085
Emthomjeni Community Psychology Clinic	011 717 4513
Lifeline	0861 322 322

APPENDIX E

Returning Form and Remuneration Agreement

I _____ agree to participate in Katie Bromley's study on the Baby Mat Project and will return on (date and day) _____, at (time) _____ to the Alexandra Well Baby Clinic to be interviewed. I have spoken with Katie and we have agreed that R20 will be given to me on the day that I return and at the end of my interview to cover my transport costs. I am happy with this decision.

Signed _____

Date _____

APPENDIX F

Consent Form (Interview)

I _____ consent to being interviewed by Katie Bromley and (translator) for Katie's study on the Baby Mat Project. I understand that:

- Participation in this interview is voluntary.
- I have the choice to not answer any questions I do not want to answer.
- I may stop the interview at any time.
- Direct quotes will be used in the report, however, no personal information that may identify me will be included in the research report, and my responses will remain confidential.
- After the report is finished a copy will be kept in the library at the University of the Witwatersrand and will be available to people who have access to the library.
- If a journal article is published the interview recording (or notes taken) as well the transcript will be kept in password-protected files as well as in a locked cupboard for 2 years. If no publication arises they will be kept in these places for 6 years
- There are no direct benefits for me in participating in this study.
- There are no anticipated risks for me participating in this study.

Signed _____

Date _____

APPENDIX G

Consent Form (Audio Recording)

I _____ consent to my interview with Katie Bromley and (translator) for Katie's study on the Baby Mat Project to be tape-recorded. I understand that:

- The tape and transcript (these are written documents which contain what has been said in the interview) will not be heard or seen by any person at the Alexandra Health Clinic or the Baby Mat Project at any time.
- The tape will be heard by the researcher and the translator only.
- When the tape is used to write up the transcript, only the researcher will listen to it. Everything will be kept in a secure place, which only she will be able to access, while the study is ongoing.
- No personal information, such as names (yours, your infant's, your family etc.) or places (where you live, where you are from etc.), will be used in the transcripts.
- Only the researcher and her supervisor will have access to my transcript, however, the supervisor will not know any of my identifying information.
- After the report is finished my interview recording and transcript will be kept in a safe place, that only the researcher will have access to for 6 years.

Signed _____

Date _____