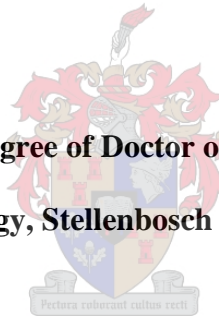


**INSIDE THE BLACK BOX OF A SUCCESSFUL PARENT-INFANT
INTERVENTION IN A SOUTH AFRICAN INFORMAL SETTLEMENT:
MOTHERS' AND COUNSELLORS' ACCOUNTS OF THE PROCESS.**

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**Dissertation presented for the degree of Doctor of Philosophy in the Department of
Psychology, Stellenbosch University**



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DECLARATION

By submitting this dissertation electronically, I declare that the entirety of the work contained therein is my own, original work, that I am the owner of the copyright thereof and that I have not previously in its entirety or in part submitted it for obtaining any qualification.

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ABSTRACT

Extensive research over the past 30 years has shown that reliable, sensitive, responsive and empathic care of the infant by the mother or mother-substitute in the early months facilitates the development of secure attachments in infants, and ultimately their healthy development towards competent adulthood and future relationships with others. This study analyses interviews with 17 mothers selected from an intervention proven successful by means of a randomized controlled trial. The intervention took place in Khayelitsha, a peri-urban settlement close to Cape Town, South Africa, and was delivered by previously untrained lay counsellors to at risk mothers and infants. Supervision and training of the counsellors was provided by the author. Mothers were purposively selected on the basis of being experienced by counsellors as easy, difficult to reach, young/immature mothers and HIV-positive mothers, and were interviewed by a clinically trained interviewer not involved in the project individually and in groups. Counsellors' process notes, exploring the impact, relevance and meaning that the intervention had for the recipient mothers, as well as the supervisor's notes were also used as data. The findings identify what changes mothers reported, their experiences of the intervention, cultural issues in the intervention, and mothers' suggestions for modifications to the programme. The results are discussed in light of theories of change emerging from the literature on psychotherapy change research and research on community-based interventions. The study shows that though results of randomized controlled trials are necessary for policy planning, in-depth interrogation of the design and process issues at stake in complex community-based studies yield complementary data which are also important to consider. Finally, the study considers the implications of this understanding of process for the future dissemination of the training and application of this programme, as well as policy, research and funding challenges.

OPSOMMING

Wydstrekkende, uitgebreide navorsing van die afgelope 30 jaar toon dat betroubare, sensitiewe, aandagtige en empatiese sorg vir die peuter deur die moeder of moeder-plaasvervanger, die vorming van veilige bindings, sowel as die uiteindelijke gesonde ontwikkeling van bevoegde volwassenheid en toekomstige verhoudings met andere fasiliteer. Hierdie studie analiseer onderhoude met 17 moeders, gekies uit 'n intervensie wat bewys is deur middel van 'n ewekansige kontrole toetsing. Die intervensie het plaasgevind in Khayelitsha, 'n peri-stedelike nedersetting naby Kaapstad, Suid-Afrika, en is uitgevoer deur voorheen onopgeleide vrywilliger beraders wat moeders en peuters wat blootgestel is aan risiko bedien. Supervisie en opleiding van die beraders is deur die outeur voorsien. Moeders is vooraf uitgekies deur die beraders, volgens die criteria: maklik en moeilik bereikbaar, jong/onvolwasse moeders, en HIV positiewe status. 'n Klinies opgeleide onderhoudvoerder wat onbetrokke is by die res van die projek het met die moeders individueel en in groepskonteks onderhoude gevoer. Beraders se prosesnotas wat die impak, relevansie en betekenis van wat die intervensie vir die moeders ingehou het, sowel as die supervisor se notas is ook gebruik as data. Die bevindings is bespreek in die lig van veranderingsteorieë wat uit die literatuur oor psigoterapie veranderingsnavorsing, sowel as navorsing oor gemeenskapsgebaseerde intervensies vorendag gekom het. Die studie toon dat hoewel bevindings van ewekansige kontrole toetsing nodig is vir beleidsbeplanning, in-diepte ondersoek van die proses en ontwerp kwessies ter sake in komplekse gemeenskapsgebaseerde studies komplimentêre data lewer wat ook belangrik is om in ag te neem. Ten laaste oorweeg die studie die implikasies van hierdie ondersoek van proses vir toekomstige disseminasie van die opleiding en toepassing van hierdie program, sowel as beleid, navorsing en befondsings uitdagings.

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CONTENTS

	Page
DECLARATION	ii
ABSTRACT	iii
OPSOMMING	iv
ACKNOWLEDGEMENTS	v
LIST OF TABLES	xiii
LIST OF FIGURES	xiv
FOREWORD	xv

CHAPTER 1. INTRODUCTION

1.1. Basic needs of infants for attachment security and healthy development	1
1.2. Interventions that target the quality of early parent-child relationships	2
1.3. Addressing the mental health needs of mothers and infants in South Africa	4
1.4. The aim of this thesis	5
1.5. The structure of the thesis	5

CHAPTER 2. EARLY INFANT DEVELOPMENT AND RISK FACTORS IN THE RELATIONAL CONTEXT

2.1. The process of infant growth and development	7
2.1.1. The capacity and agency in the newborn	7
2.1.2. The neurological infant	8
2.1.2.1. Brain development	8
2.1.2.2. The gene-environment interaction	9
2.1.3. The infant in relational context	11
2.1.3.1. The infant in the psychoanalytic literature	11
2.1.3.2. Intersubjectivity and the establishment of attachment, affect-regulation, self-regulation, empathy and mentalization	13
2.1.3.2.1. Attachment Theory	14
2.1.3.2.2. Affect regulation in the context of intersubjectivity	15
2.1.3.2.3. Implicit relational knowledge or procedural knowledge	17
2.1.3.2.4. Dyadic expansion of consciousness hypothesis	17
2.1.3.2.5. The social biofeedback theory of parental affect-mirroring	19
2.1.3.2.6. The development of mentalization	20
2.1.3.2.7. The development of empathy	22

2.1.4. Influential factors in the maternal and broader environment	24
2.1.4.1. The psychological adjustments to motherhood	24
2.1.4.2. Failures of attunement in the early environment	27
2.1.4.2.1. Maternal factors	27
2.1.4.2.2. Infant responses to maternal failures	30
2.1.4.2.3. Infant factors	32

CHAPTER 3. KHAYELITSHA: THE CONTEXT WITHIN WHICH THE STUDY WAS LOCATED

3.1. The cultural context	34
3.2. The community of Khayelitsha	35
3.3. Environmental risk factors	38
3.3.1. Violence	38
3.3.1.1. Violence against children	40
3.3.2. HIV and AIDS	42
3.3.3. Parenting and poverty	43

CHAPTER 4. MECHANISMS OF THERAPEUTIC CHANGE AND AN OVERVIEW OF EARLY PREVENTIVE INTERVENTIONS

4.1. Mechanisms of therapeutic change	46
4.1.1. Core therapeutic elements and techniques	47
4.1.1.1. Interpretation, insight and other explicit knowledge	47
4.1.1.2. Affects as a key element of change	49
4.1.1.3. The therapeutic alliance	50
4.1.1.3.1. Accurate empathic understanding and listening	51
4.1.1.3.2. Congruence, or genuineness	51
4.1.1.3.3. Unconditional positive regard: acceptance, support, reassurance and encouragement	51
4.1.1.4. Client involvement	52
4.1.1.5. The therapeutic frame	53
4.1.2. Recent models of intersubjective mechanisms of therapeutic change	54
4.1.2.1. The Change Process Study Group's Procedural Theory of Therapeutic Action	54
4.1.2.2. Interpersonal interpretive mechanisms (IIM) - The contribution of Fonagy et al, (2004)	58
4.1.2.3. The concept of "marked" or mature empathy	60

4.1.3. Therapy in infancy	62
4.1.3.1. Parent-Focused Therapy in infancy	62
4.1.3.2. Being with the baby and the parent.	65
4.1.3.2.1. Infant Mental Health Group at the Royal Children’s Hospital in Melbourne	65
4.1.3.2.2. Being with the parent with her baby – An infant–led therapeutic approach): “Watch, wait and wonder”	67
4.2. Evaluation of early preventive interventions	68
4.2.1. Introduction	68
4.2.1.1. Characteristics of programmes	69
4.2.1.2. Differences in programmes	69
4.2.1.3. Description of two seminal programmes	70
4.2.1.3.1. The nurse family partnership (NFP)	70
4.2.1.3.2. Healthy families America (HFA)	73
4.2.2. Overview of intervention evaluations in “high income countries” (HICS)	74
4.2.2.1. Evaluation of the nurse family partnership programme	75
4.2.2.2. Overview of significant overall benefits of other programmes in HICS	81
4.2.2.2.1. Benefits for parents	81
4.2.2.2.2. Benefits for children	82
4.2.2.2.3. Benefits for parenting and parent-child interaction	85
4.2.2.2.4. Long-term effects	87
4.2.3. Overview of Interventions in “low and middle-income countries” (LAMICS)	87
4.2.4. Some of the key characteristics of programmes and their roles	89
4.2.4.1. Characteristics of families that benefited	89
4.2.4.2. Characteristics of the most effective programme	90
4.2.4.2.1. Home or centre-based programmes	90
4.2.4.2.2. Content and focus of visits	90
4.2.4.2.3. Structure of visits	91
4.2.4.3. The home visitors	91
4.2.4.3.1. Professional versus non-professional home visitor	91
4.2.4.3.2. The parent-provider relationship	93
4.2.4.3.3. The role of the home visitor	95
4.2.4.3.4. Experiences of home visitors	95
4.2.4.3.5. Selection of home visitors	96
4.2.4.3.6. Training	97
4.2.4.3.7. Supervision	99

4.2.5. Research gaps and challenges in the field	101
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CHAPTER 5. METHODOLOGY IN THE CONTEXT OF THE BROADER RESEARCH STUDY

5.1. Description of the Khayelitsha parent-infant project	104
5.1.1. The Khayelitsha Thula Sana: Epidemiological study	106
5.1.2. The Khayelitsha Thula Sana Intervention: Pilot study	106
5.1.3. Thula Sana (Khayelitsha): A randomised treatment control trial	107
5.2. The structure and nature of the Thula Sana (Khayelitsha) intervention	108
5.2.1. The intervention structure	108
5.2.2. The nature of the intervention	108
5.2.2.1. The client-centred counselling approach	108
5.2.2.2. The “educative” or “informative” component	109
5.2.3. The role of the parent-infant counsellors	113
5.2.4. Selection of community counsellors	113
5.2.5. Training of community counsellors	115
5.2.5.1 Training goals	115
5.2.5.2 Training format	116
5.2.6. Adaptation of the intervention programme for the Khayelitsha context	118
5.2.6.1. Extension of the intervention from 2 months to 6 months	118
5.2.6.2. Appointment schedules	118
5.2.6.3. Incorporating the childminder	119
5.2.6.4. Privacy	119
5.2.6.5. Involvement of other family members	119
5.2.6.6. Additional NBA Items	120
5.2.6.7. The role of grandmothers	120
5.2.6.8. Language	120
5.2.6.9. Culture	120
5.2.6.10. Accommodating the HIV/AIDS pandemic	121
5.2.6.11. The therapeutic frame	121
5.2.7. Supervision	121
5.2.8. Ethical considerations for the intervention	123
5.3. Methodology	124
5.3.1. Introduction	124
5.3.2. Selection of “key participants” or respondents	127

5.3.3. The individual interviewer and group facilitator	129
5.3.3.1. Neutrality	129
5.3.3.2. Power, gender and finding the voices of disadvantaged women	129
5.3.3.3. Race, language and culture	130
5.3.3.4. The professional interviewer and inequalities of power	130
5.3.4. Interviews	131
5.3.4.1. Group interviews	132
5.3.4.2. Individual interviews	133
5.3.5. Process notes from visits and supervision sessions	133
5.3.6. Data collection and management	133
5.3.7. The analysis	134
5.3.8. Ethical considerations	139

CHAPTER 6. RESULTS

6.1. The mothers' recall of the structure of the visits	137
6.2. What changed from the mothers' perspective?	139
6.2.1. Mothers' knowledge and behaviours	139
6.2.1.1. Changes in knowledge, perceptions, attitudes, management and interactions with their infants	139
6.2.1.2. Intrusive and insensitive behaviours were also observed by the counsellors	145
6.2.2. Changes in aspects of mothers' self-concept	147
6.2.2.1. Changes in maternal moods and emotions	147
6.2.2.2. Confidence, self-esteem, agency and empowerment	148
6.2.2.3. The mothers' sense of worth and capacity to inform and nurture others	149
6.2.3. Changes in other aspects of the mothers' lives	150
6.2.3.1. Relationships with partners	150
6.2.3.2. Relationships with other children including siblings	152
6.2.3.3. Relationships with their own mothers	153
6.3. How had the Intervention been experienced and valued?	154
6.3.1. Authenticity and understanding of the counsellors	154
6.3.2. The creation of a therapeutic frame	154
6.3.2.1. The structural frame	154
6.3.2.2. The development of trust	156
6.3.3. The therapeutic alliance	160
6.3.3.1. The mothers' appreciation of the visit by the counsellors	160

6.3.3.2. The quality of the therapeutic relationship	161
6.3.3.2.1. Counsellors as surrogate mothers and grandmothers	161
6.3.3.2.2. Counsellors valued over family or friends	163
6.3.3.2.3. Counsellors were idealized	165
6.3.3.2.4. Care, concern and interest for the mother-infant unit	165
6.3.4. Interventions valued	166
6.3.4.1. Empathic listening	166
6.3.4.2. When listening, thinking and reflecting was difficult	168
6.3.4.2.1. Maternal feelings of ambivalence towards the infant	169
6.3.4.2.2. Partnership conflict and abuse	170
6.3.4.2.3. Poverty and the pressures of idealization by the community	172
6.3.4.2.4. Mothers who struggled to change	172
6.3.4.2.5. Death and dying, loss and separation issues	173
6.3.4.2.6. Completion of the programme	173
6.3.5. The counsellor as benign authority and witness	175
6.3.5.1. Witnessing the positive and mirroring	175
6.3.5.2. Witnessing the negative	176
6.3.5.2.1. Partners as offenders	176
6.3.5.2.2. Mothers as offenders	178
6.3.5.2.3. Intervening with others	179
6.3.6. The relevance of information, advice and skills development and modelling	180
6.3.6.1. The value of knowledge through information and observation of infants interacting with counsellors	180
6.3.6.2. The mothers' responses to practical and directive advice	183
6.3.6.3. Learning through modelling	184
6.3.7. The value of support, encouragement, normalizing and reassurance	185
6.3.8. The value of material assistance and referrals	186
6.3.8.1. Material assistance	186
6.3.8.2. Referrals	187
6.3.8.3. Advocacy	188
6.4. Straddling the cultural divide	189
6.4.1. The mothers' experience of exposure to new and foreign ideas	189
6.4.2. The negotiation of differences between the traditional and western 'knowledge	191
6.5. What improvements were suggested?	193
6.5.1. When should the visits begin?	193
6.5.2. When should the visits end?	194

6.5.3. What other changes were suggested by the mothers?	196
6.6. Summary	197

CHAPTER 7. DISCUSSION

7.1. Limitations of the study	199
7.2. Summary of results from interviews and process notes	200
7.2.1. What changed?	200
7.2.2. What elements were valued and identified as having facilitated the process?	201
7.2.3. How had new ideas been introduced?	202
7.2.4. How could the intervention be improved?	202
7.3. Links identified by the mothers between the intervention elements and changes they experienced	202
7.4. Significant elements that connect to theory	203
7.5. Less obvious insights gained	205
7.5.1. The challenges to reflective listening	206
7.5.2. The role of information and advice	208
7.5.3. The role of witness and setting of limits	209
7.5.4. Researcher reflectivity	210
7.5.5. Ethical dilemmas	211
7.6. Implications	212
7.6.1. For practice	212
7.6.1.1. Providing advice	212
7.6.1.2. Providing alternative motherhood constellation structures in the context of massive social transition	212
7.6.1.3. The earlier the better	212
7.6.1.4. Application and adjustments to the programme	213
7.6.1.5. The employment of untrained lay counsellors	213
7.6.2. Research	216
7.6.3. Policy and funding challenges	218

CHAPTER 8. CONCLUSIONS	220
-------------------------------	------------

REFERENCES	224
-------------------	------------

APPENDIX I: Description of the cohort of 17 mothers interviewed.	250
APPENDIX II: The Khayelitsha Parent-Infant Intervention Manual.	260
APPENDIX III: Interview guide for interviewing mothers.	296
APPENDIX IV: Cooper, P.J., Tomlinson, M., Swartz, L., Landman, M., Molteno, C., Stein, A. et al. (2009) Improving quality of mother-infant relationship and infant attachment in socioeconomically deprived community in South Africa: randomised controlled trial.	297
APPENDIX V: Developments in the parent-infant work consequent to the Khayelitsha research.	

LIST OF TABLES

Table 1 For Nurse-Visited Mothers	75
Table 2 For Nurse-Visited Children	78
Table 3 For Para-Professional Visited Mothers in the Denver Programme	80

LIST OF ILLUSTRATIONS

Fig. 1a. The sprawling township of Khayelitsha.	35
Fig. 1b. Khayelitsha viewed from Cape Town.	35
Fig. 2. Wood and corrugated iron shacks.	36
Fig. 3. No electricity or water borne sanitation.	36
Fig. 4. More formally organised shacks.	37
Fig. 5. A development of core brick houses.	37
Fig. 6. The community counsellors in front of the cabin with the research unit in the background.	105
Fig. 7. A supervision session.	105
Fig. 8. Illustrating an item from the newborn interactive assessment.	110
Fig. 9. Illustrating an item from the newborn interactive assessment.	111
Fig. 10. Illustrating an item from the newborn interactive assessment.	111
Fig. 11. Illustrating an item from the newborn interactive assessment.	111
Fig. 12. Illustrating an item from the newborn interactive assessment.	112

Foreword

This thesis represents the culmination of the work with parents with which I have been involved at the Parent Centre over the past 26 years.

The Parent Centre, an independent non-government organization, was established as a preventive project of the Cape Town Child Welfare Society in 1983 to prevent maltreatment of children by enhancing the knowledge, insight and confidence of parents, as well as promoting their well-being. It aimed to serve all parents in all communities through all the stages of parenthood from infancy to young adulthood, with a strong focus on parents who are more vulnerable or struggling in difficult circumstances. The organization is staffed by a professional team of social workers, psychologists, community counsellors and administrative staff. Services offered include: education and skills training workshops, support groups for parents, other caregivers and professionals working with children, public talks and workshops, individual counselling, primary preventive home-visiting programmes, teen parenting programmes at high schools for teens caring for their own children or siblings, and a well stocked library on all aspects of parenting for caregivers.

During my clinical training I joined one of several steering groups, comprising mental health professionals from various fields, that were being set up to explore the viability of an organization which would provide a preventive service through support, information skills and counselling for parents. My own training experience had made me aware of how often parents felt blamed, guilty, ignorant, unskilled, and confused when things went wrong with their children as they interfaced with “helping” institutions. I realized how often they simply did not know what it meant when advised to “listen more”, “set limits”, “encourage”, “spend more quality time” or “problem solve” with their children. It felt essential that, if children were to benefit from the help they received, parents would need support in enhancing their parenting and interpersonal skills in the home. As I completed my clinical training, I applied for and was appointed one of three professionals whose job it was to get this service up and running. Parent Centre, then known as Family Focus, began with lectures in the community offering information on all stages of child development. The Systematic Training for Effective Parenting (STEP) programme was imported from the U.S. and used until we developed our own Positive Parenting Programme which was more appropriate to the South African parent. We set up support groups for single parents as well as mothers and toddlers. At an early stage we realized that there were a group of mothers who were not benefiting from such groups. When we explored this we found that these represented a group of depressed mothers who felt excluded from other ‘normal’ mothers. In response to their need, in 1985, we began running our postnatal support groups that some years later evolved into an associated organization called, Postnatal Depression South Africa (PNDSA).

Working with mothers of infants and toddlers in the early years brought three important insights to our attention: a) mothers of infants and pre-school children tend to be an isolated and particularly needy group, b) many of the parents in greatest need struggle to make voluntary use of services and need to be reached out to in their own communities and homes, and c) to impact significantly on children's development, intervention with parents would need to focus on prevention in the early years.

My focus thus shifted to looking at ways of providing support at home, particularly for new parents struggling in circumstances of poverty. In 1992 the Director of the Parent Centre brought back a programme from a conference in Chicago called Healthy Families America (HFA). Despite limited experience and financial resources and with the generous assistance of materials and advice from Healthy Families America, we set up a demonstration project in 1993, adapting the HFA model to a needy community in Cape Town. For the first time, rather than professional personnel who were unaffordable, we employed formerly untrained community counsellors who were carefully selected and then trained and supervised as home visitors.

This demonstration project was presented at the 1st South African Congress on Infant Mental Health in 1995 in Cape Town and, while its design had limitations, it raised social awareness about important issues and attracted the attention of other services as well as national and international researchers. Both Professor L. Murray, from the Winnicott Institute and Professor P. Cooper from Reading University were involved with research on postnatal depression and its deleterious effect on mother-infant interaction and communication, and the influence of these on infant development in Britain (Murray, 1995). They were keen to collaborate with a team of South African researchers working in the field of infant mental health with a view to adapting, replicating and evaluating the Reading Health Visitor Preventive Programme, through a randomized control trial (RCT), in Khayelitsha, Cape Town. The team of interested parties that came together included: Professor Leslie Swartz, clinical psychologist and director of the Child Guidance Clinic of the University of Cape Town, Professor Chris Moltano, a paediatrician from the Psychiatry Department of the University of Cape Town, and I, a clinical psychologist seconded to the UCT Child Guidance Clinic from the Parent Centre. Early in the process a clinical psychology masters student, now Professor Mark Tomlinson, was invited to join the team. The Khayelitsha Thula Sana project was established which represented a mutually beneficial international collaboration between researchers from both wealthy and low income countries. The adaptation of the intervention was also assisted by the input of the formerly untrained community counsellors selected from the Khayelitsha community.

While a great deal of parenting work involves working in a more cognitive behavioural frame, my own training and preferred frame of reference both in my private practice and when working with parents is broadly psychoanalytic. It is this understanding which makes the most sense to me and informs my thinking, understanding and approach to all the work I do. It has been particularly useful in managing the training and supervision of the counsellors as well as my own, often difficult and painful,

countertransference with the work and the community. It is with this background, experience and interest in support for parenting that I embarked on this study which, having established the effectiveness of our intervention, explores what changes the recipient mothers experienced, explores how various aspects of the this intervention were experienced and valued and perceived to be helpful in meeting the needs of the recipient mothers at this early stage of development in this community.

CHAPTER 1

INTRODUCTION

1.1. Basic needs of infants for attachment security and healthy development

The Maine Association of Infant Mental Health, in 1997, defined infant mental health as

the ability of infants to develop physically, cognitively, and socially in a manner which allows them to master the primary emotional tasks of early childhood without serious disruption caused by harmful events. Because infants grow in the contexts of nurturing environments, infant mental health involves the psychological balance of the infant-family system. (Fitzgerald & Barton, 2000:28).

The quality of parent-infant interaction in the early months forms the bedrock of emotional security, mental health and future relationships (Bion, 1991; Bowlby, 1969; Lyons-Ruth, 1998; Stern, 1995; Winnicott, 1960a). There is growing evidence that environmental factors and the process of learning have the potential to alter genetic expression (Barlow & Durant, 2005; Sapolsky, 2004). While change occurs throughout life we know that the plasticity of the brain, the development of which is dependent on the quality of parent-infant interaction, is at its peak in the first three years of life (Siegel, 1998). The longer negative experiences are allowed to influence brain development, the more established these pathways become and the more difficult they are to change (Thomson-Salo et al., 1999)

Though the exact mechanisms involved in infant development still remain unclear, much exciting work has been, and is being, done by such researchers as Lyons-Ruth (1998) and other members of the Change Study Group, including Fonagy, Gergely, Jurist and Target (2004) and Aragno (2008). We have learnt that the capacity and manner in which primary caregivers, usually mothers, respond to their infants' needs for emotional connectedness (Tronick, 1998), providing predictable and affectionate care (Bowlby, 1969) and responding to the behavioural cues and signals from their infants (Brazelton & Cramer, 1991), determines their infants' attachment security. The way caregivers manage their own and their infants' affective states (Tronick, 1998) and spontaneous interactions (Sander, 1998; Stern, 1998) determines their infants' eventual capacity to regulate their own emotions. More recently we've become aware that the capacity of caregivers to give meaning to their infants' actions and provide sensitive, attuned and "marked" empathic mirroring (Aragno; Fonagy et al., 2004) play an important role in the development of infants' eventual capacity to mentalize (think about the intentions of other) and to relate to others with empathy and compassion.

Even in ideal conditions the adjustment to parenthood is tough, relentless and demanding. The ordinary mother often begins a process of adjusting psychologically to her new role and maternal functions even before the pregnancy. The success of this adjustment and capacity to mother depend on many factors

which include her own experiences and knowledge of being parented and growing up (Brazelton & Cramer, 1991; Pines, 1993; Raphael-Leff, 1991; 1993; 1997; 2000; Winnicott, 1956). If in addition, her immediate environment provides her with the support she needs (Stern, 1995), she is helped to provide a “good enough”, intimate, interactive maternal environment required to facilitate, in the infant, attachment security and healthy emotional development in the early months, she is able to lay the foundation for healthy future relationships and competent adulthood.

The degree to which the mother is able to provide this facilitating environment varies tremendously. Many factors, emanating from the mother, the child and the interplay between them, have the potential to adversely affect the infant’s quality of care and nurturing experience. “Poverty is a powerful predictor of negative psychological outcomes for children ... as a consequence of the multiple stressors associated with poor living conditions” (Dawes et al., 1997, p.193). Consequently, it is also not possible to talk about the maternal facilitating environment without giving due consideration to the impact of the socio-economic environment, particularly in low income communities.

Two very broad categories of factors that, independently and in association, seriously threaten the quality of infant care and development are: i) conditions of socio-economic adversity and ii) antenatal and postnatal depression, and anxiety, which are now termed, “common mental disorders” (Murray, 1992; Murray, Fiori-Cowley, Hooper & Cooper, 1996; Patel et al., 2008; Rahman, 2007). It is essential to remain mindful of the fact that more than 90% of infants are born and live in low income or “developing” countries, while the vast majority of knowledge produced about infant development comes from wealthy countries (Tomlinson, 2003; Tomlinson, Swartz & Landman, 2003) who do not carry the same risk burden with respect to social and health problems. The over-representation of high risk factors found in conditions of low income and poverty include: maternal depression (Rahman, Iqbal, Bunn, Lovel, & Harrington, 2004), adolescent motherhood (East, Matthews & Felice, 1994; Levine, Garcia & Oh, 1985), low maternal education (Patel, Rahman, Jacobs & Hughes, 2004), unplanned and/or unwanted pregnancy (Cooper et al., 1999), poor attendance at antenatal clinics, low birth weight and preterm delivery (Patel, Rodrigues & DeSouza, 2002; Patel et al., 2004), undernutrition, malnourishment (Rahman, Lovel, Bunn, Iqbal & Harrington, 2004; Richter & Mpelo, 1995), poor growth and diarrhoea (Rahman, Iqbal et al., 2004), failure to thrive (Patel et al., 2004), marital disharmony (Patel et al., 2004), domestic violence and child maltreatment (Boris et al., 2006), financial stress and hostile discipline (Leinonen, Solantaus & Punamäki, 2002), and the effects of human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) (Petersen, Drotar, Olness, Guay & Kiziri-Mayengo, 2001; Sandelowski & Barosso, 2003).

1.2. Interventions that target the quality of early parent-child relationships

In response to the need to enhance attachment security and healthy, non-oppressive social relationships from infancy through childhood and into competent adulthood, we need to find ways of supporting parents, in their pivotal role. Specific perinatal interventions, targeting the quality of the early relationship between the mother, or other caregiver, and the infant, can have a significant impact, resulting in caregivers engaging with their infants in more responsive and sensitive ways, expressing more positive affect (Cooper et al., 2009)

The past 20 years have seen enormous financial and professional resources committed to the development and evaluation of such community-based resources and programmes, particularly in high income countries in the Western world. Not all evaluations report significantly successful results (Gomby, 2005) and not all community-based resources were perceived by recipients, particularly by low income parents, to be responsive, respectful, useful or empowering (Silverstein, Lamberto, DePeau & Grossman, 2008).

Several effective programmes have however reported various successful outcomes and benefits (Geeraert et al., 2004; Gomby; 2005; Harding, Galano, Martin, Huntington & Schellenbach, 2007; Klevens & Whitaker, 2007; Olds & Robinson et al., 2002; Olds et al., 2004; Zeanah, Stafford & Zeanah, 2005) including some from low and middle income countries (Cooper et al., 2009) and one that includes the selective use of drugs (Patel, Chrisholm et al., 2003).

Despite many differences in approach to this work, the importance of the parent-home-visitor relationship has consistently been acknowledged by all researchers and workers as an essential feature of what is essentially a therapeutic process. This relationship, which allows difficult issues to be addressed (Krysiak, LeCroy & Ashford, 2008) and facilitates parents who receive support, nurturing and understanding and in turn are more able to nurture and understand their own infants (Lieberman, 1998), is thought to contain the central mechanism affecting programme outcomes. While the therapeutic alliance has been found to predict therapeutic change and symptom improvement (Kazdin, 2007), none of the methods used so far to examine possible mechanisms has fully explored the parent-counsellor relationship (Riley, Brady, Goldberg, Jacobs & Easterbrooks, 2008)

While researchers located in high income countries have emphasized the superiority of professional compared to paraprofessional home visitors (Bower, Gilbody, Richards, Fletcher & Sutton, 2006), and questioned the use of therapeutic techniques delivered by previously untrained lay community counsellors in sub-Saharan Africa (Bolton et al., 2003; Rahman, 2007), interventions demonstrating the effectiveness of previously untrained lay community counsellors in changing maternal mood and behaviour towards their infants have recently been published (Cooper et al., 2009; Omer et al., 2009; Rahman, Malik, Sikander, Roberts & Creed, 2008).

I have trained and supervised counsellors on our intervention based in Khayelitsha, Cape Town, and this thesis explores aspects of this work. Targeting the quality of the early relationship between the mother and

her infant and delivered in an economically deprived community in Cape Town, the study demonstrated that the use of counselling and psycho-educational principles by community counsellors with only a basic education, could have a significant and positive effect, resulting in mothers engaging more sensitively with their infants, an increase in affect security in infants and some reduction in maternal depressed mood and the expression in more positive affect (Cooper et al., 2009).

1.3. Addressing the mental health needs of mothers and infants in South Africa.

No intervention can be undertaken without carefully considering the socio-cultural factors involved. In South Africa, a country in which millions of children live in poverty environments (Dawes et al., 1997), the picture is complicated by the recent transition from an inhumane regime which traumatized families and fractured family structures and relationships, to a democracy which has not been able to effect all the changes promised. De Swart (2004) refers to how, “the combined effects of social engineering, spacial planning and rural urban immigration have contributed to the urban sprawl, the expansion of racialized economic geographics, and the creation of an apartheid city” (p. 1), of which Khayelitsha is one. Large-scale migration from rural to urban areas has resulted in the loss of traditional cultural structures and beliefs that previously supported community life, and has not improved the rate of unemployment and widespread poverty that many families struggle with daily. Inadequate schooling, an out of control human immunodeficiency virus and acquired immunodeficiency syndrome (HIV/AIDS) pandemic (UNAIDS & WHO, 2008) and unacceptably high levels of crime and violence, particularly against women and children, leave many children orphaned, abandoned and in various ways neglected, maltreated and compromised (Dawes, Long, Alexander & Ward, 2006). These conditions often make it difficult for poor, pregnant and new mothers to feel sufficiently protected to allow themselves to become primarily preoccupied with providing the facilitating environment required for the healthy development of their babies. The results of an earlier study in Khayelitsha (Cooper et al., 1999) indicate that in this community, the rate of depression in the puerperium was 34%, more than double that reported in many international studies. Depression was also associated with more insensitive and intrusive care on the part of the mother, and less secure emotional attachment in the infants.

The need to empower new parents through support and information, particularly in circumstances of poverty seems clear, however, the concept of democratizing knowledge in the context of power inequalities, between communities and professionals, has been complicated in the past (Tomlinson & Swartz, 2002). More recently with communities having begun to own their own power and holding professionals more accountable, it seems more possible for professionals too to think less defensively about sharing the particular knowledge and skills they have, as long as their input is meaningful and useful for the community and is experienced as authentic, cooperative and consultative in nature.

1.4. The aim of this thesis

The intervention which I co-developed and supervised has been shown to be effective through a RCT (Cooper et al., 2009). What these outcome data cannot tell us however, is the story of the texture of the intervention, and especially how it was experienced and what meaning and relevance it had for the mothers themselves, the lay counsellors and the supervisor (myself). As far as I have been able to ascertain, this kind of qualitative information is not available for any similar project in low income settings or even, indeed, in wealthier settings.

I recognize that it is never possible to get completely inside the “black box” of this intervention (and my insider role, as I discuss later, brings both advantages and disadvantages to this attempt). I regard this thesis, though, as a first step to developing an understanding of key process and implementation issues.

To this end, through information accessed from the counsellors’ and supervisor’s process notes and the content of interviews with 17 recipient mothers, using a developmental and psychoanalytically-based clinical understanding of the work with infants and their mothers, this study aims to explore and identify various factors, particularly the quality of the therapeutic alliance, identified by the mothers and the counsellors, that were valued and may have played a role in the success of this intervention delivered by previously untrained lay counsellors. I wished furthermore to establish a basis from which:

- To make some suggestions as to theoretical mechanisms from the literature that might describe or explain what the mothers reported and the counsellors observed.
- To give some thought to identifying the sufficient and necessary supports required when lay counselors take on the role of therapists.

1.5. The structure of the thesis

- This first chapter has introduced the problem the thesis addresses.
- The second chapter provides a summary of theoretical issues and recent research into early infant development, the elements contributing to growth, change and the maternal and infant factors that represent risk to healthy infant development.
- The third chapter locates the community and outlines the problems in the cultural and socio-historical context and describes the predominant environmental risk factors that prevail.
- The fourth chapter explores the elements and mechanisms of therapeutic change that underpin therapeutic interventions and reviews evaluations of primary prevention home visiting interventions attempted globally.
- The fifth chapter locates this qualitative study in the context of the broader research undertaken by the team in Khayelitsha and describes the methodology used.

- The sixth chapter presents the results in order of themes that emerged.
- The seventh chapter provides a discussion around the themes which evolved, and the meaning they have in the context of the requirements at this stage of development in this community.
- The eighth chapter provides some conclusions that are drawn from the results and discussion.

CHAPTER 2

EARLY INFANT DEVELOPMENT AND RISK FACTORS IN THE RELATIONAL CONTEXT

In this chapter I will address some of the important elements, key processes, theories and concepts involved in early infant development. I believe that an understanding of the above is a prerequisite when planning early psychosocial preventive interventions which aim to support and enhance the parent-infant relationship and infant development and well-being. I further believe that such an understanding of the mechanisms involved in early infant development and growth is essential in informing the search for the elements involved in the process of therapeutic change. I will then consider some of the maternal and interpersonal risk factors that tend to threaten this process.

2.1. The process of infant growth and development

2.1.1. The capacity and agency in the newborn

For many years researchers in child development were forced to make many assumptions about infant capacity and development. Modern technology over the past forty years has made us aware that the perceptual, emotional, behavioural and social capacity of the newborn is greater than we ever imagined. Far from being an “inert” passenger in a pregnant mother, the foetus in utero is very involved in the pregnancy, as it guarantees the endocrine success of the pregnancy and induces all manner of changes in maternal physiology to make her a suitable host says (Lilley, 1972). It determines which way it will lie and move around, flexing and stretching in order to find comfort in a progressively restricted womb. Its physiology also determines the duration of the pregnancy, and is an active participant in the birth process - crawling, writhing and “swimming” through the birth canal. At 28 weeks of pregnancy, hearing develops and the mother’s voice is recognized and “remembered”.

Using ultrasonographic technology, Piontelli (1989) found that there were clear individual temperamental differences between twins in utero that remained consistent after the birth. Universally, infants are born with the capacity to express a set of basic emotions that include anger, fear, sadness, disgust, surprise and enjoyment (Pert, 1997). Within hours of birth they can mimic facial expressions and gestures and can begin to take part in reciprocal communications and behavioural “conversations” with their caregivers. (Aragno, 2008; Bowlby, 1969; Brazelton & Cramer, 1991; Meltzoff & Moore, 1977; Murray & Andrews, 2000) They are able to focus at a distance of 22 centimetres, (the natural distance between the infant’s and the mother’s eyes while feeding), they discriminate her visually within the first 3 days, and are able to recognize her smell by the second week (Brazelton & Cramer; Murray & Andrews). They are also equipped with innate perceptual, learning, behavioural and representational capacities that function to ensure opportunities and preparedness for emotional expression, communication and social engagement

with their caregivers from birth (Barnard, Morisset & Spieker, 1993; Brazelton & Cramer; Stern, 1995; Trevarthen, 1979).

2.1.2. The neurological infant

2.1.2.1. Brain development.

The new research in neurophysiology and brain function inextricably links the structure and functioning of the neural system with behavioural and emotional development. It has also gone a long way to support many of the psychodynamic concepts and theories of early development. It has been able to demonstrate a strong bio-neurological base to support attachment and self-regulation (Siegel, 2001) and empathy and affect mirroring (Gallese, 2008). It also indicates that the infant's brain structure is literally changed and shaped by early experiences mediated by the 'parental' environment (Shore, 1997). In other words, the early interpersonal relationships with caregivers are building blocks of brain development (Sander, 1998).

The infant is born with 100 billion brain cells many of which are unconnected. These get "turned on" or connected in response to interpersonal interactions within the relational environment. In this way new connections or neural pathways are formed and existing neural pathways are strengthened. With increasing and repeated interactions within the environment, neural pathways form neural networks. These networks ultimately shape the brain structure and the mind of the infant in which memory and perceptions, which predict later behaviour, are laid down (Sander, 1998; Siegel, 1998). It is therefore the infant's interactions with the primary caregiver that will directly affect gene function, neural connections and the organization of the mind (Siegel, 2001). These interactions will also affect the quality and rate at which brain cells develop and establish the fundamental patterns of behaviour and emotion. An influential UNICEF report (2001) refers to the way in which babies' interactions with their caregivers literally change their minds.

When distressed infants cry and are responded to in ways that bring comfort and leave them feeling contained and understood, particular neural pathways are laid down which contribute to those infants' perceptions of their own sense of agency, and to their expectations of the world they occupy. When there is an absence of response or the response is inappropriate or even abusive, neural pathways are also set down (Perry et al., 1995), but lead to more dysfunctional perceptions and expectations that have consequences for attachment security and the emotional development of those infants.

While neural pathways are able to change throughout life, we now know that the plasticity of the brain is at its peak in the first three years, during which most of the neural networks have been largely laid down (Siegel, 1998). Furthermore, different areas of the brain seem to have optimal periods of development, after which development in these areas is less effective. Fonagy et al. (2004) report on studies by Plotsky and Meaney (1993), in which rat pups were separated from their mothers within the first two weeks of life resulting in a permanent increase in the expression of genes controlling the secretion of CRF

(corticotrophin-releasing factor) which seemed to predispose them to life-long vulnerability to stress. In contrast, mothers who provided increased care in the form of licking and grooming during nursing “seemed to provide them with a life-long protection from stress” (p. 115).

2.1.2.2. The gene-environment interaction

In the last decade our understanding of development has been revolutionized by research into genetics. While for some, this has rekindled the outdated nature versus nurture debates, it is only in very few cases, such as in diseases like Huntington’s Disease, that genes are the sole cause of the disease, and even then environmental factors are able to speed up or delay the onset of the disease (Will, 2007). Mostly the expression of genetic endowment is the result of a complicated interactive relationship between genetic endowment and the varied and different environmental conditions within which genes express themselves (Sapolsky, 2004).

In the early 1980s, Eric Kandel and others suggested that the environment and the process of learning could change the genetic structure of cells and activate or turn on cells that were dormant. Such a mechanism is thought to change the number of receptors at the ends of neurons, which would change the biochemical functioning of the brain. Fonagy et al. (2004) report on evidence that demonstrates that at a molecular level, the environment is able to alter gene expression. Sapolsky (2004) describes how particular proteins produced by the genes are able to function quite differently in different environments. There has also been evidence supporting the view that the brain’s plasticity in response to environmental changes during development extends beyond maturity (Barlow & Durand, 2005). The view that genetic influences might be less powerful than initially believed was also supported by research using cross-fostering strategies with rat pups. This research demonstrated how rat pups genetically predisposed to fearfulness and intolerance to stress by their biological mothers, when exposed to calm and supportive maternal caregiving, by surrogate mothers, became less fearful and more tolerant to stress. Barlow and Durand conclude that maternal behaviour not only mediates but is able to reverse the genetic contribution to the expression of temperament.

Sapolsky (2004) raised the fact that we have ‘known’ for some time, that environmental influences begin prior to birth. He talks about the prenatal environment as one of the “subtlest” and “least appreciated” and reports on research in which, through in vitro fertilization, mice were cross-fostered as embryos, from a calm or “relaxed-strain” of females, into a reactive, “timid-strain” that carried the embryos to term. At birth the pups were divided between both sets of mothers who provided their early care. The results showed that when these “supposedly genetically hardwired relaxed-strain mice went through both foetal development and early puppyhood with timid-strain mothers, they grew up to be just as timid as other timid-strained mice. Same genes, different environment, different outcome” (p. 2). Clearly there are neurobiological factors in utero that affect the anxiety levels of the offspring.

Barlow and Durant (2005) also refer to studies that demonstrate the positive effects and reversibility of genetic vulnerability when “high-reactive” female monkeys, having been nurtured by sensitive foster mothers, tended to reflect the maternal style of these nurturing mothers rather than their own temperament.

To quote Barlow and Durant (2005):

A specific genetic disposition, no matter how strong, may never express itself in behaviour unless the individual is exposed to a certain kind of environment. ... it seems that environmental manipulations, particularly early in life, may do much to override the genetically influenced tendency to develop undesirable behavioural emotional reactions. Although current research suggests the influence of everything in our environment in its totality ... affects this genetic expression, the strongest evidence exists for the effects of early parenting influences and other early experiences. (p. 39)

One model described by these authors that attempts to explain the interaction between genes and the environment as it relates to psychopathology is the Diathesis-Stress Model. It describes how genetically inherited tendencies to express particular behaviours also thought of as the genotype, traits or vulnerabilities or “diatheses”, need to be activated by certain conditions of stress or life events to result in a disorder or disease. It also implies that genetic endowment is able to mediate environmental impingements. The important point to be made is that neither genes nor environmental life-experience, in themselves, are able fully to explain the onset and development of the phenotype which refers to the characteristics of an individual determined by the interaction of the genotype and the developmental environment. Genes need to be thought of as reflecting potential and vulnerability. The phenotype seems to be the result of: the effect of many genes working in combination and interacting in complex ways, indirectly providing instructions about how to function in an environment in which both internal and external stimuli influence brain development, hormone production, stress levels, learning and social interactions. All these influences play a crucial role in regulating which and when specific genetic vulnerability will be turned on in the process of development from genotype, to phenotype (Rutter, 2002; Sapolsky, 2000). The impact of early trauma seems to activate the gene which reduces the capacity for interpersonal adaptation, resulting in vulnerability to trauma. There is also some evidence that people who experienced early trauma are less sensitive to the mental states of others. Sensitivity to mental states may be implicated in mediating the selective effect of trauma (Fonagy et al., 2004)

In general it is clear that the infant’s genotype requires an interpersonal environment in order to evolve into a phenotype. Schore (1994) talks about the infant needing to be in contact with “a thinking mind” in order to develop optimally. This means that it is vital that neurobiologists and psychotherapists recognize the value of the other’s work and work together in coming to an understanding of the many factors involved in playing a role in development.

2.1.3. The infant in relational context

From the psycho-social perspective, despite profound life adversity, some children are resilient and do well. Two factors identified as primary for resilience are, i) competent parenting and, ii) a positive and nurturing relationship with at least one primary caregiver (Halpern, 1990). It is not possible, in fact, to think about infant mental health separately from a relational environment.

It has been very exciting to realize that much of what is being presently “discovered”, through empirical research in infant studies and the neurobiological sciences, in the broad field of intersubjectivity, was ‘known’ clinically and written about conceptually and theoretically by some of the great psychodynamic theorists of the past. Unfortunately, until now, there was little knowledge or attempt to identify or describe the specific mechanisms and socio-neurological links involved.

2.1.3.1. The infant in the psychoanalytic literature

From the time of Freud, maternal care has always been viewed as playing a central role in early emotional development. Winnicott was one of the first to focus our attention on the obvious, but not necessarily recognized fact 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” (Winnicott, 1960a, p. 39 *footnote*). He referred to the mother-and-baby unit as the “nursing couple” or dyad and believed that this “unit” is what facilitates maturation in the infant and precedes object relationships (Clancier & Kalmanovitch, 1987). Object relationships refers to relationships the infant forms with the people in their environment. Winnicott understood the maturational process of infants to be facilitated by their real relationships with ‘real’ maternal environments, in which they experience support and holding, particularly in their mothers’ minds (Widlöcher, 1970). Through this interaction infants are able to establish a basic sense of “being”, first psychosomatically and then physically, emotionally and socially in satisfactory relationships with others (Winnicott, 1962; 1988).

Winnicott (1956) introduced the concept ‘primary maternal preoccupation’ to describe an ‘organized’ state of heightened sensitivity towards the infant which although normal in pregnancy and early motherhood, could be compared with a psychotic episode at any other time. He writes:

It gradually develops and becomes a state of heightened sensitivity during, and especially towards the end of the pregnancy. It lasts for a few weeks after the birth of the child. It is not easily remembered by mothers once they have recovered from it. I would go further and say that the memory mothers have of this state tends to become repressed. (p. 302)

In this state the mother gradually becomes increasingly interested, concerned and narcissistically identified with her infant that is a part of her. This predisposes and enables the mother, after the birth, to be empathically attuned to her infant’s needs to the point of being able to just ‘know’ what her infant

needs. Steiner (1997) referred to this passionate affair between the mother and her baby as “the primal relationship”, a kind of “folie à deux”.

While this maternal attitude might be more easily acquired by the biological mother as pregnancy progressed, Winnicott (1988) acknowledged that this kind of attuned, consistent and continuous care from a primary parental figure was not limited to the biological mother, and that this was not necessarily a universal phenomenon. Many women are not able to give themselves over to such abandonment in the service of their infants. He also believed that where mothers might have ‘missed the boat’ at this earliest stage of development, they could gradually adapt and make up for what had been missed as the child matured (Hayman, 1997).

Winnicott (1988) referred to the good enough mother, meaning an ordinary devoted caregiver, not necessarily the infant’s own mother, who could adapt to the infant’s needs and then gradually as the infant’s ability to manage failure developed, could allow her infant to tolerate increased levels of frustration. At the earliest stage of adaptation, “The good enough mother meets the omnipotence of the infant and to some extent makes sense of it. She does this repeatedly.” (Winnicott, 1960b, p. 145). She needs to recognize make sense of and reflect back the infants spontaneous gestures and communications in an attuned, robust and non-retaliatory way that allows the infant to experience a sense of being and existing. Rejection of the infant’s gestures, forces the infant to comply to the mother’s needs and it is this compliance that leads eventually to a defensive strategy he called the false self organization which compromises the development of a sense of authenticity (Phillips, 1988).

The important role of affects was acknowledged from the time of Freud but it was the theorists concerned with infant development such as Melanie Klein, Donald Winnicott and Wilfred Bion who began to consider the role of affects and their regulation as essential to early emotional development. Winnicott (1947; 1971) spoke about how the mother, being the primary object both of the infant’s intense and passionate love as well as its destructive impulses, is required, despite possible feelings of fear, rejection, hurt and temptation to retaliate, to continue to hold in mind the infant’s emotions and provide the loving, protective, benign environment her infant needs for healthy mental development. If able to do this, her infant’s feelings of extreme anxiety and guilt about these destructive wishes and impulses will be allayed and the capacity for concern for her wellbeing will develop. Horwitz, (2005) describes an essential feature of healthy development as being:

... the ability to internalize a stable good internalized object... the more likely the individual is to overcome the early split between good and bad and thus integrate part-object representations into a more realistic whole. This development achievement permits a more stable and consistent internal object world. ... (It is) the major factor underlying not only the capacity to forgive but most of the other relational achievements (including)... The capacity for concern, the capacity for

reparation, successful negotiation of the rapprochement phase, the development of a secure attachment, the capacity to mentalise, and the ability to mourn the loss of others. (Horwitz, 2005, p. 501)

Bion introduced the concept of the “container contained”. He believed that, if the mother has the capacity to love her child and enter a relaxed state of mind or attention he called ‘reverie’, she is able to recognize attend to, hold, digest, metabolize, integrate, translate and transform her infant’s, good and bad raw, affective, “beta” experiences, as he calls them, into known manageable and tolerated, “alpha” experiences, closely linked to thinking and providing containment. This is known as the mother’s “alpha function”.

While there is debate in the literature about the difference between Winnicott’s concept of “holding”(physically, emotionally and in the mother’s mind) and Bion’s concept of the maternal function of containment, they both refer to a maternal mental function that involves the processing of infants’ emotions and needs and for the purpose of this thesis will be considered as similar concepts.

Mothers who can do this, enable their infants to manage or regulate their affective experiences and provide their infants with a growing sense of understanding, containment and continuity of self (Bion, 1957, 1991; O’Shaughnessy, 1981, Winnicott, 1960a; 1960b; 1964).

The consistent message from psychoanalytic theorists therefore, has been that infants need an environment, mediated by caring and emotionally mature mothers (or other caregivers), with the capacity to recognize, receive, bare, hold, contain, metabolize, process and survive the impact of the infants’ intense, raw and unprocessed emotions without over-identifying or being overwhelmed, and without contaminating their infants’ experiences with their own emotions. Such mature and benign adult minds are thus able to give meaning to the infants’ emotional experiences and begin to assist in regulating and managing their strong emotions and impulses.

2.1.3.2. Intersubjectivity and the establishment of attachment, affect-regulation, self-regulation, empathy and mentalization

Sameroff (1989) conceptualized individual human development as “the adaptive establishment of interpersonal boundaries. The construction of these boundaries, which are formed anew with every adult relationship, begins with the infant’s first relationship” (p. 17). Tronick (1998) made us aware that human infants strongly seek states of emotional connectedness. Intersubjectivity is one of various terms including emotional and social connectedness, attunement, emotional synchrony, reciprocity and attachment that have been used to describe a similar concept. Each of these terms evolved from different theories which assigned them specific theoretical meanings and definitions. All of these terms however, describe a concept that is useful for the purpose of application, and this thesis may use them somewhat interchangeably.

2.1.3.2.1. Attachment Theory

Bowlby (1969), who was trained in the psychoanalytic tradition, developed a theory of attachment which he understood to be a necessary mechanism for the survival of human and other higher order species. Once the young are securely attached to primary caregivers through relational bonds, separation from these caregivers is resisted, and in dangerous circumstances, proximity to these caregivers is sought, thus ensuring their protection and survival.

Bowlby (1969) spoke of secure relationships needing predictable, reliable, continuous and calm care in the form of, “a warm, intimate and continuous relationship with his mother (or permanent mother-substitute) in which both find satisfaction and enjoyment” (p. 12). Physical and mental health are most closely aligned in infancy, and secure attachments are primarily established by the manner in which infants are held and cared for. How infants are touched, held and spoken to, constitutes a “language” that conveys the early affective, experiential messages from primary caregivers that represent mirrors reflecting to infants how they are perceived in the world, and inform their self-concept. It is this affective quality of the infant’s relationship with the primary caregiver which Bowlby described as an affectional bond, that shapes their sense of self and security.

Brazelton and Cramer (1991) describe how infants are born with an innate capacity to interact powerfully and reciprocally with their environment and how, from the start, they participate actively in shaping their parents’ responses to them through a repertoire of behaviours and signals (smiling, nestling and moulding into the body of the other and quieting when consoled, and looking interested, alert and engaged when addressed in a sensitive way), that signal their needs and reward their caregivers. Bowlby (1958) described how, “It is fortunate for their survival that babies are so designed by nature that they beguile and enslave their mothers” (p. 369).

Parents and other caregivers are programmed to reach out to such characteristics of “babyishness” and cuddliness, and are hungry for responses from their infants that tell them that they are providing the comfort and nurturance that their infants needs.

Attachment theory holds that when infants feel emotionally or physiologically overwhelmed, the thoughtful, sensitive and comforting responses of caregivers, that are able to regulate their emotional and physiological state, bring about reassurance and comfort, and provide an experience of a containing relationship with a trustworthy “object” which lays the foundation for a secure attachment. Through the aggregation of affective experiences with caregivers, infants develop internal representations or what Bowlby (1969) called an “internal working model” of the self, others and the relationships between them which come to influence the expectations and affective responses in future relationships. In due course these models come to function as a relatively stable and unconscious prototype for all future relationships, organizing the person’s behaviour in all significant relationships, including, eventually their relationships

with their own children (Bowlby, 1973). Ainsworth (1985) referred to the baby having attained some capacity, in the absence of his principal attachment figure, to retain or create a state of organization in times of distress that involved the first representational model but did not involve cognition. The mechanisms for this, however, were not explained. Fonagy et al. (2004), report on a number of studies that show that security and the establishment of a secure attachment during the first two years predicts many of the attributes that have been shown to be characteristics of the resilient child.

For Fonagy et al. (2004), the role of attachment, rather than being an end in itself, provides the context for the development of social or emotional intelligence and interpersonal understanding, through a construct they call “mentalization” and the “reflective function”, which represents a capacity for interpreting the world or “meaning making” (described in a later section), and predict symbolic abilities in general and in particular, cognitive capacity, memory, comprehension and communication.

2.1.3.2.2. Affect regulation in the context of intersubjectivity

Fonagy et al. (2004) identify the primary developmental task of infants as acquiring the capacity to regulate, balance and maintain their physiological homeostatic and emotional experiences. Affect regulation refers to the capacity to manage and process affective states, and it is has increasingly been recognized as occupying a central role in psychological development, and is understood to be the prototype of self-regulation. It is closely associated with self as agent, self-reliance and self-esteem. Various models of the psychological mechanisms underlying the processes defined as affect regulation have been described.

Barnard et al. (1993) proposed that the earliest communicative behaviours are those of affect shared between mothers and infants in the first weeks of life, and that it is through this socio-emotional process that mothers and infants adapt to each other. Tronick (1998) described a dyadic homeostatic and emotional regulatory system that he called the Mutual Regulation Model (MRM). This is a mutual, collaborative, affect regulation process of communication between parent and child that creates “dyadic intersubjective states of shared consciousness” involving “the infant’s central nervous system (e.g., limbic sites) and the behaviors it organizes and controls (e.g., facial and vocal emotional displays) and the caregiver’s regulatory input (e.g., facial expressions, touches, gestures).” (Tronick, p. 293).

At the earliest stage, affect regulation is co-regulated through the active participation of caregivers and occurs largely outside of conscious awareness. It is equivalent to homeostasis and begins with the integration of body-related experiences that define the physical boundaries of self in the world communicated mostly nonverbally in the way the infant’s physical and biological needs are managed, how the infant is held literally and the parent’s recognition of the child’s intentional stance (Fonagy et al., 2004). In its basic form the object (mother/primary caregiver) is required to modulate the affect for the infant in order to maintain or regain homeostasis. This involves the ability to recognize and understand the

physiological and emotional state of the infant, hold and bare the emotions, and provide the comfort and reassurance that the infant requires.

The dyadic emotional regulatory system is guided and evolves when infants' moment-to-moment signals about their changes in state are understood and responded to by caregivers (Tronick, 1998). Beebe, Lachmann and Jaffee (1997) established that infants engage in preverbal interactions with their caregivers that demonstrate a degree of self-regulation and sensitivity to the state of the other. Between birth and five months, the affective signals that are expressed between the infant and caregiver, in face-to-face exchanges, play a key role in the development of the child's regulation and representation of affect (Beebe et al., 1997)

As they become more aware of their subjective experiences the more effective regulation becomes, until self-regulation is achieved (Fonagy et al., 2004). "When the affective regulation of interactions goes well, development proceeds and increasingly, complex tasks are approached, resolved and incorporated, not by the child alone, but by the child in collaboration with others. ... as a consequence of their resolution, the child expands and becomes more coherent" (Tronick, 1998, p. 297).

When mothers and infants play and interact it is often without awareness of a specific goal. The mode of interaction is improvisational, self-finding and self-regulating in which goals may shift. In this process the mother and infant are active participants and each has the capacity, "to appreciate the meaning of the affective displays of their partner, and to scaffold their partner's actions so that they can achieve their goals" (Tronick, 1998, p. 294). It is important that mother and infant "come to know" (p. 294) the current emotional state of the other if the mutual regulation process is to succeed.

This process of mutual regulation is characterized by repetition, "matches-mismatches, ruptures and repairs". "Coming to implicitly know how to repair and redirect the improvisational process" is "one of the main hidden agendas of the parent-infant interaction" (Stern, 1998, p. 303).

The dyadic regulatory system, if successful, reassures the infant that arousal does not necessarily lead to disorganization beyond his capacity to cope. If the mother misinterprets and does not "come to know" the state of the infant, reparation of the state will fail.

Barnard et al. (1993) describe a wide range of expressive, affective and often unintentional behaviours between mothers and their infants that function as "an affect-based feedback system to produce a 'coupling' of mother and infant behaviours"(p.395) These interactions become the prototype for early affective interactions that resemble dialogues that are the precursors to later language and speech. The quality and quantity of parents' verbal input have been shown to be important for positive linguistic experiences and child competence in that, "stimulating and responsive maternal input was predictive of several child outcome measures, including cognition (IQ), language mean length of utterance [MLU], and positive interaction with mother" (p. 395).

2.1.3.2.3. Implicit relational knowledge or procedural knowledge

Beebe (1998) refers to implicit relational knowledge as knowledge we accumulate from infancy, through our interactions with others. It relates to expectations concerning how things are done and how to proceed in relationships. Specifically, it is shaped by the quality of early experiences of mutual affect regulation between infant and parent before the availability of language and may never find verbal expression. It informs the way in which we relate with others in the world and it continues to operate implicitly throughout life. It is distinguished from other forms of procedural knowledge in that it is as much affective and interactive as it is cognitive in nature. Implicit relational knowing may operate consciously or unconsciously but has no sense of being defensively excluded from awareness. This concept resonates strongly with Bowlby's concept of "internal working models" referred to previously.

Lyons-Ruth (1998) describes how, based on the mutual regulating model, implicit relational knowing represents the mutually self-regulating, co-constructed, moment-by-moment exchanges that shape adaptive and recurrent regulatory patterns of interaction that are "constantly accessed and updated in day-to-day encounters" (p. 285), at first between the mother and infant and then in all subsequent relationships. In all interactions, the intersection of the "implicit relational knowledge" of one of the partners intersects with the "implicit relational knowledge" of the other. When the implicit relational knowledge of the parent and infant intersect, a unique intersubjective field is created between them creating "dyadic states of consciousness" in which each develop reasonably accurate sensings of each others' ways of being with others, which Lyons-Ruth, calls, the 'real relationship' (p. 282). With repeated encounters between them this field becomes more complex and creates the possibility for more elaborate, coherent and adaptive forms of shared experience that facilitates "more mutual and responsive regulation between them," (p.288), and creates more adaptive strategies in order to manage ongoing challenges as life unfolds.

Implicit relational knowing thus describes a representational system of relating. It is a mutually constructed regulatory pattern that is adaptive and constantly updated and "re-cognized" as it is accessed in daily encounters. It encompasses normal and pathological knowings and integrates affect, fantasy, behavioural and cognitive dimensions. Under favourable conditions it will become "more articulated, integrated, flexible, and complex" (Lyons-Ruth, 1998, p. 285).

2.1.3.2.4. Dyadic expansion of consciousness hypothesis

Tronick (1998) expanded on this development by describing a process derived from systems theory and based on the principle that, "open biological systems, such as humans, function to incorporate and integrate increasing amounts of meaningful information into more coherent states" (p. 295). In the case of the infant and mother - both self-organizing systems with their own state of brain organization - dyadic moments occur in their interaction that create the potential for each to be expanded into more coherent and complex states in collaboration with each others' "self-organizing system". When this happens, a

mutually created dyadic state of organization between the infant and the mother emerges that contains more information and which is more complex and coherent than either the mother's or infant's own original self-organized states. This, in turn, expands the states of consciousness of both partners as they restructure their mental organizations by incorporating elements of the state of consciousness of the other. This experience of expansion and cohesion of their own states of consciousness through incorporation of elements of consciousness of others, through dyadic moments of meeting, is the unconscious force driving human connectedness or social engagement. Modell (1998) explains how it is the infant interacting with a mother with a more developed, experienced, mature and complex mind than the infant's mind that offers the potential to expand his or her state of consciousness. "... the infant 'borrows' or uses the mother's more developed consciousness as a 'scaffolding'" (p. 343).

The concept of a "now moment" was introduced which refers to a moment in which both partners, through the daily interactions between them, recognize a change in the range of regulation that can be achieved between them. Stern (1998) talks about "biologically pre-programmed developmental shifts" in both mother and infant which create novel or "emergent properties" or "now moments" within the mother and infant dyadic system. These authentic and unique moments involve an affective interchange when something unpredictable happens in the maternal environment, or a new level of development is achieved by the infant that requires a re-evaluation of the implicit relational knowing between them. Examples of this include; an unexpected expression, the first social smile, a toddler's refusal to comply. This interrupts and challenges the "implicit relational knowledge", enabling an expansion of the dyadic consciousness between mother and infant.

An authentic response to a "now moment" from both participants represents a "moment of meeting" that shifts the dyadic state of consciousness of both parties. Sander (1998) compared the "moment of meeting" to Winnicott's "sacred moment", when "the child becomes aware that another is aware of what the child is aware of within" (p. 590). In a "moment of meeting", two states of consciousness are "matched", in the sense that "the way one would 'know' oneself would be matched by the way one was 'known' by an other" (Sander, 1998, p. 589).

Stern (1998) describes how these 'moments of meeting' catalyse change in parent-infant interactions and are immediately followed by an "open space" in which both participants tend to disengage from their "meeting" and, alone in the presence of the other, they can "assimilate the effect of the moment of meeting in finding a new equilibrium in the altered intersubjective state they now inhabit." (p. 306). Following this "open space" and within a now expanded dyadic state of consciousness that has changed the relationship, the "moving along" process between both participants is resumed.

This model of dyadic expansion of consciousness is dependant on the infant interacting with a more mature mind that is benign and reflective in nature and able to serve a scaffolding function for the less

mature and developing mind of the infant (Modell, 1998). The unprocessed emotions on the part of parents who can't bear to witness their children's negative affect or are otherwise easily overwhelmed by them, may leave infants feeling they have contaminated or otherwise damaged the parents and this may leave infants feeling traumatized rather than contained. This provides support for Winnicott's belief that for the child's healthy emotional development, the parent needs to survive and not be hurt by the negative expressions of their infants (Winnicott, 1947).

2.1.3.2.5. The Social Biofeedback Theory of parental affect-mirroring

This model has been adapted from adult biofeedback studies and refers to the way in which a natural biofeedback sensitization training is offered to the infant by their parent. The development of a representational system is initiated by the internalization of mothers' empathic mirroring responses of their infants' emotional state of distress or of wellbeing.

The infant internalizes the mother's empathic expression by developing a secondary representation of his emotional state, with the mothers' empathic face as the signifier and his own emotional arousal as the signified. The mother's expression tempers emotion to the extent that it is separate and different from the primary experience, although crucially it is recognized not as the mother's experience, but as an organizer of a self-state. It is this "intersubjectivity" that is the bedrock of the intimate connection between attachment and self-regulation. (Fonagy et al., 2004, p. 126-127)

Through the parents' sensitive and attuned empathic affect-mirroring, the infants' experiences become linked in their own mind with "the consequent affective-reflective facial and vocal displays" of the caregiver through "a contingency-detection mechanism" described by Gergely and Watson (1999), as cited in Fonagy et al. (2004). The effect of this link is:

- a) That "infants come to associate the control they have over their parents' mirroring displays with the resulting improvement in their emotional state, leading, eventually, to an experience of the self as a regulating agent." (p. 8).
- b) "The establishment of a second-order representation of affect states" (p. 8), which enables the recognition, naming, sharing and holding of affects internally which translates to affect-regulation and impulse control.

It is thus the parents' empathic affect mirroring responses that are required to play a central role in the development of the agentive or psychological self, and of a representational system, in early psychological development and throughout life. This requires sensitivity and attunement, the capacity to observe the moment-to-moment changes of the infant's mental state and to think about what they might be

communicating, and a responsive style that is reflective, non-intrusive and reciprocal (Fonagy et al., 2004; Tronick, 1998).

2.1.3.2.6. The development of mentalization

According to Fonagy et al. (2004), mothers of securely attached infants are more sensitive to their infants' needs. They define parental sensitivity as comprising two independent psychic processes; the first refers to the mothers' attitude and behaviour independent of the infant's mental state, for example her enthusiasm and other positive feelings about the expected child and her loving acceptance and encouragement of exploration and joint play after the birth. The second is the mother's capacity to envisage the infant as a mental entity, a human being with intentions, feelings and desires.

Fonagy et al. (2004) described two fundamental needs of human beings as:

1. The need, 'intrapsychically', to maintain a sense of the internal equilibrium between all the biological, emotional and mental forces that demand our attention.
2. The need, 'interpersonally', "to be integrated into the social world, in which we must respect the separated other minds, while being able also to build flexible bridges across that separateness to create close emotional and working relationships" (p. 19).

While parents are always giving meaning to children's behaviour, "mentalization" or "mind mindedness" describes a model of psychological development in which "interpersonal interpretive capacity" develops as "a core aspect of human social functioning" (p.5). This describes the capacity of the human brain to give thoughtful and plausible interpretations of one's own and others' behaviour in terms of underlying mental states and intentions. Fonagy et al. (2004) state:

Exploring the meaning of others' actions is then a precursor of children's ability to label and find meaningful their own psychological experiences. This ability arguably underlies the capacities for affect regulation, impulse control, self-monitoring, and the experience of self-agency – the building blocks of the organization of the self. (p. 25)

The reflective function refers to the "active expression" or "operationalized form" of mentalization and the term "interpersonal interpretive mechanism" or (IIM) is used, "... as the assumed mechanism that interacts with the genotype to enhance or reduce the likelihood of genetic expression" (Fonagy et al., 2004, p. 125).

It is this capacity on the caregiver's part, to reflect on the mental state of the other, that in psychoanalytical terms, has great relevance to the development of the self-structure in the child. It is associated with security of attachment and superior symbolic capacity and mentalization in the child.

... primarily by behaving towards the child in such a way that the child is eventually led to postulate that his own behaviour may be best understood if he assumes that he has ideas and beliefs, feelings and wishes that determine his actions, and the reactions of others to him can then be generalized to other similar beings. (Fonagy et al., 2004, p. 53)

Mothers who approach their crying infants with a question in mind about what the infant is attempting to communicate about their physiological or emotional state, such as “Are you wet and uncomfortable?” and “Are you lonely and want a cuddle?”, are able to link the external physical reality with the child’s internal experience and ascribe a mental state to the child’s behaviour, thus treating the child as a mental agent. As infants share and experience evidence of the mental world of their caregivers, the concept and perception of mental states in themselves and then in others emerge and are elaborated.

While biologically determined, the development of ‘theory of mind’ or mentalization needs to be facilitated by a close intersubjective process between infants and caregivers who exercise their own reflective capacity. This development is dependent on the process of affect regulation. As the child experiences the parent reading their moment-by-moment behaviour, feelings and needs, he begins to identify with the parent’s mentalizing ability. Gradually, with the development of “mentalized affectivity” which denotes “a more mature capacity to discover the subjective meanings of one’s own subjective states” (Fonagy et al., 2004, p.5), affects that were co-regulated become self-regulated. This process is intrinsically linked to the gradually elaborated inner organization and development of the self, allowing affective experience to be processed in more complex ways. Ultimately, the adult develops “mental affectivity” which describes a capacity of being conscious of the meaning of one’s feeling state, while in that state.

For this experience to be containing and facilitate the development of a higher order representational structure for infants, it is essential that parents provide, what Gergely & Watson (1996) called “marked” responses”. This was later incorporated into the model described by the Change Process Group (1998) and the mentalization model described by Fonagy et al. (2004). These are responses that make it clear to the infant that while corresponding to the infant’s feelings, the parents’ displays are not equivalent to theirs, nor are they too realistic or emotionally arousing or overwhelming when reflected back to the infant.

When parents are not sufficiently emotionally separated from their infants and feel overwhelmed by their expressions of negative affect, the tendency is, for these parents, to impose their own realistic ‘unmarked’ emotional expression, which disrupts the development of affect regulation in infants. The caregiver’s mirroring needs to be a higher order representation of the child’s experience, incorporating some processing of the “raw” state. This is akin to Winnicott’s (1956) “holding (in mind)” function and Bion’s (1991) “alpha function” of the mother in which the raw, concrete beta elements are transformed into more tolerable, manageable and thinkable forms, providing for a distressed infant displays that are soothing and imply coping. According to Fonagy et al. (2004), “marked” responses offer the child “representations of

his mental state that can be internalized and used as part of a higher order strategy of affect regulation” (p. 42).

In summary, mentalization relates to the development of both the representational self which refers to the characteristics and qualities we believe ourselves to be as a result of the reactions of others towards us and to the sense of self as agent, which refers to the knowledge that one has the power to act in the interest of one’s needs in the world and, according to Fonagy et al. (2004), “... arises out of the infant’s perception of his presumed intentionality in the mind of the caregiver” (p. 11). This capacity has been observed in very young children. It evolves when infants begin to understand their own minds, affects and desires, through the minds of others close to them. They not only respond to the behaviour of others but to their “*conception* of others’ beliefs, feelings, attitudes, desires, hopes, knowledge, imagination, pretence, deceit, intentions, plans and so on” (Fonagy et al., p. 24), as though reading other peoples’ minds. In so doing they are able to make people’s behaviour meaningful and predictable, empathise with the emotional reactions of others and mediate their experiences of the world.

2.1.3.2.7. The development of empathy

Empathy, as a mode of interaction, is seen as the basis of all our intersubjective experiences (Litowitz, 2008). Richter (2000) referred to the “newborn reactive cry” as an innate empathic response that accounts for the way in which 2 to 3-day old infants are able to set each other off in hospital nurseries. She refers to the toddler’s “egocentric empathic distress” to describe their response to the distress of others as though they themselves were experiencing the distress, for example, by the toddler putting her arms around her mother who is crying. While we have been able to describe this response, the discovery of the “mirror neuron system” (MNS) (Gallese, 2008, p. 770), offers a neurophysiological explanation and support for the mechanism involved in the development of empathy as well as those of attunement, affect regulation, and mentalization, previously conceptualized by inference and described in the context of infant observational research and clinical practice.

Aragno (2008) explains that the “mirror neuron system” refers to a mirroring mechanism in which “neural activity”, known to be activated or triggered by deliberate actions, emotions and sensations, is activated when witnessing or observing similar actions, emotions and sensations in others. Gallese (2008) reports that in humans, MNS is directly involved in the imitation of simple movements, when learning complex skills, when perceiving communicative actions and when detecting the intention by others to act. Because the premotor cortex containing the MNS is also involved in processing action-related words and sentences, the suggestion is that together with other parts of the sensorimotor system, it could play a relevant role in language semantics. He suggests that other mirroring mechanisms might be involved with the human capacity to share emotions and sensations with others. He describes how,

when perceiving others expressing a given basic emotion by means of facial mimicry, the observer's facial muscles activate in a congruent manner ... with intensity proportional to their empathic nature. ... both observation and imitation of the facial expression of basic emotions activate the same restricted group of brain structures, including the ventral premotor cortex, the insula and the amygdale. (p. 771)

He refers to a “we-centred” dimension in affect states underpinned by a shared neural substrate. He suggests that our capacity to empathize or share and reciprocate multiple forms of intersubjectivity such as attunement, the meaning of action, intentions, feelings and emotions with others, “is mediated by embodied simulation mechanisms, that is, by activation of the same neural circuits underpinning our own emotional and sensory experiences”, and that the MNS is “a necessary prerequisite for scaffolding the development of human social cognitive skills” (p. 772).

Aragno (2008) explains that empathy originates, as does mental perception or understanding and attachment, in the “undifferentiated soil of infantile synesthesia” (p. 729) or subjective sensation of the infant. The infant is genetically pre-programmed, with an autonomic nervous system that is ready to mimic, imitate or react in a like fashion to the signals from other humans. This offers the biological basis for the facial imitations described by Meltzoff and Moore (1977). The earliest responses are unmediated, instinctive, automatic, global neurophysiological reactions expressed through somatic or sensorimotor responses involving the infant's entire body and nervous system. Through a bidirectional affect-matching and communication process, these responses, or signals, are mediated and thus modulated and increasingly differentiated, by adult caregivers who interact empathically in ways that “unconsciously endow their infant's affects with meanings generated by feelings to which they can themselves relate, and then they label them as such” (Aragno, p. 728). Gradually these responses are translated into increasingly meaningful communication mediated by various “semantic and semiotic socializing and/or verbalizing processes” (p. 728).

Aragno (2008) explains that over time, “the overt expressions of affect-matching will be interiorized and subdued as feelings are modulated and mediated by increasingly differentiated, ever more expedient defences and/or acquired referential processes.” This diminishes their intensity “to a mere signal-of-a-signal”, eventually leaving only a “miniscule, barely perceptible neurophysiological trace-signal that the activation of affect-resonance or an emotion-like response continues to depend” (p. 727). For the human infant, “a grasp of emotional messages and concomitant *semiotic* patterns is a crucial forerunner of social adaptation and verbal communication” (p. 731). A mature empathic response involves the perception of these subtle signals and an engaged response requiring “focus and attention, feelings and thought”, in a way that is mediated by references and ideas that are associated with all that is known of the state of the person.

Although many of the above concepts and theories pertaining to development through intersubjectivity refer to different terminology and seem to be offering explanations of subtly different processes, there is significant and sufficient overlap and consistency to provide useful and practical guidelines for application in interventions such as ours.

In essence all infants are genetically predisposed and neurologically ready long before birth, to take in the environmental stimuli that facilitate or obstruct the genetic potential, and to use them as neural building blocks to develop their brain and their mind. It is in the dialectical process of early relational interactions with caregivers that lasting sensorimotor traces are encoded which will determine how infants experience their own feelings and learn to read the emotions of others. It is where attachment security, affect and self-regulation, an implicit knowledge of how to relate to others, how they feel and who they are in the world, empathy, a capacity to mentalize, and a sense of agency become “internalized” and established. The parent-infant dyad is an intrinsically self-regulating system able to self-repair when ruptures occur in the system. If “now moments” are noticed but fail to become “moments of meeting”, the developmental drive is strong enough that they will in all likelihood reappear under “good enough maternal” conditions (Stern, 1998).

2.1.4. Influential factors in the maternal and broader environment

2.1.4.1. The psychological adjustments to motherhood

Early parenthood represents a developmental stage requiring major adjustments physically, psychologically and socially for all parents and mothers in particular. The manner in which mothers are able to adjust to their new role impacts on their capacity to nurture (Raphael-Leff, 1991; 1993; 1997).

With a deeper understanding of the importance of parent-infant interactional relationships for infant development and the emotional demands these make on the parent-infant couple, we need to consider the personal and interpersonal factors that support healthy development and those that constitute risk, threatening the responsive and sensitive quality of nurturing the infant receives from caregivers, the infant itself, and the broader social and cultural environment.

Stern (1995) identifies the ‘motherhood constellation’ (p. 171) as a special psychological condition representing a unique organization of mental life appropriate for and adapted to caring for infants. It is defined by him as a new, normal, unique and transient psychic organization dominating the mother’s psychic life in which “a new set of action tendencies, sensibilities, fantasies, fears, and wishes” are determined which “pushes to the side the previous nuclear organizations or complexes that have played that central role” (p. 171). He concedes that this constellation is not necessarily universal across and within cultures but points to the universal, “ unquestionably, psychobiological, especially hormonal influences that prime the sensibilities and tendencies of the new parent to develop some form of the

motherhood constellation.”(p. 173) acknowledging that the socio-cultural context and conditions will determine how these will be enacted.

The motherhood constellation consists of four specific themes and related tasks that the mother is expected to fulfil in the early months.

1. ***The life-growth theme*** refers to the central issue which concerns the mother learning that she is an adequate mother who is able to keep the baby alive and grow a thriving infant.
2. ***The primary relatedness theme*** refers to the form of relationship that take place in the first year of life before words, symbols and speech develops. The mother learns to be attuned to the infant’s signals and relate in a non-verbal and spontaneous manner. She has to establish the human ties of attachment, security and affection, the regulation of the infant’s body rhythms and the holding of the infant both physically and emotionally. There is some resonance with Winnicott’s (1956) state of “primary maternal preoccupation”.
3. ***The supporting matrix theme*** refers to the mother’s need to “create, permit, accept and regulate a protecting, benign support network, so that she can fully accomplish the first two stages of keeping the baby alive and promoting his psychic affective development” (Stern, 1995, p. 177). This network of support protects the mother from external demands, provides for her needs and appreciates, encourages and informs her. In most societies and cultures, there seems to be an expectation and need by new mothers to find the support and guidance they need in adjusting to this new role and its demands, from older maternal figures including their own mothers, and other maternal figures; aunts, sisters, mothers-in-law, grandmothers. Pines (1993) refers to the “secret society of women” which dominate the stage at this time. There is also evolutionary evidence that grandmothers enhance the lifetime reproductive success of their children and the survival of their grandchildren (Lahdenperä et al., 2004). Hawkes (2004) goes on to suggest that it is the contribution to childcare available from post menopausal grandmothers that determines the extension lifespan in human societies and evolution.
4. ***The identity reorganization theme*** refers to the need for the mother to “transform and reorganise her self-identity” (Stern, 1995, p. 180).

Perhaps the most important factor affecting mothers’ capacity to provide the optimal relational environment for their infants is their own history of nurturance. This would have determined their object-relationships, internal working models of relationships or implicit relational knowledge, and shaped their attachment security (Fonagy et al., 2004; Sroufe, 2000) emotional maturity (Modell, 1998), sensitivity (Tronick, 1998), capacity to mentalize (Fonagy et al., 2004) and preparedness for motherhood and relationship styles (Raphael-Leff, 1993). Raphael-Leff (2000) writes: “Childbearing reactivates primary issues. Nurturing capacities and receptivity to the baby’s feelings are underpinned by unconscious

representations of ones own benign or damaging baby-self, coupled in interaction with internalized carers” (p. 12).

The “psychological work” of pregnancy, birth and early parenthood has been recognised and described by many contributors in the field. (Birksted-Breen, 2000; Bradley, 2000; Brazelton & Cramer, 1991; Pines, 1993; Raphael-Leff 1993; 1997; 2000). This process, ideally, begins with the wish to have a child. Raphael-Leff, (1997) writes that, in many ways, women have carried imagined babies through their growing years and their relationships have been with the infants of their dreams. Conception inevitably confronts the mother with, “anxieties about her own capacities to contain, sustain, protect and nourish, and her entitlement to keep a baby” (p. 123). She likens the impregnated womb to

a seething cauldron, a receptacle for the parent’s fantasies, projections, and unconscious transgenerational transmissions, as the baby being created inside is incorporated into the psychic world and imbued with numinous aspects of internal figures residing there. Thus each baby is born into a place within a constellation replete with fantasies and imbued by various family members with representations of their internal figures and projected aspects of themselves. (p. 123-124)

Pregnancy, although a natural event, is in itself “a bizarre experience, arousing primitive feelings about two people residing within one body and anxieties about engaging in female mysteries of formation, preservation and transformation” (Raphael-Leff, 2000, p. 7). The task of the mother is to accept the real pregnancy and gradually the real infant that is developing inside her, as a child that is not seen or wanted is a child at risk (Raphael-Leff, 1991).

Brazelton and Cramer (1991) describe how at the time of birth, for all mothers-to-be, three babies come together. “The imaginary child of their dreams and fantasies, and the invisible but real fetus, ... now merge with the actual newborn baby who can be seen, heard, and finally held close”(p.3). This marks the abrupt adjustment to the ending of the sense of fusion or merger with the accompanying fantasies of completeness and omnipotence, with their foetuses. The imaginary perfect children need to be mourned and the characteristics of their real, individual and specific babies, who provoke feelings of otherness and strangeness, have to be discovered and accepted.

The enormous demands and dependency of infants on their mothers, and the powerful ambivalent and frightening feelings that are evoked, as well as simply “not knowing”, are managed in very different ways by different mothers. Mothers who by nature are “accommodators” or “facilitators”, tend to manage this stage with less of a struggle and with more responsive and less intrusive styles of parenting than mothers who have a need to regulate their interactions and the lives of their infants in order to cope (Raphael-Leff, 1993).

There is a need also to mourn their loss of independence socially, financially, emotionally and physically and manage the exhaustion and lack of sleep in the early months. For many women the loss of the work

environment represents the loss of a primary source of affirmation and self-esteem. It is important that mothers experience a sense of efficacy in their parenting role and a sense of optimism about their child (Fonagy et al., 2004).

2.1.4.2. Failures of attunement in the early care-giving environment

2.1.4.2.1. Maternal factors

Valenzuela (1997) reports that maternal sensitivity in low-income mothers in Chile, was associated with maternal education and marital satisfaction. It was also significantly associated with infant nutritional status, attachment security and mastery behaviour. There are many factors, however, that have the potential to interfere with the mothers' ability to become "maternally preoccupied" and to find attunement with their infants. Antenatal and postnatal depression and anxiety, now subsumed under the term "common mental disorders" (CMD) (Patel et al., 2008), have come to be recognized as a key risk factor in infant development. Globally, common mental disorders are the fourth leading cause of disease burden (Rahman, 2007). The rate of perinatal depression in the Western world is estimated at 10% to 15% (O'Hara & Swain, 1996), although in welfare and high risk communities on visiting programmes up to 50% of the population may have symptoms of depression (Gomby, 2005). In low income, under-resourced communities, postnatal depression is estimated to be two to three times higher than in wealthier communities (Cooper et al., 1999; Patel et al., 2002; Rahman & Iqbal et al., 2004).

Depression in pregnancy has been linked with poor attendance at antenatal clinics, low birth weight and preterm delivery (Patel et al., 2002; Patel et al., 2004). Low birth weight was however, not found to be associated with poor maternal mental health in Ethiopia (Hanlon et al., 2009). Antenatal depression is a major determinant of postnatal depression (Mills, Finchilescu & Lea, 1995). The risk of adolescents experiencing depression was found to be 4.7 times greater if they had been exposed to maternal antenatal depression (Paulby, Hat, Sharp, Waters & O'Keane, 2009).

Countries such as India and Pakistan report a strong causal association between ante- and postnatal depression, and both maternal and child health (Ramchandani, Richter, Stein & Norris, 2009), undernutrition and failure to thrive (Patel et al., 2004), as well as higher risks of diarrhoea and poor growth (Rahman, Lovel et al., 2004). In Pakistan the infants of depressed mothers have a four times higher risk of being malnourished and developmentally stunted at 6 months (Rahman, Iqbal et al., 2004). This has the potential to lead to very damaging effects on infants' physical, emotional, intellectual and social development.

Although it has been established that depression and anxiety disorders are transmitted intergenerationally and impact on the children of depressed mothers by, for example, increasing the risk of depressive symptoms in infants through to adolescence (Halligan et al., 2008), the contribution and interplay of the genetic and environmental factors remain poorly understood (Cooper, 2008). Suggested mechanisms

range from the biological, such as the hypothalamic-pituitary-adrenal (HPA) axis (Halligan et al., 2007), to the early relational environment. In the case of social anxiety, the early maternal behaviour and infant social responses rather than genetics seem to play a major role (Cooper & Murray, 2008). Patel et al. (2004) have linked postnatal depression with failure to thrive, and perceive the emotional quality of parenting to be an important mediator of the effect of maternal depression on the infant's ability to thrive.

Bosquet and Egeland (2001) refer to maternal psychopathology and maternal state of mind as two significant factors that seem strongly and independently linked to maternal interactional skills and quality of child care. They note the varying presentations of maternal depression in the literature, from disengaged interactions with their children seen with withdrawn mothers, to intrusive interactions from more hostile mothers, and how these maternal factors are associated in turn with difficulties in infant emotional regulation, attachment security and cognitive development.

Tronick (1998) describes in more detail how mothers who are sufficiently depressed, withdrawn, overwhelmed and preoccupied, fail to attune and collaborate with their infants to establish a healthy dyadic intersubjective state of shared consciousness between them. Infants' drive to expand the complexity and coherence of their state of consciousness exposes them to the depressive elements (pain, sadness, anger, withdrawal and disengagement) of the state of consciousness of the depressed mother, which they take on. The dyadic state of consciousness formed between them is thus negative at the core. A further complication that might arise when other relationships become available to these infants is that, the only way they have available to expand the complexity and coherence of their states is "by establishing dyadic states of consciousness around the depressive features that were first established with the mother ... The consequence ... is often a debilitating attachment to negative relational experience" (p. 297).

Modell (1998) suggests that the failure of depressed mothers to respond to their infants "psychic aliveness" and "recognize the uniqueness, originality, and separateness of their child's inner world, may have a profound effect on the child's developing sense of self" (p. 343).

In wealthier and disadvantaged communities, maternal depression has been shown, empirically, to impact on the emotional quality of interaction between mothers and their infants and early parenting in general. More specifically, depressed mothers tend to be significantly less sensitively engaged with their infants, less responsive and expressive; they could either be hostile and intrusive or withdrawn and disengaged (Cooper et al., 1999; Murray et al., 1996).

The negative effect of maternal depression on children's cognitive development has also been described (Hay, 1997). Murray et al. (1995; 1996,) described children of postnatally depressed mothers; at 18 months being more likely to be insecurely attached and perform worse on cognitive tasks; at 19 months to show more anger and less affective sharing during play with their mothers; and at 4 years, to perform worse on cognitive tasks.

East et al. (1994) found that mothers who reported high parenting stress, had low confidence in themselves as mothers, low acceptance of their children and lacked empathy for their needs. Raphael-Leff (2000) writes that,

women with a fragile sense of self, panic states in pregnancy, traumatic experiences during labour and emotional arousal in early parenting, can result in the eruption of unmetabolized primal anxieties of personal disintegration, fears of fragmenting, dissolving or spilling out. Identification with the baby may lead to dread of being re-engulfed within a womb-like state of fusion, or terror of impotent helplessness. (p. 11)

Earlier maternal trauma or loss of significant relationships that have not been processed psychologically can result in their response to their infant being filtered through the traumatic memory and painful affect that cannot be attended to (Raphael-Leff, 2000). Ammerman et al. (2009) found that interpersonal trauma played a significant role in the lack of improvement of depressive symptoms in a 9-month home visiting programme. Previous miscarriages, stillbirths or sudden infant death (SIDS), unless mourned, are likely to heighten the levels of anxiety and over-protective behaviour that is associated with managing the needs of her new infant, and might result in the next child being conceived, consciously or unconsciously to replace the sibling that has died (Etchegoyen, 1997)

Any serious maternal physical illness represents at the very least, a competing preoccupation for mothers and a risk to attachment security. Petersen et al. (2001) found that no differences were found in the security attachment of infants of Ugandan mothers diagnosed with human immunodeficiency virus (HIV) versus those who were (HIV)-negative. Once the acquired immunodeficiency syndrome (AIDS) developed however, infant security attachment became undermined and infants of mothers with AIDS were less securely attached than infants of mothers without. AIDS immediately confronts mothers with the likelihood that they will not see their infant achieve adulthood and this brings about fear and guilt.

Low education has also been identified as a risk factor for the development of depression following childbirth (Patel et al., 2004). The high incidence of adolescent motherhood in South Africa carries the danger of mother being too young, alone and psychologically insufficiently prepared to devote themselves to the demanding task of sensitive motherhood. Levine et al. (1985) found that, compared to adolescent mothers, more mature mothers talked more, showed more positive affect and demonstrated tasks more often, while teaching their infants. They suggest that therefore, less educated adolescent mothers with lower ego development and less social support represent a higher risk subgroup in the provision of optimal infant care. East et al. (1994) found that being a poor, minority, adolescent mother with a young infant was associated with low child acceptance. Young maternal age has also been associated with a lack of improvement of depressive symptoms in the first nine months of enrolment in a programme (Ammermann et al., 2009).

Many mothers do not plan their pregnancies and may not have wished for them. Unplanned and/or unwanted pregnancy, which might include an attempted abortion, is strongly associated with postnatal depression and insensitive parenting in the early months (Cooper et al., 1999). This study also identified that in conditions of deprivation, emotional and practical support from fathers represents a protective factor in the mother's healthy adaptation to motherhood.

2.1.4.2.2. Infant responses to maternal failures

Factors such as neglect, maltreatment, trauma, separations and loss, not being held in mind, a lack of attunement, mirroring or empathy and responsive care, particularly before the infant has developed the capacity to give meaning to the experience, may constitute significant relational failures, and may be emotionally overwhelming for infants. Winnicott (1960a) spoke of infants experiencing "unthinkable anxiety" and fears of "total annihilation" from which they need protection.

Spitz (1945) published a seminal paper on "Hospitalism" in which he described the devastating effects of the lack of human stimulation and relatedness children experience when removed from their parents. Bowlby in 1952 wrote about similar symptoms in children who were separated from their mothers and placed in alternative care. Bowlby (1952) quotes Bakwin, who in 1909 wrote,

Infants under 6 months of age who have been in an institution for some time present a well defined picture. The outstanding features are listlessness, emaciation and pallor, relative immobility, quietness, unresponsiveness to stimuli like a smile or a coo, indifferent appetite, failure to gain weight properly despite the ingestion of diets which in the home are entirely adequate, frequent stools, poor sleep, an appearance of unhappiness, proneness to febrile episodes, absence of sucking habits. (p. 16)

Ainsworth (1962) wrote about "maternal deprivation" that occurs when a child receives insufficient care or experienced insufficient interaction from his or her primary caregiver. More recently, Hundeide (1991), who has worked in high and low income countries many of which have been torn apart by war, refers to many deprived children the world over who live in a reality in which a continuous and predictable flow of care giving has not been their reality. Caregivers who disappear physically or are emotionally absent as a result of being distracted by their own thoughts and concerns, or who cause the infant suffering and pain and becomes feared, create a reality constructed of "bits and pieces". Children find themselves living in a world that can't be trusted or relied on, and tend to withdraw their investment from their human caregivers.

At this early age, any strategy adopted by infants to protect themselves from overwhelming stimuli has the potential to seriously and permanently compromise their development of a sense of self. Ainsworth (1962; 1985) explained that children who are failed by their nurturing environment develop a distrust of closeness and learn to protect themselves through patterns of defensive attachment strategies. Sroufe and Waters

(1977) described attachment as an organizational construct. Resistant attachments in infants are understood to be the result of ambivalence, inconsistent availability and intermittent lack of responsiveness by caregivers. These infants show distress when left, lack interest in play and exploring the world around them, are inconsolable when their needs are frustrated and tend to exaggerate distress in order to gain the mothers' attention or become aggressive in their expression of needs. Avoidant attachments are the result of children having detached themselves from people who have disappointed, frustrated and let them down. Despite their need for contact, they have learnt that parents are not reliable and can't be trusted and develop precocious independence (Sroufe, 2000). Dissociated and disorganized attachment is often the result of early abuse or other betrayal or trauma in which children have not even been able to apply a strategic relational defence with their caregivers (Main & Hesse, 1990). A 68 to 75 % correspondence between attachment classification of infancy and those of adulthood has been shown (Fonagy et al., 2004). Allen (2001) supports this continuity of defensive attachment strategies that aim at avoiding further traumatization from infancy into adulthood.

The importance of social connectedness and mutual affect mirroring and regulation was dramatically demonstrated by Tronick's "still face" experiment in which he demonstrated how, when there was a breakdown in social connectedness and infants were unable to engage their suddenly "still-faced", unresponsive mothers in the usual way, they were immediately distressed and actively attempted to draw her back. Following repeated failure to re-engage her and repair the interaction, they began to turn away from her. Eventually when all attempts to repair the interaction failed, they disengaged, lost their ability to comfort and regulate themselves and progressively became more withdrawn and cut off. This process, preventing the recreation of a dyadic state of consciousness between infants and their caregivers, corresponds to "a model of emotional neglect and the denial of intersubjectivity" (Tronick, 1998, p. 292).

When affect regulation fails over time, "development gets derailed and the child's complexity is limited or even reduced (i.e., the child may regress)... With continued failure and the structuring that goes on around the failure, affective disorders and pathology may result." (Tronick, 1998, p. 297). Fonagy et al. (2004) note that where affective responses by parents have corresponded poorly with infants' emotional states and mirroring has been too inaccurate, the second-order representations of affects are more weakly connected to the "true" self states and might be less capable of providing the means of "accessing and attributing emotional states to the self". As a result "words will not form the basis for the child's emerging ability to think about his or her real thoughts and wishes" (p. 15).

Aragno (2008) points out how the development of empathy, which relies on a sense of attunement, merging or "feeling with" others, is dramatically subverted by any threat of separation or emotional distancing or distraction by parents from their infants. However, when affect-mirroring is congruent but lacks 'markedness' infants can feel overwhelmed and traumatized by the imposition of their parents' realistic and "unmarked" emotional expressions which tends to disrupt the development of affect

regulation and mentalization. It also disrupts the sense of separateness and boundary between the self and other for the infant. On the other hand, when affect-mirroring is appropriately ‘marked’ but the infants’ emotions are misperceived, infants still feel mirrored but the secondary representation created will be distorted, and incongruence with the infants’ actual feelings will exist. Self-representation will tend *not* to have strong ties to the underlying emotional states which could leave infants feeling quite empty. Both of these situations lead to alienation of the self. To some extent we are all exposed to normal transient experiences constituting unattuned or neglectful parenting by normally “good enough” parenting. As a result all of us have, to some extent, developed an alien or false self.

Fonagy et al. (2004) describe how,

Where parental caregiving is extremely insensitive and misattuned, we assume that a fault is created in the construction of the psychological self. We follow Winnicott’s (1967) suggestion that the infant, failing to find *himself* in the mother’s mind, finds the mother instead. The infant is forced to internalize the representation of the object’s state of mind as a core part of himself. But in such cases the internalized other remains *alien* and unconnected to the structures of the constitutional self. In the case of chronically insensitive or misattuned caregiving, fault is created in the construction of the self, whereby the infant is forced to internalize the representation of the object’s state of mind as a core part of himself. (p.11)

This theory supports the psychoanalytic understanding that the early mother-infant relationship is fertile ground for the projection, onto their babies, of the mothers’ unconscious feelings, fantasies and fears resulting from their own inadequately processed experiences (Fraiberg, Adelson & Shapiro, 1975; Freud, 1957; Raphael-Leff, 1993; 2000; Stern, 1995). In Freud’s paper on "Mourning and Melancholia" in writing about the shadow of the object falling on the ego, he was referring to such trans-generational transmission of unresolved experience.

Fonagy et al. (1994) consider maltreatment or trauma by caregivers as examples of failure to understand infants’ intentions, representing an absence of reflective functioning. This, in turn, deprives those infants of reaching an understanding of such traumatic interpersonal experiences, and thus, of developing the capacity for resilience.

2.1.4.2.3 Infant factors

Infants themselves may present difficulties which may contribute to early interaction disturbances that could interfere with, and undermine their relationships with their primary caregivers and thus, their attachment security, placing their emotional development at risk.

The innate characteristics and appearance of the infant inevitably help to fixate particular forms of projection from parents (Brazelton & Cramer, 1991). Gender is also a factor in India where the unwanted birth of a girl baby can represent a substantial risk to survival (Patel et al., 2004).

Infants who require special care such as pre-term, disabled and physically ill infants, tend to place enormous emotional demands on parents as they confront their fears, pain, disappointments, guilt and ambivalences (Papousek & Papousek, 1992; Raphael-Leff, 1997; Stern, 1995). The birth of a disabled baby particularly confronts parents with a reality that they can usually not cure or alter. It also has the potential to confront parents with their own internal unconscious destructiveness (Sinason, 1997) which they might find unbearable and feel guilty about.

Brazelton and Cramer (1991) talk about the “disappointing infant” and describe how, in such infants, the normal idealization of the infant prematurely breaks down and results in a sense of disappointment or disillusionment which represents “a sudden traumatic breakdown of the parents’ self-esteem” (p. 161). When infants are not responsive or unrewarding in their responses to their parents, or are difficult to manage, the parent’s intuitive behaviours may be inhibited and parents may develop a sense of failure and become less effective, or give up all together, missing or misreading the fragile and/or delayed emerging cues from the infant, and failing to provide the interactive behaviour that is needed (Papousek & Papousek, 1992).

Field (1997) reported on several studies in which babies of mothers depressed in pregnancy and after the birth, were doubly compromised in that their own behaviours in the early months, whether pre-dating or the result of the maternal depressed state, potentially contributed to interferences in the early relationships with their depressed mothers. These infant behaviours included increased fussiness, inconsolability and irritability. They also included reduced motor control, activity levels, physiological regulation, robustness and endurance on examination, as well as more limited expressivity and imitative behaviours.

In summary, following an exploration of the key elements, theories and concepts involved in the process of early infant development, parental qualities that contribute to the development of attachment security, empathy and the healthy emotional and social development of children, are determined by parental psychological resources, the characteristics of infants as well as the environmental stresses and supports available to the parent (Valenzuela, 1997).

While this chapter considered a range of maternal, infant and interpersonal risk factors that threaten this process, the following chapter will consider important environmental factors that play an influential role in infant development in the social context within which the Khayelitsha study was located.

CHAPTER 3

KHAYELITSHA: THE CONTEXT WITHIN WHICH THE STUDY WAS LOCATED

In the previous chapter I argued that in order to understand development in infancy, one needs to understand not only the relational, but the cultural context which inevitably varies from one community to the next. Our study, being situated in Khayelitsha, locates our intervention in the context of social transformation, poverty, violence, the HIV/AIDS pandemic, and limited resources. This being the case, and not denying the impact of other influences, it is important to consider these contextual factors which all carry risk to maternal and infant wellbeing. My goal in this chapter is to provide a historical and socio-economic description of Khayelitsha, as well as to outline various prevailing risk factors identified above. A detailed overview of the vast literature on the impact of violence, poverty and HIV on parenting is beyond the scope of this thesis, but there are some key issues that need to be kept in mind when considering the adjustment, curricula planning and design of interventions.

3.1. The cultural context

LeVine et al. (1994) remind us how important it is that any meaningful intervention be located in its socio-political context and culture which represent defining factors in infant development. Lieberman (1998) defines culture as “the sum total of a group’s way of living and being, including language, ethnicity, religion, moral values and rules for relating in social situations, expectations of oneself and others and, most basically, the question of what meaning people find in different aspects of life” (p. 12). Swartz (1998) refers to culture as “a process of being and becoming a social being, about the rules of society and the ways in which these are enacted, experienced and transmitted” (p. 7). With respect to parenting, while the developmental theories and research explore universal concepts and processes, what is believed to be good for babies and constitutes an ideal early maternal environment varies considerably across cultures (LeVine et al.1994).

In South Africa today, it is difficult to talk about any particular or ‘pure’ culture. People will at any time belong to multiple groups sometimes with very different and opposing “cultures”. Even family groups within the same “culture”, may differ in what they believe, and the way they live their lives. Furthermore, there is no ‘culture’ or group in South Africa today that is not struggling to meet the demands of our very new and challenging adolescent democracy.

The mothers in our cohort referred to their experiences through migration from rural to urban and peri-urban areas such as Khayelitsha, of being unable to rely on the traditional and cultural knowledge held by their mothers and grandmothers. Many of the structures, guidelines, beliefs and practices that helped

individuals to negotiate life in the rural areas are no longer meaningful as they struggle to adjust to their new circumstances (LeVine et al., 1994).

While the motherhood constellation seems to have a place in traditional society across the board in South Africa (Berg, 2007b), the experience of childbirth and transition to motherhood for many women in low-income communities, is often a far cry from the ideal (Youngleson, 2006). Kruger (2003, 2005) reports on the painful experiences of low-income women from a peri-urban “coloured” community which reflect tremendous vulnerability and lack of control in this life-stage transition. In Khayelitsha we were aware of the multitude of factors, reported by mothers, which contaminated the transition to and experience of parenthood. These included; ignorance, a lack of a sense of agency and control, constant stress related to survival needs and a lack of respect, support and control throughout the birth experience.

3.2. The community of Khayelitsha

The study I will be discussing was based in Khayelitsha, a peri-urban settlement approximately 45 kms. from Cape Town (See Fig. 1a & Fig 1b). Khayelitsha, meaning “new home”, represents one of the constantly growing and changing peri-urban communities in the Western Cape. It was established in the early 1980s, when black Africans residing in greater Cape Town were forcefully relocated. Large scale unemployment in the rural areas and the lifting of population influx control laws resulted in rapid urbanisation over the past twenty-five years, which has seen a sharp increase in numbers of people coming to the city to find work, schooling and better health facilities. Today Khayelitsha is South Africa’s largest single township, covering an area of 47km², with an estimated number of residents varying from 329,026 (Erasmus, Mans, Nel, Davids & Macrae, 2004) to 500,000 (Médecins Sans Frontiers, 2007) people, with a steady stream still moving in from the Eastern Cape. The population is almost entirely Xhosa speaking and compared to the Provincial average of 15%, only 6% of the population of Khayelitsha comprises people over the age of 50 years (Erasmus et al., 2004).



Fig1a. The sprawling township of Khayelitsha.

Fig 1b. Khayelitsha viewed from Cape Town.

Khayelitsha is a mixed formal and informal community. Residents live either in: a) Informally set up shacks made of wood and corrugated iron with no electricity or water-borne sewage (See Fig. 2 & Fig. 3).



Fig. 2. Wood and corrugated iron shacks.

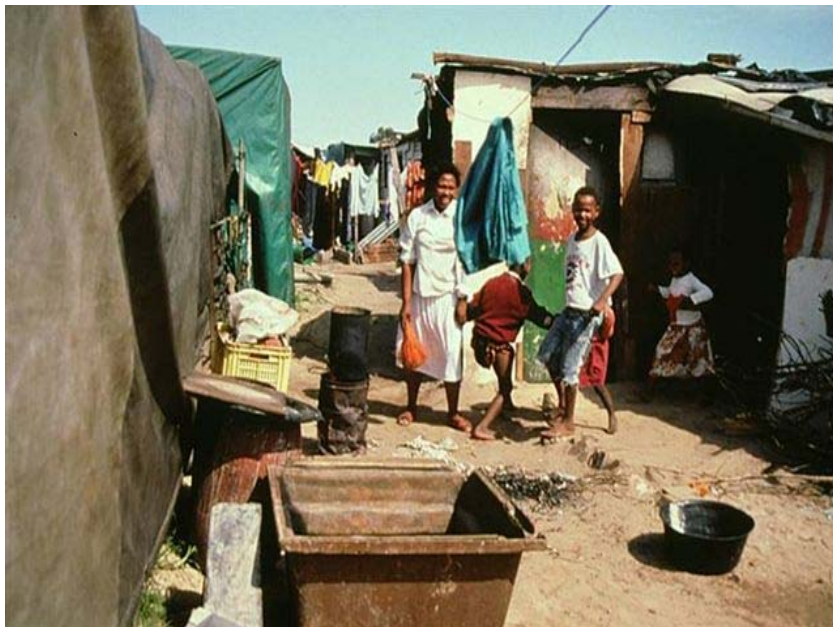


Fig. 3. No electricity or water borne sanitation.(All photographs shown with subjects permission.)

b) More formally organised areas with electricity, a tap and an outside toilet with water-borne sewage. In these areas, brick houses that are subsidised by government are increasingly replacing more established and larger shacks (See Fig. 4).



Fig. 4. More formally organised shacks.

c) Formally organised housing with larger more isolated plots. Core brick houses have inside toilets, taps and electricity (See Fig. 5). The population is highly unstable as families migrate from the rural areas and move from one area of Khayelitsha to another to upgrade their accommodation, to distance themselves from violence or move from flooded to drier areas.



Fig. 5. A development of core brick houses.

Keeping in mind that employment determines poverty, De Swart (2004) reports that in the greater Nyanga and Khayelitsha area, 64% of adults were unemployed and 52% of households had no wages at all. This is not entirely accurate however as in many households there tended to be multiple sources of funding including wages, income from informal trading and grants, with 55% of households receiving one or more social grants. In the Department of Social Development nodal baseline survey of 22 South African township communities, Khayelitsha (2008) emerged as the poorest community (Strategy and Tactics and Khanya – AICDD, 2008). This was based on the elevated rate of female-headed households, unemployment, no income, informal housing, functional illiteracy, overcrowding, lack of refuse removal, poor standard of water quality, and limited electricity for lighting. In line with other communities, residents identified poor service delivery, referring to grants and other government services; they had very little awareness, but also made little use of services available such as drop-in centres. As a result of distance and payment required, access to health services was considered a problem. HIV/AIDS is the major health problem followed by alcoholism, tuberculosis and to a lesser extent, drugs.

3.3. Environmental risk factors relevant to this context

3.3.1. Violence

South Africa is a country in transition. It has recently emerged from a regime in which inhumane laws, which victimized, traumatized and generally disempowered the majority of the population and tore at the fabric and structure of the family, community and society, prevailed for over forty two years. Despite the “miraculous” political changes of the early 90s and an enormous amount of good will, hope and genuine attempts by many at all levels to address the problems, a large proportion of the population continue to live in conditions of abject poverty, struggling for resources. Many express feelings of frustration and despair with the failures to address the high levels of unemployment, inadequate housing, violence and the lack of resources in services such as health and education.

Violence, with all its gendered dimensions, is extremely prevalent and permeates every level of our South African society but the exact scale of the problem is very difficult to quantify.

Violence against women is highest in the context of poverty while women who are empowered educationally, economically and socially tend to be better protected (Jewkes, 2009). A large scale community-based prevalence survey conducted in three provinces in South Africa (Eastern Cape, Mpumalanga Province & Northern Province) found that the prevalence of women ever having been physically abused by an intimate partner ranged from 19% to 28% (Jewkes & Abrahams, 2002). Forty two percent of men interviewed in Cape Town indicated that they had been physically violent towards their partners in the past 10 years and 8.8% admitted physical violence in the past year (Abrahams et al., 2006). The authors found that factors associated with abuse were: no further training once schooling had been completed, having witnessed parental violence in childhood, drug and or alcohol abuse, a belief that

hitting women was acceptable, frequent conflict and involvement in fights at work and in the community, as well as alcohol abuse in women. Jewkes and Abrahams point out how difficult it is to provide accurate statistics on rape. They found that police reports represented approximately 10% of incidents reported by community-based surveys and concluded that definitive rape statistics remain elusive. They did report, however, that one third of adolescent girls report forced sexual initiation.

Other forms of violence that prevail are: taxi violence (Dugard, 2001), vigilantism (Harris, 2001) and xenophobia (Landau et al., 2005).

It was recently observed that, “Even when political and legal systems change and traumatizing elements within the society are removed, individual and societal responses to the previously existing and devastating political system do not disappear overnight. Depending on the severity of the traumatizing events and how long they lasted, the influence of the shared trauma on the victimized group and their descendants may continue for decades” (Volkan, 2006, p. 15).

The problem of poor human quality of care has been recognized and interrogated (Jewkes et al., 1998; Penn-Kekana & Blaauw, 2002; Penn-Kekana, Blaauw & Schneider, 2004) but continues at this stage. A pertinent and relevant example of such enactment are the ongoing reports by the mothers of emotional, verbal and in some cases physical abuse they have to endure from some of the nursing professionals when making use of health facilities. In part this seems to come from the historical situation in which nursing was one of a few professions open specifically to black African women (Martineau, 1997), resulting in many entering the profession without the necessary interest or compassion required by the work they were trained to do. Further, the state of health care in the public domain is dominated by a lack of adequate resources (Benatar, 2004). This might include understaffing, enormous caseloads, poor pay and inadequate training, support, recognition and low morale for the primary care staff. These conditions place unmanageable emotional and physical demands on health professionals who also complain of abuse by the public.

Gibson (2002) speaks of “traumatic living”, which refers to the continuous emotional consequences of living in a society characterised by conflict. These consequences are represented in the way people think about themselves, their country, and their future. She states that “such consequences also exist in the quality of relationships people develop with one another - the degree to which these can be open, respectful and compassionate or are damaged by hatred and suspicion” (p. 10-11). Horwitz (2005) identifies vindictiveness, revenge, as well as failure to achieve, as consequences of failing to process trauma. Unless the victim is able to “let go both of their sense of grievance and of the wish to seek revenge” (p. 490) they are not able, satisfactorily, freely and with fulfilment, to get on with life. He also questions whether following horrendous trauma, and usually without apology, forgiveness is possible even for relatively mature and healthy people. Gibson alerts us to the dangers of ignoring the profound

consequences of the past violent repressions, social injustices and disruptions to family and social life. Nowhere is this more relevant than in the early parent-child relationship which represents an opportunity to mediate such negative transgenerational cycles. It is understandable that many parents have grown up having had to cut off their own pain in order to survive, however, unless they are encouraged to confront their own emotions, they are likely to struggle to recognise and appropriately respond to the normal emotional expressions and needs of their infants.

It is within this context that parents, and particularly mothers who often struggle alone, are attempting to rebuild families and relationships of mutual respect and to raise their children in ways that will equip them for a 'better', more secure and hopeful future.

Volkan (2006) suggests that one of the ways to break the cycle of what is termed the transgenerational transmission of trauma, is to intercede at the earliest stage of infancy and early parenting to support sensitive and responsive parenting, which facilitates attachment security and promotes respectful and compassionate relationships.

3.3.1.1. Violence against children

Maltreatment of children and its consequences has only been recognized as a social problem relatively recently, even in wealthy western countries, and for all forms of maltreatment from physical violence to emotional abuse, reliable epidemiological data remains elusive (Egeland, 2009).

In South Africa, in the wake of the previous regime, many relationships between parents and between children and their parents and families with whom they did not grow up, have been significantly damaged. It would seem that much of the unresolved and unexpressed hurt and anger, resulting from previous trauma, has been turned into unmanageable and helpless rage. This rage which has no "legitimate" expression and cannot be directed at any oppressing group seems to have been turned inwards to be expressed between members of the victimized group.

For many years, including the present, it has been very difficult for this nation to think about the emotional needs of children and their parents (Tomlinson & Swartz, 2002). Even today, many parents are still forced to act counter-intuitively to their parental role in order to manage the often very difficult choices that confront them.. An example of this is the ongoing practice of sending babies and toddlers to family in the rural communities in order for mothers to find work and earn the money required for the family to put food on the table, in the cities. This can only be done if the adults concerned don't think too much about the emotional consequences, for the child, of this early loss of primary caregiver.

While it is accepted that mandatory reporting of abuse is imperfect and represents an unreliable data source (Benjamin & Bross, 2008), it is all we have to go by and to abandon it would simply compromise child protection. Dawes et al. (2006), in a situational analysis of children affected by maltreatment and

violence in the Western Cape, using hospital records, report that most of the children identified as having been physically abused were under 5 years of age, and more than half were boys. Typically the perpetrator was a male parental figure and the assault took place in the home. Abuse and neglect cases, serious enough to reach Children's Court enquiries in 2006, were 3 in every 1000 children.

Waterhouse (2008) reports that in the three years from 2004 to 2007, rape against children reported to the South African Police Services totalled 68,564. This represents an average of 22,854 per year which, on the basis of earlier research, is likely to represent only 11% of actual rapes committed. These figures include the rape of young children and babies (Richter, Dawes & Higson-Smith, 2004).

Dawes et al. (2006) report that 20% of youths in the Western Cape were exposed to domestic violence of all kinds. Eight percent of teens witnessed domestic violence involving a weapon and 8% reported that the violence was associated with drug and alcohol use at the time of the attack. In the same report, 23% of teens reported being threatened or hurt, mostly by other learners in secondary schools, 56% by teachers or principals as punishment, 24% were sexually assaulted, and 20% were involved with illegal substances at schools. In communities, 68% of teens reported having seen someone intentionally hurt outside their home, and 75% of these teens knew the attacker, which put them at risk. In other surveys, 29-39% of learners witnessed stabbings or shooting in their communities (Ward et al., 2004).

Dawes et al. (2006) remind us that children who experience violence anywhere are at risk of injury, psychological trauma, and of repeating similar strategies of dealing with conflict in their interpersonal relationships. Campbell (1992), in attempting to explain the apparent upsurge in violence refers to a crisis in masculinity in African men:

The undermining, disempowerment and humiliation experienced by African men in the apartheid years in both the private domain of the family where they were unable to provide and support their families adequately and the public and political domain, resulted in the erosion of the traditional view of men as potent, powerful, proud beings. (p. 621)

She describes violence as one of the compensatory mechanisms used by oppressed men in seeking to reassert their masculinity through socially sanctioned power over women and young men in the family. She refers to the family, as "the cradle of violence"(p. 625), where "experiences of violence in childhood and family life are invariably socialized into a cycle of violence – manifested inter-generationally in families and perpetuated in wider society in many forms"(p. 625). In the political sphere, Achmat (2009) describes how the language of politics remains a language of intolerance and disrespect that continues to legitimise violence.

3.3.2. HIV and AIDS

UNAIDS and WHO (2008) report that by 2006 an estimated 1.8 million people had died of AIDS-related disease in South Africa and an estimated 5.5 million people were living with HIV, making this the country with the largest number of infections in the world. Those infected represented an estimated 18.3% of adults between 15-49 years, and 55% of these lived in KwaZulu-Natal and Gauteng Provinces. Mah (2008) reports that while population-based prevalence measures of Khayelitsha are not available, antenatal surveillance prevalence estimates there were 33% in 2006.

Men are not put in the same position of confronting the disease as women, who are routinely screened in pregnancy. As a result, women are still often thought of as the causal agent for the infection. The HIV prevalence amongst pregnant women in 2006 was 29% (UNAIDS and WHO, 2008). Those screened are given the choice of knowing the results.

Knowing brings with it emotional turmoil with anxiety and depression, guilt towards the unborn infant who might also be infected, and fear about what will happen to their child if they die (International Community of Women Living with HIV/AIDS, 2008; Sandelowski & Barroso, 2003). In HICS, disclosure offers support and more successful management of the disease process (Sandelowski & Barroso), of the mothers who choose to be informed of their status in South Africa, many still refuse to disclose their positive HIV status to their partners and families (Medley, 2004). Some of the reasons for nondisclosure include the fact that the disease still carries a powerful stigma. Women are discriminated against (International Community of Women Living with HIV/AIDS (2008) and fear being blamed, beaten or otherwise rejected by their partners, families and communities (Medley et al., 2004). Women who seek support from the support groups available in communities have to come to terms with the possibility that they will be identified by participants of the group they might know, or by community members who notice their attendance. Sandelowski and Barroso refer to a report on a meta-analysis of qualitative studies in the United States of America, on the way in which HIV/AIDS impacts on motherhood. They conclude that "Motherhood both intensifies and buffers the negative effects of HIV infection, and HIV infection both enhances and impairs maternal identity and mother-child relations" (p. 477). Long (2009) refers to the two the contradictory identities of motherhood and of being HIV positive colliding at this point.

Montgomery (2003) reports that HIV is transmitted from mother to child, in utero before the birth, during labour and the delivery and after the birth through breastfeeding. The larger the amount of the virus the mother carries, the more likely the transmission of the virus to the foetus so that the appropriate use of antiretrovirals during the pregnancy and birth the lower the risk of transmission. During delivery, interventions which may traumatize the foetal skin will expose the infant to transmission and, unless necessary, should be avoided. O'Neill et al. (1999) found that that in untreated mothers, transmission of

the virus to the infant is about 30% and about 65% of HIV infected infants, if not treated, will develop AIDS within the early months after birth.

HIV positive infants are at risk of altered patterns of growth and failure to thrive and therefore need extra nutritional and health care (Meleski & Damato, 2003). Infants with HIV tend to be compromised by the poor mental (International Community of Women Living with HIV/AIDS, 2008) and physical health of the mother as well as their own poor health. Montgomery (2003) refers to some of the reasons for the failure to thrive and higher rates of infection seen, these include the fact that the process of the disease tends to consume the infant's energy as the virus replicates and the body fights off the viral infection as well as other infections related to the virus and those commonly contracted by children. When disease strikes progress tends to be far more rapid and health care needs to be taken seriously and with thoughtful care.

Those not infected with the virus are likely to be affected nonetheless, by the interference the mothers' emotional turmoil will have on her ability to become preoccupied and think about her infant in utero and during the early months. There is likely to be some fear and guilt about being responsible for putting the unborn infant at risk, and not being able to breastfeed, thus, compromising their infants' health from the start.

3.3.3. Parenting and poverty

Halpern (1990) notes that the link between poverty and inadequate parenting leading to compromised child care and development has concerned American researchers and social reformers since the 19th Century.

Poor communities tend to be characterized by adversity, high unemployment, inadequate or unreliable income, substance abuse, high levels of violence, restricted access to good education, health services and information, inadequate, substandard and crowded accommodation, as well as a lack of basic resources such as safe and reliable fuel, funds for transport and food, which has particular relevance in the context of high levels of HIV/AIDS. There is also a tendency for uninformed fertility practices resulting in unplanned and unwanted pregnancies, many to teenaged mothers who do tend not to complete their schooling.

Multiple challenges, created by socio-economic stressors, confront parents with a range of obstacles to primary maternal preoccupation, and other attentive and sensitive qualities associated with early parenting which children need (Barnard et al., 1993; Halpern, 1990; Richter, 2003). Richter, Bac and Hay (1990) write that such social disorganization disables the nurturing capacities of mothers and caregivers: "The material and psycho-social conditions of economic hardship ... increase the vulnerability of children through their detrimental effects on the morale, motivational states and actions of the women responsible for childcare" (p. 491).

Leinonen et al. (2002) found that financial stress affected parental mental health, marital interactions and impaired the quality of parenting. They found that there was increased use of coercive and hostile discipline, non-involvement in parenting, or reduced attention to children's whereabouts. Preoccupation with financial insecurity, deprivation of resources and the needs to survive on a daily basis overburdens and overwhelms parents, leaving them with little space for preoccupation and reflection on the needs and communication of their infants.

Maternal mental health suffers in the face of poverty where we find up to three times more than the rate of postnatal depressions in higher income communities (Cooper et al., 1999). Richter (2004) argues that maternal depression is an important feature of maternal deprivation and that maternal deprivation is a factor linked to infant malnutrition and failure to thrive, even when sufficient food is available to the family. Tomlinson, Cooper and Murray (2005) found that infants in circumstances of poverty and maternal depression were less secure for longer. Murray et al. (1996) refer to adversity as applying a potentiating role in the adverse impact of postnatal depression on parent-infant interactions. Poverty and gender disadvantage are also increasingly being identified as major contributors to the risk for CMD (Patel et al., 2006).

Marital disharmony (Patel et al., 2004; Ramchandani et al., 2009) and a lack of support from partners have been shown to be strongly associated with both maternal depression and poor mother-infant interaction in the early months (Cooper et al., 1999). The presence of domestic violence in the home is associated with poor effects in a broad range of interventions aimed at reducing child maltreatment (Boris et al., 2006), and therefore has substantial long-term impact on children. Many of the mothers in high risk populations enrolled in home visiting intervention programmes in the United States experience partner violence. Ramchandani et al. (2009) found that antenatal exposure to extreme stressors such as witnessing violent crime or having ones life threatened proved to be a strong independent predictor of postnatal depression.

Infant nutritional needs and ability to thrive needs to be considered from a wider social and relational context than simply on caloric and nutrient intake (Berg, 2007b; Tomlinson & Landman, 2007). Richter (2003) refers to the combined effects of poverty, AIDS, maternal depression and malnutrition in under resourced countries, with a lack of development of capacity for social adjustment and productive competence in children. Richter and Mpelo (1995) remind us that malnourishment, in particular protein-energy malnutrition (PEM), is associated with poor socio-economic conditions, and that these two factors affect the nurturing capacities of caregivers. They describe the emotional states of malnourished infants and their mothers, and the effects of these states on their interactions with one another, as observed in 34 mother-infant pairs at a nutrition unit in South Africa. The malnourished infants were observed to be deficient in a range of behaviours. They tended to show reduced activity, insecurity and excessive dependency on the mother, limited expressive and cognitive capacities, which manifested in slow responses, poor adaptability and muted emotional tone. To compensate for such deficits, and facilitate the

emotional and cognitive development of these children would require “extraordinary enterprise, tolerance and perseverance” (p. 3) on the part of the parent. What they in fact observed, in more than 50% of the mothers, was a “defensive detachment” previously recognized by Polansky, Gaudin, Ammons and Davis (1985), thought to be a consequence of experiences of extreme deprivation. The mothers’ mental state was inevitably expressed in interaction with their children as unresponsive, insensitive and inappropriate. Scheper-Hughes (1984; 1989) explores a phenomenon that contributes to infant mortality in circumstances of extreme poverty and scarce resources in Brazil. This phenomenon has several names including “post-partum abortion” and “passive infanticide” (p. 535) and refers to the selective neglect and gradual elimination of a child judged by their mothers to be innately weak or “less fit” for survival and whom she feels unable to nurture and keep alive.

Despite the challenges, writers such as Halpern (1990) have for many years believed that many of the obstacles brought on by conditions of poverty can be “mediated by the interaction of situational factors, personal developmental history, and cultural affiliation” (p. 6). The presence of education, support from extended family, employment (Patel et al., 2004), support from a partner (Cooper et al., 1999; Richter & Mphelo, 1995), support received from other family and friends, and particularly the mothers’ mother (Stern, 1995) can go a long way to mediating such risk.

Richter (2003) argues strongly for the need for interventions that provide support for caregivers and children in conditions of extreme material need that can be implemented by trained non-professionals in conditions of poverty. The effect of a therapeutic intervention with new mothers and their infants around newborn behaviour, communication and regulation, could provide very effective preventive interventions that could alter the mothers’ knowledge, attitude and behaviour towards her infant. The concept of democratizing knowledge, in the context of power inequalities, between communities and professionals, which has been complicated in the past (Tomlinson & Swartz, 2002) seems more possible now that communities have begun to own their own power and to hold professionals more accountable. It seems more possible for professionals too to think less defensively about sharing the particular knowledge and skills they have in a respectful, meaningful, useful, cooperative and consultative way.

In summary, the harsh environmental challenges that have to be taken into account when designing interventions that hope to be preventive in nature in communities such as Khayelitsha have been outlined in this chapter. The next chapter will review of the relevant literature on preventive interventions undertaken across a broad spectrum of community contexts with a focus on those in low-income communities . It will also consider important elements and processes that have been identified as key in the process of therapeutic change.

CHAPTER 4

MECHANISMS OF THERAPEUTIC CHANGE AND AN OVERVIEW OF EARLY PREVENTIVE INTERVENTIONS

Before reviewing the relevant literature on preventive intervention evaluation across a broad spectrum of environments, the first section of this chapter will consider, at some length, what have been identified as key elements and processes involved in therapeutic change. Having some understanding of these is essential for understanding what it is that forms the bedrock on which all therapeutic interventions are based. The rich literature on change provides a useful framework for thinking about forms of change even in interventions which are not viewed normally as therapeutic, for example, psycho-educative interventions and community-based support interventions.

The range of literature discussed in this chapter is vast and could be organized according to a number of principles; for example it could be organized chronologically, or by topic, or approach. In keeping with my view though, that there are useful parallels between the literature on therapeutic change and on optimal infant development that seem to apply equally to all growth throughout life, I have organized the material to parallel the order of presentation given in Chapter 2.

4.1. Mechanisms of therapeutic change

Stern (1995) observes that any therapeutic intervention at this stage of early parenting, in which infants and parents are naturally experiencing “the greatest and fastest human change process known” (p. 3), offers unique opportunities for positive change. At this stage, and while not unique to this stage, certain elements dominate the process. These elements include the fact that any therapeutic intervention needs to address the adult parents, the infants and the relationship between them, interventions with infants are conducted largely nonverbally and presymbolically, infants in therapy are both the real infants, who are yet to be known, and the infants as constructs or representations, who carry in the mind of the parent all their wishes and fears and unconscious projections. Of note, is that many of the elements of the developmental processes of early infancy have parallels and inform the past and emerging theories of therapy.

The process of change in psychotherapy has fascinated theorists ever since Freud first spoke of the “talking cure” in the late 19th century. In general, the concept of psychotherapeutic change is intrinsically linked to the particular goals and the core aspects of personality conceptualized by the various theorists and approaches to therapy. It has been reported that different approaches to psychotherapy tend to work equally well in bringing about change independent of theoretical assumptions (Cooper & Murray, 1997; Gaylin, 2000), and this applies equally to parent-infant therapies (Stern, 1995). More recently, however, a comparative analysis of controlled trials showed long-term psychodynamic psychotherapy (LTTP) to have

“significantly higher outcomes in overall effectivity, target problems and personality functioning than shorter forms of therapy” (Leichsenring & Rabung, 2008, p. 1551) which make it clear that much still has to be learnt.

In an attempt better to understand what it is that facilitates therapeutic change, this first section of the chapter will consider some of the core therapeutic elements and techniques identified as central to the process of change. This will be followed by a section on the recent development of models attempting to describe mechanisms of therapeutic change. The last section will focus on therapeutic approaches developed specifically for infants.

4.1.1. Core therapeutic elements and techniques

4.1.1.1. Interpretation, insight and other explicit knowledge

In the psychoanalytic tradition, lasting change requires challenging the established false or distorted assumptions about the world and then rediscovering the real world. This is dependent on the development of insight which requires that the links between the unconscious anxieties, defences and hidden feelings or impulses become conscious and understood (Malan, 2003). Until recently, insight through interpretation was thought to be the transformative element in psychoanalytic psychotherapy or analysis. However, to quote Stern (1998):

.. even in a ‘talking therapy’, a vast amount of therapeutic change occurs in the realm of procedural knowledge that is not conscious, especially implicit knowledge of how to act, feel and think when in a particular relational context (implicit relational knowing). (p. 307)

Lyons-Ruth (1998) makes the point that what might be articulated in a therapeutic context is likely to be only a small part of the patient’s¹ implicit relational knowing and the patient’s and therapist’s implicit operating procedures. Morgan (1998) goes so far as to suggest that, because “implicit relational” or “procedural knowledge” is acquired, developmentally, long before the development of symbolism or language, verbal interpretation seems insufficient and unnecessary for insight and change to occur. Stern (1998) recognizes that appropriate and well-timed interpretations that are experienced as attuned and congruent, can change “now moments” into “moments of meeting” resulting in an intensification of affect between the participants, thus, altering the implicit and explicit knowledge between them.

¹ The term “patient” tends to be more frequently used in the psychoanalytic literature while the term “client” tends to be used more often in the cognitive-behavioural frame of reference. I will be using both terms interchangeably in an attempt to be true to the way they have been used by the various contributors. in the literature.

Despite inconclusive evidence, interpretation remains a key element in the development of “explicit” knowledge, conceptualization and insight, and of facilitating lasting change (Beebe, 1998; Gaylin, 2000; Stern, 1998; Tronick, 1998).

Kazdin (2007) points out that while it is well established that cognitive therapy is effective in bringing about change, little is known about how it works. Gaylin (2000) states that when explicit knowledge and information is linked to certain emotions such as fear, shame or guilt, or is shared with another, it is able to influence the individual’s state of mind and can motivate them to change their behaviour. He uses the term “adaptational insight” (p. 135) to refer to knowledge which emerges exclusively through a more conscious process of analysis of everyday transactions in the present, which forces a questioning and a different understanding of relationships.

The question of whether advice facilitates change in behaviour is controversial.

Freud (1973) believed that advice served no purpose and that the repercussions of such advice was unpredictable. Malan (2003) points out however, that even psychoanalytically inclined psychotherapists acknowledge the usefulness of advice if used properly. He warns though, that there are potential pitfalls in giving prescriptive advice on emotional issues. These include the fact that often advice is simply ineffective; no one is omniscient and knows what solution would be best for another, nor is anyone fully aware of all possible consequences of actions for others. Ultimately, for the development of self-as-agent, empowerment and confidence, it is important that people take responsibility for important decisions in their lives.

Requests for advice may be due to defensiveness and a means of avoiding emotional issues or conflicting feelings, and some exploration of this question, reflection of the feeling or interpretation often brings about a realization of the underlying issues. When such understanding occurs it often brings relief which tends to deepen the rapport and trust in the counsellor, allowing for more vulnerability to be expressed and explored, and resolutions tend to become evident to the person experiencing the problem.

Gaylin (2000) cautions that emotional struggles are not rational in nature, they require the resolution of internal conflicts that drive the client to repeat dysfunctional patterns of behaviour and are symbolic in nature. Furthermore, advice introduces therapists’ values and judgments into the process. He argues here, that because no therapist or therapy is value-free it may be useful for these values to be openly shared between the therapist and patient, allowing the therapist’s biases to be carefully examined. He suggests that the place for advice is valid “particularly when one has expert knowledge not possessed by the other person” (p. 26), which could assist the person in their decision-making. Often a request for information is simply a request for information. It suggests that there is something the person has thought about but cannot understand or manage to resolve alone. We need to recognize too that in the field of explicit knowledge, information and understanding about how things work is likely to enhance a sense of

competence, understanding, efficiency, confidence and agency in the world. It can also enhance the capacity to “hold” and “contain” difficult emotions.

Bandura (1977b) also wrote about the importance of “observational learning” and “participant modelling”, as a way of conceptualizing and learning new patterns of behaviour. Many of the parenting programmes, across the developmental stages such as Systematic Training for Effective Parenting (STEP) (Dinkmeyer & Mc Kay, 1975), Parent Effectiveness Training (PET) (Gordon, 1970; 1976), How to talk so children will listen and listen so children will talk (Faber & Mazlish, 1982) and others, are based on modelling, role-playing, skills building, education and practice and other psycho-educational programme strategies (Dattilio & Freeman, 1992). Cognitive therapy is based on the belief that experiences are cognitively structured, based on the core beliefs or central values determined by the early relational environment, which go on to determine how a person feels and behaves (Bandura, 1977b). Therapy therefore focuses on exploring and exposing the content of the client’s dysfunctional thoughts and beliefs or “cognitive distortions” and the impact these have on the way they feel.

4.1.1.2. Affects as a key element of change

Although Freud realized that “abreaction” did not shift the presence of symptoms, affects became considered as an important contributor to change in later psychoanalytical thinking. Gaylin (2000) notes, “... the patients’ emotions supply the only source of power capable of shifting the weight of conduct. ... the power of emotions can be mobilized to force actions, to change behaviour from self-destructive to self-fulfilling” (p. 299). Catharsis is able to bring about substantial relief which works in several ways: In the first instance it serves to purge or release toxic emotions, wishes and thoughts. This belief formed the basis of many popular therapies. Secondly, it is effective in relieving anguish through confession and forgiveness by an authority figure who makes no judgment. It frees the person from moral responsibility, and torturous shame and guilt. Thirdly, sharing shameful and painful feelings with others creates a sense of community which can be very comforting, especially in circumstances where people are isolated in their psychological distress. Many self-help groups like Alcoholics Anonymous operate on this principle. It seems that while catharsis plays an important role and has the potential to be transformative, unless it is experienced within a relational environment and is accompanied by mental processes which bring understanding and offers more constructive alternatives to dysfunctional behaviours, it may not be sufficient to produce change.

Rogers (1946) describes a model of catharsis and insight in the safe presence of, and in relationship with, a concerned, non-critical, understanding and accepting other, while Modell (1998) refers to the need for an affectively charged present moment, shared by both parties, as having the potential to change a “now moment” into a “moment of meeting”.

4.1.1.3. The therapeutic alliance

There seems always to have been a sense that something more than talk, technique or interpretation is required to bring about change through the therapeutic process. While all therapeutic theories and approaches have tended to focus on technique, their reliance on the establishment of a therapeutic relationship in order to proceed was always implied. Freud (1973), for example, was very aware of the need for an affectional bond to be developed in the transference. Marziali and Alexander (1991) reviewed the psychoanalytic literature and concluded that, across the board, it was the quality of the therapeutic alliance that remained the central determinant and powerful predictor of therapeutic change and treatment outcome. Zetzel (1956) used the terms “working alliance” and “therapeutic alliance” to describe this relationship that develops between the therapist and client. Cognitive therapists refer to collaboration between therapist and client (Dattilio & Freeman, 1992).

It was Carl Rogers who pioneered the shift in therapeutic focus, “from an emphasis on technique to that of a relationship” (Corey, 2001, p. 184). Rogers considered the relationship with a facilitating counsellor as the cornerstone of “person-centered” counselling and the instrument of change. Within this critical relationship, the client is enabled to define, clarify their own goals, and organize and resolve their own issues (Rogers, 1946; 1957)

The contribution of Rogers’ “client-centered” or “person-centered” therapy provided a basic empathic model of counselling and therapeutic technique that recognized the importance of the therapeutic alliance. While Rogers did not attempt to explain the mechanisms involved in this process, his model could equally apply to all therapeutic relationships and has become the most versatile and accessible approach across a variety of therapeutic treatments, varying from brief crises management to medium-term support in adjusting to new life stages and long-term treatment focusing on insight and the uncovering of unconscious processes.

His theory postulates an innate human striving for self-actualization and reflects his belief in people’s capacity to understand themselves and resolve their own problems if given the opportunity to engage in a particular kind of personal or therapeutic relationship. This was a shift away from focusing on problems to one aiming at facilitating greater independence and integration, thus enabling people to manage their lives more effectively. This approach relies on the role of the therapist being facilitative and non-directive, based on the belief that if provided with some understanding of the way clients experience themselves in the moment, they have the capacity to change themselves. They will know the areas that concern them, know when to address these concerns without evoking too much anxiety or panic and thus, will be able to protect themselves from elements that are still too powerful or painful to confront at that time. As they are more able to explore the repressed material necessary, they will be able to gain understanding and insights

that are more accurate, and to translate these into more constructive behaviours with respect to balancing their own needs (Corey, 2001).

Rogers (1946) identified three essential personal characteristics in the therapist that he believed were necessary and sufficient for the development of a transformative therapeutic relationship or alliance; accurate empathic understanding, congruence or genuineness, and unconditional positive regard and acceptance.

4.1.1.3.1. Accurate empathic understanding and listening

In psychotherapy, clinical empathy, which can be traced back to Freud's understanding of the role of analytic listening, refers to the therapist's capacity to understand clients' experiences and feelings sensitively and accurately as they emerge in the moment-to-moment interactions in the therapy. For Rogers, this required identifying with the client and experiencing the client's feelings as though they were his own but with a clear sense of boundary between counsellor and client. The purpose of this is "to encourage clients to get closer to themselves, to feel more deeply and intensely, and to recognize and resolve the incongruity that exists within them" (Corey, 2001, p. 178). Rogers (1946) believed that the experience of being listened to with concern, heard and understood with empathy by an "other", enabled self-directed regulation and change.

4.1.1.3.2. Congruence, or genuineness

Congruence refers to the therapist not being in a "role" but being integrated, authentic, genuine or "real". This resonates somewhat with what Lyons-Ruth (1998) referred to as the "real relationship". This equality and openness of attitude, feelings and knowledge exists within clear boundaries and psychological separateness, which need to be maintained so that any interaction within the relationship is appropriate and works in the service of the client's development.

4.1.1.3.3. Unconditional positive regard: Acceptance, support, reassurance and encouragement

Unconditional positive regard and acceptance refers to the need to communicate to the client a genuine caring and acceptance of their thoughts and feelings, uncontaminated by evaluation and judgement (Rogers, 1946). Gaylin (2000) describes one of the most profound effects of therapy as having the opportunity as a client to experience, identify with and internalize; instead of experiencing a critical, remote, punitive internal authority, he describes encountering a supportive, accepting, patient and benign therapist who is an ally displacing the critical parent and whose approval is sought. He adds that the use of reassurance seems legitimate in endorsing self-confidence and hope at such critical life stages as early motherhood. This is a concept that resonates with the "internal object" of psychoanalysis and the "internal

working model” of attachment theory. The question that remains is whether this transference requires analysis in order to produce change.

While person-centred therapy is described as non-directive, it is only non-directive in the sense that the patient’s preoccupation leads the process. This sense clients have of being able to set the agenda, be attended to with interest, listened to and heard and responded to by someone in authority, is likely to represent an unusual experience in contrast to earlier relationships with parental and authority figures, and represents a new model of authority and interaction.

Rogers (1946) warns however, that this approach, with its clearly defined and simple to understand and uncomplicated basic conditions and skills, gives the “illusion of simplicity”. It seems simple until put into practice when one discovers that there is absolutely nothing simple or uncomplicated about listening empathically with genuineness and unconditional positive regard, even with clients being responsible for their own process and progress. The approach requires the capacity to provide “marked” responses, thus, a relatively intact sense of separateness, self-awareness and self-acceptance on the part of the therapist. Listening deeply to others requires a capacity to bear and be open to feelings without becoming contaminated, overwhelmed or defensive. One needs to have a capacity to manage “not knowing” but remaining thoughtful with someone who might put pressure on one to provide direction and answers. Although Rogers’ person-centred approach does not require the use of directive interpretations it does require an ability to reflect mindfully on affects, thoughts and intentions of the client which defines mentalization and the reflective function (Fonagy et al., 2004).

4.1.1.4. Client involvement

Marziali and Alexander (1991) report that an important factor associated with outcome was client involvement. Clients who felt involved in a collaborative process with their therapist showed greater improvement than those where therapists carried the major responsibility. Furthermore, the level of pathology and quality of interpersonal relationships and pre-treatment functioning affect the development of the therapeutic alliance. The healthier and less defended the client, the more successful the treatment. Clients who “disclosed” and “expressed” rather than become “walled off” or “avoidant” had better outcomes. If by the third session the therapist has not been successful in engaging the client, the predicted outcome can be judged to be poor.

Gaylin (2000) spoke about the need for some emotional capacity to form a relationship, and the courage and will to change. He identified passivity based on a fear of failure and infantile dependence as two destructive character traits which threaten to undermine therapeutic growth. Corey (1991) identifies the client’s motivation, cooperation, interest, concern, attitudes, perceptions, expectations, behaviour and reactions to the counsellor as important contributing variables to the development of the therapeutic relationship and treatment outcome.

An important consideration with preventive interventions is that unlike individual therapy which is undertaken by motivated clients who have identified a need and sought help, many of the community clients who are offered this type of service often come from a place of passivity, a lack motivation and a sense of powerlessness in their lives, and do not necessarily see the value of such services. For this reason, it seems important to establish the therapeutic alliance as a priority.

In reviewing the key concepts and therapeutic processes of the full spectrum of therapeutic approaches and techniques, Corey (1991) concludes that:

Counselling is a personal matter that involves a personal relationship, and evidence indicates that honesty, sincerity, acceptance, understanding, and spontaneity are basic ingredients of successful outcomes. Therapists' degree of caring, their interest and ability in helping the client, and their genuineness are factors that influence the relationship. ... describes what he considers to be the common characteristics of "highly successful therapists": a genuine respect for people, flexibility, a nonjudgemental attitude, a good sense of humour, warmth, authenticity, and the willingness to recognize and reveal their shortcomings. (p. 436)

4.1.1.5. The therapeutic frame

Fundamental to the integrity of any therapeutic process is the notion of the therapeutic frame and professional boundaries, which is a relatively recent consideration in psychoanalysis (Gabbard, 1995). The frame defines the ground rules and reliable circumstances, including the essential and optimal conditions, arrangements and agreements under which therapeutic work progresses best. Differences in frames derive, amongst others factors, from differences in the therapists' work situation, their client population and their personal circumstances (McWilliams, 2004). These include the concrete space and practical arrangements and regulations set up between the parties that determine the predictable and dependable routine, and the accepting, non-judgmental relationship with their counsellor that respects confidentiality. The frame serves to protect the therapist, client and their relationship and is fundamental to the development of trust (Petts, 2007). Frenkel (2003) describes how the frame, which implies emotional connection as well as separation and distance in which the psychological interest and needs of the client are primary, provides the necessary containment required for the work of therapy to take place. She makes the point that this space is not one limited to the concrete space but incorporates a "metaphorical" frame that is carried in the mind of the therapist. In settings such as a community where the safety of the physical space provided by the therapy room and negotiated boundaries is absent, this concept of an internal frame that is transportable, becomes very useful. It has particular relevance in community settings in which community counsellors are far more exposed and vulnerable due to their compromised sense of separateness as a result of living and working in the same community as their clients. Their lack of training also reduces

their capacity to protect themselves from enactments due to transference and countertransference dynamics.

4.1.2. Recent models of intersubjective mechanisms of therapeutic change

One of the core mechanisms of the psychoanalytic approach is the transference relationship between the therapist and the client, in which the client's unconscious feelings and fantasies are transferred to the analyst. It is through these becoming more conscious through the therapeutic relationship with the therapist that "unfinished business" from past relationships are resolved (Freud, 1973).

Alexander and French (1946) introduced the term "corrective emotional experience"; by this they meant:

... re-experiencing the old, unsettled conflict *but with a new ending* is the secret of every penetrating therapeutic result. Only the actual experience of a new solution in the transference situation or in his everyday life gives the patient the conviction that a new solution is *possible* and induces him to give up the old neurotic patterns. (Malan, 1979, p.140)

Gaylin (2000) provides us with a more general description of this form of experience as:

- a) An active engagement in the form of an event or series of events, lived through, with another person leading to the accumulation of knowledge, insight or skill. This knowledge does not emerge from self-examination or cognitive understanding but represents implicit learning and knowledge derived through the experience of a relationship.
- b) It is an experience that engages the most profound emotions of the patient.
- c) It is an experience that in itself challenges and corrects previous misconceptions and expectations determined by former relationships. "Good therapy is a corrective emotional experience" (p. 218) which is subsequently explored outside in other relationships.

He states that "the regressive aspects inherent in the psychoanalytic (or other therapeutic) situation enhances the power of the therapist to mobilize the patient's emotions" (p. 300). Perceived as the parent who must be pleased, the therapist holds the power to encourage health which "should be used unapologetically" (p. 300). Through the power of the corrective emotional experience the patient learns to trust at least one (safe) person, the therapist.

Until infant research and observation began to track in minute detail the interactions of infants, and new techniques made it possible to observe neural functioning in the brain, speculation about the specific mechanisms of growth and change within the interpersonal environment could not be attempted. More recently great strides have been made in the construction of realistic and accurate models of therapeutic processes.

4.1.2.1. The Change Process Study Group's Procedural Theory of Therapeutic Action

In the late 1990s, a group of intersubjectivists calling themselves the Change Process Study Group (N. Bruschweiler-Stern, A. M. Harrison, K. Lyons-Ruth, A. C. Morgan, J. P. Nahum, L. Sander, D. Stern, and E. Tronick) met regularly in Boston from 1995 to 1998, bringing together their combined expertise to explore the 'something more' in the therapeutic interaction that 'catalyzed' the change process. They defined the goal of therapy as acquiring a sense of agency and effectiveness in life which translates into a feeling of well-being, containment and confidence in the world. Therapeutic change, therefore, is described as the process that supports the strengthening of this development.

The point of departure of the group came from an observation the group made about how patients "remember 'special moments' of authentic person-to-person connection with their therapists, that altered their relationship with him and thereby their sense of themselves" (Lyons-Ruth, 1998, p.284). Drawing on the new understanding of brain development in early infancy, non-linear dynamic systems theory, observations of clinical and therapeutic processes, microscopic attention to interactional exchanges in the early nonverbal mother-infant interactions and particularly knowledge gained in the process of mother-infant regulation and the notion of change in implicit knowledge through the creation of "dyadic states of consciousness", they developed the "procedural theory of therapeutic change" (Tronick, 1998).

Unlike the mother-infant dyad, the adult therapeutic process is not a biologically determined developmental process, as both participants begin with their own unique and already established "implicit relational knowledge". Change therefore requires a transformation of affective memory (Modell, 1998).

What is required for change to occur is the introduction of a new element or "something new" in the intersubjective space between the therapist and patient that challenges the client's implicit relational knowledge of relationships. It requires the client and therapist to reconfigure and reintegrate their existing state to form a new state of consciousness or implicit relational knowledge. When this emerges in the therapy the potential exists for change in all subsequent intimate and social relationships with others. Distinct from psychoanalytic theorists, the group use the term, intersubjective field, in a specific way to mean the unique field or dyadic state that is created, in therapeutic interventions, when the 'implicit relational knowing' of the therapist and client intersect, through a process of mutual regulation of affect. It is a state that "extends beyond the transference-countertransference domain to include authentic personal engagement and reasonably accurate sensings of each person's current 'ways of being with'" (Lyons-Ruth, 1998, p.285).

What follows is a description of the various elements of the theory, with a summary of change process of a therapy session, described by Stern (1998).

The session begins with the therapist and patient in an initial and particular "dyadic state of consciousness" or "intersubjective state", each with the "implicit relational knowledge" they have

concerning how they usually relate. As the session proceeds, both parties are involved in what Stern calls the “moving along process”. It is similar to what Beebe (1998) called “ongoing regulations” which describes, “the usual ongoing way that therapist and patient relate to each other” (p. 337). It is analogous to the “recurrent interactive sequences” or “mutual regulation process” in mother-infant interactions in which both participants are in an improvisational, self-finding, self-regulating mode in which the goals may shift. Each step in this process comprises a “present moment” in which both come to understand what is happening between them before an intention or wish motivates them to move off in a particular direction, marking the next present moment. These present moments strung together represent “schemes of ways of being-with-another” The patient and therapist “move along” from “present moment” to “present moment” until, at some point, a qualitatively different, spontaneous, unpredictable, affectively charged present moment emerges, creating an unforeseen, unexpected, non-linear leap that he called a “now moment”. This emergent “now moment” is potentially transformative in that it presents a conscious challenge to the “implicit relational knowing” of each participant and their relationship. (e.g., the patient suddenly accuses the therapist of being uncaring of her). In the therapy, these “now moments” are anxiety-provoking as they tend to challenge the frame. If the therapist is able to resist the urge of resorting to role and “known” techniques, and instead, is able to bare the discomfort and risks of space or “not knowing” what to do next as well as remaining conscious and authentic, allowing, in Model’s (1998) words, “a moment of affective authenticity that equally engages both participants” (p.344), the “now moment” has the potential to change to a “moment of meeting”. It is this “moment of meeting” that represents a potential transition to a new dyadic state of consciousness between them. To quote Morgan (1998), “The ‘now moment’ ... loosens the grasp of the patient’s past patterns and recontextualizes those problematic aspects of the past” (p. 330).

In parent-infant work, ‘a moment of knowing or meeting’ allows the perception of a separate and “real” baby by the mother and an experience of relief from projections for the baby, in the presence and with the facilitation of the therapist. This seeing something differently in ‘a real relationship’ results in a dyadic expansion of consciousness for both mother and baby (Thomson-Salo, 1999).

Sander (1998) identified “the moment of meeting” as the element required for transformative change. He was influenced by Buber (1965) who believed that:

... an important kind of healing occurs through “meeting” rather than through insight and analysis. Through “entering into relation” men confirm each other, and each becomes a self with the other. By mutual confirmation, man knows himself to be “made present in his uniqueness by the other. (Buber, cited in Beebe, 1998, p. 335)

“Moments of meeting”, also referred to as “moments of changed reciprocal recognition” (Lyons-Ruth, 1998; Sander, 1998; Stern, 1998), moments of being understood (Nahum, 1998), and “moments of shared

awareness or realization” were thus identified by the group to be the transactional events pivotal in the change process (Tronick, 1998). For Stern, it defines moments “when the participants interact in a way that creates a new implicit, intersubjective understanding of their relationship”, that, “points to a new way-of-being-with-the-other” (p.300). Lyons-Ruth describes jointly constructed moments in which “there is a specific recognition of the other’s subjective reality. Each partner grasps and ratifies a similar version of ‘what is happening now between us’” (p. 286). Tronick talks about shifts in anticipation of each partner making new forms of interaction between them possible.

These shifts in consciousness, change and transformation do not necessarily require an awareness of a particular moment when change occurs, but can happen over time (Nahum, 1998). Nahum describes “delta learning” which refers to “what one learns about the world because something does not happen” (p.318), good or bad, for example, one’s feelings not been dismissed and not being humiliated for something said or done. This describes a “good enough” series of interactive exchanges with a benign, interested, caring and generally attuned other capable of creating “now moments” and “moments of meeting” that shift self-perception, creating change.

As with mother-infant interactions, a “moment of meeting” tends to be followed by a concept Sander, (1998), called “open space” in which the couple can now disengage so that each partner is alone and able to create something for themselves but in the presence of the other. For Stern (1998), this open space has the function of assimilating the “moment of meeting” before taking up the “moving along” in a changed and expanded dyadic state of consciousness. Modell (1998) states that, “For the “now moment” to be therapeutically effective there must also be a recontextualization of memory ... leading to a transformation and transcending of the past” (p.344).

In this model the “real relationship” has a very specific meaning and has nothing to do with the patient’s or therapist’s relationships in real life. It represents an essential aspect of the therapeutic relationship, within the safety of the therapeutic frame, when in a spontaneous interchange with the patient, the therapist experiences and expresses him or herself in a spontaneous moment, in an authentic, real or genuine way, as opposed to being dictated to by his or her role (Morgan, 1998).

“Now moments” and “moments of meeting” are characteristic of all relationships in which both participants have an opportunity to take on elements of the other and expand their respective states of consciousness. However, in therapy, as in infant development, and in line with non-linear dynamic systems theory, relationships between participants are asymmetrical and serve the interests of clients exclusively. When this happens, the client, in relationship with a more complex system in the shape of the therapist who represents emotional maturity, experience, the voice of authority, expertise, status and power, is able to expand to become more complex and coherent. While not denying the effect of the interaction on the therapist, the role of the therapist is to provide opportunities for such expansion to occur

and to change and expand the implicit relational knowledge or state of consciousness of the patient (Morgan, 1998).

The process of therapeutic change also depends on the patient's capacity to internalize the more complex and multileveled mindset of the therapist. To this end, it is the patient who remains the primary regulator of the relationship, the one to lead the interaction.

Bateman (2004; 2009) emphasized the point that "mimicking" or "mirroring" infants' or patients' response too accurately has the potential to drive babies or patients "mad". Morgan (1998) points out that feelings or thoughts need to be communicated in a "marked" or changed way, allowing the patient to perceive the thought or affect as a representation in the mind of the therapist or "other". This process seems to describe what Bion (1991) termed the "alpha function". Patients then re-introject such marked responses or perceptions and experience them as representations of their own thoughts. Through the use of "marked", empathic mirroring of the mothers' feelings and concerns, secondary "marked" representational structures are able to emerge. The integrity of this separate and asymmetrical relationship is maintained and protected by the therapeutic frame.

Bruschweiler-Stern (1998) illustrates how a "now moment" was turned into a "moment of meeting", in a brief interaction that took place when she demonstrated and explained the capacity of a distressed infant to calm down and regulate itself, to a mother who was feeling incompetent and projecting a nervousness onto her infant's uncontained and disorganized behaviour. This "moment of meeting" created relief and pleasure for the mother and "provided her with a chance to reconnect with a representation of a gratifying baby that permitted her to feel like a competent mother, while the threatening representation of a "nervous little girl" could fade into the background" (p.322). This moment freed the mother up to be able to talk about her isolation and lack of social support.

For Stern (1998), the "now moments" that are missed in therapy and not transformed as "moments of meeting" represent missed opportunities for change. These moments, however, tend to recur providing opportunities for transformation at a later stage.

4.1.2.2. Interpersonal interpretive mechanisms (IIM) -The contribution of Fonagy et al. (2004)

Fonagy et al. (2004) attempted to adapt the social-biofeedback model of affect-mirroring between mother and infant to the therapeutic relationship, the goal of therapy being the enhancement of mentalized affectivity. They describe this process as having three elements: a) identifying, b) modulating, and c) expressing affects either inwardly or outwardly. Each element is reliant, to some extent, on the previous element and all have basic and more complex forms.

- a) The ability to identify affects is often complicated by not understanding or knowing what one feels, feeling uncomfortable with the feeling or confused by conflicting feelings. Complexities arise when feelings are superseded by others (e.g. fear or guilt by anger) as happens with defence mechanisms.
- b) The modulation of affects relates to the capacity to alter the intensity and/or duration of the feelings felt, through the understanding and interpretation of the environmental circumstances which includes empathy for the other. They defined empathy as requiring the mechanism that, “allows one individual to assume another’s perspective and to infer and, to some degree, experience their emotional state of mind” (p.137). This state of “mindedness” or “mentalization” resonates strongly with the concept of “accurate and empathic understanding” (Rogers, 1946). An example of the modulation of affects is when the mother’s feelings of helplessness when her baby cries, comes to feel less overwhelming and more easily managed once she understands that the baby is distressed rather than thinking her baby is “getting at her”. This ability to interpret the meaning of the affective state in the other in the present might require some re-evaluation of one’s own earlier experiences.
- c) The expression of affects refers, at a basic level, to the choice we have of restraining our expression or allowing it to flow, that is to experience them inwardly or outwardly. The inward expression of affect depends on the presence of a representational system that provides this option when it might be strategic to restrain our expressions. It is consistent with self-reflexivity and entails recognition and reflecting on one’s affects while in an affective state and deciding whether their expression would be desirable or not. (e. g, recognizing, identifying and experiencing feelings at a deeper level without expressing them outwardly as it would not be possible for the other to bare these feelings at that moment.) Mentalized affectivity gives us options about how to respond and forces us to take responsibility for our affects. As a form of communication, affect expression is complex and can be used in a dialogue with regard to others or without. The communication of affects implies the expectation of a response that will reflect understanding and reflects an investment in intimate and social relationships and is based on earlier affect mirroring.

Fonagy et al. (2004) refer to the interpersonal interpretive mechanisms (IIM) which they believe, as does Aragno (2008) (discussed in the following section), “subdivides anatomically into two substructures: the IIM-a (a for affect) and the IIM-c (c for cognition)” (p. 137). Emotional resonance or empathy manifesting in IIM-a and reasoning in IIM-c while “the theory of mind” or “mentalization” covers both of these.

According to Bateman (2009), mentalizing refers to implicitly and explicitly interpreting the actions of oneself and others as meaningful on the basis of intentional mental states (e.g: desires, needs, feelings, beliefs and reasons). Mentalization develops within an attachment system and is highly dependent on the

developmental competence and current circumstances capable of affecting the performance of each participant. Emotional and affective arousal tends to interfere with the process of thinking and mentalization. He stated that the goal of therapy was not insight but the capacity to have insight.

Fonagy et al. (2004) believe that interventions that work are likely to be those that enhance the functioning of the (IIM) and moderate genetic endowment towards expressing themselves more positively. In order to enhance the mentalized psyche, “the child needs repeated experiences of: his current mental states, these states represented -thought about- in the object’s mind, and the ‘frame’ provided by the parent” (p.266) or an other. Like the child, an adult client needs an “other” who will ‘play along’ or experiment with fantasies, ideas and feelings represented in the mind of that “other” in an “as if” way, that he or she can introject and use as a representation of his own thinking.

These authors make the point that, in the therapeutic situation, when patients have developed relatively good symbolic and reflective capacities based on adequate early attachment relationships with at least one early caregiver with adequate mentalization capacities, traditional psychoanalytic interpretations seeking to provide understanding and insight, can be significantly transformative. Where there has been early failure resulting in inadequate attachment and where ‘presymbolic’, more concrete thinking predominate and mentalization capacity is limited, there are limits to listening to and understanding such interpretations. The primary aim of therapy then becomes:

to create an environment within which thinking about feelings and ideas can be experienced as safe, perhaps for the first time. There is then the opportunity for the patient to find himself as a thinking and feeling person within the analysts’ mind. The analyst presents a picture to the patient that is related to the patient’s experience at that moment but is also sufficiently different for the patient to learn the possibility of alternative perspectives. (Fonagy et al., 2004, p. 478)

Bateman (2009) adds that this therapeutic relationship requires that the therapist takes on an inquisitive stance rather than imposing interpretations on the patient. He notes that mentalization is an important implicit aspect of all therapies and might eventually evolve as the crucial agent of social change.

4.1.2.3. The concept of “marked” or mature empathy

Having addressed the role of empathy in infant development and as a core element in the skill of attuned listening in the previous section, this section will address the concept of “marked” or mature empathic understanding (Morgan, 1998) in the light of Gallese’s (2008) and Aragno’s (2008) contributions, which extend the discovery of the mirror neuron system to the therapeutic relationship.

Freud (1973) had understood implicitly how empathy and the capacity to understand others by attributing to them feelings and thoughts could inform the use of interpretations in the development of insight.

Empathy is both easily understood yet at the same time is a complex and multimodal concept. Aragno (2008) views empathy:

as a way of knowing, a way of arriving at an understanding of another's feeling state. ... emotional cognition plays a crucial role in penetrating human experience (and) ... the attentional stance from which it emanates appears to have profound impact on the 'other'. .. it is a way of interacting, of putting oneself in another's emotional experience. (p. 714)

Gallese (2008) explained that it is through the mirror neuron system that “The behaviour of others is immediately meaningful because it enables a direct link to our own situated lived experience of the world. ... (and) because we share the neural resources on which the same behaviour is mapped“ (p. 775). It is empathy, based on “embodied simulation”, that seems to be the functional mechanism that underpins our “mirroring” and generates our “intentional” attunement stance, that operates between the therapist and client in any therapeutic setting.

Aragno (2008) describes how, at the most archaic levels, where empathy is an automatic and direct way of accessing the inner world of the other, this process of “analytic listening” or “entering into” or “mirroring another's emotional state”, “probably functions as a substitute, or equivalent, for the maternal gaze of early mirroring, ideally conveying unconditional presence, attention, and acceptance” (p. 734). In its mature form empathy becomes highly mediated by “semiotic (and semantic) processes that increase its complexity, radically transforming that experience by adding representational, referential, and conceptual dimensions” (p. 725). Both automatic modes of attunement and highly mediated interpretive activities occur simultaneously in clinical empathy. She points out however, that “ordinary empathy, unmediated by conscious application, is different in *kind* as well as in neural substrate from deliberate or specialized empathy as used in the clinical stance” (p. 731), a view supported by Gallese. Aragno covers an in depth discussion of this issue.

Mature and clinical empathy, which is required by parents and those helping others for example in counselling, depends on the capacity of the helper to “formulate an idea of what the other's experience is like, and on having come to this understanding by way of a synthesis of perceptual, sensory-emotive, and ideational referents generated *in oneself* by the *other*” (Aragno, 2008, p.733). This implies a paradigm in which, “information can be “taken in” and assimilated as part of personal knowledge” without the interpreter experiencing the emotions of other but conveying them through symbolic medium.

The bi-directionality of this process relies on emotional and often unconscious information being allowed to flow through the less differentiated channels of communication. The goal of psychoanalysis is to interpret the defenses that might be blocking this flow.

Aragno (2008) supports the view of most authors that in the therapeutic situation, despite a state of temporary de-differentiation, the mature, empathizing therapist who is object-centered rather than self-

centered, is aware of and able of maintaining intra-psychoic separateness or “markedness” when empathizing.

Zepf and Hartmann (2008a; 2008b) warn however that empathy while playing an important role in the analyst’s countertransference understanding of the patient cannot simply be equated with the theoretical concept of countertransference which is embedded in the theoretical concepts of psychoanalytical theories of development. In essence, the procedural, which tends to operate outside awareness, is a different mode of organizing experience and critical to our understanding of therapeutic action. The process of therapeutic change is one that in many ways parallels the developmental changes that occur in the early stages of childhood. New ways of being with others, “implicit relation knowing”, evolve as new neural pathways and are set down, reinforced and strengthened with repeated opportunities for doing things differently.

Fonagy et al. (2004) conclude that, as the connection and integration between the affective and cognitive structures occur in the brain of infants in an attachment context, so effective psychotherapy, especially with people who lack the capacity for mental representation of internal states, needs to focus on affects as well as cognition and needs to be offered in an interpersonal context. Consistent repetitive experiences are required to enable the creation of alternative neural networks that facilitates the development of more secure attachment relationships. They also note that empathic affect-reflective gestures, which parallels with good parenting, are as much part of adult interactions as they are of parent-infant interactions and therefore that emotional- or affect-mirroring is likely to be a central mechanism of therapeutic change.

4.1.3. Therapy in Infancy

In general, changing the way parents view themselves and providing more accurate information and understanding of their children’s needs and communication, changes parental attitudes, self-esteem and confidence and behavioural responses towards their children’s behavioural expressions. With knowledge, misbehaviours tend to be met with increased understanding and more constructive discipline rather than frustration and harsh punishment or physical violence. Confident parents tend to provide warmth, nurturance and appropriate and respectful limit-setting such that negative cycles of interaction can be reversed and cooperative, mutually respectful and rewarding relationships between parents and their children that are likely to lead to closer and more secure emotional attachments between them can develop (Gomby, 2005). There are many ways of facilitating parenting growth but given that our focus is parenting in early infancy the types of therapeutic approaches that are most meaningful are those that stem from psychoanalytic understanding and theory.

4.1.3.1. Parent-Focused Therapy in infancy

Until very recently, therapy in infancy has tended to focus on working with the parents. Parent-infant oriented therapy is relatively new and began with the work of Selma Fraiberg and her team in the 1960s who practiced home visiting with the purpose of supporting the parent-infant relationship through a

parent-infant led intervention (Fraiberg, 1987). Since then this infant mental health model has been adapted internationally (Weatherston, 2001)..

Stern (1995) reviewed some of these approaches and divided them into: a) Approaches that evolved from the psychoanalytic tradition and aim to change the parents' representations of themselves and the infant in order to free infants from the effects of distorting projections from their parents and b) Approaches that evolved from educational and behavioural traditions and aimed to change parents' interactive behaviours. He expressed his belief based on his own research that all approaches, when well done, seemed to work.

Stern (1995) identified features that were common to them all:

1. All approaches bring changes in that, acting in the domain of representations invariably changes overt behaviour and vice versa.
2. Mother-infant therapies tend to be serial, short-term and focused interventions. When they are successful, the therapeutic work is quickly accomplished. If further therapy is required the nature of the treatment usually changes becoming parent or couple based.
3. An essential, indeed "crucial," feature of such approaches for parents across the socioeconomic spectrum, is the use of the positive therapeutic alliance.

Stern (1995) recognized that the encouragement of the positive transference, in which the therapist remains "a benign, potentially available source of help, strength, and support" (p.162), carries the treatment process across the non-treatment periods that are so common. He acknowledged, that while possibly not creating the cure, the positive transference creates the conditions that may effect the cure. Stern also believed that working with the unanalyzed positive transference protects the parent from unnecessary blame that results from analyses of the parents' feelings and fantasies that are believed to contaminate their babies. He questioned why working with positive transference is seen as more superficial and simply supportive compared to working with the negative transference, and why ego strengths are often considered less important than defences or deficits and the identifying, naming and understanding of psychopathological aspects of the patient.

4. All the parent-infant approaches, directly or indirectly, act to help mothers who are motivated to help their infants as well as to help themselves as mothers. They occur at a time when adaptations to continuous developmental changes are already imposed on the parent-infant couple. Stern (1995) points out, "The question is not how or why to put the relationship in motion but where to direct it. Under these circumstances, the parents work best in an atmosphere of benign regard" (p.163).

To some extent Stern concurs that parent-infant therapy is too short to change parents' damaging representations and therefore to bring about permanent structural changes overall. He explains however, that "most parent-infant therapies are concerned almost exclusively with those representations that are

activated and then enacted in the parent-infant interaction” (p.164). It is possible to change enactments directed towards the infant without necessarily changing the parents’ overall representations. There are always many competing and co-existing representations of the child in the parent that might be present during the interactions between them. Parents are more likely to be able to change their attitudes and behaviour toward their infants if therapists are able to help them to;

- Inhibit or reinterpret and substitute damaging activated representations for less damaging ones (i.e. helping a parent to see her infant as distressed rather than aggressive, or curious and interested rather than defiant),
- strengthen a parent’s representation that is available but weak (i.e. while the parent perceives the baby to be vulnerable and in need of care, reinforcing the perception that the baby is a sensitive and sentient little being needing responsive emotional care) ,
- activate representations that already exist (i.e. reconnecting parents to previous representations of relationships that were successful if her own primary relationship was not, this might include the positive alliance with the therapist)

Stern (1995) believes that most of the criticisms of the parent-infant therapeutic approaches arise from a lack of appreciation of the unique conditions imposed on therapists by the dominant and determining psychic organization of early motherhood that Stern calls the ‘motherhood constellation. He reminds us that mothers are not “ordinary” patients, nor are they simply parents to infant patients. They are women in a unique period of their own lives fulfilling a unique and essential cultural role in the survival of the species and of their own infants in particular. The motherhood constellation requires an enormous amount of conscious and unconscious mental reworking that temporarily require the oedipal triads of mother’s mother, mother, and mother’s father, to make way for a preoccupation with new triads involving the mother-father-baby as well as the mother’s mother, the mother herself and the baby. She is concerned about her discourse with her own mother or other maternal figures (as–mother-to-her-as-a-child); her discourse with herself, particularly with herself-as-a-mother; and her discourse with her baby.

With the birth of her child, the mother experiences a profound realignment. Her interests and concerns now are more with her mother and less with her father; more with her mother-as-mother and less with her mother-as-woman or wife; more with women in general and less with men; more with growth and development and less with career; more with her husband-as-father-and-context-for-her-and-the-baby and less with her husband-as-man-and-sexual-partner; more with her baby and less with almost everything else. (Stern, 1995, p.172)

With the dominance of these new psychic triads, the therapist has to adjust to a new framework for treatment and a different kind of therapeutic alliance. He argues that, under the ‘motherhood

constellation', "the 'positive oedipal complex' issues of the mother's identifying with her own mother and her mother's giving her permission to become a mother herself remain cardinal" (p.172).

Stern (1995), describes the best form of therapeutic alliance and transference for mothers in the motherhood constellation in terms of, "the good grandmother transference" in which there is "an elaboration of a desire to be valued, supported, aided, taught and appreciated by a maternal figure" (p.186). Daws (1989) talks about mothers needing "confirmation of themselves as parents from their own parents." (p. 174). Mothers look for other women to fulfil this role in some way, someone they can share their experiences with who is encouraging. If the mother's mother is not available then other maternal figures, siblings or friends are sought out.

If the therapist adheres to rigidly to the traditional analytic role and is unable to meet the mother's need for support and appreciation of her maternal function, the relationship may break down. However, if the therapist is able to form an adequate "good grandmother transference", the work can continue. At this stage the therapist is able to be freer, to be real and more active, in the sense of doing a home visit if required or giving information and advice, making physical contact with both mother and her infant and focusing on encouraging the mother's capacities and strengths. Stern (1995) makes an interesting point that, "the maintenance of such a positive transference is desirable during the reign of the motherhood constellation , and its termination poses no problem, because the transference fades away naturally when the mother passes out of the motherhood constellation" (p.188).

4.1.3.2. Being with the baby and the parent

4.1.3.2.1. Infant Mental Health Group at the Royal Children's Hospital in Melbourne

Several therapists view the infant as the subject of intervention. Norman (1999) talks about the baby analysand who needs to be talked with and Thomson-Salo et al. (1999) make the point that simply observing an infant is a powerful, intimate two-way interaction. To know that they have captured the gaze of another is a very powerful experience, which provides them with a powerful sense of agency. However, it is necessary not to just look, but observe mindfully, in order to understand the infants' experiences. The infant's need for interaction with, and containment by, an open, thoughtful and understanding adult mind has been widely recognized (Aragno, 2008; Bion 1991; Fonagy et al., 2004; Schore, 1994; Thomson-Salo et al., 1999; Winnicott, 1960b). This approach brings together psychoanalytic theory and infant developmental models of affect mirroring, mentalization, the reflective function, and empathic mirroring, and applies them therapeutically.

Direct work with the infant is particularly indicated where parents seem unable to use their own thinking to make the necessary links. Where parents seem unable to think about their infants, there has often been a very early fixed identification with the infant, rather than an empathic one (Shorer, 1994). Sometimes depressed or otherwise preoccupied mothers do not notice, and need to be helped to identify their infants'

attempts at engagement and communications, or to persevere in reaching their children who might already have disconnected from them and the world in general.

Thomson-Salo and Paul (2001) describe an approach adopted at the Infant Mental Health Group at the Royal Children's Hospital in Melbourne, Australia, where Ann Morgan believed that the therapist "being with the baby", as well as being with the parent, was essential in order to effect changes in mother-infant relationships. The rationale is that infant symptomatology is an expression of both the infant's behaviour and parent's unconscious representations, which are often difficult to shift. The therapist connecting and interacting directly with the infant provides the parent with a more realistic image of their infant. This helps the parent to switch off the projections that interfere with healthy interactions with the infant. Through the process of mutual exploration and interactive dialogue between the therapist and the infant, and the sharing of understanding between therapist and parents, parents see that the infant can be understood. When this space is safe enough, it allows parents to be separate and thoughtful about their babies, and to face and share their struggles with the inevitable ambivalent feelings of love and hate without feeling condemned, yet knowing that acting these out is unacceptable and that the baby will be kept safe.

This is not a process that necessarily requires the interpretation of unconscious needs. Simply providing a reparative and corrective experience for the mother facilitates shifts which consciously or unconsciously allow the difficult feelings to be shared and thought about by the therapist, and this thoughtfulness is communicated to both the mother and the infant. In Bion's terms, there is the presence of a thinking, and thus containing, mind (Bion, 1991). The core principles of Morgan's approach are:

1. The therapist relates to the infant as the subject that thinks and feels and has her own sense of agency. In the intersubjectivity between the child and therapist, the therapist knows that the infant understands that the therapist understands, and "she knows that what she is getting is communication" (p. 16).
2. The therapist begins an exploration of the unknown baby by using the experience he or she has but "without memory or desire", by allowing the baby to impact on the therapist in a more intuitive way that is not limited by the therapist's senses, memories, desires or projections (Bion, 1967) through a state of "reverie".
3. A link or connection is made with the baby so that the baby, too, can see and explore the therapist. This link allows a gap or transitional space with respect to the mother so that something else can happen, a thought in the mind of the mother or a preconception in the mind of the baby. The baby has a contact that is separate from and not through her mother, which in turn helps the mother realize that there is some separation.

In summary, when early in the infant's life, instead of an empathic relationship with the infant, the parent, through projection, identifies in the infant some internal object in their own mind, the therapy creates a gap or transitional space between the parent and the infant that did not exist before. This space permits the parent to see the infant as separate and different, and what is reflected back to the mother is something more realistic and saner. This space also allows the therapist to become the container for the parents' hate, and other toxic projections previously received by the infant. The therapist's acceptance of this hate allows the parents some hope of loving and being loved and valued, and the infant, relieved of her parents' projections, is free to be.

Thomson Salo and Paul (2001) endorse the belief that

When the therapist does something relieving with the infant the mother in turn feels mothered and a good internal object can be experienced again ... (such that) ... nearly all mothers can shift from looking at things totally from their own neediness so that if you include the baby they feel more adult and the need is in the baby. (p. 15)

Morgan reports a mother describing how she could see her baby differently when the therapist talked to him, she could think of him in a different way (Thomson Salo & Paul, 2001). Had the therapist not been there she would probably have continued repeating the same patterns of behaviour. Thomson Salo et al. (1999) point out that often there is no time to wait for parents to change in order to effect the change required. Through this approach there is the potential, not only to reshape the representations of the parents and the infant, but the implicit knowledge of relationships of both parents and their infants. This suggests that far-reaching and long-lasting positive changes are possible. The group report that long-term changes were maintained in 90% of out-patient cases. Thomson Salo (2007) reports that the use of videotaped sessions also showed rapid changes.

4.1.3.2.2. Being with the parent with her baby – An infant-led therapeutic approach: “Watch, wait and wonder”

Infant observation, introduced by Ester Bick in 1948 (Bick, 1964), has been used increasingly, as a training and therapeutic tool for child psychotherapists (Houzel, 1999). The technique focuses on what is seen and felt during the observation of an infant free to express itself in its normal home situation. It is an approach that is particularly useful when working cross-culturally (Berg, 2002). Observers are urged not to pre-judge or attempt prematurely to interpret the infants' behaviour, but just to be mindful. (Reid, 1997).

Thomson-Salo et al. (1999) describes how a 'moment of knowing or meeting' allows the perception of a separate and "real" baby by the mother and an experience of relief from projections for the baby, in the presence and with the facilitation of the therapist. This seeing something differently in 'a real relationship' results in a dyadic expansion of consciousness for both mother and baby (Thomson-Salo et al., 1999).

An example of this approach with parents is the “watch, wait and wonder” programme developed to be used therapeutically to prevent maladaptations in relationships, to repair parent-infant relationships in which attachments are insecure, and to enhance parents’ capacity to respond to their infants sensitively, reciprocally and without intrusion. It is an infant-led therapeutic approach in which infants are provided a space to behave and communicate freely. Parents are simply instructed to observe, be mindful and responsive without intruding. This is recorded and when the recordings are replayed, parents are asked to think about how the infant might have been feeling or otherwise communicating (Cohen et al., 1999). The idea is that the parent, watching and allowing the expression of the actual baby to emerge, while being still and with an open mind, allows for the possibility of something new and more authentic to be perceived and happen between them. Simply observing, thinking and having to suspend and contain often powerful feelings, instead of acting out, helps the parents to “switch off” the projections and hold the feelings thus, once again, providing a space for change to occur, altering both the parents’ and the infant’s internal representations, which affects their interactions and relationships with their parents and others in the world.

While there remains a need for ongoing exploration and debate about the fine distinctions between many of these overlapping concepts, which is beyond the scope of this thesis, each of these models, if used mindfully, offer useful insights that add to our understanding of implementing potentially powerful and useful therapeutic interventions.

4.2. Evaluation of early preventive interventions

4.2.1. Introduction

Recently acquired knowledge about the rapid rate of neurological growth, brain development and plasticity in the first three years of life as well as the recognition of the impact that early caregiving experiences have on children’s development, has led to the creation and evaluation of early preventive interventions that aim to benefit the early development of children. In many European countries, early intervention has been a routine part of maternal and child healthcare for many years (Olds, 2004). In the United States, Canada and elsewhere this has been less well established and, where it is offered, it has historically been limited to health guidance and treatment of health and illness problems (Kitzman, 2004). In the past 20 years however, enormous financial and other resources have been committed to the development and evaluation of early preventive programmes.

Home visiting is defined by its attempts to create early childhood environments that promote positive attitudinal and behavioural changes in parents and their children by providing information, education and problem-specific, brief counselling and practical assistance (Zeanah, Larrieu, Boris & Nagle, 2006; Zercher & Spiker, 2004). Riley et al. (2008) report that the appeal of home visiting as a strategy is its ability, at a time of transition with the birth of a baby, to take services to the homes of needy individual

families who tend to be under-resourced, isolated, have limited access to transportation and are unlikely to take the initiative to seek outside help themselves.. The informal and intimate nature of home visits is believed to foster a positive rapport and relationship between the family and home visitor. Kitzman (2004) adds that providing a safe opportunity for parents, at this early stage, to reveal, explore and address their real-life psychosocial struggles could sufficiently reduce their stress and enable them to apply their minds, and focus on nurturing their infants. Facilitating more sensitive and responsive interactions between parents and their infants enhances their relationship, infant development and attachment security (Ammaniti et al., 2006).

4.2.1.1. Characteristics of programmes

Gomby (2005) compiled a report based on 13 meta-analyses and 11 literature reviews of randomized and non-randomized primary preventive home visiting programmes for families and infants, from pregnancy to 3 to 5 years after birth between 1993 and 2004. These were established primarily in the United States, Canada, Britain and Europe but also included a few other countries, and altogether covered thousands of sites across the world.

Certain characteristics were described as common to primary preventive home visiting programmes across their sample. These included:

1. Broad goals which aimed to:

- Promote enhanced parental knowledge, attitudes, and/or behaviour related to childrearing;
- Promote children's health;
- Promote children's early learning and development;
- Prevent child maltreatment, abuse and neglect; and/or
- Enhance mothers' lives (e.g., decrease stress, provide social support, decrease rates of subsequent births and tenure on welfare rolls, and increase employment and education).

2. Home visiting as the service delivery strategy.

3. Developing a relationship of trust between the home visitor and the parent.

4. Providing practical assistance such as linking parent with other available services.

4.2.1.2. Differences in programmes

Despite these commonalities however, there were substantial differences across programmes.

Interventions have differed enormously with respect to specific goals, theoretical underpinnings, characteristics of families targeted, stage of initiation, duration, number and schedule of visits, nature and quality of services, curriculum, degree of manualization and adherence to implementation, and the

background, selection, training and supervision of the home visitors. Of particular interest was how staffing varied from professional mental health clinicians, nurses and social workers in high income countries (HICS), to non-professional community members with little, if any, formal education beyond that prescribed by the intervention in low and middle-income countries (LAMICS).

Zeanah et al. (2005) conceptualize the Infant Mental Health service continuum as consisting of three broad levels of intervention that range from “preventive approaches, to focused interventions for high risk groups, to tertiary intervention (psychotherapeutic treatment)” (p. 3). There has been much debate about whether programmes should target the mothers, the infants or the dyads, how intense and how long they should be, and whether they should be delivered by professionals or non-professionals (Ammaniti et al., 2006).

Most programmes are reported in scientific journals where space is limited and emphasis is placed on outcomes and outcome measurement. As a result very limited information about programme content and their implementation is available (Kitzman, 2004). Exceptions to this are the Nurse Family Partnership (NFP) (Korfmacher, O’Brien, Hiatt & Olds, 1999) and Healthy Families America (HFA) (Daro & Harding, 1999), which have been described in some detail.

4.2.1.3. Description of two seminal programmes

The proliferation of home visiting specifically targeting the early infant stage was driven by the long-term benefits for parents and children demonstrated by one programme in particular, the Nurse Family Partnership (NFP). This programme and Healthy Families America (HFA) have both greatly influenced and established the prototype of a broad national and international network of home visiting services for families at risk.

4.2.1.3.1. The nurse family partnership (NFP)

The NFP, initially called the Nurse Home Visiting Program, was originally designed and established in 1977 as a research demonstration project in the form of a randomized control trial in Elmira, New York. It is a seminal project and probably represents the best studied, most systematically evaluated and most effective example of an early preventive intervention for families at risk. It is a nurse home visiting programme to first-time, low income mothers, beginning antenatally and ending with the child’s second birthday, that has been successfully replicated in three sites - in Elmira (New York State), in Memphis (Tennessee) with low-income African-American families, and in Denver (Colorado). Over the last 20 years, the protocol has been tested in different contexts and population groups and while there is adherence to the common core of the original model, the content and clinical methods have been refined, reshaped and improved with use (Olds et al., 1997; Olds & Henderson et al., 1999). By 2002, the programme had been established in 250 communities in 22 states, serving more than 24,000 women and

families. The plan is by 2020 to reach 50% of all low-income first-time mothers in the United States (Gomby, 2005).

The programme aims, primarily, at improving;

1. The outcomes of pregnancy by promoting health-related behaviours.
2. The quality of caregiving practices and associated health and developmental outcomes.
3. The maternal quality of life, or life-course development by promoting family planning, continuing education, and finding employment (Olds et al., (1997).

These were supported by the following secondary goals (Korfmacher et al., 1999):

1. The enhancement of material support for families by linking them to the health and social services they need.
2. The promotion of supportive relationships with family members and friends.

Olds et al. (1997) believed that the provision of support at this stage of transition in which women found themselves with the birth of their first child, would enhance the influence of the visitors as they were learning to parent for the first time, and this knowledge would extend to the care of subsequent children.

The theoretical foundations of the programmes' protocol was informed by Bandura's (1977a) Theory of Self-efficacy; Bowlby's (1969) Theory of Attachment; and Bronfenbrenner's (1979; 1992) contextual model of human development.

The elements based on Bronfenbrenner's (1979; 1992) Human Ecology Theory included:

1. Promoting informal support, by family and friends, for the parents' attempts at improving their health and caregiving behaviours. For this reason, some of the visits were planned when partners, grandmothers or other significant figures were present, as well as those controlling household budgets.
2. The identification of family stressors and health and other services needed by the family such as Aid to Families with Dependent Children and antenatal clinics. At times the visitors took on an advocacy role for the families in their care.
3. The development of culturally sensitive protocols.

Bandura's (1977a) cognitive-behavioural self-efficacy theory essentially holds that efficacy expectations are what influence both the initiation and persistence of coping behaviour. The theory is based on the individual's belief and confidence that they have the capacity to achieve change. This confidence emerges from their performance accomplishments which are founded on authentic experiences of mastery, vicarious experiences of observing others modelling success, verbal persuasion, and the containment of emotional arousal or anxiety which can undermine opportunities for mastery.

The researchers believed that the promotion of self-efficacy in at-risk women, many of whom had little sense of control over their lives, would enable them to gain control over a wider range of challenges. This approach emphasized helping women set small achievable goals that, if accomplished, would strengthen their confidence in coping with similar issues in the future.

Bowlby's (1969) Theory of Attachment led to the addition of the developmental, intra-psychic, and emotional aspects of the parent-infant intervention:

1. In the first instance, it informed the fundamental elements required in the formation of a therapeutic alliance with the mother and other family members. It implicitly offered a "corrective" experience and a model of care and support that they hoped would challenge historical relational models of possible neglect, abuse and insecurity. When mothers came to see themselves as deserving of support they could see their children as deserving of the same.
2. It provided a space, in the early phase, for mothers to review their own relational and child-rearing histories. This helped caregivers develop a more accurate understanding of children's needs and communications.
3. It promoted sensitive, responsive and engaged caregiving in the early years through teaching parents to read accurately, and respond to, their infants' communication and cues.

For this purpose, selected items of the Brazelton Neonatal Behavioural Assessment (Brazelton & Nugent (1995) was incorporated into the programme and used by trained nurses in a didactic way to build parents' confidence in being able to interact with their infants. This was not felt to be entirely successful, and other programmes were gradually explored which helped promote the parents' emotional availability to their infants (Olds et al., 1997).

The programme began during pregnancy with registered nurses forming a therapeutic alliance with their assigned mothers. Visits lasted 1-1½ hours. They focused on personal strengths, informed and advised women and encouraged them to problem-solve, clarify plans, make decisions and change behaviours pertaining to fertility, education, employment and childcare that were in their own and their babies' best interest. Relationships with other family members were strengthened and family members were encouraged to participate in home visits when desired by mothers to do so. Referrals were made to appropriate and relevant services as needed. Maternal, child and family functioning were assessed and although the interventions were guided by a detailed curriculum, the focus of sessions was determined by the priorities as they emerged through the assessments (Olds, Henderson, Tatelbaum & Chamberlin, 1988). The approach is described in further detail in Olds et al. (1997).

The "Home Visitation 2000" programme was a randomized treatment trial established at the Denver site of the NFP. It was designed to examine the differences in effectiveness and implementation between

nurses and paraprofessionals using essentially the same intervention model (Korfmacher et al., 1999; Olds et al., 2002; Olds & Robinson et al., 2004). Each visitor group was supported by well-developed programme guidelines, one month of extensive training and regular supervision, with paraprofessionals receiving twice the level of supervision that the nurses received

In 2003, Boris et al. (2006) were keen to assess the feasibility of augmenting the nurse teams by inserting a level of trained and supervised mental health consultants (MHC) or clinicians, specifically trained in the principles and practice of infant mental health, to train and supervise the nurse teams. This “academic-public service partnership” was set up in Louisiana in a social context of high risk mothers in which 26% presented as depressed and 41% had experienced domestic violence. The evaluation focused on mental health issues impacting on the mother-infant relationship and aimed to assess whether, with access to mental health consultation, already well-trained and committed nurses could effect changes in the levels of domestic violence and maternal mental illnesses, particularly depression, which are known to be highly resistant to change. The results have not yet been published.

4.2.1.3.2. Healthy families America (HFA)

HFA was another important initiative by the National Committee to Prevent Child Abuse in 1992, to address the rising recorded rates of child maltreatment in families at highest risk. It was developed as a national programme which was offered, with training, to organizations and other programmes, such as Healthy Start programmes across the U.S. and Canada (Geeraert, Van den Noortgate, Grietens & Onghena, 2004; Green et al., 2008). The first component of this initiative was a home visiting programme designed in partnership with the Hawaii Family Stress Centre (Daro & Harding, 1999). In some cases, an organization offered two or more home visiting models to the community (Bower et al., 2006). By 2002, HFA programmes served more than 66,000 families in more than 450 communities in 39 states, the District of Columbia and Canada (Gomby, 2005).

To offer the model, organizations are required to submit extensive documentation to prove that they meet the credentializing guidelines. Organizations are visited and a detailed review of their training, technical assistance, evaluation, quality assurance and administration systems are conducted and compared to HFA’s set standards (Green et al., 2008). By June 2007, Oregon’s Healthy Start programme was the sixth officially recognized and accredited multi-site state HFA programme. At that point there were over 400 individually accredited programmes throughout the U.S. and Canada. Each accredited programme was tracked through regular and ongoing evaluation conducted by an external evaluator (Green et al.).

With respect to individual families, home visiting aims to promote positive parenting, to enhance parent-child interactions, the child’s emotional, cognitive and social development, maternal and child health, to encourage the utilization of health care and social supports and improve maternal life course outcomes, in order eventually to reduce child maltreatment (Daro & Harding, 1999).

While guided by the HFA model and having to meet 12 critical elements representing best practice standards described by Gomby (2005), each site application is not a strict replication of the model. Flexibility is seen as essential in order to ensure cultural sensitivity and to allow details of the programme to accommodate local parameters of various communities, and it is this that is responsible for much variability in site implementation. Each of the sites with their available services and funding resources determine the target population, their risk level for enrolment, service initiation point and selection criteria (Harding et al., 2007). At sites selected, all newborns and their parents are targeted for assessment, usually in hospital, and encouraged to accept the services offered based on individual need, thus, providing a universal base of support (Daro & Harding, 1999).

Visits can be intensive (once a week) for families at greatest risk. They are comprehensive, supporting parents, parent-child interaction and child development, linking families to other services and programmes; and case loads are manageable and allow adequate time to be spent with each family. The frequency of visits is reduced as the families meet the specific goals which they had initially developed with their home visitor. Services could continue until the child reached five years of age (Gomby, 2005).

The flexibility which allowed for early implementation problems to be improved in later programmes was an advantage in some ways but it also created substantial difficulties by limiting the applicability of the results of these early studies today (Harding et al., 2007). It is only from 1997 that any attempt was made to form a network to standardize evaluation studies being undertaken at the various sites, and to build a knowledge base. By 1999, a HFA Research Network had been established. One of the difficulties was that the variety of evaluation designs reported made direct comparisons impossible and limited the synthesis and generalization of results from one programme to another. Of the 17 completed evaluations selected for review by Daro and Harding (1999), 15 were quasi or pre-post or non-randomized designed evaluations and two were randomized trials in Hawaii and Virginia. Many of the HFA evaluations tended to be overrepresented in other reviews undertaken in this field. Geeraert et al.'s (2004) meta-analysis of evaluations included 17 HFA evaluations, 10 which had been included in the Daro and Harding analysis and 7, mostly unrandomized evaluations, which were more recently completed. By 2007, Harding et al. (2007), in their comprehensive review, report on 33 evaluations, including eight randomized controlled trials (RCTs) and expressed their belief in the importance of considering outcomes of quasi-experimental as well as non-experimental evaluations.

4.2.2. Overview of intervention evaluations in “high income countries” (HICS)

This section will focus on reviewing the significant benefits of home visiting programmes in high income countries, in order to gain insight into the usefulness of the home visiting approach, and identifying key issues raised and insights gained.

In the past three decades a vast number of preventive home visiting programmes have been evaluated and there have been several meta-analyses reported in the literature (Geeraert et al., 2004; Gomby, 2005; Zeanah et al., 2005). Some focused primarily on interventions aimed at the prevention of maltreatment (Geeraert et al.; Klevens & Whitaker, 2007), while others focused on those enhancing sensitive parent-infant interaction and attachment security (Bakermans-Kranenburg, Van IJzenboom & Juffer, 1989). There was often an overlap of studies reported in the meta-analyses, and overall, very few of the vast number of interventions reported were evaluated by rigorous, structured, evidence-based randomized trials. Some of the reasons for this lack of rigorous evaluation relate to a) the scarcity of resources required for funding and skilled research, b) the fact that many interventions tend to evolve from the field, and are driven by clinical and community needs rather than research and, c) there are ethical issues involved in withholding potentially helpful treatment from the control group in families at risk. There are also very few long-term studies, with most evaluations immediately following treatment. The results have varied widely across programme models, goals, site characteristics and families; one exception being the Nurse Family Partnership (FNP) programme which tends to be seen as representing the gold standard. For this reason an overview of the FNP will be presented separately.

4.2.2.1 Evaluation of the nurse family partnership programme

I have decided to present the results of the influential Nurse Family Partnership in some detail first, as this programme has been tested with randomized trials and tends to be the standard against which other programmes are judged. The overall significantly positive and enduring outcomes of the Nurse Family Partnership from their three sites over 15 years of follow-ups are presented in Tables 1, 2 and 3 below.

Table 1

For Nurse-Visited Mothers

Outcome compared to controls	When	Where	Reference
1. Smoking in pregnancy was reduced.	Pregnancy	Denver	Olds et al. (2002)
		Elmira	Olds et al. (1999)
2. Subsequent pregnancies deferred.	At age 2	Denver	Olds et al. (2002)
	At age 4	Elmira and Memphis	Olds et al. (1999)
	At age 4	Denver	Olds & Robinson et al. (2004)
	At age 5	Memphis	Kitzman et al. (2000)
	At age 6	Memphis	Olds & Kitman et al. (2004)
	At age 9	Memphis	Olds & Kitman et al. (2007)

Outcome compared to controls	When	Where	Reference
3. Fewer cumulative subsequent pregnancies and births per year.	At age 4	Elmira and Memphis	Olds et al. (1999)
	At age 5	Memphis	Kitzman et al. (2000)
	At age 9	Memphis	Olds & Kitzman et al. (2007)
4. Breastfeeding had been attempted by more mothers.	At age 4	Elmira and Memphis	Olds et al. (1999)
5. More responsive interaction between mother and child.	At age 2	Denver	Olds et al. (2002)
6. Environments more supportive of early learning where maternal psychological resources were low*.	At age 4	Denver	Olds & Robinson et al (2004)
7. Reduced rates of child injuries and ingestions associated with abuse and neglect.	At age 4	Elmira and Memphis	Olds et al. (1999)
8. Fewer months of using food stamps and Aid to Families with dependent children (AFDC).	At age 5	Memphis	Kitzman et al. (2000)
	At age 6	Memphis	Olds & Kidman et al. (2004)
	At age 9	Memphis	Olds & Kitzman et al. (2007)
9. Increased maternal employment from the second year.	At age 2	Denver.	Olds et al. (2002)
	At age 4	Elmira and Memphis	Olds et al. (1999)
10. Reduced maternal substance abuse and criminal behaviour.	At age 4	Elmira and Memphis	Olds et al. (1999)
11. Longer relationships with current partners.	At age 6	Memphis	Olds & Kidman et al. (2004)
	At age 9	Memphis	Olds & Kitzman et al. (2007)
12. Lower rates of substantiated reports of parents identified as perpetrators of abuse and	At age 15	Elmira and Memphis	Olds et al. (1999) Eckenrode et al. (2000)

Outcome compared to controls	When	Where	Reference
<hr/>			
neglect.			
<hr/>			
14. Reduced domestic violence from intimate partners (This was a first-time effect).	At age 4	Denver	Olds & Robinson et al. (2004)

* Low maternal psychological resources refers to mothers with high levels of mental health symptoms, limited intellectual functioning and a lack of belief in being able to control their lives (Olds & Robinson et al., 2004).

Table 2

For Nurse-Visited Children

Outcome compared to controls	When	Where	Reference
1. Where mothers had had low psychological resources, infants exhibited less emotional vulnerability in response to fear stimuli and were less likely to exhibit “low emotional vitality” in response to joy and anger stimuli.	At age 6 months	Denver	Olds et al. (2002)
2. Infants had less language delays than controls.	At age 21 months	Denver	Olds et al. (2002)
3. Children exhibited superior mental development than their controls.	At age 2	Denver	Olds et al. (2002)
4. Children had more advanced language, superior executive functioning and better behavioural adaptation during testing.	At age 4	Denver.	Olds & Robinson et al. (2004).
5. More children between 2 and 4.5 years were enrolled in formal external childcare.	At age 6	Memphis	Olds & Kitzman et al. (2004)
6. They demonstrated fewer behavioural problems in the borderline or clinical range.	At age 6	Memphis	Olds & Kitzman et al. (2004)
7. More children demonstrated higher intellectual functioning and receptive vocabulary, and children of mothers with low levels of psychological resources did better on arithmetic tasks, expressed less aggression and were more coherent in story	At age 6	Memphis	Olds & Kitzman et al. (2004)

Outcome compared to controls	When	Where	Reference
construction.			
8. Children had better grade-point averages and achievement test scores in math and reading in grades 1-3.	At age 9	Memphis	Olds & Kitzman et al. (2007)
9. Adolescents had lower rates of criminal behaviour, arrests and convictions.	At age 15	Elmira Elmira and Memphis	Olds et al. (1998) Olds et al. (1999)
10. Adolescents smoked and drank less.	At age 15	Elmira Elmira and Memphis	Olds et al. (1998) Olds et al. (1999)
11. They had had fewer sexual partners.	At age 15	Elmira Elmira and Memphis	Olds et al. (1998) Olds et al. (1999)

Table 3

For Para-Professional Visited Mothers in the Denver Programme

Outcome compared to controls	When	Reference
1. More responsive interaction between mother and child where maternal psychological resources had been low.	At age 2	Olds et al. (2002)
2. Mothers worked more and reported a greater sense of mastery and better mental health.	At age 4	Olds & Robinson et al. (2004)
3. There were fewer miscarriages and low birth weight in subsequent infants.	At age 4	Olds & Robinson et al. (2004)
4. Mothers displayed greater sensitivity and responsiveness towards their children during free-play.	At age 4	Olds & Robinson et al. (2004)
5. Environments were more supportive of early learning where maternal psychological resources were low.	At age 4	Olds & Robinson et al. (2004)

The “Home Visitation 2000 program” showed that, while both nurse and paraprofessional visitors produced significant effects, the paraprofessional effects for mothers were typically half the size of the nurse effects, and the patterns of effect were different. No significant differences were found between the paraprofessional-visited children and their controls. The authors concluded that paraprofessionals tended to have an effect on maternal factors while the nurses had greater effect on factors affecting the children (Olds & Robinson et al., 2004). Both nurse and paraprofessional visitors from each of the studies reported that recipient mothers spoke of never having experienced the consistent care and support shown to them by their visitors, which contrasted with the often harsh and neglectful treatment they received from their own parents (Olds et al., 1997).

While the effectiveness of the NFP, as a preventive model, has been demonstrated over time and across a variety of groups and contexts (Olds et al., 1999), the lack of treatment effect on the incidence of maternal depression and intimate partner violence, with its negative impact on levels of child maltreatment and early child development, remained problematic (Boris et al., 2006). A 15-year follow-up study by Eckenrode et al. (2000) found a demonstrable decrease in treatment effect for child maltreatment with an increase in the level of domestic violence. This study found that only when domestic violence was reported as having occurred less than 29 times from birth to 15 years, which represented 79% of the

women, did the programme show positive effects on child maltreatment measures. The incidence of domestic violence was not affected by the number or intensity of nurse visits completed, nor the level of engagement of the women. The reduction of domestic violence from intimate partners was reported as a treatment effect, for the first time, in the Denver nurse-visitor intervention at 4 years (Olds & Robinson et al., 2004).

An interesting result reported by Olds et al. (1997) was how the nurse-visitors took on roles as advocates for families, setting up structures with policy makers where the specific needs of low-income pregnant women and parents of young children, that were not being adequately met, could be addressed.

4.2.2.2. Overview of significant overall benefits of other programmes in HICS

In response to the question about whether home visiting programmes produce benefits for parents and children, Gomby (2005) respond, “They can, but they do not always do so” (p. 9). The reality is that different programmes have resulted in different outcomes, and benefits in general have been inconsistent or small (Gomby; Zercher & Spiker, 2004), with the more positive overall results being yielded by non-randomized evaluations. With this in mind, some of the benefits achieved by programmes, other than the NFP, are briefly reported below.

4.2.2.2.1. Benefits for parents

Significant benefits reported for parents include:

1. A reduction in subsequent births was reported in one HFA study (Harding et al., 2007).
2. An increase in educational level at 24 months postpartum (Harding et al., 2007).
3. Gomby (2005) report inconsistent and small effects relating to usage of welfare and Aid to Families with dependent children, food stamps and days on Medicaid, as well as increased involvement of fathers and moves to better housing. The authors felt, however, that these were unlikely to have much effect on self-sufficiency and the economic well-being of women.
4. No programmes were found to impact on maternal stress (Harding et al., 2007).
5. The need for social support was met by home visitors (Daro & Harding, 1999), and the value of visitor support was expressed by parents (Harding et al., 2007), however, benefits in increasing mothers’ social support networks and use of other community resources were not found (Gomby, 2005; Olds, 2004; Zercher & Spiker, 2004).
6. A limited impact was reported in the reduction of substance abuse (Harding et al., 2007)
7. Harding et al. (2007), report some success in a randomized control trial where domestic violence was reduced for “high dose” treatment families who were defined as having “successfully completed or

still active after 3 years, received at least 75% of expected visits, and required no more than 3 months of creative outreach” (p. 157).

8. Most broad-based programmes have been unable to show benefits in maternal mental health (Gomby, 2005; Olds, 2004; Zercher & Spiker, 2004). Harding et al. (2007) report that three HFA RCT evaluations showed limited impact on maternal depression and that other evaluation designs yielded mixed results. Programmes that specifically focused on treating maternal depression however, were found to be more successful (Bower et al., 2006; Cooper & Murray, 1997; Cooper, Murray, Wilson & Romaniuk, 2003). Lies et al. (2009) report that in four of the six RCTs they reviewed which assessed home-based psychological intervention aimed at preventing and treating postnatal depression, significant treatment effects were found, and cognitive behavioural, psychodynamic and non-directive counselling were all effective in reducing the levels of depression. One of the studies - Cooper et al. (2003) - found that only psychodynamic therapy resulted in a reduction of postnatal depression that was significantly superior to that of the control. Grote et al. (2009), using a manualized approach, which they call “culturally relevant, enhanced brief interpersonal psychotherapy (IPT-B)”, based on principles of motivational and ethnographic interviewing by mental health professionals, found a significant reduction of depressive symptoms during pregnancy which was maintained for the first six months postpartum in addition to improved maternal social functioning. Bosquet and Egeland (2001) found an association between maternal depression and hostility in their intervention group but not in their control group, suggesting that depression characterized by withdrawal, flat affect and disengagement may be more easily treated than depression characterized by hostility and intrusiveness.

4.2.2.2.2 Benefits for children

1. The evaluations of programmes initiated prenatally show inconsistency in their effects on birth outcomes (Gomby, 2005). Some reporting none (Hodnett & Fredericks, 2004) while others, particularly HFA evaluations, reporting consistently positive impacts including fewer birth complications and a lower rate of low birth weight (LBW) (Daro & Harding, 1999; Harding et al., 2007).
2. Prenatal enrolment did not seem to increase the use of preventive health care (e.g. prenatal visits, immunization, well baby check-ups) nor lead to benefits in health status (Gomby, 2005). Where families were linked with a “medical home” (e.g. 98% in Florida) and care services were accessed more and used more effectively for services such as immunization (Gomby), and all scheduled visits were attended (Daro & Harding, 1999), there was no rigorous evidence that these were programme effects (Harding et al., 2007). However, a New Zealand RCT programme based on HFA, found that 3

years after birth the treatment recipients were significantly more up to date with well-child checks (Fergusson, Grant, Horwood & Ridder, 2005).

3. Very few studies have measured breastfeeding and nutrition as an effect (Gomby, 2005). In the HFA evaluations, however, there have been consistently positive effects on breastfeeding. Two RCTs found that when mothers were enrolled prenatally there was greater likelihood of breastfeeding (Harding et al., 2007).
4. Reports indicate that child development screenings are simply not completed in many of the studies (Harding et al., 2007), and when they are there is either no effect on physical health and physical development, or the effects are minimal (Gomby, 2005).
5. HFA did not focus directly on, nor were they effective in, enhancing children's cognitive development (Daro & Harding, 1999; Harding et al., 2007). Gomby (2005) reports that while moderate benefits in language until the age of 3 years have been recorded, only intensive and focused, centre-based early childhood education services that focus on the child, yield benefits that are twice as large and longer lasting on cognitive development than home visiting services on their own. However, Fergusson et al. (2005) reported a small reduction of early problem behaviour and enhanced access and enrolment in early childhood education for longer periods in a RCT HFA programme in New Zealand.
6. Primary preventive programmes had small benefits for emotional development compared to services staffed by professionals and sought by parents to address particular emotional and behavioural problems, or those in which particular parental capacities are developed (Gomby, 2005).
7. Benefits with respect to child maltreatment were inconsistent. While most programmes reported targeting physical abuse and/or neglect, Klevens and Whitaker (2007) found only three of the 188 studies they reviewed had specifically targeted neglect, the most common form of maltreatment. This represents a notable gap in the research. Gomby (2005) concludes that success in reducing child maltreatment through preventive programmes has been rare, while Geeraert et al. (2004) found highly significant overall positive effects in their meta-analysis. Although three large quasi-experimental studies indicate benefits of HFA in reducing child maltreatment, none of the randomized evaluations reported significant differences between confirmed reports of maltreatment in treatment and control groups (Harding et al., 2007). The use of confirmed maltreatment rate, as a measure of programme effectiveness, is problematic for many reasons:
 - The measures that have been used to establish rates of child maltreatment and neglect, tends to vary tremendously and thus make consistent and reliable measure of benefits very difficult. (Harding et al., 2007).

- The definition of child maltreatment is strongly influenced by culture (Geeraert et al., 2004; Sossou & Yogtiba, 2008).
- In many cases the concept of child abuse, its aetiology and prevention had not been clearly formulated (Geeraert et al., 2004).
- The difficulty in defining and getting accurate confirmed reports of maltreatment in low income (Sossou & Yogtiba, 2008) and in wealthy countries, (Besharov, 1996; Geeraert et al. 2004; Mathews & Bross, 2008; McGee, Wolfe, Yuen, Wilson & Carnochan, 1995) makes it an unreliable measure of intervention success.
- Assessing the impact of programmes on child maltreatment is expensive largely because, in order to detect significant effects, large samples of cases need to be evaluated (Harding et al., 2007).
- The use of abuse reports as sole indicators of programme success has been cautioned, as infants have limited contact with outsiders and they are less likely than older children to be reported as maltreated (Daro & Harding, 1999).
- Increasing reports and decreasing resources have resulted in child welfare organizations tending to limit their services to the more serious cases (Daro & Harding, 1999).
- Geeraert et al. (2004) also raise the problem that real differences may be obscured by the “surveillance effect” which refers to the greater likelihood that maltreatment will be detected in families being visited in programmes than in control groups. This phenomenon may underestimate the real effect of programmes. The positive side of this is that visited parents are more likely to be noticed maltreating their children (Daro & Harding, 1999).
- Harding et al. (2007) raise the important point that “child maltreatment rates do not capture the continuum of potentially harmful parenting behaviours and discipline practices” (p. 161). We know that any form of maltreatment is invariably preceded by damaging parental attitudes and parent-child interactions.

Harding et al. (2007) note that despite the potential social desirability bias, parent reports of child maltreatment have been found to identify more cases of maltreatment than official statistics. In four HFA RCT's (two statewide evaluations 1994-1998 and 2000-2003, one evaluation in San Diego 1996-2000 and one which began in New York in 2000), modest outcomes using self-reported child maltreatment were described. These outcomes referred to lower levels of neglect, being less likely to “threaten to spank or hit”, fewer reports of minor physical aggression, fewer incidents of psychological aggression at 2 and 3 years, and less corporal punishment. In addition, Latino mothers, particularly, showed lower rates of neglect and psychological aggression was significantly reduced in the least depressed mothers and those

free of domestic violence. Several authors point out that any reduction of child maltreatment is negated by the presence of domestic violence (Eckenrode et al., 2000; Gomby, 2005; Harding et al., 2007; Olds & Robinson et al., 2004). Klevens and Whitaker (2007) stress that rather than focusing on maltreatment, which is so difficult to measure, it is the underlying risk factors for abuse that need to be addressed. Most programmes in fact, only measured the risk factors hypothesized as impacting on child maltreatment. Geeraert et al. (2004) for example, looked at family, parent and child functioning, parent-infant interaction, and context characteristics which are more easily identifiable and measurable. Gomby (2005) report that when “proxy” measures of child abuse are used, the picture looks more positive.

4.2.2.3. Benefits for parenting and parent-child interaction

Most early interventions are based on the belief that responsive and sensitive care from adult caregivers facilitates the development of attachment security that lays the foundation for healthy development and is therefore incompatible with neglect and other maltreatment of children. Attempts to enhance this quality of parenting, and helping parents develop realistic and appropriate expectations of their children through information and positive parenting skills, is a common objective of such interventions (Geeraert et al., 2004; Harding et al., 2007).

1) Parenting knowledge, attitudes and behaviour

Green et al. (2008) do not refer to rates of abuse in their HFA Oregon Annual Report of 2006-2007, but report that in recipient high risk families; 82% consistently engaged in developmentally supportive interactions with their children, 81% reported having improved their parenting skills, and 39% reported a decrease in parent-related stress in the first 6 months after birth.

Daro and Harding (1999) report that one of the “most robust” effects found in three HFA RCT programmes, (Hawaii [2] and Virginia [1]), was in the area of parental capacity. Parenting attitudes improved at a greater rate than controls, and there were significant increases in parental sensitivity and child responsiveness (Harding et al., 2007). These authors also found that single group designs provided very positive results. Daro and Harding (1999) conclude, “regular visits provided parents with greater knowledge about alternative forms of discipline, greater sensitivity to their children’s cues, greater comfort in understanding their children’s development and less overall distress and rigidity” (p.170).

Gomby (2005) report small improvements on these parenting measures in a national evaluation of Early Head Start programmes, which disappeared when the programme ended at the age of three unless home visits were offered within a centre-based context. They also found that self-reports yielded larger effects on these measures than independent observations; the largest effects were generated by parent support groups and by programmes aimed at families where children had already been identified with behavioural difficulties. Fergusson et al. (2005) reported higher positive and non-punitive parenting and reduced rates of severe parent-child assaults in a RCT HFA programme in New Zealand.

There are writers that have contradicted these results (Zercher & Spiker, 2004).

2) Parent-child interaction

While many pathways are acknowledged as leading to risk for infants, the one factor most targeted by research and practice to mediate such risk is the mother-child affective exchanges (Ammaniti et al., 2006; Bakermans-Kranenburg et al., 2003; Harding et al., 2007; Olds et al., 1997).

Evidence of short and long-term improvements in parent-infant relationships has been demonstrated (Zeanah et al., 2005), with home visited participants consistently outperforming controls in HFA RCT evaluation studies (Daro & Harding, 1999; Harding et al., 2007). In a two year follow-up of a large Early Head Start randomized study, Daro (2004-2006) reported treatment mothers to be, “more supportive, more sensitive, less detached and more likely to extend play to stimulate cognitive development, language and literacy mothers also reported less frequent use of spanking and in general, described using milder forms of discipline in managing their two-year-olds” (p. 2), than mothers assigned to the control group.

Bakermans-Kranenburg et al. (1989) undertook a meta-analysis of 15 preventive interventions that focused on enhanced parental sensitivity and attachment security as a measure of outcome. They conclude that sensitivity-focused interventions may be most effective in preventing disorganized attachments. In a later quantitative meta-analysis and synthesis of “experimental”, randomized and non-randomized interventions, Bakermans-Kranenburg et al. (2003) concluded that both randomized and non-randomized studies were effective in demonstrating enhanced maternal sensitivity, with the non-randomized studies tending to yield more inflated effects. Furthermore, the sensitivity-focused interventions not only improved sensitive parenting, but significantly affected infant attachment security.

Bosquet and Egeland (2001) found support for the belief that mothers who lack a coherent state of mind with regard to their own attachment experiences have difficulty in responding sensitively to the needs of their children. They suggest that autonomous mothers, as compared to insecure mothers, tend to be better able to perceive, understand and respond sensitively to their children’s attachment signals without distortions. They further suggest that mothers who tend to be preoccupied, but are willing to consider attachment-relevant issues may be particularly responsive to attachment-oriented interventions.

Ammaniti et al. (2006) ran a RCT evaluating the most evolved NFP model (Olds et al., 1997) in the context of psychosocial risk and depression in Italy. By six months, all the visited mothers showed higher rates of sensitivity and cooperation and lower rates of interference and negative affect. Compared to the non-visited control group, the depressed group showed more sensitivity to the child’s signals and more cooperative behaviours in interactions with them, while the psychosocial risk group showed lower levels of negative affect (lack of pleasure, distress or hostility) when interacting with their children. By the first year, the depressed group had held onto the positive results but the high psychosocial risk group showed lower rates of interference and negative affect. This may suggest that the high risk psychosocial group

who did not present with depression, might have been more resilient and able to make use of the intervention to enhance their potential competence.

4.2.2.2.4. Long-term effects

While results indicating benefits to parents and children have in general been small, we are reminded of how even small changes can be important if produced across a whole population, and could be closely linked to a significant event or outcome (Gomby, 2005; Kitzman et al., 2000; Olds et al., 2004).

Kitzman (2004) referred to “delayed effects” and Gomby (2005) spoke of “sleeper effects”. Both of these refer to benefits that might not be present immediately following the intervention but might emerge later. An example given by Gomby was a Head Start finding that better parenting at 24 months seemed to predict child benefits at 36 months. These are useful concepts when thinking about how small effects found in early evaluations might be responsible for far more significant effects over time. Zielinski, Eckenrode and Olds (2009) have recently shown that while rates of verified reports of maltreatment between comparison and nurse visited groups of children were identical until the age of 4 years, the rate significantly diminished for the nurse visited group thereafter, particularly amongst high risk families.

While short-term effects on children’s physical and cognitive development and birth outcomes have been rare, the long-term potential, for family relationships and child development of positive effects such as improvements in prenatal health, increased spacing between pregnancies, and a reduction in subsequent pregnancies and births, is substantial (Gomby, 2005). These “small” changes provide parents with the opportunity to spend increased time with their infants in the early years, which offers the potential for a growing, beneficial impact on cognitive, emotional and behavioural development that could be life changing for both parents and their children (Olds, 2004). Kitzman (2004) refers to the potential long-term effects of more positive, and less punitive parenting attitudes and improved maternal life course which provides the possibility of a different relationship and life course trajectory for both parents and children.

4.2.3. Overview of interventions in “low and middle-income countries” (LAMIC’s)

Of particular concern in low to middle-income countries is the high incidence of pre- and postnatal maternal depression and anxiety, or what has been termed “common mental disorders” (CMD) (Patel et al., 2008). The reasons for such concern is the strong association between high rates of CMD and dysfunctionality amongst women (Bolton et al., 2003), insensitive maternal care and attachment insecurity (Cooper et al., 1999), a poorer quality of caregiving and compromised infant development (Bosquet & Egeland, 2001), infant undernutrition, failure to thrive, poor growth, higher risks of diarrhoea, disability and the long-term damaging effects on child development, even in food-sufficient areas (Rahman & Iqbal et al., 2004; Rahman & Lovel et al., 2004; Rahman et al., 2008). Interventions have thus tended to focus on the management and reduction of depression as early as possible.

Although depression is fairly easy to diagnose by mental health professionals, and could be used to identify families at risk and in need of early treatment, both primary care health workers and mothers themselves have struggled to diagnose depression (McCarthy & McMahan, 2008; Patel et al., 2008; Pereira et al., 2007; Rahman, 2007). Mental health problems often tend to be primarily expressed through somatic complaints accompanied by a sense of overall “weakness” which has become understood as an idiom for psychosocial distress (Pereira et al., 2007). Primary care clinics, the main source of health care in most low-income countries, are often insufficiently resourced, and there is seldom direct access to professional mental health services (Araya et al., 2003; Bolton et al., 2003). More than anywhere else, treatment in low income countries needs to be feasible, affordable, and acceptable (Patel et al., 2008). Evidence of success in reducing maternal depression through early interventions globally has, however, been limited (Cooper et al., 2003; Gomby, 2005; Shaw, Levitt, Wong & Kaczorowski, 2006).

A randomized control study by Patel, Chisholm et al. (2003) in India demonstrated that in the short-term, antidepressants were more cost effective and more effective than psychotherapeutic treatment in reducing the level of depression between birth and two months. The experience in HIC’s indicate that treatments offering pharmacological interventions in pregnancy and early parenthood have not proved more effective than psychological treatment and women expressed their reluctance to take medication at this stage (Cooper et al., 2003).

In Pakistan, Omer et al. (2009) report that door-to-door visits by Lady Health Workers (LHW) offering health promotion in pregnancy were effective in increasing the likelihood of antenatal clinic visits, reducing heavy work in pregnancy, providing colostrum through early breastfeeding to newborns and maintaining exclusive breastfeeding for the first four months postnatally. Rahman (2007) describes a cluster-randomised controlled trial in which LHW’s delivered a home-visiting intervention based on an adapted and simplified three-step cognitive behavioural therapy approach to treating depression, which provided 4 antenatal and 12 postnatal visits in the year following birth. They found the prevalence of depression to be significantly lower in the intervention group (Rahman et al., 2008).

Several attempts have been made to combine psychological and drug treatment for depression in primary care (Bower et al., 2006; Chilvers et al., 2001; Mynors-Wallis, Day & Baker, 2000; Ward et al., 2000). Patel et al. (2008), in Goa, India, are presently designing an evaluation of a “Collaborative Stepped Care” (CSC) model of intervention based on a successful Chilean model described by Araya et al. (2003). It is a multi-component “stepped-up” intervention that attempts to integrate a structured psycho-educational group run by social workers and nurses, systematic monitoring of clinical progress, and the prescription of appropriate medication by a medical doctor for severe or persistent depression. As a model, it is seen to maximize the efficient use of health resources, and encourages collaboration between primary care and specialist medical and non-medical staff at the Primary Health Clinics (PHC). Patel et al. (2008) and Chatterjee et al. (2008) describe this model in more detail.

Concurrent with high levels of HIV/AIDS, the mental health burden in rural Uganda is substantial, and antidepressant treatment is not feasible because of high cost and poor infrastructure. Here, the use of weekly group interpersonal psychotherapy sessions over 16 weeks run by local people trained in interpersonal psychotherapy, has significantly reduced depression and improved functioning for men and women. Although inconclusive, participant testimonials suggested that the group problem-solving element of the interpersonal psychotherapy group was vital (Bolton et al., 2003)

Richter and Mphelo (1995) address the impact of protein-energy malnutrition (PEM) in infants in poverty situations. Having observed the typically dysfunctional relationships of protein-energy malnutrition (PEM) infants and their defensively detached caregivers, they conclude that on the whole, nutrition programmes have been poorly conceptualized. They have not taken into consideration the psychological consequences of poverty such as the marginalization and poor motivation and morale of caregivers, which they see as being at the core of infant malnutrition. The authors express their conviction that “the future adjustment of malnourished children depends not only on medical treatment and supplementary feeding, but also on improving the capacity of caregivers to respond to and meet their children’s emotional and cognitive needs” (p. 3).

4.2.4. Some of the key characteristic of programmes and their roles

4.2.4.1. Characteristics of families that benefited

Across the board, programme participation is voluntary and dependent on the families willingness to engage and invest their time and energy in programmes. The success of programmes to engage families has been assessed by their ability to enrol families, deliver services at the intended level of intensity, retain families in the programme and maintain enthusiasm, motivation and involvement (Kidzman, 2004). Gomby (2005) found that up to 40% of families, and particularly those offered universal programmes refuse services; attrition varies between 20% and 80% averaging at 50 %. Families typically receive only half of the scheduled visits and do not always do their “homework” or follow up on referrals. The type of family that remains committed was inconsistent across programmes; however, McGuigan, Katzev and Pratt (2003) found that families living in communities with high rates of violence were less likely to remain engaged in their programme.

Inconsistency was also found with respect to characteristics of mothers who benefitted (Daro & Harding, 1999). Ammaniti et al. (2006) found that the best functioning mothers seemed to benefit the least and that mothers at high psychosocial risk, who were not depressed, seemed more resilient and able to make use of the intervention to enhance their potential competence. Specifically in the United States, those that tended to benefit the most and remain engaged across programmes tended to be older rather than younger, and Hispanic rather than white non-Hispanic mothers (McGuigan et al., 2003). Teen and least depressed mothers showed greater improvement in attitudes to parenting, parent sensitivity and child responsiveness

(Harding et al., 2007). Teenage and high risk mothers who presented initially with low coping skills, as well as parents who perceived the services were needed by their children as a result of specific difficulties (Gomby, 2005), children and families who were neediest and at highest risk (Bakermans-Kranenburg et al., 1989; Olds et al., 1999; Zercher & Spiker, 2004), clinically referred families and those including fathers and other adults who were significantly involved with the day-to-day care of the infant (Bakermans-Kranenburg et al., 2003), all seemed to make better use of this type of service.

Ammaniti et al. (2006), make a very useful observation that the birth of the baby played a catalytic role in the positive organization of maternal mental representations for both treatment and control mothers in that, by three months, a shift had been facilitated from “not integrated/ambivalent and restricted representations during pregnancy to more integrated representations of the self as a mother and of the child” (p. 83).

4.2.4.2. Characteristics of the most effective programmes

Gomby (2005) quote the National Academy of Sciences as concluding that the key to programme effectiveness is “likely to be found in the quality of program implementation...” (p. 39).

4.2.4.2.1. Home or centre-based programmes

Whether visits were conducted at home or elsewhere seemed insignificant (Bakermans-Kranenburg et al., 2003), however, programmes that combined home visiting in conjunction with centre-based early education or services such as case management and parent-child activities, had far larger average effects, and more lasting results, particularly for children’s cognitive development or school achievement (Gomby, 2005). Daro (2004-2006) endorses this, suggesting that benefits require “not simply a strong program ... partnering these types of intensive home-based interventions with a group- or community-based service program can dramatically increase the proportion of new parents who will use prevention services” (p. 2). Barnard et al. (1993) concur that early interventions were not enough, as approximately 50% of mothers in high risk circumstances, who were able to foster secure attachment with their infants in the first year of life, seemed to struggle to maintain stable relationships in the second year.

4.2.4.2.2. Content and focus of visits

The evidence suggests that the strongest effects were associated with aspects of the programme focused on by the home visitor. As a result, the delivery of the same model could vary enormously and the tendency was to focus on the parents’ expressed needs rather than on the children’s needs (Gomby, 2005). These authors suggest that careful evaluation and feedback from programmes such as the HFA and NFP have been helpful in modifying them to meet the needs of targeted populations. They suggest that programme curricula are clear, focused and delivered as intended. Daro and Harding (1999) found participating families appreciative of immediate and concrete input about problems that presented. Observation studies

such as those described by Riley et al. (2008) might be helpful in identifying which aspects of programmes had meaning for mothers, and engaged and effected responses from them during visits.

Programmes focusing on the caregiver-child relationship, rather than either parent or child (Zeanah et al., 2005) and on sensitivity, were significantly more effective in reducing attachment disorganization than those that also included support and work with parental representations (Bakermans-Kranenburg et al., 1989). Egeland and Bosquet (2001) suggested that interventions address not only the parent-child relationship but the mother's relationship with partners and other family members, as these impact her relationship with the infant.

4.2.4.2.3. Structure of visits

Egeland and Bosquet (2001) recommend that visits should begin as early as possible, preferably during pregnancy, be of sufficient length for therapeutic engagement and that interventions were more successful when the extenuating problems of poverty, unemployment, housing and substance abuse faced by high-risk parents, were also addressed. Bakermans-Kranenburg et al. (2003) concluded, contrary to commonly held beliefs, that short interventions (1-16 sessions), focusing on maternal sensitivity only, without focusing on support and representation, starting after the first 6 months of life, were most effective, regardless of the presence or absence of multiple problems in recipient families. They concurred however, that longer and more broadly focused support that assists multi-problem families cope with their more stressful lives might be a pre-requirement for a sensitivity-focused intervention to be successful.

4.2.4.3. The home visitors

4.2.4.3.1. Professional versus non-professional home visitor

Bower et al. (2006), using a meta-regression, identified the professional background of staff as one of the factors that predicted favourable outcomes across interventions.

Relatively few home visiting programmes were able to provide highly skilled and trained child development specialists and mental health clinicians to deliver interventions, but most of the successful interventions reported in HICS were, and continue to be, delivered by a variety of professionally trained and highly skilled staff, including nurses, teachers and social workers. Even when reference was made to paraprofessionals or non-professionals, most had a college degree or at least achieved high school diplomas (Ammaniti et al., 2006; Cooper et al., 2003; Daro & Harding, 1999; Geeraert et al., 2004; Gomby, 2005; Kitzman et al., 2000; Korfmacher et al., 1999; Mc Carthy & McMahon, 2008; Olds & Robinson et al., 2004; Zeanah et al., 2005). One exception to this was the Community mothers Programme in Ireland which showed benefits in parental skills, health care and maternal self-esteem seven years after delivery of a birth to one year programme by experienced volunteer mothers (Johnson et al., 2000). While HICs have seldom made use of lay community members to deliver home visits, Zeanah et al.(2005) raised

the need to explore the value of the non-professional, or lay community counsellors, in order to meet the challenges and respond to the needs of groups for whom services remain inaccessible with respect to location, transport, costs, language, culture, time and stigma, often from low and middle income countries.

Korfmacher et al. (1999) conducted a NFP RCT called “Home Visitation 2000”, in which the relative effects of employing professional nurses and paraprofessionals, comprising community health workers (CHW) with only a high school education but strong in “people skills”, was evaluated. The results indicated that the effects associated the CHW home visitors were sporadic and weak, and were half the size of those produced by professional nurses (Olds & Robinson et al., 2004). While the quality of delivery by both visitors were viewed equally positively by the mothers, there was a significantly greater dropout rate, greater staff turnover, and fewer, but longer-lasting visits in the paraprofessionals, who tended to spend more time on environmental health and safety issues. The nurses, on the other hand, completed more visits and spent more time on health issues during pregnancy and parenting issues during infancy (Korfmacher et al.). The results have been widely reported (Gomby, 2005), and supported by others (Haq, Iqbal & Rahman, 2008). This finding represents a challenge for interventions in low income countries where the exclusive use of highly clinically skilled professionals remains an unrealistic, maybe unnecessary, demand. Bakermans-Kranenburg et al. (2003) on the other hand, based on their meta-analysis of sensitivity and attachment interventions, conclude that interventions delivered by non-professionals were more effective than those delivered by professionals. This issue is relevant and important, particularly for low income countries and further long-term follow-up research is essential.

While professionally trained staff have been used effectively and economically in low income countries, for example, as group facilitators in the multi-component “stepped-up” group intervention in Santiago, Chile (Araya et al., 2003), the need here is to employ non-professional health workers as home visitors. In South Africa, Freeman and Pillay (1997) refer to extremely limited funding available for health care and social services in general, which has decreased the availability of experienced and skilled professionals in the existing health and welfare structures. The shift of financial resources from tertiary to primary health, high levels of unemployment and the enormous growth of poor communities that overload the existing formal structures, views the increased employment of men and women from communities, with no formal training, as a cost effective way of filling the gap in services provision, and at the same time of providing employment in struggling communities (Swartz & Gibson, 2001). It is also a way of optimising “the capacity thought to exist already within communities around mental health issues” (Tomlinson & Swartz, 2002, p. 100), and in addition, it serves the purpose of mobilising the significant shift experienced towards community participation and the democratisation of knowledge (Swartz & Gibson).

Gomby (2005) warns that targeting needy high risk families confronts home visitors with very challenging issues such as domestic violence, maternal mental health problems, including depression, and parental substance abuse, which need to be addressed with the expertise of competent and qualified staff. While

there is an enormous amount of untapped potential in the unemployed in economically deprived communities, many of these men and women have not had the advantages of formal education and training, and it remains unclear to what extent this unskilled and largely unemployed group are able to fulfil this role, without the support of trained professionals.

Community health workers have been successfully employed in various programmes supported by professional staff. Mature Hispanic women recruited from the targeted community called “Comieno Sano Promotoras” (healthy beginning promoters) and supported by health professionals, delivered a prenatal health promotional project for farm-workers in Arizona (Warrick, Wood, Meister & De Zapien, 1992). In Uganda, local community members were trained to run successful interpersonal psychotherapy groups (Bolton et al., 2003). Non-specialist, village-based lady health workers (LHWs) in Pakistan were local women who had completed their schooling and trained as educators to provide preventive mother and child health care. They formed the backbone of the Basic Health Units staffed by a doctor, a midwife and a vaccinator, and were effective in improving health care and breastfeeding practices (Omer et al., 2009). However, at times this intervention, aimed at maternal behavioural and psychosocial changes, represented an additional responsibility in addition to an already heavy workload (Rahman, 2007).

One of the advantages of employing community-based counsellors is thought to be that a cultural match between the home visitor and the families they serve would automatically be achieved that would enable responses that were culturally appropriate and sensitive (Daro & Harding, 1999). The rationale is that change is difficult and many parenting beliefs and practices are strongly defined by culture, so sensitivity to cultural beliefs, values and dynamics is therefore imperative, more so when mothers live with their extended families. The National Academy of Sciences concludes that, “...parenting interventions that respond to cultural differences in a dismissive or pejorative manner are likely to precipitate significant conflict or be rejected as unacceptable” (Gomby, 2005, p. 42). Riley et al. (2007) addressed, through a qualitative evaluation, the assumption that a “cultural match” between recipient mothers and home visitors enhances the relationship between them, and found that this was not seen as necessary by Latino recipient mothers, provided that there was recognition, respect and understanding on the part of the home visitor for differences not only cultural but in the uniqueness of each family visited .

4.2.4.3.2. The parent-provider relationship

Lieberman (1998) made the observation that each relationship affects the next relationship and parents who feel supported, nurtured and understood by their counsellor are more likely to be more nurturing and understanding towards their infants. The importance of the parent-provider relationship in home visitor programmes has also been recognized and reported by several researchers in the field (Gomby, 2005; Kitzman, 2004; Marziali & Alexander, 1991; Olds et al., 1997). Krysik et al. (2008) refer to this relationship as representing a central feature of the intervention for mothers and that when it is positive,

the home visitor was able to address parental behaviours that were detrimental to their children. It is important therefore, to recognize that home visiting interventions that aim to change attitudes and behaviour are primarily therapeutic processes for which the establishment of a therapeutic alliance with the mother, as a vehicle for change, is crucial (Olds & Kitzman et al., 1997). While this relationship is recognized as a central mechanism affecting programme outcome, very few studies have addressed the content, quality and process of home visiting and therefore, how this relationship develops and functions, is not yet clearly understood.

Riley et al. (2008) reviewed various methods that have been used to examine this mechanism and conclude that, “none of these methods fully captures the parent-provider relationship” (p. 599). In general, participants’ perceptions of satisfaction and quality of relationship with the provider using rating scales and inventories tend to be inflated. The authors report on a multi-level exploration of provider-teenage parent relationship in the Healthy Families America Massachusetts programme. Evaluated were a) participants’ engagement and involvement in the programme, b) parent and providers’ perspectives on their relationship by coding and analyzing responses to semi-structured interviews with both parties, and c) video-recordings of parent-provider interactions to evaluate the behaviours of both parties during the home visits. The findings indicate that neither the length of engagement in programmes, nor the mothers’ responses on the home visitor-client relationship inventory, were reliable measures of the quality and strength of the provider-parent relationship. Interesting differences between visitors and clients’ perceptions and beliefs about the roles, culture and parental status requirements of home visitors were expressed. The home visitors tended to take more responsibility in facilitating interactions with recipient mothers. The same visitor might interact very differently across different families, suggesting that different relationships get set up with different families, but consistency was shown across visits with the same participants. Mothers relate differently with different visitors. While this allowed some insight into the nature of interactions, the meaning of the interaction for both participants remained unexplored. They felt that what was missing was the voice of the participants providing some reflection, explanation, reality and meaning of the experience.

Kazdin (2007) notes that while the therapeutic alliance has consistently been found to predict therapeutic change and symptom improvement, this does not necessarily indicate a causal role. He suggests that a positive alliance may, in fact, follow improvements in symptoms. He points to the importance of establishing a timeline between alliance and symptom change in order to be able to establish a causal relationship.

Interesting results that seem to fly in the face of the centrality of the therapeutic alliance came from four studies reviewed by Bakermans-Kranenburg et al. (2003), in which the promotion of baby carriers, kangaroo care, a workbook on responsiveness and videotapes used in interventions, showed the largest effect size. They also reported that video-feedback interventions were more effective with mothers

classified as insecure and dismissive. Video-feedback within the context of a therapeutic alliance has also been effective for short-term sensitivity responsiveness training in adoptive families with 6 month-old infants, where infants were less likely to be classified as disorganized (Juffer, Bakermans-Kranenburg & Van IJzendoorn, 2005).

4.2.4.3.3. The role of the home visitor

Riley et al. (2007) note that the roles providers should play for recipient families has not been clearly defined, and vary enormously depending on the goals of programmes. The limits and boundaries have at times been quite specific, stating that home visitors are not therapists or social workers; some have been referred to as educators (Barlow et al., 2006), and others as a source of expertise for caregivers (Zercher & Spiker, 2004). Riley et al. found that 33% of the visitors saw themselves as “a resource for information”, 23% as family members (parental figures or sisters), and 8% as role models. The 36% remaining described themselves in terms of what they do, e.g. as “someone who cares”. The recipient mothers overwhelmingly described the home visitors as friends (75%), as professionals (social workers, nurses etc..) (16%), and as parental figures or older relatives (9%).

4.2.4.3.5. Experiences of home visitors

More recently, there have been several attempts, through qualitative research, to gain some understanding of the experience of home visitors. Kitzman and Cole et al. (1997) found that nurses who delivered the (NFP) programme felt strong satisfaction with the work not often met in other nursing settings. They enjoyed the ability and opportunity to form therapeutic relationships with their clients over a period of time. It met their needs to nurture, support, have their offerings received and appreciated, and it felt important to learn from their clients. They also believed the work served to protect and reassure mothers and children at risk, and gained confidence in diagnosing health problems and risk factors.

Distress and unhappiness, on the other hand, was also evident, indicated by the high staff turnover reported in both the HFA and NFP programmes (Daro & Harding, 1999; Riley et al., 2007). Commonly, low wages were identified as contributing to the unhappiness of staff. Also reported by Kitzman et al. (1997) were the nurse-visitors' struggle to gain physical access, engage emotionally and build therapeutic relationships with defensive, depressed and unmotivated mothers. They felt unprepared for the severe nature of the problems they encountered, which included depression, domestic violence, substance abuse, and child abuse, including incest. There were more health and socioeconomic risk factors than they had anticipated, and they struggled to minimize the impact of these, and to help mothers work towards their goals. They expressed how the work impacted on them emotionally, leaving them feeling helpless, disappointed and overwhelmed at times by the complex issues their clients faced. Time was needed to listen to and address the problems mothers needed to express. This need often required the more structured programme guidelines to be put aside. They felt that while working alone gave them flexibility, it also felt

isolating, and at times they felt vulnerable in the face of the violence that would occasionally erupt. Tandon, Mercer, Saylon and Duggan (2008) also found that home visitors became stressed addressing the more severe socioeconomic and mental health problems of families. Having received extensive training focused on the acquisition of knowledge, visitors expressed the need for more skills training, specifically on how to initiate discussions on mental health, more clarity on the extent to which these issues should be addressed and additional supervision.

Rahman (2007) reports on LHWs in Pakistan, who deliver basic health care and had been trained as health educationists and promoters. They believed that the new knowledge and skills acquired provided a structure to their work and made them more effective as health workers. They suggested that:

- Any training needs to be beneficial to their work generally and easy to follow.
- The model of care needed to move away from the medical and thus, be delivered in parents' homes.
- To avoid stigma, all family members should be included in interventions, which should be presented as parent training around infant care, development and maternal support, rather than maternal psychological and physical health needs.
- The focus needs to be a change of parental behaviour, not just of thinking or attitudes.

The research alerts us to the need to be cognisant of problems such as services being patchy in certain areas, poor selection of staff, lack of motivation, poor supervision structures and weak governance (Rahman, 2007). Haq et al. (2008) points to the visitors' struggle with significant "occupational stress" associated with low socio-economic status, long distances to travel to work, inconsistent medical supplies, inadequate wages, a lack of career structure, and difficulties in communicating effectively with families.

4.2.4.3.6. Selection of home visitors

The professional nurse-visitors selected for training on the NFP programmes were highly skilled and experienced nursing professionals, chosen for their training in maternal and child health, experience with families with complex health issues, teaching ability as well as their credibility as health providers (Zeanah et al., 2005). In the HFA model, the paraprofessional service providers were selected on the basis of their "knowledge base as represented by specific academic degrees or employment portfolios" (p. 156). While quite capable of high levels of competence in their chosen line of work, there is increasing recognition that experience as a professional nurse, even with intense training, does not guarantee the provision of the necessary basic qualities to deliver a therapeutic intervention (Boris et al., 2006; Zeanah et al., 2006).

While knowledge, education, experience and training are important factors, several researchers have identified particular personal qualities of home visitors as the factor that correlated consistently with

positive outcomes (Daro & Harding, 1999; Gomby, 2005; Kitzman et al., 1997). Qualities such as compassion, empathy, reliable support and acceptance, as well as a capacity to establish rapport, develop trust, remain focused on the curriculum and administrative needs of the programme, and deliver a therapeutic intervention which is responsive to personal crises when they arise, have been identified (Daro & Harding 1999). In addition, Gomby (2005) felt that a level of emotional maturity from home visitors was essential. NHP nurses expressed their belief that their life experiences had informed their work (Kitzman et al.). The two consistent essential qualities they identified as a requirement for this work were to be non-judgemental, and to be able to listen carefully rather than to be reactive. The authors felt that in order to establish a strong “therapeutic alliance” and function as a “secure base” for mothers, the nurses own parental and relationship histories, which might impact on their work with families, needed to be taken into account.

In lower income countries with fewer professional and financial resources available, there seemed to be far less focus on the careful selection of trainees for this work. Many of the non-professional staff employed as home visitors have tended to be local women already working in the communities as health promoters and educators (Haq et al., 2008; Omer et al., 2009; Rahman, 2007). As a result of their lack of professional training, the one factor on which they are forced to rely is their capacity to manage the complicated emotional components of this work. It follows therefore, that careful selection of home visitor trainees is crucial.

4.2.4.3.7. Training

Lieberman (1998) states that a basic principle in the implementation of preventive interventions is the need for intervention providers to be attuned to the subjective meaning of external circumstances and behaviours (their own, the infant’s and the parent’s), and what they might be communicating. This represents a fairly sophisticated concept. While it has been repeatedly expressed that the staff need to be equipped with information and skills, most evaluations fail to describe their training in any detail (Gomby, 2005). Intensive didactic training specific to their role as service providers was an aspect critical to the HFA programme (Daro & Harding, 1999). In an ambitious programme in Pakistan, Rahman (2007) describes how Lady Health Workers were taught an adapted and simplified three-step cognitive behavioural therapy approach to depression based on Beck et al. (1979) in which:

- Unhealthy and unhelpful thinking styles and behaviours in mothers would be identified.
- Mothers and other family members were helped to question how they felt, thought and behaved, and to explore alternative ways of thinking and behaving that were more adaptive.
- Homework exercises were provided to practice healthier ways of thinking and behaving.

The training workshop took place over two days plus a follow-up refresher day three months later. Supervision by a mental health professionals and public health experts took place monthly in groups of ten.

In the multi-component “stepped-up” group intervention in Santiago, Chile, the group leaders (social workers and nursing professionals) received 12 hours of training and 8 hours of supervision by the investigating team (Araya et al., 2003). Local community members who ran successful therapeutic groups in Uganda received 2 weeks of intensive training in interpersonal psychotherapy by the research team (Bolton et al., 2003).

The difficulty, from a clinical point of view, is that while parent counselling based on psycho-education principles seems simple, accessible and easy to understand, and focused but flexible curricula with guidelines are helpful, the implementation of such models is often far more complicated. The emotional nature and therapeutic requirements of home interventions will always require clinical insight and judgment in the here and now with families, and the process of change requires emotional containment and far more therapeutic expertise and “knowledge” of dynamics than just the application of a technique.

Comprehensive primary health care is an approach that follows a developmental agenda and addresses the psycho-social roots of ill-health and emphasizes active community participation and empowerment.

Health, in this sense is understood to include physical, mental emotional and social well-being (Petersen & Swartz, 2002b)

There is an increasingly robust literature on issues of training lay-counsellors in South Africa and an increasing recognition of what Petersen and Swartz (2002a) termed “emotional labour”(p. 1010) compared to other biomedical technical outcome indicators usually exclusively considered. However there have been few initiatives in re-orientating primary health care personnel from a technical skills approach to a more comprehensive approach needed to facilitate health promotion (Petersen & Swartz, 2002a) and where retraining has been offered it has had limited success (Petersen & Swartz, 2002b). The tendency is, despite reorientation programmes that aim to provide comprehensive care, for primary health workers to limit themselves to a narrower biomedical technicist approach for reasons that ; a) this role is perceived, within the health system, to be of higher status and power and b) it allows workers to avoid the difficult emotions that have to be faced. (Petersen &Swartz, 2002a)

What emerges from this literature is that all the issues that pertain to the training and skilling of professional counsellors need to be taken into consideration for lay counsellors as well. Furthermore, Petersen and Swartz (2002a) suggest that while the personality, knowledge and skills require to be taken into account so do the organizational structural provisions of emotional containment and support for both patients/clients and primary health care providers.

Zeanah et al. (2006) describes how the NFP nurses, from HICS, who were not trained mental health professionals, required extensive training in order to shift or unlearn their approach and techniques from a medical to a more psychotherapeutic model. Boris et al. (2006) describes their training in some detail. They refer to nurses having to develop a greater “psychological-mindedness” and having to learn to reflect on their work and to consider the meaning of their own and their clients’ behaviours. Over and above knowledge and skills in relationship building, and identifying and intervening with mental health issues in parents and infants, they learnt to recognize the impact of the work on their own lives and functioning. This suggests some exploration of their personal experiences of parenting and being parented and beliefs and attitudes that might undermine or enhance their therapeutic roles.

4.2.4.3.8. Supervision

Olds et al. (1997) conclude that “Sound clinical work has required substantial doses of common sense, clinical insight, and excellent supervision” (p. 24). Bower et al. (2006), using a meta-regression, identified specialist supervision as predicting favourable outcomes across interventions aimed at improving common mental disorders. While there are several models of supervision, broadly speaking, supervision provides an opportunity for therapists to step back from therapeutic encounters and think with others about their experiences with the client. As a formalized structure, the supervisor adopts an observational and authoritative stance which facilitates the development of the therapist’s own observational stance in relation their clinical work (Petts, 2007). McGuigan et al. (2003) found across 12 different communities, that the more hours of direct supervision home visitors received, the more likely their families would remain in the programme. Bower et al. found that the use of case managers with mental health backgrounds and regular specialist supervision predicted depressive symptoms outcomes in collaborative care with antidepressant use. Many home visitors, across the “professional-CHW” spectrum, do not have the training required to identify and respond to mental health problems, and need the knowledge and expertise of a clinically trained supervisor to maintain the quality of services. Daro and Harding (1999) addressed the crucial role of supervision as a protection from burnout.

Despite extensive preparation for the work and the supervision provided by more experienced nursing professionals, NFP home visitors felt unprepared for the severe nature of the problems they encountered (Boris et al., 2006), and acknowledged that their personal lives had been affected by the demands of the work (Kitzman et al., 1997).

Weiss, Daro and Wasik (2006) explored, through focus groups with supervisors in the field, what they believed made supervision effective. They identified their own needs as including a supportive work environment, good structure and communication, training and professional development, a coherent programme design, strong community links, adequate salary and compensation, adequate facilities and

administrative support, and formal evaluation to show program effectiveness. There was also explicit reference to the need for “reflective supervision” to recognize, address, examine and manage the feelings and reactions that arose in home visitors working closely with young families. They also questioned whether they had the necessary knowledge, skills and support required to provide such reflective supervision to their staff.

These supervisors similarly perceived home visitors’ needs to include; a supportive work environment where they felt guided, recognized, trusted and supported around issues of safety, opportunities for professional growth and development, structure and regular communication with their supervisors, access to mental health services for themselves and their families, evaluation of programme implementation to build upon the strengths of the programme and grow professionally, and that supervisors should have experience working in the field.

An augmented programme in Louisiana created a far more complex and sophisticated, multi-layered and professional model of supervision. It introduced an additional level of consultations of specifically trained and skilled mental health clinicians and professional consultants (MHC) who supervised the home visitors and their nurse supervisors (Boris et al., 2006). A reflective model of consultation and supervision was adopted, building in group cohesion and support. The nurses found that the availability of the MHC was helpful in guiding their work and in containing and managing their often overwhelming feelings in the face of the problems faced by their clients. Regular telephone and quarterly face-to-face supervision was provided to the MHCs from the agency team (Zeanah et al., 2006).

Attempting therapeutic processes with “at risk” and needy mothers in economically deprived communities, or with multiple problem families facing complex issues at the sensitive stage of transition to early motherhood, is challenging even for the most experienced therapists, and requires important factors to be considered. The first is that counsellors are often left with powerful and often unbearable emotions of their own, as well as emotions they unconsciously carry for their clients and the community as a whole. The capacity to listen to, hold, metabolize and contain such emotions calls for clinical, therapeutic and self-knowledge, sensitive clinical judgment, flexibility in approach, and close supervision. In thinking about her own process in coming to terms with the emotional demands of working therapeutically in a very deprived community, Stirling (2002) notes that the development of any true capacity to think as a counsellor requires engaging with the anxieties of “not knowing”. She states, “‘Not knowing’ brings up powerful anxieties that relate to the absence of containment” and we all “protect ourselves from the state of discomfort associated with uncertainty” (p. 23).

While there is no doubt that improved wages, consistent logistical support, a structured and predictable career path, and improved training in communication (Haq et al., 2008) would improve the levels of stress

in CHW, Tandon et al. (2008) identified the obvious need for those providing services in early parenting in the context of severe socio-economic deprivation, for emotional containment.

4.2.5. Research gaps and challenges in the field

Some of the most experienced researchers in the field believe that the promise of early universal primary preventive interventions for parents and infants has still not been fulfilled (Olds, Sadler, & Kitzman, 2007). Randomized evaluations have failed to demonstrate sufficiently substantial benefits. Several reasons have been offered.

There are certain limitations in the methodology and analyses used in this research, which has resulted in questions being raised about whether the conclusions are truly supported by the data, which in turn, has implications for commitment to the future implementation of programmes (Glauber, 2005). In reply, Olds, Luckey and Henderson (2005, p. 1113) support the concern about over-interpreting “single statistically significant treatment differences”. They suggest “not to make statistical adjustments for multiple comparisons”, and state that only statistically significant treatment effects that are consistent with other findings, are considered. Consistent with this are their many attempts to replicate their findings through randomized trials across different populations and contexts, which is not without challenges.

Fergusson et al. (2005) refer to problems where varying treatments designed to meet participants’ specific needs are applied to heterogeneous populations, which typically experience a wide range of issues and difficulties. Many programmes tend to be field-based and as a result of particular needs, changes are made “mid-stream”, which means the programme quality and implementation varies from one site to another (Gomby, 2005; Harding et al., 2007). Zeanah et al. (2005) refer to the inadequate availability of resources in both funding and skills required for rigorous research requiring random assignment to treatment and control groups.

Geeraert et al. (2004) felt that more research was needed to establish what role the key formal or organizational elements (e.g. home-visits vs. groups, use of professionals vs. non-professionals) and content elements or ingredients (e.g. enhancing parenting information and skills, reducing isolation) played in the success of interventions. They also highlight that, “(O)ften it is not known what really happens during the interventions in or with the families” (p. 288). While we have some fairly detailed description of the elements of these interventions, we don’t really understand how actual interactions between the service providers and family members work. We still need to discover the “active ingredients” in successful home visits through the analysis of parental engagement (Zercher & Spiker, 2004). Referring to nursing professionals, although this pertains to all home visitors, Zeanah et al. (2006) conclude:

While ... not conducting psychotherapy, their presence and the process in which they do their work are therapeutic. Future work that addresses in more detail the fundamental components of that

therapeutic stance would add greatly to our understanding of this critical component of the NFP model. (p. 52)

Klevens and Whitaker (2007) felt, from a public health perspective, that cost-effective interventions requiring the least effort by the recipient publics should be evaluated. These include: mass education campaigns through the media on corporal punishment and constructive alternatives to discipline, policies that increase the value that society places on children, information delivered to new parents in hospital settings, as well as the targeting of risk factors including poverty, partner violence, teenage pregnancy and child maltreatment, which are known to be prevalent and tend to have been somewhat neglected.

While an overview of this issue is beyond the scope of this thesis, the essential need for cost-benefit studies of home visiting programmes is recognized in order for governments to invest in childhood interventions (Zeanah et al., 2005). Well-developed and evaluated programmes such as the NFP which produced substantial and important maternal life course changes over 15 years represented a “net” saving per family to government for high-risk mothers (Gomby, 2005), however, it may not be easily transferable to the South African situation. In South Africa, with high unemployment, a HIV/AIDS pandemic, and where social grants and services are generally inadequate to meet the basic housing, health and educational needs of families and growing children, a cost-benefit analysis might remain inconclusive at this stage. Furthermore, the evaluations themselves can be costly.

Despite the many challenges and inconsistencies, sufficient positive results have been found, particularly in well-planned and researched early preventive interventions reported in the literature (Olds, 2004). This has confirmed the belief that home visiting interventions in the period from pregnancy until the second birthday has the potential to provide positive effects and enhance the lives of women, children and families for years afterwards (Olds & Kitzman et al., 2004). As a result, home visiting research has continued in both HICS (Gomby, 2005), and particularly in LAMICS (Patel et al., 2008; Rahman, 2007), where professional and financial resources are limited, in order to advance the development of interventions in the neediest communities that remain poorly resourced.

Olds et al. (2007) conclude that programmes are far more effective when they are grounded in theory and epidemiology, and based on clinical wisdom as well as common sense. Ideally they need to be carefully piloted to ascertain feasibility, engagement and behaviour change before being universally adopted. Research needs to adhere to the highest standards of randomization, yield outcomes that have relevance for public health, be replicated in different contexts and populations, and dissemination studies need to be conducted (Olds). They also need to remain true to the models tested if the benefits found are to be replicated (Olds et al., 1999). There is also an urgent need for qualitative research to explore the “active ingredients” and mechanisms involved in the process of therapeutic change reported in home visiting interventions.

The first RCT of an early primary preventive intervention undertaken in Khayelitsha, South Africa, is described in the following section. This research demonstrated that the intervention delivered was successful in bringing about more sensitive and responsive engagement between mothers and their infants during the first two years (Cooper et al., 2009; Tomlinson et al., 2006). The mechanisms responsible for effecting these changes are likely to be multidimensional, complex and, as yet, remain unclear. This thesis is an outcome of this study, and attempts to begin to explore the meaning of this intervention for a selected sample of recipient mothers. It asks for their perceptions of what changed for them, how they understand this, and what they valued in order to make some links to the available theory and to delineate some elements, processes and events that might point to potential mechanisms of change.

CHAPTER 5

METHODOLOGY IN THE CONTEXT OF THE BROADER RESEARCH STUDY

Before I describe the qualitative research methodology adopted for this thesis, I need to describe in some detail, the broader project which comprises various studies undertaken which form the background to this qualitative piece of research. I will also provide a detailed description of the Khayelitsha parent-infant intervention that was evaluated.

5.1. Description of the Khayelitsha Parent-Infant Project

The broader study aimed to run a randomised control trial to evaluate whether, in the context of socio-economic adversity and high levels of depression, a brief early preventive community-based intervention, delivered by previously untrained, lay community counsellors could be beneficial in enhancing maternal interactions with infants, and lead to improved social, emotional and cognitive outcomes.

It was important to ensure that the quality of the intervention and evaluation would stand up to international scientific community standards if it was to be useful and taken seriously (Swartz, Tomlinson & Landman, 2004). The first two years was spent gaining entry to the community, developing human resources, as well as developing material and physical infrastructure, planning the intervention study and applying for funding for this project. The initial planning meetings and travel costs were supported by a British Council Link Award.

Parent-infant counsellors were selected and a training programme was developed which incorporated the adaptation of the Reading Health Visitor Preventive Programme to the needs of the Khayelitsha community. In 1997 a prefabricated building was donated and erected. In order for the research assessors to remain blind to the treatment or control status of the mothers and infants they were assessing, the study needed to be split into two separate teams. I occupied the post of clinical director of the project overseeing the intervention team, while Mark Tomlinson, a clinical psychologist from Child Guidance Clinic, University of Cape Town, was appointed as the director of research overseeing the assessment team. For this purpose, the prefabricated building was converted into a research unit and, adjacent to this unit, a timber cabin was donated and erected, where the counsellors worked and gathered for supervision sessions (See Fig. 6 & 7). It was through the reputation and experience of the British members of the team that funding was found for the different phases of the research project, which the community staff named “Thula Sana”, meaning “be calm my baby”.



Fig. 6. The community counsellors in front of the timber cabin with the research unit in the background.



Fig. 7. A supervision session.

Through his work with Professor Cooper, Dr. John Orley, the former programme manager, Division of Mental Health at the World Health Organization, involved globally in the promotion of mental health, and with a special interest in low income countries, became aware of the project and showed an interest in promoting the research. He had been working with Professor Karsten Hundeid, a Norwegian developmental psychologist at the Centre for International Health, who had been involved in developing a psycho-social and educational intervention for caregivers to work with disadvantaged children in low income countries (Hundeide, 1991). This programme for the enrichment of interactions between mothers and children, called Improving the Psychosocial Development of Children, was adopted by the Division of Mental Health as an International Child Development Programme (ICDP) for the World Health Organization (WHO) in Geneva. The World Health Organization agreed to fund the piloting of the adapted Reading intervention in Khayelitsha and it was agreed that the basic principles of the ICDP: Improving Mother/Child Interaction to Promote Better Psychosocial Development in Children (Hundeide, 1997) would be incorporated into the programme. This pilot study was undertaken in a community adjacent to the two areas targeted for a randomised control treatment trial.

The Wellcome Trust of Great Britain was also approached for funding, but before they agreed to fund the proposed randomised control trial, they insisted that an epidemiological study be conducted in the area targeted for the RCT.

5.1.1. The Khayelitsha Thula Sana Epidemiological study

This study was undertaken to determine the prevalence of postpartum depression and disturbances in the mother-infant relationship in conditions of socio-economic adversity. One-hundred and forty-seven mothers and their infants were assessed two months after delivery. In addition to assessing their social circumstances, assessments were made of maternal mood, mother-infant relationships, and infant physical, cognitive and socio-emotional development. The findings showed the prevalence of DSM-IV major depression at two months to be 34.7%, which represents roughly three times the rate in HIC samples. Factors found to be associated with depression were whether or not the pregnancy was planned, and the availability of emotional and practical support from a husband or other partner. The study further found that in depressed mothers, sensitivity in engagement with the infant was significantly poorer, and their infants were significantly less positively engaged in these interactions than infants of non-depressed mothers. The presence of the father, over and above contributing to the depression, added significantly to the prediction of maternal sensitivity (Cooper et al., 1999).

5.1.2. The Khayelitsha Thula Sana Intervention: Pilot study

Running parallel to the epidemiological study was the intervention pilot study (Cooper et al., 2002). The aim of this study was to select and train women from the target community to deliver the adapted Reading Health Visitor Preventive Intervention Programme, extended to six months postpartum, and incorporating

the key principles of the International Child Development Programme (ICDP): Improving Mother/Child Interaction to Promote Better Psychosocial Development in Children (Hundeide, 1997), and to evaluate the efficacy of the intervention (This intervention is described in detail in the next section).

The results at six months showed a modest benefit in terms of maternal mood, although not statistically significant (19% of the intervention group were depressed as compared to 28% in the comparison group post treatment). The children who received the intervention gained weight significantly more quickly and were taller than those in the comparison group. In the mother-infant relationship there was evidence that both in play and in the feeding situations, the intervention mothers showed greater sensitivity, and specifically in the feeding situation there were indications that they expressed more positive affect. In order to evaluate the training and ensure that the intervention by the parent-infant counsellors was delivered in accordance with the requirements of the manual, the perceptions of the recipient mothers and the content of the visits were examined through a questionnaire administered by an independent assessor. The results showed that the mothers had a very positive perception of the help they received from the visiting parent-infant counsellors, and found that the intervention had enhanced their sensitivity to their infant's needs and capacities. On the basis of ordinal ratings, all the community workers showed at least moderate to good performance in the implementation of essential counselling, infant assessment and provision of information skills required by the intervention manual, with two of them being rated as excellent (Cooper et al., 2002). On the basis of these positive findings we were allocated further funding by the Wellcome Trust to proceed with a randomised treatment control trial in this community.

5.1.3. Thula Sana (Khayelitsha): A randomised treatment control trial

This study took place in two adjacent communities (Town II and SST) in Khayelitsha in which a concerted attempt was made to recruit all women in their third trimester of pregnancy. Of the 452 women found and invited to take part in the study all, except three, agreed. This cohort of 449 was randomly assigned to the control group, for whom the services of local community health workers and the state services at the local clinics and day hospitals were available, and to the intervention group who, in addition to these services, received the home visiting programme. Although the counsellors lived in the same community, the researchers made sure that they visited mothers from other neighbourhoods, whom they were not likely to know. The intervention was delivered from late in pregnancy to six months postpartum by the four parent-infant counsellors employed in the pilot study. The mothers' identifying details, life circumstances, obstetric history and mental state were assessed initially and again when mother-infant interactions were assessed at 6 and 12 months, and infant attachment at 18 months.

The results found that the intervention significantly benefited the mother-child relationship at six months. Mothers interacted significantly more with their infants and this interaction was significantly more sensitive, demonstrated significantly more positive affect, and was significantly less intrusive compared to

mothers in the control group. At 12 months the picture and pattern was similar except that differences were somewhat weaker. The intervention group remained significantly less intrusive, they tended to be more sensitive and interactions were rated as more harmonious. At 18 months significantly more infants in the intervention group (74.4%) were rated as securely attached compared to the control group (63%). Compared to control mothers at 6 months, fewer intervention mothers were depressed but the difference was not significant (Cooper et al., 2009). (A copy of this publication is presented as **APPENDIX IV.**)

5.2. The structure and nature of the Thula Sana (Khayelitsha) intervention

In this section the structure and nature of the intervention, and the process of selection, training and supervision of the parent-infant counsellors is described in some detail, as well as the adjustments made to the Reading Health Visitor Preventive Programme and the ethical considerations pertaining to this research.

5.2.1. The intervention structure

The intervention took the form of a manualized programme in which both directive and non-directive elements were built in (A copy of The Khayelitsha Parent-Infant Intervention Manual is provided as **APPENDIX II**).

Each visit was semi-structured and followed an agenda, but was flexible in that the initial phase was client-led and responsive to their individual needs. This was followed by the introduction of a relevant activity or topic for discussion that appropriately focused on the concerns of mothers and the needs of their infants at particular stages.

The intervention was conducted over 17 hourly visits in the mother's home (2 scheduled antenatally, and 15 postnatally), covering the peri-natal period and first 6 months. The visits were weekly for two months, followed by visits every second week for the next two months and then monthly for two months. Because of the brevity of the intervention and the strength of the therapeutic alliance that developed, termination issues were addressed from the start.

5.2.2. The nature of the intervention

The Khatelitsha-Thula Sana intervention was based on an adaptation of the Reading Health Visitor Preventive Programme (Murray & Cooper, 1997). It is an integration of two approaches: a) a client-centered counselling approach influenced by attachment theory and, b) an educative component which incorporates a more focused targeting of sensitivity training and the parent-infant relationship.

5.2.2.1. The client-centred counselling approach

The overall aim was, at this critical stage of early motherhood, to provide through maternal counsellors a limited relational or intersubjective experience (Lyons-Ruth, 1998; Stern, 1998; See also Chapter 2) which

represented a qualitatively more empathic and mindful model of relating than these mothers might experience in their daily lives. This model of relating is partly client-led, and it was anticipated that mothers would be able to identify and internalize this model for interacting with her own infant. We aimed to enhance interactions in mothers and other caregivers, through modelling, which were infant-led, non-intrusive, sensitive, responsive, attuned and containing (Bandura, 1977b). Finally, we aimed to encourage, promote and strengthen the mother's parenting and problem-solving skills, and thus, her self-confidence, sense of agency and competence in her life (Dattilio & Freeman, 1992), and in this way provide a more holding and containing environment for the infants.

The counsellor's first task was to facilitate the development and maintenance of a positive therapeutic alliance and collaborative relationship between herself and the mother she visited. This required an ability to listen deeply, empathically and uncritically, to be congruent and to provide an accepting and containing space for the mother to prioritize and express her concerns, needs and fears.

5.2.2.2. The “educative” or “informative” component

The theoretical influences underlying the “educative” component of the intervention include:

- a) The principles and techniques of psycho-educational approaches to parenting which attempt to assist primary caregivers to shift their perceptions, attitudes and behaviours to ones that are more accurate, sensitive and responsive, and will enhance infants' psychological sense of their agentic and representational selves (Dattilio & Freeman, 1992).
- b) The principles of “observational learning” and “participant modelling”, in conceptualizing and learning new patterns of behaviour (Bandura, 1977b).
- c) An essential feature of the intervention is a technique used for sensitivity training, which took the form of an adaptation of the Newborn Interactive Assessment from the Reading Health Visitor Preventive Intervention Programme (Murray & Cooper, 1997) also based on the principles described in *The Social Baby* (Murray & Andrews, 2000). The Newborn Interactive Assessment comprised nine items, selected from the Brazelton Neonatal Behavioural Assessment Scale (BNBAS). The BNBAS is a comprehensive “neurobehavioral assessment scale, designed to examine the newborn's responses to his or her new extrauterine environment” (Nugent & Brazelton, 2000:169), which, since its inception, has been increasingly used as a preventive intervention tool attempting to strengthen parents' relationship with their infants. Each item of the scale is worked through with the aim of facilitating thoughtfulness, sensitivity and responsiveness in mothers towards their infants. The items covered in the Newborn Interactive Assessment were specifically selected, in a systematic way to:

1. Demonstrate to parents and thus, sensitise them to the infant's individual capacities, sensitivities, sense of agency and communication signals.
2. Create awareness in parents of their infants' individual developmental needs and communication of these needs.
3. Promote and facilitate parent-infant interpersonal engagement and communication that is non-intrusive, sensitive and responsive to the infant's needs and cues.
4. Create a collaborative space with the parent for observing the infant thoughtfully and being reflective in order to understand the infant's experience, and create meaning about who the infant is and what the infant is communicating.
5. Model sensitive and responsive handling and interaction with the infant by responding to, focussing on, and following the baby's lead and providing information without undermining the mother.
6. Each item is thought about in terms of the relevance it has in assisting in the management of certain areas of difficulties. The information obtained is used to think through, with the mother, strategies for managing any sleep, crying or feeding struggles that may arise.

The following Figs. 8, 9, 10, 11, 12 illustrate aspects of the Newborn Interactive Assessment:



Fig. 8. Illustrating an item from the newborn interactive assessment.



Fig. 9. Illustrating an item from the newborn interactive assessment.



Fig. 10. Illustrating an item from the newborn interactive assessment.



Fig. 11. Illustrating an item from the newborn interactive assessment.



Fig. 12. Illustrating an item from the newborn interactive assessment.

The goal of this assessment is to help the parent to focus on and perceive their actual individual infants such that the parental representations are challenged. This helps mothers to see their infants as thoughtful and feeling little beings which has the potential to limit the negative and unhelpful parental beliefs and behaviours which can create difficulties in providing infants with empathic and sensitive care they need.

The key principles of the WHO International Child Development Programmes (ICDP) (1997) were incorporated in order to strengthen parental skills and self-confidence. The WHO “8 rules of Good Interaction” by which parents help to mediate the child’s environment are:

1. Expressing love to the child.
2. Facilitating conversations with the child through emotional expressions, gestures and sounds.
3. Following the child’s lead.
4. Showing appreciation for what the child manages to do.
5. Focussing the child’s attention on shared experiences with the caregiver.
6. Making sense of the child’s experiences by describing and naming them.
7. Helping the child widen their experiences.
8. Helping the child learn rules, limits and values.

The focus was on the first six rules at this stage of development and on encouraging the mother’s positive personal resources and skills with her baby when these are observed in the interaction between them.

5.2.3. The role of the parent-infant counsellors

A distinguishing feature in this intervention is the fact that the home visitors delivering the intervention were local, previously untrained, lay community mothers whom we called “parent-infant counsellors”. They lived in the same community as the families they visited and with whom they could identify. They were not offering psychotherapy and did not portray themselves as experts of any kind. They saw themselves as “mothers helping mothers” stepping into what Stern (1995) called “the good grandmother transference”, or a grand-mothering role, rather than as friends, educators or therapists.

5.2.4. Selection of community counsellors

Bearing in mind recent history and the ongoing power differentials that exist between professionals and the community (Tomlinson & Swartz, 2002), and keeping in mind the advice articulated by other researchers in the field (Berg, 2003), the research team was careful to negotiate entry into the community in a respectful and sensitive way. The project was introduced to other projects and services already working in the area, and permission was acquired from both formal and informal community authorities. Finally, notices were placed at the local health clinics and community non-Government organizations (NGOs), requesting women to apply for selection and training as community counsellors for the Thula Sana project. The first position to have been filled was that of the auxiliary supervisor. She was a Zulu-, Xhosa- and English-speaking woman who lived in an adjacent community selected on the basis of her experience for many years as a Parent Centre staff member. As the auxiliary supervisor, she played an essential role in the selection, training and supervision of the parent-infant counsellors.

Applicants were asked to apply in writing and to send in copies of their curricula vitae. Thirty-five women applied and 12 were short-listed and interviewed. In-depth interviews were conducted in English and Xhosa by the research staff and the Xhosa-speaking auxiliary supervisor. We looked for mature women who had been involved in some form of voluntary community work. We felt that these women should all have had some experience in mothering young children themselves and be aware of the struggles that new mothers face, and the need for support at this time. Applicants needed to be literate in both Xhosa and English for training purposes. They needed to be able to take initiative and be willing to learn, and a school-leaving certificate was considered an advantage. Most importantly, we looked for women who were thoughtful and expressed warmth, compassion, empathy, understanding, respect and were supportive and non-judgmental of others.

Nursing professionals were not considered for various reasons. These included:

1. A lack of professional nursing resources nationally.
2. Insufficient funds to employ professional or paraprofessional counsellors.

3. Nurses serving this community, although ideally placed to play a role as part of the supportive matrix, were not necessarily experienced or perceived as compassionate and credible support for mothers. Van der Walt (2002) describes the detrimental and undermining effects that the defences, used by anxious and frustrated nurses faced with the harsh realities of poverty, HIV/AIDS and inadequate resources, have on their relationships with patients.
4. This was an opportunity to provide employment to women who, under the apartheid regime, had not been able to complete their education and enter professions despite many having had the capacity to have done so.
5. We saw this as an opportunity to empower local women through the development of skills and broadening of knowledge, and in this way to build community resources which could continue to serve the residents once the research had been completed.
6. Non-professionals would not require retraining away from the medical to a psychotherapeutic model that nurses would need.
7. Community counsellors may have an in-depth, implicit understanding of and identity with the community that many health professionals lack. We felt that it was important to conduct the intervention a culturally sensitive manner. There is support in the literature for employing women who were culturally sensitive, appropriate and acceptable to the mother. Stern (1995) points out that “to be effective it (therapy) must utilise the local language and metaphor and share the basic assumptions, values and practices of the culture” (p. 192).

There were also several reasons why we decided not to consider men for this work.

1. Traditionally, it is women who are involved in the birth process and in supporting the new mothers; the dominant concerns at this time being the motherhood constellation (Stern, 1995).
2. It would not be acceptable to male partners for trained community men to be visiting their partners at home and discussing breastfeeding and other intimate issues with them.
3. We felt it was important that the counsellors had a real insider understanding of the psychological and emotional process the recipient mothers would be experiencing.

Following two rounds of individual interviews, five community women were selected for training. Neither they, nor the auxiliary supervisor, had any tertiary education qualifications. Only two had completed their schooling and then done additional courses in childcare. All had, in one way or another, had to struggle with the realities of poverty and could identify with many of the very difficult issues mothers of young children faced on a daily basis in the townships, but felt they had succeeded in overcoming these and felt very enthusiastic about the programme.

Shortly after the pilot study got underway one of the parent-infant counsellors died suddenly, following a brief stay in hospital. Midway through the pilot study another parent-infant counsellor and her family moved away. The three remaining counsellors and the auxiliary supervisor continued with the project, completing both the pilot study and the randomized evaluation.

5.2.5. Training of community counsellors

As researchers and trainers we had a great deal of information and skills that needed to be transferred to the counsellors in training. Once again we were aware of the power differentials which existed with respect to the knowledge that we wanted to “give away” (Tomlinson & Swartz, 2002). We required the counsellors to hold a concept of motherhood, infancy and early parenting with which they might not be familiar, or in agreement. Our goal was to facilitate, in the recipient mothers, interactions with their infants that were more informed, supportive, respectful, attuned and responsive. It was important therefore, that the counsellors’ own interactions with the recipient mothers and their infants reflected and modelled these qualities, and for a congruent approach in attitude throughout, the training and supervision also needed to reflect and model these qualities. We were careful to adopt a collaborative approach.

The Reading Health Visitors’ Manual, written in English for the UK context, needed substantial translation into Xhosa and adaptation to the context. We realized from the beginning that in order to limit what Berg (2007a, p. 93) refers to as “colonization of the mind”, we would need to reflect mindfully about the complications, tensions and contradictions implicit in working cross-culturally. We needed to engage in a two-way process in which both trainers and trainees from the community were encouraged to contribute to the knowledge of the other. The counsellors’ in-depth knowledge and understanding of the community, its tensions and people’s coping strategies, and their ability to interpret the nuances of behaviour and verbal expression, were invaluable in the collaborative work of “acculturating” the intervention throughout the training period. A great deal of productive time was spent discussing and debating issues and finding the best presentation of difficult and foreign concepts. Debate and discussion was also essential for the counsellors to feel at ease with the material and able to transfer the information authentically to the recipient mothers.

The training was co-led by the English-speaking supervisor and the Xhosa-speaking auxiliary supervisor, whose role it was to bridge the cultural and language gaps that were anticipated. It was through the experience of this training process that the manual was gradually revised.

5.2.5.1. Training goals

Early infancy and motherhood is a stage in which mother and infant are so emotionally enmeshed, life and death, love and hate, joy and despair are so intersected, that essentially the counsellors are required to bear and contain often difficult and painful primitive feelings being expressed. This is further exacerbated by the many emotions evoked by conditions of adversity.

The purpose of the training was to equip the trainees with knowledge, skills and insights, but most importantly, it aimed to develop their emotional capacity to listen carefully, observe thoughtfully, and respond sensitively and therapeutically to what mothers had to say. In other words, to represent a good enough benign object that could provide a safe container for the mother's projections, thus providing her with a positive empathic experience and model for relating, which we hoped could be internalized and identified with in her maternal role with her own infant.

The training was located at the interface of adult education, parenting and counselling training, and was based on the principles of all three disciplines. Various modalities of learning were used throughout.

1. Active participatory learning and experiential learning was primary. There were constant attempts to link the trainee's own experiences and memories of this stage of life to the experiences of the women they would be visiting. Memories of emotional experiences were also linked to new knowledge and skills in ways that made the learning a meaningful experience.
2. Group discussions were encouraged on every aspect of the training.
3. Skills were developed through modelling and role-plays practiced in groups and consolidated in the trainees' own home environments.
4. Infant observation as well as guided observation, where it was prescribed what trainees were required to observe were used on a limited basis to help the trainees refine their skills of observation and attunement. They were also trained to become aware of their own countertransference feelings, to tolerate the process, and learn to contain painful feelings while thinking about what was being communicated nonverbally, rather than intervening prematurely.

This intensive and extensive training involved approximately 35 three hourly sessions which ran over a period of three months.

5.2.5.2. Training format

1. A 2-day workshop was lead by Prof. Karsten Hundeide and Prof. John Orley who introduced **the World Health Organisation/ International Child Development Programme (WHO/ICDP)**. This aspect of the programme oriented the trainees to the principles of good caregiver-child interactions, many of which challenged their knowledge and beliefs about childrearing practices.
2. **Experiential orientation to early motherhood** (3 sessions X 3 hours = 9 hours).

In order to provide the mothers with a sense of emotional containment, it was important that the counsellors were in touch with, and understood, the difficult struggles, issues and feelings of this stage of early parenthood, and were able to manage the powerful feelings that would be projected

into them. In preparation, they worked through a number of experiential exercises that took them back to the circumstances of their own infancy and childhoods, and their own experiences as pregnant and new mothers.

3. Basic parenting skills training (9 sessions X 3 hours = 27 hours).

We realised that home visiting would inevitably confront the parent-infant counsellors with difficulties being experienced by parents with other children in the home. For this reason, we felt it was important to equip the trainees with practical child management skills and information. Through the parenting module it became evident that they too were struggling with common child management problems and poor communication skills with their own children and found this aspect of the training very useful.

4. Basic counselling skills training. (5 sessions X 3 hours = 15 hours).

The preventive intervention programme was delivered primarily through a client-centered therapeutic approach. We did not assume any prior knowledge of counselling skills.

5. The Newborn Interactive Assessment (13 hours).

The Newborn Interactive Assessment (Murray & Cooper, 1997) represents the catalytic core of the preventive intervention. It is through this assessment derived from the Brazelton and Nugent (1997) Neonatal Behavioural Assessment Scale, that much of the learning took place. The assessments offered an opportunity for thoughtful observation, modelling, new experiences, knowledge and insights in the context of parent-infant and mother-infant interactions. Throughout the training each counsellor observed the demonstration of 24, and practised a minimum of 10, Newborn Interactive Assessments with infants.

6. Additional Workshops. Important additional information was required with regard to associated issues that impacted on mothers. These included breastfeeding, postnatal depression, pregnancy and the birth, recognition and management of common childhood illnesses, recognition and management of child abuse and HIV/AIDS. Experts from outside were invited to present workshops in their fields of expertise.

7. Infant and child observations. The observations of mothers and their infants and children in their own homes added a valuable component to the training. Sitting quietly and observing mothers and their infants in their own homes helped to sensitise the counsellors to the many different and valid ways in which infants communicated and were cared for by their caregivers. It alerted them to the way in which depressed or otherwise distressed mothers related to their infants

and families. It familiarized them to their own countertransference and provided an experience of being with families without being drawn in, thus helping the counsellor to maintain a more separate and helpful position within families.

5.2.6. Adaptation of the Reading Health Visitor Preventive Intervention Programme for the Khayelitsha context

In Reading, new parents, as a matter of course, expect to receive at least one official visit by the health visitor. In Khayelitsha, mothers who experience uncomplicated labour and birth are sent home after a few hours and receive no further scheduled care and support unless they attend the well-baby clinics.

5.2.6.1. Extension of the intervention from 2 months to 6 months

Earlier work done by the Parent Centre in another impoverished neighbourhood in Cape Town taught us that the visitors found the two year intervention to be too long and that it lacked sufficient structure. It also threatened to become too expensive an intervention and limited the number of mothers who could be visited. However, in the context of abject poverty and very few resources and support, the eight week postpartum programme, offered by the UK Reading intervention seemed, to the researchers, to be inadequate. One of the first decisions, therefore, was to extend the U.K. Reading programme from two months postpartum to six months. This required the manualized guidelines to be extended, and to take into consideration the emotional development and associated needs of the infant from two to six months. This provided increased scope and opportunity for the counsellors to demonstrate the infant's attentiveness, alertness and communication potential.

The original Reading manual was always carefully followed. However, in order to be tuned into mothers and respond sensitively to their concerns, many issues needed to be addressed which were not anticipated by the manual. Many of these demands reflected the transitional, violent and poor socio-economic context, as well as the high incidence of HIV/AIDS and a lack of knowledge of infant needs in the community. Responding sensitively to the prevailing local conditions, traditions and needs, required some adaptation to the Reading Manual. This also meant additional training for the counsellors. These were the sort of adjustments that would need to be considered in any new community setting in a low income context such as South Africa.

5.2.6.2. Appointment schedules

The Reading Health Visitor Preventive Intervention Programme sets one-hour visits at a prearranged time in the mother's home. The policy of working according to an appointment schedule was problematic in Khayelitsha. The counsellors had to accept visiting schedules being fairly flexible. A mother might need to attend to a customer in her Spaza home shop during the visit, or decide to take her infant to the clinic in the early morning and expect the counsellor to wait for her return. There were times when mothers had no

resources to phone or did not see this as a priority. This lack of value placed on appointed times seem not only to reflect the preoccupation with short-term survival needs and the lack of planning one sees in poverty; we were also aware that this lack of value might be an aggressive enactment in response to ongoing attitudes of disrespect by abusive official social structures. An example was the state health system in which patients are expected to wait for many hours before being seen by a medical attendant, with little understanding of or concern for patients' needs and work constraints, and the sacrifices required to be there. With their understanding of the community, the counsellors accepted this struggle with scheduled visits as a "way of life". As completion of each visit was a priority, the counsellors re-adjusted their schedules constantly, either by returning at a later time or waiting for the mothers to arrive. They also left messages with neighbours or family members arranging to make up sessions at a later time. This additional time required to complete the work has important consequences in planning and funding such interventions.

5.2.6.3. Incorporating the childminder

When mothers found employment or returned to work before the completion of the intervention, arrangements were made to continue the scheduled visits with the caregivers, and to find additional times for occasional visits to mothers when they were home.

5.2.6.4. Privacy

Ideally the intervention required a space where intrusions were limited and privacy established. The assessment particularly required "a quiet, warm, semi-darkened room" where mother, parent-infant counsellor and infant would not be disturbed. In Khayelitsha, where many shacks are stacked up against one another and loud music may be blasting from the neighbour's shack, where living spaces are shared and people may be at home or drop in at the time of the visit, such conditions are often not unattainable. When parent-infant counsellors felt it important to assert some boundaries in the home they would ask visitors to return later. There were times when mothers suggested accompanying the counsellor down the road in order to secure a private conversation.

5.2.6.5. Involvement of other family members

The counsellors, concerned about the lack of involvement of fathers in the pregnancy and early months, felt it important to encourage fathers to be present to witness the Newborn Interactive Assessment. Other family members, who were present at the visit, were included by the counsellors who believed that this provided opportunities for all adult caregivers to become more informed and sensitised to the needs, interactive behaviour and communications of the infant.

5.2.6.6. Additional NBA Items

Three further “items” were formally added to the nine items of the NBA. These included demonstrations of “consolability with crying”, “following the baby’s lead” (being responsive vs. being intrusive) and “mirroring/imitation and reciprocity”. In the original Reading programme these behaviours were included as additional information that could help mothers struggling with the more “difficult-to-manage” behaviours and encourage them to engage the baby in face-to-face interactions. Because our counsellors had had relatively little exposure to these concepts, we believed it was important to include them as specific assessment items or tasks.

5.2.6.7. The role of grandmothers

The impact and role of grandmothers, when present, needed to be acknowledged and respected. The tendency for adolescent mothers to live at home with their parents after the birth of their babies required some adjustment to the programme. The decision taken was, as far as possible, to include, engage and accommodate the presence of the older maternal figures in the visits as we saw this as a significant protective factor for the mother and her infant. This inclusion needed always to be balanced with the young mothers’ need for privacy and the development of trust to feel able to share more difficult and personal thoughts when required, particularly when their relationship was conflictual. It was important always to maintain the focus on the mother and her baby.

5.2.6.8. Language

Sophisticated and academic language needed to be translated and simplified, and Xhosa words or descriptions needed to be found to explain new concepts. For example, while the counsellors were not able to find an equivalent word for depression in Xhosa, they recognized maternal expressions of irritability and anger, shouting at their children, social withdrawal, absence or lack of engagement, allowing babies to cry unattended, as well as a loss of interest in personal hygiene, indicating a mental health problem. As in many Western contexts, depression is still largely denied or hidden, but it is recognised as a dysfunction, and described symptomatically.

5.2.6.9. Culture

Concepts being introduced needed to be questioned, explored, explained and evaluated with respect to the traditional beliefs and cultural practices of both the counsellors and the recipient mothers. Whilst it was important to maintain respect for “cultural” and “traditional practices” and beliefs, the counsellors agreed that certain beliefs and practices described as traditional were not good for mothers and babies and needed to be challenged. Some examples they identified were that feelings should not be expressed in front of others, that child rearing is “woman’s work”, that children, and at times women, deserve to be physically

punished for misbehaviour, and that babies don't see or hear, don't have feelings and can't communicate. References to local conditions and resources such as health facilities also needed to be adjusted.

5.2.6.10. Accommodating the HIV/AIDS pandemic

When we began the study, prevalence estimates for HIV/AIDS in the Western Cape were still quite low, and we erroneously did not plan in enough detail for the rapid increase in incidence, which occurred during the research period. We did, however, from early on, take the HIV issues into account. While HIV testing was voluntary and confidential, all pregnant mothers are automatically tested for the virus when they first booked in at primary care clinics. Although given the option of being informed of their status, once a positive diagnosis had been made, pregnant mothers were instructed according to official policy at the time, not to breastfeed their babies and issued milk formula by their local clinics for the first nine months postpartum. This practice, in effect, informed them and us of their HIV status. This had particular ramifications for the intervention. The first antenatal visit required great sensitivity on the part of the counsellors who needed to keep in mind the possibility that the usual feelings of ambivalence that accompany so many first pregnancies might be exacerbated by the traumatic stress reaction of an HIV positive diagnosis.

While we were cognisant of the stipulation in the Reading Manual that mothers' reluctance to breastfeed be managed without judgement, the protective qualities of breastfeeding, particularly in conditions of poverty and poor hygiene, was a serious consideration which informed the general encouragement of breastfeeding for new mothers. In the context of the official policy of no breastfeeding with HIV/AIDS at the time, we had to consider that mothers' refusal to breastfeed might not be a choice as much as an unhappy decision imposed on them by their health status that, in all likelihood, carried some distress and shame. In this context the encouragement of breastfeeding had to be approached with extreme sensitivity, awareness and caution.

5.2.6.11. The therapeutic frame

Previous experience in community intervention, where counsellors lived and worked in the same community as their clients, made us aware of the need to establish what Frenkel (2003) refers to as the "metaphorical therapeutic frame" to protect the therapeutic boundaries as a matter of priority. This was done by carefully defining the structure of the intervention, including the purpose of each visit, the roles of the counsellors, and the limits of interaction. This was initially established through the training, and then maintained and reinforced through close weekly supervision.

5.2.7. Supervision

The skill of counselling, because of its relational nature, is far more complex than it seems, and as a result, the value and importance of supervision in working with parents individually or in groups has been a basic

tenet of the Parent Centre from the start. This has been important in order to protect both client and counsellor from the unconscious and unmediated responses resulting from countertransference feelings that may otherwise be acted out. In addition, supervision is used to provide counsellors with support and with ongoing training (Obholzer, 1994; Petts, 2007; Shapley, 2007).

Supervision has particular relevance when working in the field of parent-infant relationships as a result of the primitive affects that define the relationship between infants and their parents. Raphael-Leff (1993), describes how, “countertransference perhaps resembles the often empathic experiences a receptive mother has with her baby” (p. 166). She continues explaining how a female helper working with women, “may experience a host of countertransference feelings that arise out of their primary female experience and imagery, their meshing or clashing feminine identifications” (p. 167).

The disadvantaged community characterised by deprivation of basic needs and hardship imposes powerful influences which further complicate the emotional quality of therapeutic interactions between mothers and their infants and mothers and counsellors. For example, counsellors perceived that they felt envied by others in their own community for having a job, income, growing experience and knowledge. This left them with feelings of guilt and obligation, which made it difficult for them to manage their boundaries effectively.

Regular supervision was established to provide a space for counsellors to express and think about their strong feelings and concerns about the work, to find encouragement and support for their own struggles, to improve their knowledge and skills, to protect both the counsellors and their clients from boundary transgressions, and generally to ensure the quality of the intervention by reviewing their written records and addressing administration issues.

The provision of ongoing education and skills training was an important function of supervision. We had learnt that simply providing a training course was insufficient to ensure that knowledge and skills were internalised, retained and skilfully put into practice. An example of how the supervision was used in the early stages to confront and process the fears of entering the homes of strangers and facing the unknown with potential differences and possible rejection, was the opportunity offered to the counsellors to role-play these situations, and experience being both the recipient mother and the counsellor, which proved very containing and useful.

Modelling was always considered a primary method of learning, so the need for integrity and congruency throughout required that trainers and supervisors manage the trainees and counsellors with the same respect and sensitivity with which they were expected to interact with mothers and, in turn, the mothers with their infants. This model was one of parallel processes and concentric circles of containment and care.

Supervision sessions were held one morning a week for three to four hours with a break for tea. As the number of recipient mothers grew it gradually became increasingly difficult to find the time needed to cover all the issues. By necessity, the supervisor began to rely increasingly on the counsellors' ability to judge for themselves the issues that needed more urgent attention. The result was a sense, in the supervisor, of losing touch with the week-to-week concerns of the counsellors, yet they seemed to be managing well. It emerged later that the auxiliary supervisor began to make herself available for extended supervision time following the regular supervision slot in order to address all their more personal concerns that could not be addressed earlier.

5.2.8. Ethical considerations for the intervention.

There were several ethical points to consider with respect to the intervention study. (I will deal with the specific ethical considerations of this qualitative study separately in a later section.):

- The intervention was not invasive in nature, it was aimed at providing recipient mothers with support at a difficult stage of life.
- Participation was voluntary. Each mother was invited to participate, fully informed about the intervention process and asked to sign a form consenting to both assessments and visits.
- The assessments for both the control and recipient mothers were a way of monitoring the development of the infant. When delays or abnormalities were detected, the mother and child were referred to the appropriate resources.
- The project took place in a community where the Zibonele community health workers were already monitoring and providing basic health care.
- Privacy, confidentiality and anonymity were assured to all participating mothers. It was only under extreme circumstances when we considered that the mother or baby's well-being was at risk, that confidentiality was transgressed. (In such cases the professionals involved had a legal obligation to report and refer).
- When tape recorders were used during interviews this was openly declared to mothers.

We believe that the issue of capacity-building is an ethical concern in these sorts of contexts so that with both the recipient mothers and the counsellors, there was an action research element. Their input played an important role in the improvement of the intervention from which the community will hopefully benefit in the future. Further, at least two of the counsellors so increased their skills that they were ready to be trained as trainers for the next phase. (See **APPENDIX V: Development in the parent-infant work consequent to the Khayelitsha research.**)

5.3. Methodology

Having shown the effectiveness of the intervention through a randomised controlled trial (Cooper et al., 2009), this qualitative study plans to explore how this intervention was experienced by the mothers themselves, by the lay counsellors and by the supervisor (myself). This represents a first step to exploring and identifying factors identified by the participants, as having been valued and instrumental in bringing about changes, and to developing an understanding of key processes and implementation issues that may have played a role in the successful delivery, by previously untrained lay counsellors, of this intervention. I hope to make some suggestions as to theoretical mechanisms from the literature that might describe or explain what the mothers reported and the counsellors observed, and to give some thought to identifying the sufficient and necessary supports required when lay counsellors take on the role of therapists.

5.3.1. Introduction

Over the past 35 years, there has been a major shift in the thinking and application of methodology in research, particularly in the fields of social and political sciences. This shift has resulted in a move away from focusing only on “methods driven” evaluations that attempt to insulate against bias in order to ensure objectivity and truth, towards the selection, design and implementation of evaluation methods that are more appropriate, flexible and shaped by the practical problems and questions being researched. The focus has become one of providing support for efficient and effective programme management in addition to more traditional outcome measurement (Miller & Crabtree, 2005).

Kazdin, (1999; 2006) notes that in research, the concept of, and emphasis on clinical significance evolved from a need to understand whether interventions have had meaningful impacts on the lives of people in treatment studies. Statistical significance does not inform whether the intervention in question has had any meaningful or practical impact on the everyday functioning of the recipient individuals. He states: “Measures of clinical significance require supporting evidence to establish that they actually do reflect important, practical, worthwhile, and genuine changes in functioning in everyday life” (Kazdin, 1999, p. 336).

Similarly, Miller and Crabtree (2005) refer to the relativity of all knowledge and speak about the need for a mixed method approach in order to treat and recognize the complexities, individualities and multiplicities of suffering and the human condition, and to deepen and contextualize the practical and ethical questions, concerns and emerging understandings for healers and their patients and policymakers. They refer to the clinical research space which brings together both the evidence base as well as the participatory and qualitative models of research in order to think deeper, allowing us to “rediscover the missing evidence (the people, experiences, ecology, power, and contexts) and the richness and depth of what “effectiveness means” (p. 610). Long (2002) alerts us to the need to recognize that the power, in any situation including research, is held by all the players in various ways. Expanding the evidence based

space by including participatory and qualitative models involves more imaginative and reflective thinking, the need for a common language to be understood by both service providers and recipients, sharing the tools for listening and together sowing the seeds of transformation.

Greene (1998) makes the point that because social programmes are practical responses to needs defined by communities, they are located in the public domain and tied up with political decisions, relating to social priorities, resource allocations and power. It is through political processes that they are proposed, defined, debated, funded and implemented and, as such, are subject to political pressures both supportive and hostile (Weiss, 1987). For this reason it is imperative that in the analysis of the data, the broad socio-political context needs to be taken into account. Results need to be in the form of practical knowledge and have significance for concrete programme experiences for the various stakeholders (Greene).

In our clinical research, the quantitative methodology - the randomised control trial - demonstrated the effectiveness of the Khayelitsha parent-infant intervention, delivered by previously untrained lay counsellors, in bringing about significantly more sensitive and less intrusive interactions between mothers and their infants and increased attachment security during the first two years in the context of poverty (Cooper et al., 2009). While representing an essential step in the study, this RCT was not fully able to provide us with the knowledge that could deepen and contextualize the practical and ethical questions, concerns and emerging understandings for helpers, those in need and the policymakers (Miller & Crabtree, 2005). As intervention developers, we need to explore the contextual meaningfulness of the programme and provide useful guidelines in the planning and implementation of improvements for future programmes (Greene, 1998).

The overall design of the study reported in this thesis therefore included a mixed method approach in which participatory and qualitative models of research were employed (Miller & Crabtree, 2005). Though we have the hard (RCT) evidence that the intervention worked, it was important to be guided by the perceptions of a selected sample of recipient mothers' perceptions and experiences of the intervention. More importantly, in the context of socioeconomic adversity, gender violence and disempowerment, we needed to hear the "community's conversation" through the voices of the mothers themselves in order that they retained some power over the ongoing development of this intervention, and to expose their truth and challenge the dominant paradigm (Miller & Crabtree).

The current study represents an exploration, in the context of complex socio-political circumstances, of experience and meaning, of what mothers said they had gained, of some process issues involved, and of some of the key elements that might be associated with the changes measured, as well as how the intervention might be improved.

This study endeavours to meet the guidelines of good research publishability and practice described by Elliott et al. (1999). For all research these are described as; locating the study in the context of the

available relevant literature and clarifying the purpose of the study, selecting the most appropriate methodological approach, maintaining respect for the participants through informed consent and ethical research conduct, specifying the methods used, discussing the interpretation, understanding and implications of the data, clearly presenting the study and making a contribution to knowledge. The guideline particular to qualitative research are described as; owning one's perspective and specifying my theoretical and personal orientation situating the sample by describing the participants' life circumstances and context, grounding the interpretation in examples, establishing credibility checks through discussions with others, providing a coherent and integrated yet nuanced account of my understanding of the data, acknowledging the general vs. the specific limitations of the results based on the range of informants, and finally to present the results in a way that resonates, expands, clarifies and deepens the understanding of the reader.

The analysis of this material for meaning and relevance required a philosophical inquiry framework that is qualitative, ethnographic and naturalistic in nature. Greene (1998) referred to interpretivism which, at the root, is about "contextualized meaning" (p. 536). Denzin (1998) describes the central premise being that, "In the world of human experience, there is only interpretation" (p. 8). In interpretivism, reality is viewed as socially constructed and "based on a constant process of interpretation and reinterpretation of the intentional, meaningful behaviour of people including researchers" (Smith, 1989, p. 85). Greene makes the point that reality resides neither in the objective world nor the subjective mind of the researcher, but in the dynamic transaction between them. Inquiry and interpretation as construct are therefore mind dependent and the investigator cannot be separated from the investigated. As such, "(I)nterpretivist inquiry is unabashedly and unapologetically subjectivist. It is also dialectic so that the process of meaning construction transforms the constructors" (p. 536).

Methodologically, understanding meaning fits in appropriately with a case study approach in natural settings, where information is gathered by use of interviews with "the human inquirer as the primary gatherer and interpreter of meaning" (Greene 1998, p. 384). In this study, interpretation of the themes that emerge will be based on relevant psychodynamic and developmental theories and models previously described in Chapter 3.

The questions we wish to address in this thesis deal directly with issues of relevance, meaningfulness, processes, mediating factors and improvements required for future implementation of this particular intervention or social programme, as well as considering some of the key elements that might underlie the changes measured. Kazdin (2007) refers to "mechanisms" of change and blockages to change in programmes. He defines mechanisms of change as "the processes or events that are responsible for the change; the reasons why change occurred or how change came about." (p. 3). He writes that understanding the mechanisms of change is essential if we wish to extend treatments from research to the therapeutic environment and beyond. To do this we need to be able to focus on the critical and essential elements and

conditions for the optimal effectiveness of treatments that can be applied effectively with respect to the economic resources available.

As a guide to my analysis of the data and a more in-depth understanding of the often complex processes involved in the delivery of such an intervention, my exploration will be guided by certain questions which included:

- What had the intervention meant to the mothers?
- How was the intervention perceived and experienced by the mothers?
- Which aspects of the intervention were valued and experienced as having the greatest impact by the mothers?
- Were new ideas offered to the mothers acceptable or did they feel alien and an imposition?
- What improvements in the intervention did the mothers suggest?

5.3.2. Selection of “key participants” or respondents

One way of addressing the question of how mothers experienced the intervention would have been to conduct a survey of all, or a random sample of the 220 mothers who received the intervention, by questionnaire or interview. Low literacy rates precluded a questionnaire approach, and as this aspect of our study was unfunded, it was not financially feasible for us to conduct many interviews with mothers. More importantly, we were interested in the rich descriptions mothers could give us of what they had experienced, and we therefore chose an approach which allowed us to enter into conversations of some depth with carefully selected mothers who would be well positioned to comment on the programme from what could be different points of view.

We were conscious of the need for data saturation (Caelli et al., 2003), also called “sampling to redundancy” (Kelly, 1999, p. 381), which refers to a stage in the sampling and analysis of data when the new material or information being gathered no longer throws up new facts, themes or trends to add to or challenge the emerging interpretation and understanding of the concepts being explored (Hayes, 2000; Kelly, 1999; Kuper et al. 2008; Whitley & Crawford, 2005). However constrained by the practical limitations of time, finances and the use of a neutral interviewer who was unfamiliar with this field of work, we were unable strictly to adhere to the principles of an open ended process in which sampling ends only when a thorough understanding has been reached.

In recognition of the fact that each case fits into a general group and is also unique, the collective case approach was used. Throughout there was an attempt to balance an understanding of the particularities and complexities of each case (intrinsic case study) with a search for issues and generalizations applicable to the broader membership of cases in the community (instrumental case study) (Stake, 2000).

Denzin and Lincoln (2000) describe a collective case approach simply in terms of a number of cases analysed, in terms of specific and generic properties, when multiple instances of a process is examined as it is displayed in a variety of different cases.

The “key informants” were a group of 17 mothers selected from 220 mothers in the intervention group. In order to attain a sample which covered a range and diversity of experiences, a procedure called purposive/theoretical sampling (Denzin & Lincoln, 2000) was followed. The mothers who were visited seemed to fall into four, fairly discrete groups which I perceived, over and above the generic issues of early parenthood, confronted them with slightly different but overlapping issues to manage. I believed that in order to gain as full a picture as possible these groups needed to be represented in this study. Each of the four counsellors were therefore asked to nominate four mothers with whom they had completed the six month intervention programme each of whom represented a mother they considered to have been a) depressed, distressed or difficult to reach; b) a teen or immature mother; c) a mother with a confirmed HIV diagnosis and d) a rewarding, coping, co-operative mother. An additional 17th mother became part of the sample as one of the nominated mothers was not able to attend the focus group so another was invited in her place. The original mother was nevertheless interviewed individually and included in the analysis. (A description, of the four groups of mothers, as well as brief descriptions of each mother and her socioeconomic circumstances, sourced from the counsellors notes, appears in **APPENDIX I**)

To a large extent the work of gaining access to the community and respondents had been undertaken some years previously. At this point the counsellors and the project in general were recognized and accepted as a resource for the community and a great deal of trust has been established.

Each mother was asked whether she would be willing as a member of a group and individually to provide the developers of the programme with valuable feedback about her experience of the intervention in order to bring in improvements for future use. Each was assured that whatever she said would remain confidential and that the groups and individual interviews would be conducted by an independent Xhosa-speaking psychologist who had had no previous exposure to the intervention, and was unconnected with the community counsellors.

As a result of the manner in which they were selected, the length of time that had elapsed between these mothers having concluded the intervention and being interviewed varied between less than one month and 22 months. The median was 12 months and the mean 11.3 months. This lapse of time varies for each respondent which means that we have to consider that this may be a factor affecting the accuracy and detail of the responses. While it needs to be acknowledged that the reliance on memory for detail may be problematic, my primary interest lay in the mothers’ overall and lasting impressions of their experience of the counsellors and the intervention.

5.3.3. The individual interviewer and group facilitator

We knew that we were more likely to produce accurate and true data resulting from emotionally honest and open discussion amongst the group members or respondents in interviews if they felt safe, listened to, understood and their confidentiality respected. This environment needed to be created and facilitated by an interviewer, acceptable to them all and conducting the interviews in a manner that held the balance between finely tuned skills of inquiry and facilitation.

Some of the potential challenges that needed to be considered in appointing such an interviewer are discussed below.

5.3.3.1. Neutrality

While we felt it was critical to provide an empathic but ‘neutral’ interviewer, we were also aware of the many factors that could interfere with this stance. We kept in mind Fontana and Frey’s (2000) observation that interviewers “are not invisible, neutral entities; rather they are part of the interactions they seek to study and influence those interactions” (p. 663).

5.3.3.2. Power, gender and finding the voices of disadvantaged women

We were also mindful that gender was an important element to consider and that, “gender filters knowledge” (Denzin, 1989, p. 116). Recent literature notes that the voices of certain groups, specifically women of colour, have been absent and invisible. Where women who have held strong opinions have felt suspicious, or feared retaliation, they have used passive strategies of resistance such as lying, withholding the truth or silence for survival and self-determination (Madriz, 2000).

In South Africa, despite the fact that many households both rural and urban are headed by “strong” women who for generations have kept, and still keep, the family together under the most desperate circumstances, women don’t always speak out about the difficulties with which they struggle. Many come from economically deprived circumstances with high levels of clinical depression and a history of oppression as a result of a patriarchal cultural tradition and a long history of a regime which has functioned to undermine and undervalue their sense of worth. While a growing number of women are finding their voices, many still continue to adopt subordinate roles and submissive attitudes with both men and other women in positions of power (Ramphela, 2008). This is exacerbated by the implicit hierarchy that exists in any interview situation with respondents occupying a subordinate position. The possibility that submissive attitudes, attempts to please the interviewer, protect the counsellors and avoid confrontation by some, might result in some of the recipient mothers’ inability to articulate their true feelings and opinions and thus, affect the authenticity of the responses needed to be kept in mind.

It was important to recognize that in this community, with its patriarchal culture, pregnancy, childbirth, breastfeeding, contraception and early childcare are extremely gendered in nature and still fundamentally

considered women's business. A male interviewer would be experienced as out of place. Furthermore, where male dominance and cross-gender violence still features in the social order, the influences of past relationships with men is likely to distort the data obtained from certain respondent mothers by male interviewers. It was felt that a female interviewer, who would know and understand the respondents' circumstances from an insider's perspective might be more easily trusted and have easier entrée into the world of pregnancy, birth and early motherhood with all its sensitivities around female and sexual issues, and would avoid that which would prevent honest and authentic sharing of information with a male interviewer. One of the difficulties, for a woman interviewer, was raised by Fontana and Frey (2000), who cautioned about the need for interviewers to maintain sufficient objectivity and not to be drawn into the issues and emotions expressed by the respondents; not to allow the moral concern for the well-being of the respondents to interfere with the objectivity that is required.

5.3.3.3. Race, language and culture

In Khayelitsha, the majority of the mothers were born in the rural areas of the Eastern Cape where Xhosa is spoken, and few are able to speak or write in English. The kinds of beliefs and traditions that guided many mothers at this developmental stage were foreign to the researchers and, at times, hidden by mothers for fear of being judged. We were concerned about the potential difficulties of misinterpretations and misunderstandings and biases during the interviewing process and we realized that, in order to gather data that was rich in meaning and relevance, we would need an interviewer who could understand and guide discussions in a nuanced way.

5.3.3.4. The professional interviewer and inequalities of power

Interviewing is a skill requiring some depth of knowledge, the ability to balance careful listening and asking of relevant questions with a more directive process of inquiry, and professional respect for confidentiality and boundaries. We felt that this called for a trained professional to conduct the group and individual interviews.

A significant difficulty emerged as we became aware that some mothers viewed professionals, even black, female professionals, with varying degrees of distrust. Several mothers talked about frank abuse by nursing professionals at both the clinics and the midwife obstetric units. There were descriptions of how mothers were "put in their place" when they shared their observations or made suggestions concerning the status of their child's health to nurses and doctors. One reported the doctor as saying, "Well do you want to put on my coat and take over my job then?" They also spoke of feeling let down by social workers and teachers, many of whom were demoralized and depleted and operated in systems that were failing the communities they served.

Whilst we recognized that this methodology was unable to ensure completely unbiased and objective data and that the judgements of the interviewer would be heavily relied on, we attempted to adopt the

maximum methodological integrity possible in order to establish credibility of the data and therefore, of the conclusions reached.

Keeping in mind all the requirements of the person in this pivotal role, it was decided to recruit a woman interviewer and group facilitator who was:

- A sensitive, observant and empathic listener.
- Fluent in the language spoken by the respondents with in-depth knowledge of and sensitivity to the culture, circumstances and dynamics in the community, in order to apply reliable intellectual judgement.
- Skilled in interviewing and group facilitation and thus, able to balance the facilitator (or team) role with the directive, inquisitorial (or task) role.
- Aware of the need to maintain a neutral, impersonal but friendly and interested stance.

We employed a Xhosa speaking Masters student in clinical psychology, who had completed all professional and clinical requirements for the degree and had done well in these components. She was then working part-time on completing her research dissertation required for the degree. She had had considerable experience as a hospital social worker before retraining, and was in her late thirties. She had been clinically trained and could be relied upon to conduct these sessions appropriately and professionally. She was culturally compatible, empathic and sensitive to the culture and circumstances of the respondent mothers. Some of the safeguards included the fact that guidelines were provided for the semi-structured interviews, ensuring that the important topics were addressed. While the interviewer had inside knowledge of the respondent mothers' culture, language, circumstances and struggles, she was an outsider with respect to the study and had no interest in the outcome thereof. She knew none of the parent-infant counsellors and had only a brief description of the training and intervention schedule. She was further informed that the purpose of the study was to gain feedback from mothers about their experiences of the intervention which would inform future planning and improvements to the programme. We felt that this would go a long way in establishing neutrality in her role and ensuring, what Fontana and Frey (2000) refer to as, a more feminist ethic of commitment and equalitarianism in contrast to the ethic of role differentiation between researcher and subject.

5.3.4. Interviews

Group and individual interviews were used as the primary mode of enquiry and were set up by the neutral interviewer.

- All interviews took place at the research unit in the community.

- The interviewer made it clear that she was a neutral party and that the counsellors were unknown to her, as one of the response effects we wanted to reduce was that which might have resulted from a sense of loyalty mothers might feel towards the counsellors (Fontana & Frey, 2000).
- As the interviewer was new to the field, for both group and individual interviews the interviewer was given an interview guide which had been translated into Xhosa, which she was required to follow. (See **APPENDIX III**). The interview schedule focussed on certain broad questions I wished to explore and allowed space for mothers to address issues and perspective that were meaningful for them.
- All interviews were conducted in Xhosa and taped, transcribed, translated and typed up by the same interviewer.

5.3.4.1. Group interviews

Fontana and Frey (2000) define group interviews as: “a qualitative data gathering technique that relies on the systematic questioning of several individuals simultaneously in a formal or informal setting” (p. 651).

The primary advantage of group interviews is that the researchers are able to observe the interactive processes that occur amongst the participants of the group. This interaction is an advantage in that, according to Fontana and Frey (2000), it produces “rich data that are cumulative and elaborative; they can be stimulating for respondents, aiding recall; and the format is flexible” (p. 652).

Madriz (2000), talks about providing a safe environment where participants can, “share ideas, beliefs, and attitudes in the company of people from the same socio-economic, ethnic, and gender backgrounds” (p. 835) in a spontaneous way. Specifically, therefore, group interviews can be used with oppressed women, “to unveil specific and little-researched aspects of women’s daily existences, their feelings, attitudes, hopes, and dreams” (p. 836). She also emphasizes the decreased amount of interaction needed between the group and the facilitator, which tends to give more weight to the opinions expressed by the participants.

One of the limits of the group interview is that it often takes place outside of settings where social interactions usually occur, so observations and the range of information gathered is limited to verbal communication, body language and self-report data (Madriz, 2000).

For this study, the group interviews were conducted first as a way of creating a safe space for the respondents to think about their experience of the intervention they received and to encourage a culture of sharing these. Because, for some, the intervention had been completed sometime before, it was hoped that the group interview would facilitate recall. Although the group was guided through a semi-structured format, the aim was to facilitate a less structured rather than too rigid a process. The nature of the group interactions was more explorative than directive and the questions more open-ended.

5.3.4.2. Individual Interviews

It was decided that interviews should follow the group experience so that ideas stimulated by the group interviews that were particularly meaningful to individuals could then be explored in more depth and expanded in the individual interviews. Using this sequence it is possible that some of the mothers might have been influenced, in their individual interviews, by the responses of others in the group interview. While the unstructured interview, defined by Fontana and Frey (2000) as “an active, emergent process” that sets out to establish a human-to-human relationship with the respondent in an attempt “to understand rather than to explain” (p. 654), might theoretically have seemed ideal as a way of tapping into the emotional and process issues and other perceptions that the mothers might have offered, there were some concerns about this process. In the first place, there was concern that some of the mothers, who lacked confidence, might have felt under far too much pressure to express their opinions in such an unstructured context, particularly in a strange situation with a professional “expert”. The resulting anxiety might have significantly limited their capacity to think about the more difficult issues and to make authentic and useful contributions. Furthermore, there were specific areas that needed to be explored that might not have emerged had we facilitated completely unstructured interviews. It was decided therefore that a semi-structured interview that would guide the mothers’ attention to certain issues would feel more containing yet still offer the space for individual thinking and opinions to be expressed.

5.3.5. Process notes from visits and supervision sessions

At a basic level the case study commonly relies on interviewing, observation and document analysis (Denzin & Lincoln, 2000). Triangulation refers to, “a process of using multiple perceptions to clarify meaning, verifying ... interpretation ...by identifying different ways the phenomenon is being seen” (Stake, 2000, p. 443 - 444).

The major part of the analysis was therefore based on data or material that emerged in the group and individual interviews, however, supporting evidence was also gathered from the parent-infant counsellors’ written notes which included their observations, impressions, quotes from mothers and themselves following each visit with the mothers, as well as the supervision notes kept by the supervisor which documented the counsellors’ issues and concerns discussed in the weekly supervision sessions.

5.3.6. Data collection and management

It was felt that, having conducted the group and individual interviews and heard the various mothers’ perspectives, the Xhosa-speaking interviewer would be in the best position to transcribe verbatim and translate the recorded Xhosa audiotapes into English in ways that were accurate, true and sensitive to the colloquial beliefs, culture and spoken language.

The data from the interviews, the counsellors' observations and written notes and the supervisor's process notes were then analysed separately for content and combined into themes for data triangulation purposes (Stake, 2000). Finally, the analyses were integrated to provide a comprehensive description of the recipient mothers' perceptions of the changes they experienced, aspects of the intervention experience they valued and found meaningful, what some of the key elements were for them, how this linked to the theory and what changes they would like to see implemented .

5.3.7. The analysis

We have previously addressed the issue that when looking at the issues of relevance, meaning and process, quantitative analytic systems are inadequate. We need to rely on a framework that is qualitative and focuses on description and interpretation. My, dual role as data analyst and participant as a clinical supervisor of the intervention makes this to a large extent, a complex insider outsideraccount which in its nature has the potential to create both compromises for objectivity and advantages, particularly when working within the psychoanalytic model which makes use of countertransference to inform understanding. In order to attain maximum objectivity and validate the interpretation of the data I had regular supervision and discussions primarily with my supervisor but also with colleagues, the counsellors themselves and consulted two independent academics..

I examined the data from the mothers' interviews, the counsellors' notes and my own supervision notes several times. My analytic and methodological approach was influenced by the processes outlined by Silverman and Marvasti (2008), which provide a systematic approach to handling data influenced by grounded theory and other contemporary approaches (see also Willig & Stainton-Rogers, 2008), but given my interest in psychoanalytic approaches in particular, I also made use of these. In this regard, it is worth noting that while some of the data speaks for itself, some needed to be analysed and interpreted for the purpose of understanding and informing social action (Atkinson & Delamont, 2005). My own process of analysis and understanding of events began much earlier and evolved over the course of the study. The theoretical reviews of development and therapeutic models of change provided new insights and raised questions that further guided this process. This information helped to organize the material into broad themes and sub-themes which were understood within a broad developmental and psychoanalytic frame of reference. Psychoanalytic here refers to "a profound theory of psychotherapy, a comprehensive system of psychology" (Fine, 1979: vii), in other words, a comprehensive body of theory that attempts to understand the way in which individuals, groups and communities are motivated to act as influenced by their intrapsychic dynamics (repressed thoughts, fantasies, feelings and wishes they unconsciously hold), as well as the relational and socio-political dynamics within which they function. In the analysis I therefore considered the processes and meanings of the material in terms of defences and interpersonal dynamics reflecting unconscious fantasies in addition to my own countertransference and reflections on my

experiences as a supervisor. In this regard, the concept of the “defended subject”, as described by Hollway and Jefferson (2000) informed the analytic approach.

A further important question in the data analysis and interpretation was that of the role of culture and language in the material and in my interpretation of it. In keeping with the guidelines suggested by Swartz (1998), and Swartz and Rohleder (2008) regarding research approaches in cultural psychology, I considered all data in light of the context within which experiences occurred and also in the context of ways in which conversational rules and norms affect how experiences are spoken about and discussed. As will be seen, cultural norms did appear to affect how mothers and counsellors experienced and spoke about the intervention. In reporting on this work, examples and quotes were selected to illustrate the interpretations and specific themes that arose, eventually drawing together the material into a coherent whole narrative.

5.3.8. Ethical considerations

This study was subject to the ethical standards and procedures of the Department of Psychology and the Faculty of Arts and Social Sciences of the Stellenbosch University.

The ethics of the overall project discussed in section 5.2.8. applied to this study in addition to particular important ethical considerations which included;

- a) Each mother was invited to participate in this study and that her participation was voluntary.
- b) The use of tape recorders during the interviews was openly declared and explained to all respondent mothers.
- c) The study provided an action research element, in that the mothers’ input would be used to improve interventions from which the community will hopefully benefit in the future.
- d) Privacy, confidentiality and anonymity were assured to all participating mothers at all times.

In the following chapter I will present the results under thematic headings.

CHAPTER 6

RESULTS

The results to be presented in this chapter should be seen in the context of the results of the Khayelitsha randomized trial, which found that the intervention improved the quality of the mother-infant relationships compared to the control group. At six months, the intervention mothers interacted with their infants significantly more and these interactions were significantly more sensitive and less intrusive and demonstrated more positive affect. At 12 months, their interactions remained significantly more harmonious and less intrusive, somewhat more sensitive, and at 18 months, the infants were significantly more likely to be rated as securely attached to their mothers (Cooper et al., 2009).

This chapter presents data obtained from the group and individual interviews of the recipient mothers, as well as the counsellors' and supervisor's process notes. In the context of an intervention delivered by lay community counsellors, the interviews attempted to explore, in more depth, what some of the less obvious and visible processes were that were at play in the delivery of this successful intervention. To guide the analysis, I explored the data with certain questions in mind. These questions included: What had the intervention meant to the mothers? How was the intervention perceived and experienced by the mothers? Which aspects of the intervention were valued and experienced as having an impact on the mothers, and why? Were new ideas offered to the mothers acceptable or did they feel alien and an imposition? What improvements in the intervention did the mothers suggest?

Please note: In presenting the results I have developed a convention of referring to the mothers which are described in the table below.

Table of Annotations

(E1), (E2), (E3), (E4): each refers to the individual interview transcripts of the group of mothers who were rewarding and easy to engage.

(D1), (D2), (D3), (D4): each refers to the individual interview transcripts of the group of mothers who were selected as more difficult to engage.

(T1), (T2), (T3), (T4), (T5): refers to the individual interview transcripts of the group of young or teen mothers.

(H1), (H2), (H3), (H4): refers to the individual interview transcripts of the group of mothers who acknowledged their HIV positive status.

(fg1) and (fg2) denotes the two focus group interview transcripts.

6.1. The mothers' recall of the structure of the visits

Before presenting the recipient mothers' overall memory and lasting impressions of the intervention they received, it seems important to consider the relevance of the relative inaccuracy, when compared to the supervisor and counsellors' notes, of their memories of the structure of the visits.

The structure of the visits (see Chapter 5.2) although clearly communicated to the mothers from the start and throughout the programme, was fairly complicated in that their content and frequency changed over time. In reality, arrangements also needed to be changed in response to the demands, availability and concerns presented by the mothers themselves. Some mothers were recruited too late, were confused about their delivery date or babies were born early and antenatal visits were compromised. Mothers also went to stay with relatives or remained in hospital for extended periods after the birth and could not be found and visited from the beginning. Furthermore, mothers missed visits that needed to be made up which would require extending the programme beyond the six months planned.

Analysing the parent infant counsellors' notes, the length of intervention in our cohort ranged from 5.5 to 9 months with a median of 6 and an average of 6.6 months. Two mothers (E4, T2) were seen for eight months. One (E4) went back to her rural home for a period of 2.5 months and the other (T2) began one month late as she was kept in hospital until her smaller twin was strong enough to leave. She then moved to another suburb and missed a month before arranging a time to continue meeting at her mother's house in order to complete the programme. Mother (T3) was seen over a nine month period following a two month stay in hospital with her premature infant. The programme for mother (D1) was completed in six months but she was visited twice more at 7 and 7.5 months as the parent infant counsellor was concerned about her vulnerability. Equally, mother (H2) received an extra visit at 10 months to check on her well-being.

In general, the details of when the visits began, the number and frequency and length of visits before and following the birth were remembered with varying accuracy.

Only seven mothers (D2, D4, T1, T3, T4, H3, H4) were fairly accurate in their memory of detail.

... (Before the birth the counsellor visited) two times. ... She started when I was 8 months. ... she used to come once every week and sometimes fortnightly. .. (each visit lasted) one hour. (T4)

The rest varied in their recall and inaccuracy of the details: More often than not the details were "positively" exaggerated (E1, E2, E3, E4, D1, D3, T1, T2, T3, H1, H2). Some, however, claimed they had had fewer visits than recorded by the counsellor. Mother (D3) said that the counsellor visited her 5 times after the birth. Another claimed that since the birth:

... she came four times (the baby is now nine months old.). She came once a month and stopped when the baby was 6 months. (D4)

There was confusion about when the visits began (E3, E4, D3):

...She started when I was 4 months (D3)

For one mother visits had begun in the eighth month of pregnancy with only one antenatal visit recorded as the birth had to be induced, yet the mother recalled:

...She came to visit me 4 times until I gave birth. (E4)

While two antenatal visits had been recorded, one mother reported:

...Before the baby was born she did not visit... (visits began) one month (after the birth). (T5)

The mothers' recall of the length of the counsellors' one-hour visits varied from:

...She visited for ½ an hour. (T2)

To:

...(The counsellor) stayed for a long time, one hour or two hours. (T1)

...She would visit for three to four hours. (H2)

And there were contradictions:

She stayed for an hour. If she came at 10h00 sometimes she would leave at 12h00 or 11h30. (D3)

Mothers were confused about the frequency of the visits:

...4 times in a week (E1).

... twice per week ... 4 times a week (since the baby's birth). (E3)

...She came twice a week ...(and later) ... she visited me daily. (E4)

...As I have twins, she came frequently even two times in a week. (T2)

The length of the programme was also confused, although this might have arisen as occasionally the counsellors would drop in to greet the family and that might have been perceived as an official programme visit.

... she still visits. (E1)

... she is still visiting. (E3)

...She is still visiting me. My baby is one year and 4 months. (T3)

...Yes my counsellor still visits me; my baby is 1 year and 5 months. (H1)

Some of the "inaccuracies" reported by the mothers may well be as a result of variations brought about by the counsellors occasionally having made changes to the structure. Some of these "inaccuracies" or

confusion could in some cases also be a function of the chaos and possibly trauma mothers' go through after the birth of their infant in this kind of context. Or due to different cultural understandings or value placed on punctuality or having no watch.

6.2. What changed from the mothers' perspective?

Mothers perceived that certain valuable and significant changes had come about through the intervention. They reported changes in knowledge and attitude which changed their behaviour in interactions with their infants, changes in their own self-esteem and changes in other aspects of their lives.

6.2.1. Mothers' knowledge and behaviours

6.2.1.1. Changes in knowledge, perceptions, attitudes, management and interactions with their infants

All 17 respondent mothers reported having gained new knowledge and insights, which changed their attitudes and the way they interacted with and cared for their infants, and they expressed appreciation for this. In general, they thought differently about their children and felt better able to observe them, to recognize the needs being expressed, to express more affection, and to communicate and manage their infants' more "difficult" behaviours.

Many described how little they knew, initially, about the basic care of infants. On the whole, decisions affecting infants and childcare tended to be based on practical and economic considerations with little awareness or reflection about how these decisions impacted emotionally on children. They were unaware of their infants' emotional needs, and the capacity they had for interacting with their environment. The programme offered mothers information as well as the opportunity, with the counsellors, to interact, observe and "wonder" about the behaviour of their infants. They were amazed to realize how interactive and capable their babies were.

Some expressed the belief that without the input they might have overlooked important communications from the infant. There were many reports of mothers realizing the importance of the emotional expressions and needs of infants, and the importance of sensitive and responsive care, expressions of love and affection and reciprocal play, all of which are key ingredients for secure attachment.

There were many examples from the interviews and the counsellors' reports that supported the belief that significant changes in behaviour between mothers and their infants had come about through this intervention.

One mother in the group described how different her relationship with this infant had been compared to her previous mothering experiences:

...This baby was only four months when I noticed that his gaze follows me when I go out the room. When I leave, he cries yet the others did not care about my leaving, because they were not close to me. (fg2)

She described an infant that was being observed and noticed, thought about, responded to and who responded with distress when she left the room. She was aware that she had an attachment and closeness with this infant that she felt had been missing with her older children. Furthermore, she had a sense of how important she was to this infant compared to her older children.

The individual interviews provided further examples of how mothers began to notice and observe their infants' behaviours:

...You could notice that the baby starts playing when you give him the breast. He relaxes and throws legs about. (E2)

...First one did not stay with me so I did not observe anything. I can be observant of this one because she is with me. ... I can see when she has a temperature and I know what to do about it. (H1)

...I can say that when I notice something from my baby, I think what am I going to do. I think of the knowledge she gave me and apply it ... I can be more observant now. (H2)

...I would not be able to do that (notice and observe things). I was just going to keep (basic care) the baby. (T1)

Another also spoke of being able to recognize her infant's needs, knowing when to refer to the clinic and recognizing the importance of the father. She recognized her infant's individuality and need to be thought about and handled differently:

... My baby is different from other children even in the way he feeds. (T3)

The counsellors' notes described how, at visits, mothers began to report on their observations of their infants. For example, one mother described that her infant seemed attracted to bright colours (E1), and another began to understand the infant's likes and her expressions of need (E2).

Even a very vulnerable young mother (T2), having initially rejected and abandoned her weaker twin at the hospital, by the fourth session, had become observant and aware and spoke about her babies' likes and dislikes.

In the group, the mothers expressed the belief that without the input from the parent-infant counsellor they might only have provided the basic care the infant required. As they began to think more consciously about how their infants might be experiencing their environment, sensitive interactions towards their

infants increased. The importance of attending sensitively and responsively to the emotional communication of infants, and of expressing love and affection and playing with infants was realized.

...My counsellor showed me how to converse with my baby. I saw that when I'm with her, she talks to me and I talk to her too. It was true, you must converse with your baby and play with her, giving her love. (D3)

One mother spoke about having become aware that her emotional state could be communicated to the baby:

...As this is my first baby, these were new things. Like, I did not know that if you are unhappy, your baby can feel that you are unhappy and also becomes unhappy, I did not know that. When you play with your baby you are giving him love. Even when you wash your babies you can show him love. These were all new to me. (fg1)

...Maybe I was just going to feed the baby and put her down and (not) give any attention to her. They showed me how to feed him and play with the baby so he can grow up knowing this. (fg2)

A mother admitted that although she loved children she did not realise that she needed to demonstrate love to the infant.

...When I met my counsellor I learnt that you have to love while he is little, don't wait for him to grow before you can show him love. (fg2)

...I did not know how to love my baby and this is very important. (fg2)

...She showed me how to, as a parent, show your baby you love him while feeding him. ... Most of the time (before) I would just feed the baby and never thought of playing with him. I just gave him the breast and did not hold him properly to be able to talk to him, yet that is how I can show him love. (E2)

The counsellor noted that one young mother (T2) who had initially abandoned her weaker twin at the hospital, by the fourth session, had taken on the full care of both babies. She imitated their behaviour and interacted with them in a gentle and sensitive way. At the final two visits the counsellor noted that this mother seemed to know her twins well, was aware and was coping. When interviewed this mother stated:

...I did not know ... that I must play with my baby when I'm breastfeeding. That I must talk to him. I was not going to make time to talk to him. I did not have love for both babies. By the time I take another baby I was already tired. She told me to talk to him when feeding him so that he can get used to me. This happened in a short while. Soon they knew me. ... It is because of my counsellor. ... My counsellor encouraged (me) to show my baby that I love him. ... I can see when

a baby is neglected or not. Because I have the knowledge of how to care for babies. My counsellor taught me. (T2)

Others said:

...I know how to treat a baby. How to behave when she wants something ... and when a baby needs mother's love, how to show her. (T3)

...My counsellor used to tell me that you must play with and talk to your baby... don't just feed the baby and put him down, and really my baby knows me even if I go out he cries. (T4)

While not specifically requested, the counsellors reported many incidents in the homes that supported mothers' reports that they were gaining knowledge, learning about their infants and responding in more thoughtful and sensitive ways with their infants.

There were ten specific reports by counsellors about the surprise, delight, affection and praise that parents expressed in response to witnessing their infants' responses to the newborn assessment.

All the counsellors reported on various incidents during their visits which described responsive and sensitive interactions they had observed between caregivers or siblings and the infants. These referred to interactions with infants that were generally gentle and sensitive communications, demonstrated affection, represented conversations, displayed imitative and reciprocal play, empathy, comforting and regulation of distress and encouragement of growth, showed an awareness of the infants' likes, dislikes and sensitivities.

Fathers, grandmothers, siblings and friends were also observed speaking to the baby. The only exception was one mother (D1), who seemed never able to be free of her intrusive and paranoid thoughts and fears, to respond in a spontaneous way to her infant in the presence of the counsellor.

Greater awareness seemed to have developed with respect to infant crying being an expression of need. As infant crying requires interpretation, so much of how the mothers respond to this communication depends on their knowledge, understanding, and state of mind. Often, especially when mothers are sleep deprived, ignorant, preoccupied or distressed, such cries can be experienced as quite persecutory in nature. One mother expressed how she felt that she might have responded very differently to her infant had she not been informed as she had been by the parent infant-counsellor:

...Maybe, I was going to be rough to her, when she cries I ... I don't know why is she crying. My counsellor told me that if a baby is like this, treat her like this. If she is crying, check this and this, don't shout at her because she will grow into an anxious child. If you shout or hit her, she won't be close to you. If your baby grows up in your care she must be happy. There has been a difference. (T5)

Another described how she learnt to be more loving, gentle, accepting, understanding and sensitive to the infant's crying:

...They (the visits) have changed me because I did not have love for children. So when she cried at night I was angry and did not know what to do. There is a change now in my reaction. I know that when she cries I must think that she needs something. Maybe she is hungry or she is uncomfortable, because the baby expresses her feelings crying. ... I knew that the baby has feelings but I did not know that when she cries she must be hungry or needs something. ... It was very useful because now I know what to do when she cries. ... When she cries I comfort her by holding her close to me, if she does not stop then I know that there is something. (H2)

Even without sophisticated insight, both these mothers described how they were able to override any negative projections that previously might have evoked anger towards the infants. Their ability to express their difficult feelings and reactions and the input they were offered by the counsellors clearly protected the infant from the potential of maltreatment on the part of their mother.

They spoke about their relationships with their infants, and thoughts about dependency and attachment were expressed:

...This baby got to know me quickly yet other (the older) children took time before they knew I was their mother. (fg2)

There seemed to be a growing capacity to recognize their infants' attachment needs and the painful effects of early separation for both mothers and their infants. Mother T4 understood that, had she not interacted with her infant as encouraged, the quality of attachment would have been affected and her infant would have learnt to survive without her:

...The baby was not going to cry for me because he does not know me. (T4)]

This mother, despite her own mother offering to care for her infant in the rural community she came from in the Eastern Cape, as she was seeking work in Cape Town decided not to send her baby away but to look for a caregiver locally in order to keep her infant with her as she liked her infant a lot and would miss her. The counsellor's notes mentions that the mother explained how, "a next door granny will look after baby" when she works. In the last two months the infant seemed securely attached and when a friend held her she would cry. the counsellor spoke about how she liked to be with this mother (T4).

As a result of the visits, another mother (T5) believed that her infant knew her and felt they had developed an attachment to each another: In her interview she stated:

... What she taught me are good things. ... The baby now knows how to play with me when she grows, she knows everything. My counsellor suggests to me how to care for my baby. And the baby grows nicely knowing me. (Initially) It crossed my mind to ask somebody to keep the

baby for me. ... They (the counsellor) showed me that I can live with my baby. ... I found this knowledge useful a baby needs her mother's love... even now when I left her at home she cried and did not want me to leave her because she is used to being with me. (T5)

A mother described how she had started developing an interest in and relationship with her infant, which she had not experienced with her first child, who was cared for by an aunt:

...I can say it has changed me because as I say my first child is with my aunt, I used to hear that a baby has this and this but I did not care. Now when I ask about the baby she tells me and I know. I used not to care about babies, now that there are counsellors I want to know things about the babies. (H1)

Mothers began to think about the effects of attachment and separation:

...A baby must not know only one person ... It helps her not to be upset when she meets new people. (H3)

... and how to manage separations:

... You can leave your baby in the care of someone you trust, whom you know ... will handle her (baby) the way you were going to handle her the way you were going to handle. So, I realise that taking a child to a care centre is not a waste of money or you can ask somebody you trust to look after her. (H3)

Two of the four HIV positive mothers in the cohort expressed concern about a time in the future when they might no longer be there to care for their own children who will need to be cared for by others. For these mothers, encouraging babies to form healthy attachments to others would be seen as helpful in this regard.

Mother (H4) had previously spoken about how she was alone and ignorant and did not know where she would get the food she needed to feed her infant. Her assurance to the interviewer that she'd never thought of killing her infant might belie a quite contradictory sentiment, yet her response describes how her understanding, perceptions and attitudes changed:

...She would show me how to play with the baby, disappearing from the baby and the baby following her. ... After she (the counsellor) showed me these things it seemed like the baby is growing faster. Sometimes if she hears my voice she laughs thinking that I am still playing with her.... I know how to play with my baby. I can see she grows faster and other people confirm that, when they hold her they comment on that. They ask what I feed her and I tell them that I give her everything that is there to feed babies. (H4)

She ended the interview suggesting that some attachment had formed between them:

...No I don't want to lose her now that I have her. (H4)

The notes illustrated how mothers tended to make more thoughtful and informed choices. A mother (E3) reported increased perseverance with breastfeeding despite discouragement from those around her.

The parent-infant counsellor noted how the partner of (E1) “could not believe how babies are”. As a result of this new understanding this father spoke of how he “enjoyed every bit of it” when he was left to look after the infant when the mother went off to work.

6.2.1.2. Intrusive and insensitive behaviours were also observed by the counsellors

There were also exceptions to this positive trend. Responsiveness and sensitivity were not consistent. There were times when counsellors would have to talk to mothers about some of the more intrusive behaviours they witnessed. The counsellors noticed that sensitive and responsive interactions with their infants decreased significantly when the mothers were distressed (E1, D1).

Mother (E1) needed to understand that the shouting between her and her partner was likely to be stressful for the infant. She also needed to be advised, against roughly combing her infant's hair. The week after receiving this feedback the mother had bought a special cream that made this task easier for both mother and infant. Although generally sensitive to her infant's cues, mother (E4) consistently tended to overdress her infant.

One mother (D1), who was “amafufunyama”, which refers to a wide range of psychotic or psychiatric symptoms believed to be forms of negative spirit possession caused by bewitchment or a negative relationship with the ancestors (Swartz, 1995), was of great concern from the beginning. Her inflexible beliefs in witchcraft, delusional understanding of events, and her anxiety, distress and preoccupation with the problems in her life made it extremely difficult for her to focus on the experiences and needs of her infant. Although the mother valued the visits and the support she experienced from these visits, the counsellor never really believed that she could respond to the needs and communications from her infant.

Another mother (D4), whose interaction with her infant, despite her depressed mood, was consistently described as good by the counsellor, spent most of the visits preoccupied and distracted by her struggles with abandonment by her husband and insufficient money for food and schooling for her two older sons. The notes suggest that there was very little focus on interactions with her infant during the visits.

Mother (T1) was also found to be initially distracted by her difficult situation, and needed to be drawn into relating with her infant.

Mother (T2) having initially, in despair, abandoned her weaker twin at the hospital, went back to care for him. Once discharged from the hospital, she responded very positively to the input from the counsellor, and by the third postnatal visit she was far more sensitively engaged with both twins, who were thriving.

Mother (T5) was able to speak to the counsellor about the anger she experienced at night when the baby wakes and cries. With the input she was able to manage her infants crying with more understanding and sensitivity.

Mother (H1) interacted well with her infant but the notes reveal that a large part of the visit seemed to focus on her own struggles with being HIV positive.

Mother (H2) was struggling with a great many family problems as well as her HIV positive diagnosis. Her relationship with her baby began with an unwanted pregnancy and the wish for an abortion, but her pregnancy was too advanced. She hoped all along to miscarry. She was frightened of labour, which was prolonged due to the baby lying breach. Once the baby was born she seemed to accepted her and named her "Thimna", which she said meant "my baby". The relationship, however, continued to be characterized by great ambivalence in which the mother demonstrated insensitive and rough or aggressive management of her. This took the form of allowing her to lie uncovered and cold after her bath, pulling her baby's hair as she brushed it saying "It's not sore" as the baby cried, overfeeding her with inappropriate food (cooked flour and custard), leaving her to cry as she believed that the baby was making a fool of her when she cried and she picked her up. The counsellor notes, "mother seems to hate her baby. "When the counsellor suggested that she manage her baby more gently the mother responded by saying, "No, the baby must get used to it. I was brought up like that." She believed that her baby must know the world as it is, harsh and tough.

The notes indicated that, at the seventh visit, mother (H2) began to talk about her fears of what would happen to her baby when she died. She did not want to leave her in the care of her own family as her own mother never cared much for her. She wanted to protect her baby from getting ill with HIV. At the eighth visit the baby was "nicely dressed" but once again had overeaten and seem uncomfortable with a distended tummy. The counsellor witnessed mother kissing and talking to her baby, although loudly which the baby seemed used to. The counsellor demonstrated the baby's interest at soft noises and irritation at loud noises. Mother seemed to understand and reported that she had noticed respiratory changes as the loudness increased. Mother seemed less angry, and spoke to her baby about her concern about who would look after her when her father and she die. From three months, the mother was reported to be more consistently positively engaged with her baby. She kissed her softly and the baby smiled and giggled. The mother reported enjoying interacting with her baby and there was reciprocal communication between them. By the fourth month, the father (who has a girlfriend and denied paternity) and the counsellor witnessed the mother telling her baby what a crook he is. In the sixth month, despite her good health, the mother was preoccupied with whom she could approach to adopt her daughter.

Mother (H3) seemed generally aware and sensitive to her infant initially. In the later visits, however, she was observed distancing herself more; ignoring her baby's crying and placing the responsibility of her care on others.

There were also examples which suggested that the basic principles of sensitive parenting did not automatically generalize to the care of older children. In the first case, mother (E3) continued to struggle to communicate with a 16 year-old child in her care, and relied on the counsellor to reach him.

In the second case, mother (T3), despite all the counsellor's input and contrary advice from her own mother, was not able to apply what she had been told and taught to her older child, whom she continued to shout at and hit. She states:

...I tell my mother that we must hit the child so he can be like other children. She says that I must talk to my child and not hit him. (T3)

Importantly, however, the maternal grandmother had understood the need for communication and constructive discipline, and was able to reinforce the information the mother had been offered by the counsellor long after the visits had ended.

6.2.2. Changes in aspects of mothers' self-concept

6.2.2.1. Changes in maternal moods and emotions

Ten mothers spoke about being left feeling uplifted and happier following the visits:

...I felt happy, she is like my mother and like a sister to me. ... She is easy to reach. (E1)

...I felt very happy because of them (the parent-infant counsellors). (D1)

...I was happy when she came to visit and wished that she would visit frequently. I felt good because I was visited. (E4)

... I was happy when they visited because I have twins. It felt like I was different from others. I was happy. ... The visits made me happy. I got worried when I got twins. My counsellor talked to me until I accepted it. (T2)

A mother who had considered committing suicide because she felt her life was worthless stated that the visits had changed how she felt:

...The visits made me happy...I had someone to help me. (H1)

Another spoke about her improved health:

... They (people) also comment that I have gained weight and I say that it is because I am happy and I have a counsellor that cares for me ... I am happy and my counsellor helped me. (H4)

6.2.2.2. Confidence, self-esteem, agency and empowerment

We began from a point of being aware how lacking in confidence and very needy mothers felt. They felt lacking in resources and knowledge about managing their babies. There was little awareness and confidence of the resources they had within themselves. Many women also struggle to assert what they know to be true for themselves and their children within their own families, but particularly within the more formal social structures. Their concerns were often ignored or minimised. There were many occasions when a mother would be concerned about her baby's health but the symptoms were not obvious to the attending primary health care nursing sister with the result that the mother and baby would be sent home, at times with serious disorders such as pneumonia. The caregiver's ability to assert herself with confidence in such situations is therefore crucial.

We questioned whether, once they received information and felt heard, cared for and nurtured by the counsellors, they would feel more confident and able to assert themselves better. The interviews and notes reveal that such changes did occur in our sample. As mothers gained knowledge, they began to feel nourished, emotionally fulfilled, empowered and more effective and able to manage in the world. Their self-esteem grew, and they began to trust in their own internal 'knowledge' or intuition.

One mother claimed that her counsellor had changed her thinking, and that if she had another infant she would feel prepared. Another agreed that she too felt she could care for own infant independently, after having been very worried about how she would manage to care for this first infant. (fg1).

Mothers experienced themselves as far more confident, capable and self-sufficient:

...I realized that a baby can grow up without a father if the mother is strong. I was taught that a mother could raise a child in a good way. Yes, I have managed; he is big now. (D4)

...I was able to do things for myself (after she showed me). (H4)

Some mothers felt more able to regulate their emotions, following the support and information they received:

...My counsellor is the only adult who helped me....I knew nothing about babies. So much (so) that I left her to cry at night ... I used to cry too because I did not know why was she crying and nobody seemed to care about me ... (and) I don't know what to do with her. ... She (the counsellor) taught me a lot about babies. (T5)

One mother felt more able to manage her anxiety. She seemed to have developed a more supportive and containing voice inside her. She could say to herself:

.... I must not panic. (T4)

Being offered direction and advice helped:

...I felt a change in me because she gave me advice. (H2)

...I felt good because she advised me ... I never got these visits with my other children, the 2 older children. (D3)

... We talked about interesting things, it was nice, getting advices and even when they leave me, they left me happy ... What I found really helpful was their advices that they used to give me. (E2)

...I was happy because I got advices from her. (E3)

It helped some to think things through:

...I think, then I feel good. (H3)

She spoke of how knowledge had empowered her and she felt enabled to rely on her own initiative:

...I felt very happy and comfortable to receive advices about several things that I did not know. I felt relief from burdens. ... When I noticed something from my baby, I think of the knowledge she gave me and apply it, then I feel good.” “I value them because during these visits I get information. They really helped me.” (H3)

Mothers seemed to have developed a better trust in their own knowledge and judgement when common problems arose.

6.2.2.3. The mothers’ sense of worth and capacity to inform and nurture others

The question arose as to whether mothers would start sharing their knowledge with others as a result of feeling that they had something of value within. This was supported by what some of the mothers said in the interviews:

...I found them very helpful, so much that whenever she advised me I used to share this knowledge with somebody else. I told people about the help from Thula Sana. (E2)

...I thought that the knowledge that they gave me was useful, and that I should inform others about it. (T1)

...Now I also do help others with the knowledge that I got from my counsellor. (T4)

...What I valued most is that I could tell my friends and my neighbours about the knowledge my counsellor gave me. (H1)

...They were developing me in so much I could advise other mothers about what I was told. (H2)

They became particularly aware of mothers who neglected their babies:

...If there is someone who neglects her baby, these (visits) will help her and she will end up caring for her baby. (E1)

6.2.3. Changes in other aspects of the mothers' lives

6.2.3.1. Relationships with partners

Some marriages that had been conflictual were experienced as having benefited from the visits.

In one family, the counsellor's speaking to the father seemed to have brought about, at the very least, a temporary change in his abusive behaviour:

... He came back to ask for forgiveness. But I did not want to forgive him because of what he made me go through. ... She talked to him. He seemed to have changed because he stayed for 4 months but left again. (E1)

Two mothers spoke of feeling that they had gained an ally in the parent-infant counsellor and how this helped them better manage the problems in their relationships. They both believed that the visits had helped their husbands to behave themselves better, as they knew mothers were talking to the counsellors about them:

... We always argued during my pregnancy When my counsellor started visiting, things changed. ... I have a parent now, just like him (just like her partner has his mother). I wanted to leave him. (D3)

The mother would tell her partner that the counsellor would ask how he had been treating her, and whether he was looking after the infant:

... He also realized how important these (visits) are, if he did not do things for us. I have an adult who is there to support me. Maybe, if I did not get these visits he was going to neglect me and the baby. He is looking well after us. ... He realizes that if I experience problems, I've got somebody to talk to. (T5)

Gratitude was expressed when the counsellor spoke to them both about their relationship because mothers felt that then the partner would listen:

... She talk to both of us and he would listen. (T1)

There was felt to have been a transfer of conflict management skills:

... Sometimes when you fight with your husband and you talk to your counsellor about it. She could help you calm down and guides you how to deal with it. (E2)

The intervention seemed to have drawn some of the fathers into parenthood, and as they became aware of how important this role was, were more supportive and appreciated what the counsellor explained and showed them:

...He first learnt from this one how to care for a baby. ... He is interested, he is very kind to children. ...there was a lot that he learnt. (E2)

...He listened to what she said. (When) not at home ... I told him that my counsellor visited ... He did not object to what my counsellor brought. He would agree that this is a good idea. (E4)

... because he did not have information and knowledge about bringing up the baby, now he (too) has knowledge about the baby. (T4)

Sometimes mothers passed on information to fathers:

...The baby's father did not meet the counsellor. ... I have been telling him that I was visited by this person, she told me this and asked me this.... He also realized how important these are. (T5)

One of the husbands told the counsellor how wonderful it was that she was visiting his wife because since the counsellor's visits, she had changed. She had learnt to tell him how she feels and was not "just grumpy" (D1).

Other changes concerned the way financial issues were managed. In one case, problems would arise because the father would give his money to his sisters without consulting his wife:

...When I told my counsellor, she showed him not to do like that as a married man. His wife must be involved in everything he does. He must not let people use him because he won't be able to attend to his own problems. She would further say that he must, however, not cut ties with his relatives, but must first talk to his wife before doing anything. (E2)

This example brings up issues around transition from rural circumstances with extended family allegiances and involvement to urban circumstances where the focus and available resources tends to shift to the needs of the immediate nuclear family. Although this met with the mother's approval, this intervention raises some concern that, with the best intentions, the counsellor's intervention does impose a Western solution on the couple. They may well have come up with a different understanding and resolution had the conversation between the couple themselves been facilitated by a family elder or other traditional facilitator.

Another spoke about the resolution of a financial issue:

...The visits made a big difference. We (she and her husband) used to argue a lot, about money. He did not show me his payslip. I reported him, they set up a joint session for us and talked to us. And there was a difference. He brought his payslip home. Then I can get money from him. (E3)

One mother felt the counsellor had helped her to manage the conflict arising over her husband's attention to other women. She stated:

...Our husbands tend to be attracted to other women outside, when he has got you in his house. ... She (the other woman) talked to me and I told him what she said. He did not push me away. He could see that he was wrong. He stopped it. (E4)

One mother felt empowered to prove the paternity of the child's father, and enforce maintenance by following through with the information she was given by her counsellor. She states:

...Nnow (at 15 months) he supports the baby and does everything for her. (H2)

6.2.3.2. Relationships with other children, including siblings

Many of the mothers did not seem to know that they could address problems with their children and that bad behaviour often masks painful and difficult feelings. Perhaps preoccupation with survival issues has determined that parenting beyond basic care and provision has not been a priority or a focus.

A mother described subtle, but for her, significant changes in her children that occurred when she observed how the parent-infant counsellor addressed her 'difficult' children with respect and understanding. She explained:

...She (the counsellor) came and talked to the older one like she does with the baby. ... there is a difference. I don't know how to put it but there is a difference. (E1)

A very distressed mother described how the visits had made her aware of how she had been taking her anger out on her older child and found another way of managing these overwhelming feelings:

... I'm a very rough person, I used to hit the old child until he knows that what he is doing is wrong. Sometimes I could notice that I was taking out anger on him for what his father was doing but it would be too late after the hitting. Then after the visit I change. I knew when I was too angry and what to do. I would take my snuff and lie down. (D1)

She explained why she never spoke of this to the counsellor:

...I was afraid she was going to tell me about the abuse, and the system I was using was the system that my parents were using to me. (D1)

Another spoke of her struggles with her 12 year-old who would not come home after school. She had consulted a Sangoma (traditional healer) who told her that it was the work of evil spirits, however, when encouraged by the parent-infant counsellor to communicate with her daughter, things began to improve.

The mothers believed that the knowledge they had gained would be applied to subsequent children.

...I will be able to use it (the knowledge) again when I have another baby. (T3)

As well as other children in their care:

... For example, I can see that one (another child in the house) is mentally not right and also that it is difficult for him to gain weight, he is unwell in that sense. The other one is too big, he likes food too much and I would like to limit him in food. (H2)

6.2.3.3. Relationships with their own mothers

In three cases mothers spoke of the way the visits had changed the way grandmothers interacted with the infants and supported the mother. Of the paternal grandmother one mother stated:

...When she saw my counsellor visiting me. I could see a change in her because sometimes she takes the baby and spend some time with him. ...she does everything for him, I think she realizes that I do need somebody to support me. ... She was never going to do that I'm sure (had there been no visits). (E4)

The counsellor's notes describe how one of the maternal grandmothers thanked the counsellor for the visits. She was grateful that the counsellor had persevered against her resistance and felt guilty about her own rejecting behaviour at the beginning. The mother concerned spoke of how the grandmother had:

...Liked them. ...She asked them to help so that I don't abandon the baby in hospital. She encouraged me not to miss their appointments. She can see how they help me. (T2)

The counsellor's notes also reflect the involvement of grandmothers (T3, E4), who were present at several of the visits and were observed speaking to the infants, thus, supporting and reinforcing the input provided by the counsellors. At the final visit, the grandmothers who had been involved expressed their regret that they would be losing the counsellors.

The project gained a reputation as a valuable and trustworthy service and the counsellors were perceived as having information and skills to offer, and were called upon, on a regular basis, to provide assistance with broader issues including grant applications, lack of food and protection from an abusive spouse. One counsellor described how a woman passing by expressed her wish that she could have been part of this intervention when she lost her baby, as she had had no-one to talk to at the time. Neighbours also dropped in on visits, to talk about problems and listened to the advice given.

The counsellors believed that their training on the intervention informed the work they did in other settings. They shared their knowledge and skills informally with members of their own families and witnessed their children becoming more socially skilled. Another counsellor described a brief interaction with a mother and her crying infant in a taxi. Having established that he was not hungry or too hot she began to talk to him and comforted him and he stopped crying. The mother and other passengers expressed amazement that one is able to talk to a two-week-old baby.

6.3. How had the intervention been experienced and valued?

6.3.1. Authenticity and understanding of the counsellors

From the counsellors' perspective and my own observations and experience as clinical supervisor of the work, the authenticity of the counsellors was a notable feature of this intervention. It is not to say that it was an essential feature, but I was aware that their deep and personal knowledge and understanding of their clients' experiences was important. They implicitly knew and understood the community and the cultural context, spoke Xhosa, and had experienced early parenthood themselves. They felt able to identify closely with the mothers they visited. Before being able to take on the role of counselling mothers, they were required to undergo a training which explored their own beliefs and attitudes and provided knowledge and skills that they were expected to apply in their own families. This had a very powerful impact in their lives. It broadened their knowledge, challenged and shifted beliefs and attitudes about childhood and childrearing, and changed the way they thought about and managed their own children and families. Perhaps the most important and profound and life-changing insight was what we hoped to impart to the mothers, was the revelation that children were sentient beings capable of emotions and of communicating their feelings. All four of the counsellors believed implicitly in the value of the intervention, that there were always solutions to problems and that change was possible, but above all, they were passionate about their work.

An example of this came from a mother who was concerned when her infant burped and brought up milk onto the counsellor's jersey. The counsellor told mother not to worry as she is also a mother. The counsellor felt that this had pleased the mother (perhaps the mother felt that sharing this identity as a mother brought them closer or that the counsellor could bear this physically and emotionally messy stage for both her and her infant) (T4).

6.3.2. The creation of a therapeutic frame

The role of the therapeutic frame, which is defined by the structural parameters of time, space and role, create the important boundaries in the professional therapeutic relationship which protects both the therapist and the client. In this project, as in all community work, this frame was significantly challenged. The responses of mothers suggest that the manner in which the structural and emotional frame was created, managed and maintained, in the mind of the counsellors, seemed helpful and containing for the mothers.

6.3.2.1. The structural frame

Unless for specific complaints, mothers of small infants seemed not to have the time and/or internal resources to seek the help they needed outside the basic routine of home or the health clinics. It seemed important in these early, emotionally overwhelming, chaotic and demanding weeks and months after the

birth of the infant, that the counsellors made themselves available and accessible by visiting the mothers in their own homes. This need for someone to depend on whose presence was predictable was expressed:

...They are the only people we can trust and are accessible to us, they come to us. (D4)

The value placed by the mothers on regular appointments and use of time varied. The notes indicate that some mothers were consistently and reliably at home in expectation of the visits (E1, E4), and expressed their appreciation of the regular visits:

...She was always available to check on us when we had the baby. (fg2)

... If I miss them, I was not going to get them again. I had to be home and wait for my counsellor. (E2)

...She came to calm me saying that you will give birth, be patient. ... On my return from hospital she was there. (D3)

The counsellors were expected to respect scheduled appointments and length of visits. They were often disappointed, however, by mothers being unavailable, and forced to compromise and be flexible in their visiting schedule. They often waited for mothers to return from clinic visits, shopping or visiting friends in order to ensure that the scheduled visit took place.

While we were aware that some acting out was taking place around this schedule, it was difficult to make sense of this behaviour, even in specific cases. In the first instance, this behaviour was inconsistent and could not just be explained as avoidant. Mothers who would not be at home at the appointed time would at another time complain if the counsellor missed one of her visits or was late herself. In the second place, life for new mothers is often chaotic and disorganized and needs arise without notice. The mothers' failure to be there would be noted and would raise concern but felt less abusive of the counsellor's time than it might at any other stage. Accommodating to the needs of mother felt paramount as they indulged their "ruthless" infants. Thirdly, there was some sense that we were being made to feel, as they often did, disrespected and abused by a health system, on whom they depended, which operated without taking patients needs into account, expecting patients to just fit in. Fourthly, there was an acceptance by the counsellors that there existed a different value placed on time in this community.

The priority was that the visits take place, and in service of this goal the counsellors felt the need, while drawing attention to missed appointments, to accommodate the mothers' routine or lack thereof and broader needs in ways that provided her with an experience of respect.

Mothers appreciated the way the counsellors persevered in their attempts to find them when they were not at home:

...Sometimes she (the counsellor) would visit (repeatedly) even three times but did not find me, I was at work. (H1)

... and left messages that they had been and rescheduling visits.

Sometimes she won't find me ... and will leave a message with my sister that she will visit again. ... She would inform me if she was unable to come, she won't just disappear. ... She would ask where I was when she visited the last time and I would tell her ... She was concerned about me and kept on checking if everything was all right. (H4)

Being visited at home was important to many women.

... (She or it) made me happy because she was an adult who frequently came to check on me. ... she was my only hope. (fg2)

...What I valued most is that she often came to visit me and my baby. (E4)

...It felt so good that I wished she would come to my house frequently, all the time. (D2)

6.3.2.2. The development of trust

The development of trust is associated with the establishment of confidentiality, respect for privacy and boundaries, non-judgementalism, and respect. Within the context of this community where overcrowding creates difficulty in finding a private space, even in ones' bedroom, a political past in which people were divided, spied on and denounced, created a culture of fear and distrust in which feelings, beliefs and thoughts had to be kept secret. The added fear and stigma concerning the rampant HIV/AIDS pandemic and the continuing lack of tolerance of difference continue to fuel distrust in South African communities. Consequently, the counsellors faced a challenge in establishing relationships of trust and confidentiality with mothers.

The success of the counsellors, in this regard, was evident in what the mothers told the interviewer. They described how an enormous degree of trust developed between the mothers and parent-infant counsellors, often from the first contact. The neutrality or anonymity of the counsellors and the fact that they were, sufficiently "other", not family or friend, seemed to help some mothers "open up" and trust that confidentiality would be maintained:

... When you have a problem, you cannot just open up to your friend ... she may talk about our problem in the township. We don't know our counsellors and they don't know us, they keep our problems confidential. (D2)

...They are the only people we can trust ... (D4)

They felt sufficiently accepted and believed that there was little they felt that they could not talk to the counsellor about:

... Most of the times they are open (accepting) with whatever problem you have and they give you advices, then you find a solution to the problem. (fg1)

...Every problem that you are confronted with, you can share with them, they can advise you. (fg1)

They were described as accepting and non-judgemental:

...From the beginning I felt comfortable with her. She is easy to reach and tell you to sit down and talk to her about anything, even things that you are not happy with. ... I realized that this person is the right one. You have friends but when you tell them about your problem you find that everybody in the neighbourhood knows about it. ...

...I was comfortable with her even in the first time she visits me. (E1)

The counsellors were expected to be respectful and careful to follow the lead of mothers. They were sometimes so aware of not being intrusive that important issues would not be explored for fear of being experienced as “nosey.”

The counsellors’ notes indicate that 16 of the 17 mothers from our sample spoke openly about their feelings from the first session and were open and trusted them with difficult questions, feelings and issues. These issues related to fears about the birth, acting against advice given by the counsellor, allowing the counsellor to witness conflict being played out, deception with regard to admission to a hospital, the loss by death of a previous child; shame felt about the pregnancy, abuse of alcohol in the family, aggressive and neglectful behaviour towards a child, the wish for an abortion, a grandmother’s incarceration; guilt about not completing school, disappointment and conflict with partner, the aggression and jealousy of a partner as a result of alcohol abuse. (E1, E2, E3, E4, D1, D2, D4, T1, T2, T3, T4, T5, H1, H2, H3, H4).

Even distressed and difficult to reach mothers who struggled to express their feelings (D2) spoke about the family’s anger with her planned pregnancy, fears about the infant and conflict with her partner. She reported,

...I felt good. I told her my problems. I did not keep them a secret. (D2)

Despite enormous concern for a mother (D1) who experienced intermittent psychotic symptoms and struggled with intense anxiety, the counsellor constantly tried not to judge prematurely and attempted to understand, accept and reach out to her in whatever mental state she would find her at the time. Sufficient trust built up very early that enabled this mother to be open from the first antenatal visit. She spoke of her fears, family problems, her controversial beliefs in bewitchment, use of ‘muthi’ (traditional cures and potions) for the infant and regular visits to the Sangoma (indigenous healer) concurrent with visits to the clinic and western doctors. She was also able to hear the counsellor’s concern about the indiscriminate

use she made of ‘muthi’ that the counsellor felt was too strong for the infant’s use, and accepted practical help with problems she was experiencing with her breastfeeding. This was corroborated in the interview when she said:

...I use to feel free to talk to her about the problems that I had and be able to take control of myself.
(D1)

Another example was mother (T2) who, having abandoned her second born and weaker twin at the hospital, gave the counsellor permission to call the hospital to establish what had happened. She was subsequently required to return to care for her twin in hospital and when she was finally discharged with both her twins she called to let the counsellor know and resume the visits. This suggests that significant trust had been established very early between this despairing and depressed mother and the counsellor despite the very confronting and firm limits the counsellor had set. Neither the mother nor the maternal grandmother seemed to have experienced the counsellor as judgemental or threatening. They were both able to accept her firm management as caring of both them and the twin boys.

Mother (T5) was able to trust the counsellor sufficiently to speak to her about how angry she became at night when the infant kept her awake. This allowed them to think about what his crying might mean and better ways of managing this common problem.

Although the counsellor felt very welcomed by one of the mothers (D3) she remained “difficult to reach” throughout. She tended to struggle with problems alone and did not always follow the advice she was offered.

The presence of HIV and AIDS takes the issue of trust to a different level.

When first tested and informed that they have tested positive to HIV, the MTCT (Mother-to-child-transmission) counsellors at the clinics encourage the mothers to share this information with their family. However, disclosure carries dangers. There is fear of social prejudice, blame and rejection. Many mothers reported feeling very frightened of their partner’s response to being informed as there are still HIV positive women who are evicted from their homes when partners or family discover their HIV positive status.

Three of the HIV positive mothers interviewed demonstrated a high degree of trust in which they felt that an unbearable shame could be shared and held in confidence by the counsellors. In the group one mother stated:

...They helped me a lot because I had a problem, I was sick I could not talk about my illness, I did not want to tell even the baby’s father, and I told my counsellor. She told me not to keep it a secret. She encouraged me until I could tell him my problem. (fg1)

Another mother stated

...I was not shy to tell them about my problems. (fg2)

One mother (H1) was informed of her HIV positive status during her pregnancy and disclosed it to her counsellor at the first postnatal visit. The counsellor was the first person she confided in. She shared that she had been thinking of committing suicide as she felt her life with HIV was useless, but after the visit felt she had the strength to move forward. She cried openly as she spoke to her counsellor and expressed her gratitude for what counsellor had told her. At the following session she reported feeling better having shared her problem with counsellor. When interviewed she said:

...I am HIV positive. I was afraid to tell my boyfriend, I did not know how to tell him. I waited for my counsellor to visit; she is the one person I could tell so that she could talk to him. She consoled me saying there are lots of people who have got it (HIV/AIDS). I told her that what worries me most is my partner, he does not know it and I want him to know. She promised to sit with us when he is available and talk to both of us. She told him and talked to him about it. I was afraid to tell him and thought he would not accept it. (H1)

Some mothers needed a little longer before they were able to disclose. It took until the seventh visit for mother (H2) to feel sufficiently trusting in the parent-infant counsellor to confide in her that she was HIV positive. Again the counsellor was the only one to know at that stage, and she asked the counsellor to keep it confidential.

Mother (H4) clearly felt that she would not be judged by her counsellor as she might be by her family as she opened up immediately about her HIV status:

...I am HIV positive ... the first person I was able to talk to about it was my counsellor because she was like a parent to me ... I felt I could talk to her. I had not told my sisters yet ... I would have kept it a secret....(She added later) I can tell her everything and she guides me.... She asked me how I was going to tell my family (about being HI V positive) and I said I did not know. She asked if I want her to tell them and I said no, she must not tell them. She guided me how to deal with this and I realized that it is no use keeping it a secret, it is bothering me. ... She will come back to me and refer to the TV programme saying that people do not hide it anymore, I also should not hide it. I asked one of the counsellors at the clinic to tell my sister and I said that they want to see her at the clinic. She told her and her reaction was not bad. (When her mother arrived for a visit it was agreed that the counsellor would tell her), she (mother's mother) did not react badly because she (counsellor) was able to talk to her. (H4)

Having enabled this mother to tell her family provided the mother with direct support from them as well as external resources becoming available to her:

...My sister's employer is HIV+ and is taking certain pills. My sister brought me the paper, she gets them from the chemist, I buy them and use them. ... Now I don't get sick, I see some (others) get weak. (H4)

The fourth mother (H3) struggled more to share her diagnosis. It was only at the thirteenth visit that she spoke to the parent-infant counsellor about suffering from acute abdominal pain and explained that she had “a poison” in her system. She never really labelled her illness.

This was evidence of a need or pressure to talk and share difficult, frightening and shameful thoughts and feelings. The distrust that tends to dominate in difficult circumstances seemed to be absent. It is as though the appearance of a trustworthy, supportive and interested other, at this stage, was almost unquestionably accepted almost like the expectation of a full breast for the hungry infant.

6.3.3. The therapeutic alliance

From all accounts, the therapeutic alliance proved to be a consistently very positive and powerful feature of the intervention, particularly in the context of mothers feeling abandoned, lonely, lost and forgotten. The early development of trust seemed to have established a positive therapeutic alliance between the mothers and counsellors, which seemed strengthened by the counsellors' responses, which were experienced as supportive, sensitive and responsive, and seemed to fulfil the mothers' needs and wishes for sensitive and responsive relationships with their own parental figures.

6.3.3.1. The mothers' appreciation of the visit by the counsellors

Without exception, the recipient mothers, when interviewed, expressed their appreciation of the visits. Appreciation was also expressed by other family members such as partners, brothers and grandmothers who had witnessed the intervention. Appreciation went beyond the family, when some envy was expressed by a neighbour not visited:

...A woman that lives next door, she complains that she was never visited by a counsellor. I told her that this must be a new thing. She says she envies us. (E4)

All those interviewed stated that, as a result of their experience of the visits, they would encourage friends and other women with young babies to participate in such visits. An example from the group expresses this view:

...Yes, we would encourage them (to participate in the programme) so that they can gain as we had gained. When you can see that one has a problem and you know that she can get help. (fg1)

One mother unconsciously illustrated the role of implicit relational knowledge as a powerful determinant of how the help and care being offered could be utilized when she warned that some of her friends had given up, and were no longer open to help from adults:

...It depends whether you listen to your parent. Some of us don't listen to our parents. With those, they won't change from the way they see their children. (E1)

One of the counsellors measured the mother's interest in her visits and the intervention by her willingness to switch off the radio she'd been listening to in order to engage with her.

The counsellors were aware that the mothers placed greater trust in their judgements than in the judgements of other health providers.

6.3.3.2. The quality of the therapeutic relationship

6.3.3.2.1. Counsellors as surrogate mothers and grandmothers

Most new parents in this community lived in conditions of extreme deprivation within which there was, literally, never "enough". Mothers spoke of feeling alone, unsupported, isolated or emotionally abandoned at this time. There seemed very few experienced and available maternal figures available and accessible to take on a supportive maternal role for them. It was into this gap that the parent-infant counsellors stepped when they began to visit, very much in line with what Stern (1995) referred to as the motherhood constellation. It is also within this relationship that the factors they saw as facilitating change needed to be identified, explored and understood.

When asked what she valued of the visits, a mother (T4) explained:

...I used to feel happy (after each visit) because I knew that my mom is visiting me, and would ask everything and how is the baby and I would tell her the way things were that made me feel good because there is someone who is checking the baby. ... (We) used to talk and she used to take the baby to her as a parent of mother (a grandmother).

...When she was there I used to be very happy, so it was the relationship, it was the support that I got from her. (T4)

She describes the need for a relationship with an interested, observant, mindful and active mother figure of her own to mirror her own pleasure as she shares and participates in this special process of getting to know her infant.

Clearly, the counsellor was experienced as someone with whom she felt she could share the little daily things that came up for her and her infant, and the counsellor's questions and checking up seemed to leave the mother feeling cared for.

There were other statements that indicated that the mothers perceived the counsellors to have fulfilled a familial, parental, and specifically a maternal role in their lives. In the focus groups the mothers said:

... the counsellors are just like parents. (fg1)

For a mother who had lost her parents:

...They helped me because I do not have parents. (fg2)

Even for mothers who had support from partners:

...I live with my partner and do not live with my parents ... We had nobody else to look up to... I mean someone from his family or from my family (fg2).

This was reinforced in the individual interviews:

...Because I don't have anyone. I don't have parents or sisters. I have a problem. I felt happy she is like my mother and like a sister to me. ... The way the counsellors talk to us, they are like parents. (E1)

...The problem is that I don't have my family members here. I'm on my own, my mother is not here. I buried her in August. My family is not here. ... I thought I have a family with the counsellor... She was just like my own mother because she helped me with a number of things. I felt good when she visited. I got worried when she stopped. (E4)

...Oh, yes, she was a mother ... really a mother. ... She was an angel and yet she was not from here (from another community). ... she was (like) a parent.(D1)

...She is my parent here. (D2)

...My mother was not there and I was the oldest. My counsellor became a parent to me. (H2)

...It would feel like I'm with my mother.... When my own mother visited, she told me the same things, then I realized that she (the counsellor) is really like my parent. (H4).

... I live alone. I don't have parents to teach me about babies. I did not know that I could talk to my baby when she was small. They taught me that, things I did not know. What I valued most is that she was like a parent to me. I told her about my problems and she would help me solve it. I lived alone with the baby, she helped me look after the baby. (T1).

I was alone with no one to help me. Even when I had problems with the baby ... I knew that I had someone to advise me what to do. (H1)

6.3.3.2.2. Counsellors valued over family or friends

There were instances where even when family were present, the parent-infant counsellor was the only support on which a mother felt she could rely:

...She found me alone, as I live with my baby.... when I met her I did not have support of an adult. I told (her) all my problems, she supported me. She is the only one that helped me, my family did not care at all. (T5)

... (The parent- infant counsellor did) maybe more than a parent could do. Maybe parents would care for us the way they did. ... Yes, they were like parents, were kind and made us feel happy.” (D2)

It is not that the motherhood constellation is entirely absent from this community, as many newly married women in Khayelitsha are known as “makoti” traditionally become part of her husbands family and have access to his maternal figures. In practice, however, this involves serving, submitting to and relying for support on her husband’s mother who is responsible for her and for many, in the early weeks of motherhood, this is a difficult and unsupportive place to be. Mothers-in-law may have beliefs and practices that differ from the mother’s, and might not be in her or her infants’ best interest.

Mothers in the sample experienced the counsellors as more caring and offering more support:

... She was like my parent to me. I don’t have a parent here, only a mother-in-law. (D3)

... My mother-in-law tried to help me but her help does not match the kindness of my counsellor (E4)

This mother spoke about how difficult it was to make decisions for herself as she needed her mother-in-law’s permission to take her infant to visit her own mother in the Eastern Cape. The notes describe how the paternal grandmother said she would find it difficult to be without the infant, and believed the mother should leave the infant with her.

In another case, the counsellor had offered the mother different knowledge and safer alternatives:

...She told me what to buy and use (to clean the umbilical cord). She brought me the spirits and showed me how to use it. I could see that she was encouraging me because I did not know what to do. I heard that you can use a Disprin (from her mother-in-law) but I did not know about the spirit. (H1)

Other older relatives were not necessarily a helpful resource either:

...My mother died, I live with my aunt. ... She would not (notice anything) because she drinks a lot. ...you get it (the information you need) only when your counsellor visits and advises you ... Now I have got somebody who helps me. (H3)

There were times when older sisters were not helpful and the parent-infant counsellor was perceived as “far more caring”:

... Even when I stay with my sister it is like I don't live with my siblings. ... Mos you differ as sisters, my sister would pretend as if she cares for me when visitors are here but when they leave there is nothing like that. Yet when my counsellor visits she would see if I'm unhappy and ask what is worrying me. ... I did not know what was happening to me and my sister never noticed anything because she was busy working. My eldest sister has a child but she did not care about me. My counsellor was far more caring. ... She would advise. ... She was concerned about me and kept on checking if everything was all right. ... She guided me ... she would show me how to play with the baby, ... I am not alone and my counsellor shows me a lot of things. (H4)

Friends were not always able to fulfil the need either:

...Sometimes a friend does not give you good advices. (E1)

...Oh, yes, she was a mother, I do see others but the one that was visiting me was really a mother. (D1)

...I had friends who showed me how to care for a baby but I learnt a lot from my counsellor. (D2)

Some valued the fact that the counsellors were older women. In this context older might infer motherly, experienced, knowledgeable and wiser:

...Because she was older she would guide me on how to solve them (problems). (D1).

...I found her very helpful because I did not stay with older people and I don't have my family here to come and see the baby. (D2)

From the counsellors' perspective it is clear that they perceived themselves as mothers, mothering new mothers in the role of caring, or as informed grandmother figures. In the supervision sessions, there was considerable evidence of the counsellor's countertransference involving maternal concern, protection and pride for mother and infant.

An example of this was mother (T1) who had lost her own mother earlier. The counsellor took on the role of supporting and educating the mother in social skills, much as a mother would. At the second last session the counsellor reported the mother as saying:

...I am like her mother who cares about them although I don't live with them.

This was supported by another counsellor who, at visit six, noted that mother (H3) shared things with her that made her feel as though the mother had taken her into her family.

6.3.3.2.3. Counsellors were idealized

The maternal role into which the counsellors were cast had an idealised quality to it. They were perceived as idealized mothers who had it all to give: plenty of knowledge, expertise, wisdom, authority, power and support to offer. The mothers put enormous store in the counsellor's ability to find solutions for their problems. They were the ever-ready and plentiful breasts offering to dispense the milk of human kindness and knowledge. This is illustrated by the statement:

...Even if we had a problem she can solve it by talking to you. (fg1)

Without exception, the mothers interviewed referred to the counsellor visiting them as "my counsellor". While this might reflect a convention in speech or a feature of the translation, it does support a degree of attachment to, dependency on and ownership of the counsellor by the mothers: a sense that the counsellor had been taken in. This is illustrated by a few examples taken from each category of mothers from the sample:

...I had to be home and wait for my counsellor. (E2)

...I had friends who showed me how to care for a baby but I learnt a lot from my counsellor. (D2)

...I was very happy because even when I had a problem, I would talk to my counsellor about it. She would talk to me and leave me feeling much better. (T1)

...My counsellor was far more caring. (H4).

6.3.3.2.4. Care, concern and interest for the mother-infant unit

Commonly, when help is sought, the focus of health services and professionals tends to be exclusively on the mother or the infant. In the early weeks and months the mother is so powerfully merged and identified with her infant that care given to her infant is felt by the mother as care given to her and vice versa, so the care given to the mother is in effect care given to the infant. Conversely, neglect or abuse of the one affects the other. There was evidence from mothers that the care and needs of both were held in mind by the counsellors. Mothers reported that:

...Most of the time when she visits she wants to see us happy. (fg1)

... She often came ... Wanting to know how we are doing and how the baby was growing. (E4)

...I felt good when she came and talked to me and the baby. (D2)

...I found them very helpful. They (the information and teachings) are good for my life and my baby's (life). (D4)

Even mothers whose aggressive behaviour towards their infants, at times, needed to be addressed, stated:

...She did not come here only for my baby, she was there for all my problems ... What I found valuable is that these counsellors do not come for the babies' problems only. They help out even in the family problems that we experience. (H2).

...She did not come for the baby alone. We were able to talk about our problems, they supported us (the mothers). (T5)

One mother spoke about how her partner experienced the counsellor's interest and commitment for his pregnant wife as an expression of care and love for the infant:

... He would say this baby is loved before birth. (D3)

HIV positive mothers were very aware of the rejecting and negative attitudes (and projections) they, and by extension their infants, attract from others. These infants seem to be perceived as “damaged” and “shameful”. When one mother, for example, observed the counsellor being caring, interested, affectionate and playing with the infant, something important changed (“a moment of change”) for her. It was a moment of seeing and experiencing something different. In a merged state and identified with her infant, observing the counsellor playing with her baby was experienced as being played with and cared for herself, and she was left feeling that they were both loveable. She explained:

...I can say we feel happy when we are visited because the counsellors play with our babies and you find that our children are also loved. Sometimes we play together and we feel good and that she will come again and make us happy. (H3)

There is a real opportunity at this stage to create and extend a culture of care to the father and other siblings by including them in the intervention where possible, and in so doing strengthening the sense of family in a similar way.

6.3.4. Interventions valued

6.3.4.1. Empathic listening

For Carl Rogers (1946) and the psychoanalytic tradition in general, the experience of being listened to with concern and understood with empathy by an “other” is a core element of counselling which provides containment through affect regulation and facilitates change.

The counsellors' ability to empathise, identify with, reflect and mirror the parents' pleasure and concerns, interest, excitement and pride with each new step in the infants' development, was consistently evident from supervision discussions. This was also evident from the mother's responses.

The importance of listening and containing the feelings before anything else could be addressed was clearly understood by the counsellors. For example, one counsellor wrote that when she found a mother

(T1) “sobbing with tears running on her cheeks”, she let her cry, and later, listened to both parents talking about how difficult it was to be a young parent.

Many women spoke of always having needed to keep their feelings and problems to themselves. Expressing their feelings and having them validated was foreign to many of the mothers, yet they experienced the counsellors as willing to listen to their problems and concerns, and they felt safe and free to talk:

... Most of the time they (counsellors) are open so you can open up with whatever problem you have.... (fg1)

...Something else that was important was that she attended to your problems. (fg2)

Mothers expressed their appreciation that they did not have to hide how they felt. They felt that they could share difficult feelings and negative thoughts and would not be judged. The counsellors were able to hear and process these thoughts and feelings in ways that felt calming and containing. This process felt relieving to mothers, it enabled them to release their feelings, and they felt less inclined to act on them and more able to find solutions to problems:

...Sometimes she would find me in a good mood, sometimes I would not be right. She would try sit down with me and talk to me. ... From the beginning I felt comfortable with her. She is easy to reach and tell you to sit down and talk to her about anything, even things you are not happy with. (E1)

...When you have problems you think a lot, for example you even think that you may end up killing yourself, throwing yourself to a moving car. So when you talk about this to her (the counsellor) during the visits, you forget about that. Your wish that she would not go and always be with you talking to you. ... I felt well after talking to her. ... She said I must not hide my problem, talk about it ... By opening up and telling my situation I got more than the others got. ... When he (the child) is still with you and you have evil thoughts, the counsellor will visit you and make you feel better and forget about these thoughts. (E1)

...Sometimes when you fight with your husband and you talk to your counsellor about it...she could help you calm down and guides you how to deal with it. (E2)

Even a mother (D1) who was ‘amafufunyama’ found the accepting, calm and listening presence of the counsellor allowed her to think more clearly. She felt she’d been listened to and relieved from what felt to her like torture. This alone might have facilitated more positive interactions with her infant:

I used to feel free to talk to her about the problems that I had and be able to take control of myself, she helped me you know ... They came listen to me and supported me. ... There is nothing more than that she helped me out of torture. I was really sad. (in her presence) I used to forget

about the problems that I had in my head (her beliefs and the voices). ... she would guide me on how to solve them. ... so that I can find solution. (D1)

One mother (D4) spoke of how, given the opportunity to express her feelings, she felt able to come off her medication and move on from a very painful emotional paralysis:

... I locked myself in the house. I went to Day Hospital, unaware that I was pregnant and they said that ... (amongst other things) ... I have nerves. They gave me pills which I take and sleep the whole day. When I realised that I was pregnant and I met my counsellor I never felt the same, I stopped those pills and I don't feel anything bad. ... There was a big difference because I no longer feel pain whenever I think about him (her husband). I just think that he is wherever he is and I don't know how he ended up there. He will come back the same way. That is all I think, I don't feel sore about it. I used to be sad and cry but now I don't have the feeling anymore ... There is nothing more than that she helped me out of torture. (D4)

There was still, perhaps, an unrealistic wish that her husband would return and some denial about what she might sometimes still feel in the future but, having spoken and been heard, the feelings felt more manageable and no longer “tortured her”. She felt able to live her life.

Feeling understood and tuned in to by the counsellor was a powerfully significant experience for a mother who reported:

... She would see if I'm unhappy and ask what is worrying me. She can see that I am angry and she would ask. I can't wait for her visits or when she is there I can't wait for my sister to leave us alone so that I can tell her. (H4)

6.3.4.2. When listening, thinking and reflecting was difficult

“Client-centred” counselling by nature relies on a process which leaves the counsellor feeling not in control. In this setting, counsellors were often confronted by difficult and painful situations and feelings, many of which may have resonated with their own experiences, which, to some extent, might still have been unprocessed. As a result, a great deal of anxiety was generated, and although they understood and believed in the primacy of listening, their ability to listen deeply and authentically and to contain the emotions raised, there were often times when this brought about anxieties they could not bear.

Through the supervision process several issues seemed, consistently, to undermine their ability to simply listen and reflect when this was required and lead them to adopt a far more directive stance, giving advice or instructions to mothers or partners or otherwise attempting to fix problems which were not targeted as part of the educative component of the intervention.

6.3.4.2.1. Maternal feelings of ambivalence towards the infant

In this environment in which child abandonment, neglect, abuse and even rape are far too common, even normal maternal ambivalence and feelings of hate are difficult to process. The threat to the infant's wellbeing was always a possibility (there had been occasions when babies, in this community, had died in suspicious circumstances in the context of maternal abuse of alcohol).

This concern about the infants' wellbeing, at times, prevented the counsellors from staying engaged with and allowing the full expression and exploration of the more destructive feelings and behaviours reported by the mothers. Instead, a need to rescue would be triggered, and the counsellors tended, immediately, to establish the necessary limits and look for and sometimes impose ways that would help the mother better manage these stressful situations. Examples of such situations included:

- neglect of the infant when mother was distressed, and rough and aggressive combing of the infant's hair (E1);
- neglect, disengagement from the infant, and irrational and paranoid thinking and decision-making (D1, T1);
- attempted abandonment of the baby as a result of despair and hopelessness (T2);
- the threat of abuse resulting from feeling angry and tormented by her infant's crying at night, and rough and insensitive handling of the infant (T5);
- the expressed hope of losing the infant in pregnancy, insensitivity to, and ignoring the infant's cues and needs, aggressive overfeeding of the infant, often with inappropriate foods, partly to force the father who was being unfaithful, to pay more for the maintenance of the infant, rough and aggressive and painful brushing of the infant's thick hair (H2);
- ignoring the screaming infant, and a tendency for mother to forcefully hand her over to others (H3);
- drinking throughout the pregnancy (T5).

Sometimes the counsellors would offer mothers advice, and implied promises that could never have been honoured. An example was counsellors who were so concerned by the possibility that mothers would send their children away to be brought up by relatives who lived a long distance away, that they advised the mother to care for their infants themselves in a way that led the mother to understand that the counsellors would be available to help her to look after the infant should she find herself abandoned by her partner.

When interviewed the mother said:

...She would arrive and support me and tell me not to abandon the baby or give her away. I must keep my baby and promise(d) to support me. When I encounter problems I must come to her and talk to her when I find the baby's father is neglecting us. (T5)

...She advised me to stay because they are available to help me if my husband leaves me with the baby. They are going to tell me what to do. (D3)

Fortunately this mother managed well and grew through this process. She stated how the counsellor taught her to be a mother:

...She taught me to stay and be a mother and bring up my own baby. (D3)

The counsellor's promise of availability for the mother was unrealistic and ill-considered and could have been experienced as a profound betrayal had the mother been let down.

6.3.4.2.2 Partnership conflict and abuse

Any threat to the relationship and mother's wellbeing which emerged in nine of the mothers in this sample (E1, E2, D1, D2, D4, T2, H1, H2, H4), through abuse (linked to alcohol abuse from 5 of the mothers: E1, D1, D2, H1, H4), lack of financial support even for basic foods, neglect, infidelity, abandonment by partners and the denial of paternity, raised feelings of concern and anxiety in the counsellors which undermined their neutral listening stance. Well aware of the precarious nature of many of the parental relationships at this stage and the harsh reality for both mother and infant of the loss of emotional or financial support by her partner, the counsellors at times felt compelled to rescue in the relationship.

The counsellors were not trained in couple counselling and were required to refer couples to appropriate services. In practice, however, this did not often occur as there was seldom sufficient money to pay for transport and once relationships had developed between them, the mothers preferred speaking to their counsellors. Some mothers would complain openly in front of their partners when the counsellor arrived for her visit, thus trapping the counsellor into acting. Feeling unable to ignore the problem, concerned and wishing to help, she would comply and attempt to help the couple to manage the conflict as best she could. At that point the intervention became quite intuitive and counsellors dealt with such situations in various ways.

The mothers reported being advised not to leave their partners. One mother complied and later reported in her interview:

...I did as she told me. ... I found that these things are right for my life. (E4)

They reported also being cautioned and advised against exposing their partners to behaviours or feelings and needs that might threaten the relationships in any way:

... When the baby's father arrives he must not find you in different moods, even if you had a quarrel with him. You must be warm. (fg1)

... These visits were valuable ... they gave us advices on How to treat your husband and how he should treat you. That was important for me. (D3)

They were also advised how to manage conflict more constructively. Having spoken of her frustrations with her partner and of not wanting anything to do with him initially, after the birth, a mother was told that her angry response had been counterproductive. The counsellor told her not to be angry with the father and to meet him halfway. She helped her to manage the conflict by discussing the problem with her partner openly and directly. He subsequently did help with maintenance and the mother reports with appreciation that the information she was given by the counsellor was:

... The best information, it is good. Even when we quarrelled with my partner, I told her about it. ... She advised me that he knows nothing about the baby, do this and this ... She made me aware of that (the importance of a father to a growing baby). (T3)

... There was a misunderstanding between the baby's father and me. She (counsellor) advised me to calm down and communicate with him because there are some mothers who are neglected by their partners ... If I communicate with him, he will be able to help (to maintain the baby)... I did not even care about my partner. But she guided me and everything is all right, he comes, bringing some things for the baby and I am able to talk to him. ... When I am upset she will tell me what I should not do, etc. She says that if I dwell on some things I am going to be unhappy, I must ignore him even if he says this is his home. (H4)

The counsellors mediated for couples which sometimes produced an immediate change in behaviour:

... My counsellor encouraged me to stay (with my partner). She talked to him until he changed his behaviour. (fg2)

Having requested help from the counsellor one mother explained how the counsellor,

... Promised to sit with us when he is available and talk to both of us. She told him and talked to him about it. ... My counsellor's presence really helped me in that. ... She really talked to him and he listened. ... My counsellor guided him on how we can live better. (H1)

There were occasions when mothers were given perhaps unrealistic reassurance. This was instantly rewarding to the counsellors as the mother immediately felt better.

... I have a problem with my husband, I did not want to speak to anyone and I locked myself in the house. When my counsellor encouraged me that I still have a life, I must not give up, that he is going to realize that and come back to me. After that I felt much better as I am still happy. (D1)

All of these seemed to lead to the immediate relief of stress, at least for the short-term, for both mothers and the counsellors. However, none of the above allowed for the thoughtful expression, reflection and exploration of feelings and beliefs and resolutions that inspired long-term change.

6.3.4.2.3 Poverty and the pressures of idealization by the community

The community was economically deprived and hungry for input and support as were the parents. The intervention had been ‘sold’ to the community with great enthusiasm and represented abundance of funding and other resources of knowledge and expertise. The counsellors, having been carefully selected, intensely trained and supervised and equipped with very special and valuable insights, knowledge and skills, undoubtedly left them feeling advantaged and placed them in an ‘elevated’ position in their own minds and that of the community with whom they were keen to share their knowledge. Their sense of being special was reinforced by the openly expressed enthusiasm for the quality and importance of the intervention and belief, admiration and affirmation of the counsellors selected to deliver the intervention by the local and international research staff. In this sense they carried a great number of projections, expectations and pressure from all sides.

For the community, the counsellors personified the project. At times they spoke of how they felt the community had expectations of them, but often they were unconscious or unaware of the powerful idealised transferences they carried and the pressure this would put them under. They found it difficult not to act out their countertransference and the projections placed on them. They saw their roles as providing hope and frequently felt pressured to make it better for the mothers they visited.

6.3.4.2.4. Mothers who struggled to change

The counsellors were aware that respect for the client’s right to make the necessary changes to her behaviour in her own time was an important aspect of the intervention. However, counsellors often spoke about their frustrations when clients were not ready to make the choices and changes they were aware they needed to make to improve their situation. It was a struggle to hold back and follow the client, accept her pace and witness her continuing to struggle and inability to make use of information given to her.

A counsellor often described being caught up in a kind of ‘madness’ with one mother (D1). She needed to recognise, tolerate and hold powerful anxieties and fears if she was to be of any help to the mother, and by extension, her infant. Her notes also described the need to respect the mother’s traditional beliefs and have sufficient knowledge and authority to judge and discern what might be delusional and what would be harmless or damaging to the mother, her infant and other child.

Counsellors also found it very difficult to just reflect the feelings when they knew that the mothers did not have the confidence, knowledge or skills to be able to effectively manage a particular situation that was damaging to others in the family. Counsellors would then literally coach the mother in skills that would

help her. A mother whose 7 year-old son had been sent home from school as she could not pay the fees, had given up and kept him at home. She reported:

...He (her son of 7 years) was not even attending school because of the school fees. She advised me to go to the school and talk to the school principal to admit him. I went to school and talked to the principal and he said I could bring the child and pay the fees later when I have the money. She helped me with my children. (D4)

6.3.4.2.5. Death and dying, loss and separation issues

The HIV/AIDS pandemic created circumstances that, despite their basic training and regular supervision, were challenging for the counsellors to contain emotionally. The training had not specifically included a component on HIV/AIDS. It was only once the pilot programme began that the extent of the pandemic became apparent. Working with HIV positive mothers and babies often meant having to manage unbearable shame and denial. They were also potentially working with AIDS, which confronted them with the potential of witnessing the deteriorating physical health and death of mothers and their children. Despite having been provided with further specific training on HIV/AIDS, dying and grief work, and although they seemed to manage well, they felt emotionally overwhelmed at times.

The painful experience of death resulting from AIDS, in poor communities, was often compounded by a lack of funds required for care and for funerals. Deceased babies were often left in the care of the hospitals to “dispose” of and families had difficult choices to make about terminally ill parents. Sending mothers back to the rural areas to die was far cheaper than the cost of transporting her body later. On the other hand, the mother might believe that the care she and her surviving children needed would be better provided in the city. There were times when such choices needed to be made when mothers were still denying their illness in their families. Counsellors often felt forced to intervene in these cases as they saw their commitment as ultimately to the infant. Children were often not given accurate explanations of their parent’s death. There were times when they were not told that their parent has died and the parent would just disappear.

6.3.4.2.6. Completion of the programme

The termination of the visits was a constant struggle and a regular supervision issue. Despite the carefully explained structure and time frame of the intervention, the gradual nature of the withdrawal, and the consistent and regular reminders of the ending, feelings of confusion, distress and abandonment were expressed by the mothers.

...I was worried when she stopped coming. I wished she would continue until the child was years older. (E4)

...She just stopped and I did not know what was happening. I liked it when she visited me. ...There are no visits since the babies reach 6 months. We do not see our counsellors anymore. ... She (the counsellor) disappeared when the baby was 6 months. ... It worries me. (E4)

...So when they leave us in the middle, who is going to help us? ... They told us that they would stop at 6 months. But they left me abandoned because some of us don't have parents. We talk to them about our worries. (D2)

... She (the counsellor) did not tell me (when she would stop visiting) but she said that they are going to have a break in December. (T3)

...I feel very bad and hurt, I still need her. (T4)

... I was confused because my counsellor does not visit anymore. ... I depended fully on my counsellor to help me with my baby. (T5)

...My counsellor did not say when would they stop. (H2)

It seems that once trust and attachment became established between many of the mothers and the counsellors, the repeated reminders about the ending of the visits tended not to be “registered” or “remembered”. The hurt and a sense of having been abandoned and the angry feelings mothers expressed, reflect something of how bereft they feel about the withdrawal and loss of this valued relationship and support.

While feelings of loss and abandonment are all part of endings, it is a particularly sensitive issue in this community where important figures disappeared from early in life. For many of these mothers, their first experiences of loss occurred in infancy. They might have been left in the care of, or sent home as babies to be cared for, by their grandparent/s or other relatives in rural communities while their mothers and fathers worked in the cities.

In the mothers’ present environment, partners disappear, people around them are dying of AIDS or tuberculosis, often with no explanation. It is happening to everyone, and so often that there is no time to mourn, and consequently, people have learnt to blunt their emotions or split them off and little fuss is made about it, but in fact but the whole community is in a constant state of grief. This defence seems to have desensitised mothers to the experiences of, and ability to process grief, which, in turn, might make the continuing practice of sending babies and toddlers away to live with grandparents in the rural communities easier to manage. In this cohort, some mothers had become aware and were able to think about what this might mean to her and her child, and to make alternative arrangements to keep her child with her.

One of the ways the counsellors dealt with the difficulty of termination was to promise that they would pop in when they passed by on their visits to see how the infant was growing. This seems to have

represented a continuance of the programme by some mothers in the form of continued interest and being kept in mind by the counsellor.

There were many ways in which the counsellors attempted to manage their anxiety. These included: requesting more training, preparation, knowledge and information, requesting more structure to the visits, giving practical advice and instruction. Clearly, the advice given by the counsellors came from their sense of care and concern, and it was much appreciated by the mothers, as we will see later. It is, however, worth keeping in mind that, despite the extensive training, five years of experience in the field and regular weekly supervision, the counsellors were still too frequently and often inappropriately tempted to “fix” problems. This illustrates the essential need for close and regular supervision in order to maintain an awareness of the powerful unconscious transference and counter-transference dynamics that inevitably prevail and threaten to undermine the effective use of listening.

6.3.5. The counsellor as benign authority and witness

The stress of living with poverty and the demands of early parenthood, as well as the increased presence of common mental disorders in low to middle income countries, resulting in preoccupation, irritation, withdrawal, and apathy on the part of parents, interferes with the emotional and physical availability of parents to focus on their infants. Knowing that there are interested and caring others, keeping an eye on them and encouraging more sensitive involvement, tends to draw parents back into more focussed engagement with their infants.

What emerged in the interviews was the importance the mothers placed on what the counsellors witnessed. They seemed to carry the transference both of a) caring, concerned and encouraging parental figures to whom mothers were keen to report the things they had done well, felt good about and were proud of, as well as b) a more protective yet benign, intervening elder/parent representing an external locus of control or conscience for the more negative and destructive aspects of behaviours expressed in the homes they visited.

6.3.5.1. Witnessing the positive and mirroring

It is seemed that a positive parental transference with the counsellor in the role of the supportive mother, with whom she wanted to share her achievements and feel special, may have developed in several of the mothers. In this role the counsellor appeared to act as a caring, interested, attentive and observant parental figure, affirming of the mother’s positive parenting practices. This ‘dependency’ on the maternal figure for positive affirmation reminds us of the way a child might show an interested and caring parent what she can do and how well she is managing and to share an exciting experience. It seemed to bring a sense of pride and hope.

The counsellors' notes, particularly, revealed how mothers excitedly reported and demonstrated their infants new achievements and successes of their own when the counsellor arrived, and how the counsellor, with a sense of pride, would mirror the mother's excitement with each new development. Throughout, the counsellors made time with the mothers to focus on, observe, think about, and interact with their babies while they looked on, implicitly encouraging this behaviour. There were many examples of how mothers would report on their infants' and their own achievements since the last visit. These would range from how a mother became aware of when her infant needs to urinate or defecate and letting her do it in a little potty, the infant's new front teeth, infants who had just learnt to sit on their own, the infants' weight gains, acquisition of new clothes, how an older child had been taught to hold and talk to the infant, initiatives taken to sell vegetables to create income, a successful trip home. It became very important for one mother, (H3), to maintain standards at home and not disappoint her counsellor whose judgement was considered important.

...Some ask why I always wake up early and clean the baby and I tell them that my counsellor can visit anytime and I would not like her to find us dirty. At least one of us must be clean, she can see that I am working. (H3)

6.3.5.2. Witnessing the negative

There were quite often threatening, abusive or neglectful situations that prevailed in which the counsellor's presence and authority seemed to provide a protective function for both the mother and her infant. The counsellor's watchful eye seemed to represent an external locus of control where there was potential for abusive behaviour in the families. Despite representing a superego, conscience or policing function, the mother's experience of the counsellors "knowing" or witnessing was felt to be benign. It felt helpful in holding and bearing the unmanageable impulses in mothers towards their babies and partners towards their partners. Both mothers and partners were appreciative.

6.3.5.2.1. Partners as offenders

Many couples in the cohort experienced conflict in their relationships, and mothers felt good about being asked about their relationships with their partners and whether they were being treated well. It seemed that the counsellors' visits improved this situation. Mothers told the interviewer that the counsellors' "knowing" helped to contain and manage the angry feelings and behaviour and provide protection. Mothers seemed to think of counsellors as their allies and were thus more easily able to assert themselves in their relationships.

A mother in the group reported:

...She (the counsellor) always asked how the baby's father was treating us. Then you tell her your problems. Yes, he gained something. Fortunately the counsellor always found him at home

during the visits. She talked to him and wanted to find out if he is taking good care of us. She asked everything about our life. So, he also knows about these visits and that anything that happens in our house will be known. ... He was also satisfied with these visits (fg2).

The notes revealed how mothers (E1) and (E3) spoke openly of their anger and disappointments about their partner in their presence. At the first antenatal visit mother (E1) told her partner that the counsellor was there to look after pregnant mothers and their husbands. The counsellor felt that she was being used by the mother to reprimand her partner. By the second visit he had been to look for a job. The counsellor recognised the struggle the mother was experiencing and decided to take on a more mediating role which included taking an interest in, and supporting the couple.

Even though the counsellor never met the partner of mother (E4), she would repeat to her partner what she had been told by her counsellor and, according to the mother, he stopped his attentions towards other women. It seemed that even the “invisible” observer who “knew” seemed to help the offending partner to think about what they were doing.

Three mothers spoke about how the presence and interest of the counsellor seemed to prevent problems that might have arisen between them and their partners. One spoke of how her partner asked her each time what she and the counsellor had talked about. She felt it was important that he knew that she had someone to whom she could report his wrongdoings:

...He asks what we talked about and I tell him. She used to ask whether he is maintaining us, I tell her that he gives me so much, which is not enough. Then he gives me more money when he knew that my counsellor knows how much he gives me. ... Somebody (the counsellor) who care about me, to whom I can report him when he does wrong things. (T2)

Others felt certain that their partners took care of them because there was a supportive adult who kept an eye on them. One mother reported that after the visits she would tell him that the counsellor had asked:

... How you are treating me and whether you are looking after the baby. He also realized how important these (visits) are, if he did not do things for us. I have an adult who is there to support me. Maybe, if I did not get these visits he was going to neglect me and the baby. He is looking well after us. ... He realizes that if I experience problems, I've got somebody to talk to. (T5).

... even when I had a problem I could talk to her about it, maybe a problem with my partner. She talk to both of us and he would listen. (T1)

A third felt that while her partner had his mother as his ally she had the counsellor. As a result, he behaved better:

...When my counsellor started visiting things changed. Now I have settled. I say, yes, I have a parent now just like him. (D3)

Even the partners were appreciative of the counsellor's watchful eye.

...My husband said that this counsellor is doing good things because I tell her what worries me with him. When I threaten to tell my counsellor what he did, he would say that he won't do such a thing to me. (D3)

6.3.5.2.2. Mothers as offenders

It would seem that mothers felt sufficiently valued that even when their behaviours were challenged, this tended to be viewed as concern from a benign authoritative parental figure.

The counsellor believed that one of her mothers (E1), having left her children unattended and risking them getting hurt, had felt embarrassed that her neglect had been witnessed, yet despite this, she felt sufficiently accepted and supported that she could continue to trust, and confided in the counsellor. When interviewed, she described:

...Sometimes she would find me in a good mood, sometimes I would not be right. ...From the beginning I felt comfortable with her. (E1)

When the counsellor observed the increasingly lethargic, withdrawn and regressed behaviour in the infant of one of her mothers (D1), who seemed quite out of touch with his needs, the counsellor believed that her work was to bring the real infant into the mother's focus and consciousness. She suggested to the mother that her infant needed to hear her voice. This process seemed to create some awareness that had been lacking in the mother, and she was quoted by the counsellor as saying, "My poor baby ... maybe I'm overprotective ... not spending enough time with him." When interviewed she also admitted to being a "rough person" and having hit and shouted at her 5 year-old. It seemed however, that while she continued to struggle to find alternative ways of disciplining her child, she seemed to have developed some insight. She realised that she was transferring the anger she felt towards her husband unfairly onto her child. When interviewed, she said:

...I used to feel free to talk to her about the problems that I had and be able to take control of myself, she helped me you know. (D1)

The firm stance taken by one of the counsellors at the very beginning of her visits with mother (T2) in the context of abandonment must have been experienced as containing rather than punitive as she was later, of her own volition, able to contact the counsellor for visits to continue. Sufficient grounds for a caring and concerned relationship had been established in the first visit.

There were times when the counsellors felt that mothers needed to be cautioned as they were not acting in the infants' best interest. One young breastfeeding mother, (T4), decided to offer her two month old infant formula that caused the infant's stomach to become "tight", constipated and painful. She had been thinking of using a syringe to give the infant an enema. The counsellor cautioned her, and assured her that

she had plenty of milk, and that it was unnecessary and too early to start the baby on formula. The mother agreed to continue breastfeeding, and at the interview described how the counsellor's interest in the infant:

... Made me feel good because there is someone who is checking the baby. (T4)

It seemed that the counsellor, in representing the needs of the infant, was appreciated and furthermore, left the infant's mother feeling cared for.

There were times when signs of mild neglect such as infrequent nappy changes that lead to nappy rash for the infant would be witnessed. Even when there was some awareness on the mother's part, this needed to be brought to her attention.

...She told me the cause of the (nappy) rash is that I sleep at night and not change the baby. (H1).

The counsellor's notes describe how, from the second visit, she had felt concerned about the insensitive attitude and rough handling of an infant of a HIV positive mother who lacked insight and information and seemed to be acting out her own frustrations and anger. The mother openly reported on her behaviour and seemed to need the counsellor to know how out of control she felt. The counsellor felt that while this mother needed support, her behaviour also needed containment. It was necessary, several times, for the counsellor to communicate her concerns about quite aggressive overfeeding with inappropriate food. This was a sensitive issue however as this mother was HIV positive and no doubt anxious to have her infant well nourished to give him a better chance of survival. At first, the mother disagreed with the counsellor or would joke defensively about what was being said to her. The counsellor needed to repeat herself often, and this process proved difficult for her. One would imagine that in some way, the frustrations experienced by the counsellor reflected the experiences of both mother and infant. Over time, the mother seemed more able to absorb the information and to hear, accept and understand more of what the counsellor was saying. This was an aggressive and undermining experience that the counsellor had to survive in a mindful way while caring for and containing the mother.

6.3.5.2.3. Intervening with others

While it was important not to undermine or alienate family members, particularly those who represented important resources for mothers and infants in the family, there were certain traditional practices which the counsellors questioned. Since the counsellors carried authority and wisdom in the community, they were able to address and discuss these practices with those concerned. For example, a mother-in-law of mother (E3), having used the ash of burnt maize cob on the infant's cord, feared that the counsellor would scold her, so went outside when the counsellor arrived. The mother explained:

...The counsellor called her and talked to her, saying that they are not against traditional ideas, they agree with them. ... She told her (paternal grandmother) not to run away, to join us as we talked. (E3)

6.3.6. The relevance of information, advice and skills development and modelling

6.3.6.1. The value of knowledge through information and observation of infants interacting with counsellors

When interviewed, many spoke of how little information they had had and how little they knew of what was required practically to manage an infant. They felt they had acquired important information which made sense to them and which they felt led to changes in the way they managed the basic care of their infants and the way they perceived their infants needs and behaviours.

While the mothers did not specifically mention the value of observing their infants being assessed and interacting with the counsellors, the counsellors' notes repeatedly refer to how amazed and excited parents were to observe and realize the interactive and communicative capacity of their infants. This opportunity to observe and think about their infants was perceived by the counsellors to be a powerful source of knowledge for new parents.

During the assessments, the counsellors were available to demonstrate infants' sense of agency and communication of needs, to answer questions and to provide information and discuss issues.

...If you have a question, they help you and answer it for you, if there is something that you are not doing right with the baby, you get enough knowledge to bring up your child. (fg1).

... We talked about interesting things. I learnt a lot from them because I did not know about some of the things. ... When she explained them to me I could understand them. I learnt a lot about my baby and about family life. (E2)

...They can suggest what to do. ... I found them helping me ... they helped me in a number of things that were problems to me. ... They were right for me. My counsellor told me good things.... We used to talk about them and discuss them until she leaves (left). (E4)

... About the baby she helped very much. all the talks and guidance (of the counsellor) were what I needed to hear. (D1)

... What she told me about was new. ... I realize that it (what the counsellor advised) is the right thing. (D3)

The provision of information on the basic care of infants:

...What was valuable is that they taught me about my baby. I did not know how to look after my baby. (fg2).

...They taught us how to manage our babies. I did not know how to manage my baby, they taught me. I was going to look after him the wrong way. (fg2).

...I found it (the knowledge) helpful how I manage the baby. (E1)

... Knowledge and information because there were things that I struggle with. (D1)

...This is my first baby. I did not know anything about babies. The counsellor came and told me how to care for the baby, how to wash the baby. ... I felt good about the things that she told me because I knew nothing about babies, I learnt from her (the counsellor). (D2)

...I thought that I would not be able to love this baby. But now because of the teachings I got here I was able to love my baby ... (D4)

...I thought that the knowledge that they gave me was useful I did not know a lot of things. (T1).

...I did not know about some things. Her ideas were helpful. ... They have changed my thinking because I did not know that after feeding the baby I must help him burp.... I can see when a baby is neglected or not. Because I have the knowledge of how to care for babies. My counsellor taught me. (T2)

...I learnt about a lot of things. (T3)

... When she (the counsellor) comes I would ask her what I need to know and she will give me information. ... She used to tell me many things about babies[2] ... I used to think that it is difficult to care for a baby but I know it's easy if you have information. (T4)

...What I valued most in them is that they give support and knowledge about babies. She taught me ways of caring for the baby, and how to hold the baby. ... (which I) found helpful is that I did not know how to handle the baby, ... [(T5)

...I found it very useful. ... sometimes the baby would have a rash and I would not know what caused it. I have not been waking up at night (to) change her yet this is what made her to develop the rash. ... Now I am able to see things. (H1)

...She gave me new knowledge and I appreciated it. It was very useful because now I know what to do when she cries. ... The difference is that now I know when she is her normal self, I know when she is sick. (H2)

...I can say that when I notice something from my baby, I think what am I going to do. I think of the knowledge she gave me and apply it, then I feel good. ... playing with the baby and talking to her. I valued them (visits/counsellors) because during the visits I get information. They really helped me. (H3)

... I feel that she is helping me to understand many things ... I don't want to tell lies, I was not going to cope washing her, and my counsellor taught me.... What was helpful was teaching me

about feeding the baby because I would just feed her and lay her down, maybe she would choke and die. ... I take good care of her and make sure she is ready to lay down after feeding. (H4).

It was helpful even for experienced mothers:

...I found them very helpful; they are good for my life and my baby's. ... I realized that I was ignorant for a long time, even though this is not my first baby. (D4)

For many mothers, the concept of emotional needs in infants was new. They were not aware that infants required to be played and communicated with:

...What was valuable is that they taught me about my baby. ... I did not know how to love my baby and this is very important. (fg2)

...She would say I must breastfeed him, play with him and make him happy. When he started sitting, she said I must not make him sit because he was still very small. ... She said I must teach him how to play with toys. (D3)

...I did not know that I could talk to my baby when she was small. They taught me that, things I did not know. ... Yes, she taught me a lot. (T1)

...I knew nothing about babies ... I left her to cry at night when I lived at home. .. I used to cry too because I did not know why was she crying and nobody seemed to care about me. When the counsellor visited, I told her that this baby cries at night., yet I don't know why. I cry too because I don't know what to do with her. ... She taught me a lot about babies. ... The baby is growing knowing her mother cares for her. (T5)

She was talking here about a potentially dangerous situation which might have spiralled out of control. The counsellor gave advice that might have been experienced as stressful by some mothers, but mother T5 expressed appreciation for the information and advice she was given.

She went on to describe that:

...Before they start visiting and teaching me, I was just going to feed her (baby) and put her away, not giving attention to her. I was going to rush off to wash the napkins outside. My counsellor taught me that after feeding the baby I must play with her until she is sleepy. I must wait until she is sleeping before doing the house chores. I must not leave the baby crying alone. (T5)

Mothers felt they had become aware of how their own behaviour and emotional states affected their children.

...I used to have lot of problems that I could not solve and that could also affect the baby, even the older child has palpitation, people are saying it's because he was affected by what I was feeling, being unhappy just like this one. (D1).

The mothers described how, in their minds, their infants became real, needy, emotional and sentient little beings. This in itself represents a significant change in the way babies are thought about and therefore treated. When this happens, it is less likely that mothers ignore, neglect or abuse the emotional needs of her child in the future.

6.3.6.2. The mothers' responses to practical and directive advice

Care not to be prescriptive and give advice when counselling was linked to a belief in the capacity of people, when given the space to reflect, to act in their own best interest. We wished to discourage mothers' dependency on experts, and encourage and enhance their sense of agency, confidence and self-esteem

While counsellors, throughout the training and supervision, were actively encouraged to remain client centred by following the client's lead, listening and provide information appropriately, there were many occasions when a very directive and prescriptive approach was adopted.

... She advised me what to do. (H1)

The notes and the interviews all seem to suggest that advice, on a variety of issues, had often been sought by the mothers and appreciated when received. Most mothers did not distinguish between being given information or advice as both were experienced as helpful and valuable.

...I could talk to them about my problems and they advised me. (fg2)

...I could talk to them about my problems and they advised me. (fg2).

...What I found really helpful was their advices that they used to give me. ... When I have a problem I could talk to them and I would get their advices of what to do. (E2)

...I got advices and found them helpful. They talked to me when I have argued with my husband. (E3)

...I felt good, I told her my problems (with partner's drinking)... I wanted her advices. She would advise me how to handle this. ... What I valued was ... When she visits she advised me about the baby. (D2)

...These visits were valuable because they gave us advices on how to care for your baby. (D3).

...I was happy because I got advices from her. ...Like how to care for my baby. (E3)

...She advised me on how to care for my baby: what to do when she cries a lot, what to do when she needs something. ... I feel all right. (H3)

*...She showed me what to do when the baby has a temperature and I could see that she helps me.
(H4)*

Problems seemed more manageable:

...Felt different from before. ... they gave suggestions which made me feel that it was not too difficult getting food. (fg1)

Receiving advice was strongly linked to feeling cared for:

...She helped me because whenever I had a problem, I talked to her and she solved it, she would advise me and say do like this and this. ... They would have to advise me because in my home nobody seems to care about me. Even my mother-in-law could not advise me, she just let me do whatever I wanted. So, when my counsellor visited, I was happy. She advised me with some of the things, my mother-in-law was supposed to have advised me. But an outsider advised me. (E4)

The effect of change following advice was also experienced as profound:

...I felt a change in me because she gave me advice ... like how to care for my baby, feed her and wash her. ... Like, in the way I thought about the baby before I had her. (H2)

Sometimes the advice given by the counsellor directly contradicted what the mother had been told by another resource but was experienced as more useful:

I had a ringworm that was in my nipple and my baby did not want to breastfeed. I went to the clinic and the nurse told me to force the baby to suck so my counsellor told (me) not to force him and it worked for both of us. [5] (T4)

Advice seemed to be unquestionably accepted, but the mothers seemed to evaluate the advice and know whether it was right for them or not. It is also evident that advice was only one of several offerings and approaches used by the counsellor in any interview. The notes describe how the counsellors would offer a variety of inputs. They listened, explored, provided information, explained processes, observed the infant and mother, demonstrated useful strategies, modelled interactions, challenged beliefs, attitudes and behaviours, expressed care and concern, referred to other resources, and encouraged the mother's attempts at finding solutions.

6.3.6.3. Learning through modelling

While not specifically noted by mothers as a valuable method of learning, there were countless observations by the counsellors of mothers, siblings and others interacting with the infants in ways modelled from their interactions with the infants.

A mother had found it useful when the counsellor modelled an interaction with mother's 5 year-old son around his fears of his infant brother needing an operation in the hospital. This enabled the boy to talk

about his fear that his brother would not come home (D1). The same mother told the supervisor how, observing the counsellor interacting with her infant, had helped her to interact differently with him too. She was better able to talk and play with him more often.

The notes describe how the counsellor encouraged mother D4 to approach her son about his depressed state of mind. At the interview mother D4 said:

...She helped me with my children. She said I must make time and talk to my child and find out what the problem is. I talked to him and asked the reason for the change in school performance. He said: "I would be in the middle of writing and just think about the fact that I don't have a father and I don't have money for lunch" ... She (counsellor) said I must talk to him and reassure him that even if his father is not there I will always be there. I did that and he has been fine. (D4)

One mother (E4) described how through watching the counsellor interacting with her infant, her mother-in-law's increased support and involvement with them was facilitated:

6.3.7. The value of support, encouragement, normalizing and reassurance

Ultimately, the aim of the intervention was to build confidence and improve the self-esteem of mothers. All the mothers interviewed spoke of having felt supported by the counsellors whose presence was experienced as support in itself:

... (in her presence) I used to forget about the problems that I had in my head (her beliefs and the voices). (D1)

... when I met her I did not have support of an adult. My counsellor is the only adult who helped me. (T5)

Encouragement was the one consistent skill in which all the counsellors seemed to excel. They reported constantly pointing out instances of positive, self-reliant, sensitive and non-intrusive behaviour. In each supervision session the expression, "I praised her for that" was frequently expressed. Any instances of sensitive, attuned, non-intrusive communication and other responsive interactions by parents when interacting with their infants was therefore observed was noted, commented on and encouraged. Examples of such behaviours included: showing interest in what the infant was doing (E2), encouraging the father's involvement (E4), deciding to breastfeed exclusively (E4), noticing the babies individual traits (D2), the couple supporting one another (T1), expressing love and warmth to her infant (T1), interacting in a sensitive and mindful way with her infant (T3), showing interest, kindness, and reporting what her infant can do for herself (T4), interacting playfully and gently, talking with her infant and giving herself time to provide her infant with a full feed (T4), being responsive to the needs of the infant and the father's participation in the infant's care (T5) continued attendance at the HIV support group (H1), being

observant of her infant's responses (H2) and supervising the play of other toddlers with her infant on the floor (H3).

This was supported by the mothers interviewed.

...She showed me and encouraged me because I did not know these things. (E3)

... My counsellor encouraged (me) to show my baby that I love him. (T2)

...I could see she was encouraging me because I did not know what to do. This encouraged me because I had someone to help me. (H1)

Normalising the mother's situation and experience was experienced as supportive and helpful by a young mother (T5) who found her baby's crying distressful and worrying:

Mothers expressed feeling reassured that the infant's development was on track and normal and by implication that they were succeeding as mothers:

...They came to check the baby, whether he has no disabilities. They were doing things to the baby to show that he is really right. (fg2)

For anxious mothers the reassurance was containing and calming:

...She would talk to me saying I must not worry. I must wait for the day of my contractions. (D4)

6.3.8. The value of material assistance and referrals

6.3.8.1. Material assistance

In this very deprived community the decision was specifically made not to provide food or clothing as part of the intervention. There were organizations that were specifically funded and involved in food distribution in the community, and we knew that providing food and clothing would have significantly changed the dynamics of the intervention as well as the attitude of the community towards the project as a whole.

There were times, however, when material help was necessary and financial assistance was offered. These were situations which impacted directly on the mother's ability to care for her infant, such as when mothers needed to get to hospital but had no fare for the transport. The decision to provide materially was taken by the group of counsellors and the supervisor at the weekly meetings. It was later discovered, however, that on several occasions food or clothing had been quietly and secretly donated to very needy mothers. It was clear that the counsellors found the level of poverty and deprivation with which some families struggled so difficult to witness that they felt compelled to make a plan to provide some of their basic needs. They also found creative solutions, for example they would approach mothers with older

babies to donate clothes that would be recycled to the very needy mothers in the cohort. Examples include:

...I had prepared clothes for one baby. ... I did not have money to go back to hospital to fetch the second baby. The counsellors gave me money for transport to hospital so I could be with my baby. (T2)

...She would bring me something to eat. ... She brought me some (curtains). I realised that I have found a real friend in her. (H1)

In recognition and appreciation of the time and effort given, the mothers were offered small gifts appropriate to the age of the infant each time they attended the regular research assessment sessions at the research unit. These items included soap, shampoo, a box of cereal, an item of children's clothing, etc ... Some mothers spoke of the appreciation they felt for these 'gifts'.

... When the baby was one month ... I was given baby food and clothes. Things that I did not have. (E1).

... It was much better because I never struggled. ... I received baby's needs.

... You don't even have soap to wash the baby. You have to beg from the neighbours. My neighbour was really struggling. I could see that. ... I was in a better position because I got many things. (E4)

... What I found most helpful is that when I realized I was pregnant I did not know where I was going to get things for the baby. I got soap, powder and Vaseline for him. (D4)

... For me they (the assessment visits) are helpful because you even get clothes for the baby. For example, one is pregnant and the partner disappears, she would get help with the baby's needs, like food and babies clothes. (T3)

6.3.8.2. Referrals

The counsellors did not see themselves as experts except in their area of training. In these areas they would speak with authority. They were, however, often confronted by requests by mothers for help with common problems such as colic about which they felt they had limited knowledge. Although they had opinions and attempted to think through the issues using the behavioural assessment of the newborn, they often referred the mothers to other community resources for assistance, such as breastfeeding counsellors and medical practitioners.

Often with mothers struggling with babies crying as a result of colicky pain and wind there was a sense of powerlessness and helplessness and a tendency to refer mothers to "Oomama Womoya". These were women in the community, whom the counsellors themselves had consulted as young mothers, who were

known to have knowledge of mixtures based on old traditional Dutch remedies still sold over the counter to the public. It became clear that these women needed to be recognised as a resource in the community despite some concern that they might, at times, provide mixtures that mothers would give their babies as prophylactics, maybe unnecessarily, before any sign of wind or colic emerged.

... What was really useful is when she advised me to take the baby for wind attention. I did not know anything about windy stomach. She even told me where to go. So I took the baby to this person who made me a bottle of medicine which helped him until now. (T3)

For many amongst this cohort counselling was a foreign concept. Traditionally most of the women did not speak of their struggles even within the family. There was thus no initial appreciation of the value that counselling offered as a space to talk, think and be heard. It was hoped that offering this to mothers might open up the potential for them to value this skill in communication and, in turn, offer their children such a space when they express the need. We see from the data, however, that the recipient mothers did not readily take up referrals for specific personal difficulties they experienced, despite the resources like marriage and parent guidance counsellors, which were offered and were easily accessible within the community.

6.3.8.3. Advocacy

The counsellors were perceived as people with status, who had information, who understood the system and knew how to make things happen. An aspect of the supportive role at times when mothers felt they had no voice of their own, required the counsellors to speak on behalf of the mothers, or to coach them to speak for themselves. Mothers were often treated with disrespect and frank abuse by the officials whom they had previously approached.

...I wish that somebody of known status, like our counsellors, would be there to support you, it (applying for grants) would be quicker and easier. It takes a long time. ... If these visits help our babies get grants, that would be helpful. They can suggest what to do. (E4)

The counsellors, at times, spoke to partners, family members, neighbours and officials, and in that way gave mothers' needs legitimacy:

I have brothers who are abusing alcohol, they (the counsellors) talk to them so that they stop making noise and let me rest. (fg1)

One counsellor played an important reconciliatory role when she interceded for a young mother (T1) when the maternal aunt refused to give back the clothes belonging to the infant that she had taken. There was no available older adult who could help her, and this influenced the counsellor's decision to act on her behalf.

Another stepped in and liaised directly with the hospital to establish what had happened to one of the twins a mother T2 had abandoned there.

At times like these, when the counsellor felt the need to step in more actively and directly, sound clinical judgement was required with respect to what an appropriate intervention might be. It was important to keep in mind not to encourage undue dependency or undermine the mother in any way. For this reason regular access to supervision was important.

6.4. Straddling the cultural divide

For many years amongst more liberal social activists, largely in reaction to the previous colonial oppression of other cultures, came an awareness for the need to have a far more tolerant and respectful approach to difference across cultures, and an extreme reticence in challenging anything “traditional” for fear of being guilty of prejudice or disrespect. However, it soon became clear in our work that the use of the term “traditional” was at times being used to justify the continuance and entrenchment of power relationships that were frankly damaging, particularly to women and children, and this needed to be addressed (Tomlinson & Swartz, 2002).

The original intervention, although moderated to accommodate language and culture, was based entirely on “Western” knowledge, research and practice. The awareness that this would, at times, challenge some of the traditional beliefs and practices held by many of the mothers made it imperative for counsellors to straddle these two different worlds. They were required to be able to keep in mind both the traditional, cultural beliefs and offer new information in ways that were sensitive and respectful and allowed for questioning and discussion.

Belonging to the same culture provided the counsellors with some knowledge of the traditional way of doing things and what needed to be respected. The way they introduced themselves, greeted the family and entered the home was important in order to establish a connection with the mother and broader family.

6.4.1. The mothers’ experience of exposure to new and foreign ideas

With the rapid migration and urbanization taking place on the outskirts of the cities, the traditional customs, structures, practices, knowledge and support previously provided by extended family structures for new parents around the birth of a baby was no longer easily accessible. The input provided seemed to fill an information gap for many mothers:

... These days, there are few traditional ideas to follow. (H3)

The training encouraged the counsellors to respond sensitively to the more benign traditional practices, even if the counsellors did not agree with them. For example, some mothers had a rather intrusive habit of squeezing the cheeks of a yawning infant. The counsellors themselves had had to become aware of this as being quite intrusive for infants, and had needed some time to change this habit in themselves. Once brought to the attention of mothers, they noticed how mothers became more aware when they were doing this.

Traditions that were helpful were encouraged. One mother states,

...They (the counsellors) also brought traditional ideas (fg1).

When practices were potentially harmful, however, mothers would be provided with information, advice, and encouragement to find alternative ways of responding.

One of the questions that concerned us was whether the recipient mothers, many of whom held traditional African beliefs, and relied on traditional practices and remedies, experienced this intervention and new knowledge as undermining, and/or conflicting with these beliefs and practices. There was also some concern about whether these mothers who had so little would just passively absorb whatever they were told without questioning the value of it.

All spoke of having been exposed to a lot of input that was new and foreign, yet the majority expressed appreciation for new ideas and felt that the information and observations brought helpful understanding and did not represent a conflict with their own beliefs.

...It was right that she showed me... I felt good about the things that she told me because I knew nothing about babies, I learnt from her (the counsellor). (D2)

... (I) did not know about some things. Her ideas were helpful (T2 ... it did not conflict with my beliefs. ... My counsellor came at a time when I knew nothing (T2)

...It was new to me because this is my first child. She gave me new knowledge and I appreciated it. (H2)

... Whenever she gave me information, I believed in it because I did not know what to do ... I took the information with the belief that it will help my baby. I am never against her advices, thinking that it won't help, I follow it and it helps, and it helps a lot. .. It is similar to when a baby is sick and you take her to the clinic, you will get new ideas. (H3)

The information was not felt to contradict cultural beliefs:

...There was nothing in what they told me that was in conflict with my beliefs. ... everything she told me was right. (H4)

... None (no information) was in conflict with my beliefs. (H2)

Information seemed to be presented in ways that involved and engaged mothers in evaluating what they were being offered:

...Some ideas were new to me, some unfamiliar. There is nothing that (I) did not trust because she brought new ideas in such a way that made me realize this does happen... .. she had a good approach. (E1)

...She did not bring things that I had to do. She started by showing you until you are clear and decide it is the right thing (for you). (E2)

...What she told me was new. ... She used to explain that if I don't believe in this, I must report (this).... So that she can explain more. (D3)

... They (ideas) were not imposed (on me). (D2)

...I never felt they (information) were imposed on me. (D4)

...These were new ideas but these were never imposed on me. (T1).

...No (foreign ideas were not imposed) she came and advised me well, she even listened to my mother's suggestion because she is older. (T3)

...It was new to me because this is my first child. She gave me new knowledge and I appreciated it. ...She has never imposed a single idea. We talked about things and she gave me this information in an acceptable manner and it was easy to follow ...She (the counsellor) would tell me that I have a choice to do it. Like, I did not feel I have to do them. She would never say if the baby has fever you must do this and this. You do what you think is right. (H1)

...She has never imposed a single idea. (H2)

...I have not experienced it ... like they are being imposed on me. (H3)

6.4.2. The negotiation of differences between the traditional and western “knowledge”

There were mothers who found themselves trapped between different cultures and this placed competing demands on them. As a result there was a tendency to use a mix of whatever felt helpful at the time.

The cleaning of the newborn's umbilical cord with a burnt maize cob was one practice that was questioned and the alternative of using surgical spirits was suggested.

I heard that you must burn a maize cob, grind it and use it. I asked my mother-in-law about this idea of spirit and she said it is the right advice. I asked my counsellor about what I heard about maize cob. She said yes, it is also used. She did not impose these ideas. She came and suggested things like spirit (surgical spirit for the cord). I did not really like this because I know that spirit can be painful. That is why I decided to ask about it. She did not force the idea on me. (E3) This quote was used earlier to make a very different point, hence the repetition.

The process of transition associated with migration often confronted couples with pressure to shift their focus from extended family allegiances to nuclear family allegiances within the context of limited financial resources. This brought its own conflict. One of the mothers (E2) was distressed as her husband,

as tradition dictated, had assumed financial responsibility for his sisters without involving her. She had brought it up with the counsellor who seemed to support her but also to take on a mediatory role:

Traditionally many ills were ascribed to “bewitchment” by a malevolent source. Once a belief that bewitchment was at play the counsellors found it very difficult to offer an alternative meaning of the problem to the family. ‘Bewitchment’ and ‘evil spirits’ explained such diverse problems as babies crying, experiencing painful wind, hernias, and not sleeping at night.

The simultaneous use of “muthi” and Western medication was another issue mothers presented with. A complex situation concerned a mother who was generally understood and accepted by her family, the community and the counsellor as being ‘different’. She, as her own mother before, experienced “amamfufunyane”, in which she heard voices and believed her infant’s abdominal hernia was the result of witchcraft. There were periods of rationality interspersed by confusion and paranoid thinking in which she resisted medical explanations for problems. When interviewed she affirmed that she never felt ideas were forced on her and provides evidence of the counsellors respect, acceptance and support:

... She never forced me, she used to say I must do what I feel comfortable with. I did not come here to force things on you, I am here to support you with the baby. (D1)

However when asked specifically whether she was able to tell her counsellor about her traditional beliefs and remedies she replied that there were certain things she would talk about such as, “the drinking medicine”, but others not (this mother believed that if she did not drink the traditional medicines and take a steam bath she could have carried her baby up to 15 months). The mother stated:

... She is more or less like a social worker so she was not going to agree with me about the steam bath, and I believe in a traditional medicine. ... (for example) She said I should wait (for) the doctors to tell me what is wrong. (D1)

This mother seemed to understand the frame within which the counsellor worked. She was able to accept the support she was offered yet still able to practice her traditional ways albeit secretly at times. She selected and took what she wanted from both worlds. The counsellor, on the one hand, encouraged the mother to seek Western medical help, yet managed to accept and hold both parts of the divide. There were times when she had to hold onto quite anxious feelings about the possible harmful effects the traditional ‘muthi’ might have on the infant.

The mother herself was also torn between her family in the rural area warning her not to allow her infant to go to hospital and undergo an operation. They believed, as she did, that it was the work of witchcraft and that if he went to hospital he would die. The counsellor had to work very hard to support the father and his family in encouraging and reassuring the mother that this was necessary, and that the infant would be fine. Eventually the mother gave her reluctant permission, and the operation was a success.

A counsellor's notes described how a mother (H3) positively diagnosed with HIV was admitted to a local hospital for a swollen and painful stomach but was immediately released by her aunt who believed "they kill people there" and taken to a Sangoma who worked collaboratively with the hospital and was able to help her. She continued to follow the treatment prescribed by the Sangoma as well as medicines prescribed by the hospital doctor to boost her immune system and supported by the counsellor.

6.5. What improvements were suggested?

The mothers were told that their feedback would be helpful in informing improvements to the intervention.

6.5.1. When should the visits begin?

All 17 mothers expressed the belief that visits should begin, when possible, earlier in the pregnancy. Suggestions as to when the visits should begin included: whenever the mothers were recruited (T3), in the early months of the pregnancy (E1); at one month (H1); 4 months (E4, D3, D4, T1, T2, T5, H2), 5 months (H3); and 6 months (E2, E3, D1, D2, T4, H4) of pregnancy.

It was felt that with earlier visits:

i) Desperate mothers might be prevented from acting on destructive thoughts that might harm herself or the infant:

... (because) one may have relationship problems during pregnancy and may think of doing something. ... even start drinking. She might want to do wrong things. ... when she has a counsellor, she will never have such thoughts. ...they should start the visits as early as two months. (E1)

ii) The exaggerated feelings during pregnancy might be better contained and managed:

... Maybe at 6 months. When you are pregnant, your thinking tends to be slow. If you had somebody earlier, I hope everything will go smoothly ... a pregnant person is like a child. Sometimes she thinks too much. Even a slight problem she takes it seriously. (E2)

iii) Mothers would be better prepared for the birth and early motherhood:

...Maybe (had) they started when I was 8 months, I was going to miss out. Maybe I was going to know only a few things. ... As the months progressed I was informed already. (E4)

...For some people it is their first pregnancy and they don't know what pregnancy is. So, the counsellors would be the ones to tell them to go and do the bookings. They will explain why they have to book. (D4)

*...Because I could have obtained a lot of knowledge. A lot more than I have. ... About the baby.
(T1)*

...Young mothers do not know what to expect in pregnancy and after giving birth, they do not know when and where to book and attend antenatal classes. Counsellors would tell you what and how to do things. (T5)

*...People should get these visits as early ...So that by the time you give birth you know everything.
... Maybe when ... you have a big problem and you feel like talking about it in early pregnancy.
(H1)*

iv) Mothers could be informed and referred to appropriate services earlier:

... You get a lot of information on where to go when you have a problem that they cannot deal with. (D1)

... Some people are sick, so you need information ... sometimes you don't get what you want from the hospital, the counsellors give you options. ... I was a sick person, I had high blood pressure and my counsellor used to encourage me to take treatment. (T4)

... We have problems in our pregnancies and we don't know where to go or what to do. Sometimes the clinic is a distance from where you live and you feel going to the clinic will take too long and you need help right now. ... She advises you in a good way, I think there are things she could have helped me with early in my pregnancy. (H3)

There was recognition too that mothers often book in late. This is a problem for HIV positive mothers who need treatment to begin at eight months:

...They only do it (book in) just before they deliver or when they are in labour. It would be better if one would know at four months. ... there is HIV, a person must know in time ... Because at eight months she has to take AZT. (H2)

One of the problems was that some mothers did not recognise that they were pregnant.

...I did not know that I was pregnant ... I visited my mother ... and she was the first person to notice. ... At the clinic they told me I was six months pregnant.” (H4)

6.5.2. When should the visits end?

All 17 mothers were unanimous in their belief that there was a need for ongoing support and that visits should continue beyond the first six months.

A mother pointed out that although she had learnt a great deal about her first infant, all babies were different, and that if her second child was born with special needs she would find it equally difficult, and would appreciate the input of a counsellor once more (fg1).

One mother felt the need for ongoing input about children and believed there were no resources for parents in their community:

...They should continue beyond 6 months because we don't have people to teach us about children. (D2)

Seven mothers felt that visits should continue until the infant was at least one year. They expressed feeling concerned that they would not have sufficient information and know how to manage their children's new demands as these changed over time. Three examples of these sentiments include:

...They should visit until the baby is a year old so that they can see him as he grows. ... the baby is changing, (if visits continued) they will tell you what to do as he is developing mentally, do this and this. ... The baby is growing and no longer an infant. (E4)

...I am unhappy now that she had stop visiting me. ... Because there are things that you don't notice when the baby is small, they are more noticeable when the child is older, maybe a year could be better. (D1)

...They (the visits) should continue because the baby is still going to grow beyond 6 months. They should stop when the baby is a year old or 2 years old. As the baby grows, she is changing. (T5)

Nine mothers took it further, suggesting that support should continue until the children began school.

Three examples include:

...They should stop when a child starts schooling, when she is 7 years old. ... Because they can continue encouraging us, and give us advices as the child begins school. When she is at school the teacher can also help caring for the child. They can give suggestions to look after our children at home. (E3)

...Maybe until the child starts school. ... until 7 years. She will show me how to handle him as she showed me when he was small. She will show me as he grows, giving me advices. ... The child's needs change. I wish she could be here to advise me (now). (D3)

...I wish that they would continue until my baby begins school, at seven years. I say that because at least when the child will be older and at school there is health education ... here in the house, you don't have anything, you get it only when your counsellor visits and advises you how to deal with it. ... At school there would be another person so that when they teach about health she would know that she should not do this because it causes this. (H3)

One mother suggests visits should continue in accordance with need:

...They should continue, depending on each individual case. Like maybe when one has lost her mother and lives with her sisters who do not care for her. ... Some of us are ignorant, we don't know how the child will grow and start school. ... if he is visited until he starts school, mothers would get help about the information they need. (H4)

The quotes described the lack of confidence that many parents experienced as they face the changing needs and new challenges of the early years. The mothers clearly felt ill-equipped. They felt lost, unsupported and unsure about how to manage the hiatus between the counsellors visits and what they perceive to be the next definite available source of support, the beginning of school. The consistent message was that mothers needed ongoing support and information. Two of the HIV positive mothers (H3, H4) expressed particular need for health education, which they felt unable to provide alone. This might reflect a general lack of security and predictability about their future health and that of their infants.

6.5.3. What other changes were suggested by the mothers?

None of the mothers expressed negative experiences, nor felt that there was a need to change the content of the intervention. The changes that were suggested included more frequent visits.

...I was happy when she came to visit and wished that she would visit frequently. (E4)

One young mother (T5) was very concerned about the abandonment and neglect of children in her community and of the rape of babies and young children regularly reported in the media. She believed that abuse of alcohol, immaturity and a lack of knowledge and awareness and capacity to cope in young mothers played a role. She saw these visits as providing protection from such experiences for infants and would strongly encourage other young mothers to agree to such visits:

...Most of my friends in my neighbourhood do not care for their babies properly. They say they are frustrated and start drinking. The baby will grow up neglected and anything can happen to the baby. She may leave the baby anywhere or lock him in the house while she goes to have a drink. The baby may be raped, abused or may disappear. Another one may feel that this baby is such a burden, she might abandon the baby, not even give her away. We saw an ugly scene, a mother apparently strangled the baby. ... a person in her sober senses would not do this. I wish that the counsellors would visit them, these mothers would think twice. (T5)

She strongly believed that had that mother received the intervention, she might have been better able to protect her infant. She was also aware, however, that despite the need, there were mothers who would not necessarily be interested in such help, but felt that the counsellors were in a better position to offer help than they were:

... It depends on individuals whether they want to be helped ...we encounter problems in advising our friends because one does not see things the way you see them. (fg1)

A strong belief was expressed by a young mother that if there was a presence, a witness, in the community, interested in the wellbeing of infants and children, mothers and others would feel more accountable in ways that might break through the apathy and ignorance that exists, and would uplift the community. She perceived that the babies who were visited were more cared for and present in their mother's thoughts:

I can see that there is a change in those children that have had these visits. I notice that the mothers take better care of the children and they are kept clean. Some people are lazy and I would lie and say we are going to be visited today. I want them to quickly wash the babies and keep them clean. (H4)

Several mothers suggested that the programme should become an official state programme within more integrated services for families. The service should not be limited by geographical boundaries (D3, D4, T1, T4):

...I wish they would be under the government so they can solve any problem we encounter. (fg2)

Others expressed the wish that there was an accessible office in the community where they could consult the counsellors when needed (T1, T5):

...I wish they can have an office here so that when we have a problem you can talk to them. They are far. (fg2).

...I would like them to be in offices nearby so that they are accessible whenever I have a problem. I would just go to the office. ... I did not get her as much as I would have loved. (T1)

...There will always be problems. I wish there was a way of contacting them whenever you need them. ... If there was a place (an office) where we could find them when we need them so we can talk about our problems and about our babies. (T5)

Five mothers wished that the service incorporated assistance with access to grants for their children, the ill and the disabled. For example:

...If these visits help our babies get grants, that would be helpful. They can suggest what to do. (E4)

6.6. In summary

Despite the possibility that mothers might have felt the need to present a positive picture for the benefit of the interviewer, their responses indicate an overwhelming appreciation of the visits by the counsellors with whom they seemed quickly to have formed a positive alliance in which the counsellors were

experienced as surrogate grandmothers. They expressed feeling supported, attended and listened to. They felt kept in mind and protected, and appreciated the confidentiality maintained.

For some, their relationship conflict (with a partner) improved for the duration of the intervention.

With many, having come from a place of relative ignorance regarding parenting skills, they were grateful for the useful information and advice with which they were provided. They reported how their perceptions, attitudes and behaviour towards their infants' emotional needs and communications had changed as a result of the information they were given and through witnessing their infants' responses to the counsellors and themselves.

However, there were several instances when mothers seemed unable to maintain these changes in a consistent way and were observed behaving intrusively and insensitively towards their infants, while others seemed to struggle to generalize the principles learnt to other children and situations.

Mothers were aware that some of the ideas they were exposed to were new, but none expressed difficulty in accepting these. Several mothers felt desperate when first seen, but by the end were managing their difficult situations better with a greater sense of agency and confidence.

It became apparent that there were issues with which the counsellors particularly struggled, which seemed to undermine their ability to listen empathically without acting. These issues included instances of neglect, abuse or aggressive feelings towards infants from mother, and towards mothers from their partners or other members of the family, substance abuse by mothers caring for their infants, mothers struggling with poverty and a lack of food in particular, mothers who struggled to change their destructive behaviours, and the confrontation of loss and termination. While material assistance was not officially offered, it was most appreciated by mothers when it was. All the mothers suggested that the visits begin earlier and continue beyond six months and all felt there was nothing that needed to be changed in terms of intervention content.

In the following chapter I will discuss the implications of the data described above. The links described by the mothers themselves, as well as the links to the theory and the implications these results have for future application of the intervention and research will be explored.

CHAPTER 7

DISCUSSION

This study examined experiences of mothers and counsellors in a successful community-based trial of a psychosocial intervention (Cooper et al., 2009). The 17 respondent mothers were selected from an intervention group found as a whole to have significantly improved the quality of mother-infant relationships compared to the control group. Results showed that these mothers interacted with their infants significantly more frequently, more sensitively, less intrusively, and demonstrated more positive affect at 6 months. At 12 months the mothers remained significantly more harmonious, less intrusive and somewhat more sensitive. At 18 months the infants were significantly more likely to be rated as securely attached to their mothers (Cooper, et al; 2009; Tomlinson et al., 2006.). The current study is not a dismantling study which attempts to link specific inputs of the intervention to specific outcomes. As the title of this thesis suggests, the intention was rather, through the voices and perceptions of the parents, to look into what is seldom reported in outcome studies – the “black box” of process issues at stake in the design, implementation and management of this intervention.

7.1. Limitations of the study

Despite an attempt to achieve a sample broadly representative of the overall research sample, the results and knowledge gained can represent only the perceptions, experiences and opinions of the 17 mothers interviewed. The results of this descriptive analysis of a collective case study of 17 selected mothers, however, reflected sufficient consistency that data saturation seems to have been successfully achieved (Caelli et al, 2005; Hayes, 2000; Kelley, 1999). They offered us a deeper understanding of these mothers’ experiences, brought important process issues to light, suggested links to theory and provided useful suggestions for future interventions, research and the broader application of this programme.

One of the limitations of these interviews and reports may well be that the changes and behaviours reported by the mothers and witnessed by the counsellors may not be an accurate reflection of the mothers’ usual interactions with their infants when not observed by the counsellors.

Another limitation is that the voices of the counsellors are limited to their notes, supervision notes and the countertransference understanding of the clinical supervisor. To some extent a richer and more in depth investigation by the researcher herself was sacrificed for the sake of a more objective but less informed approach by a neutral interviewer who was not as aware of the potentially rich memories to probe. What is also missing in this regard is feedback from interviewer about her experience of the process.

A question that remains is that, despite the intervention having been a “different” and “valued” experience, to what extent over the long term this has been a “corrective emotional experience”, which has been able, sufficiently, to shift the implicit relational knowledge of the mother in any permanent way. We

are not able to say whether the changes that have been achieved in the parent-child relationship will, in the context of poverty and without the watchful eyes and support of the counsellors, be maintained over time. Although the theory and research suggest that even single brief encounters are sufficient for significant change to occur, it is likely, as previous research suggests, and as has also been implied by the mothers themselves, that these changes require ongoing support and input (Barnard et al., 1993; Daro, 2004-2006; Gomby, 2005).

Despite the opportunity offered to the mothers by the neutral interviewer that mothers should feel free to talk we should be a little suspicious that negative experiences were very seldom expressed and that overall responses seemed positively exaggerated. There could be several reasons for this. To begin with it cannot always be easy, in the context of deprivation, to know what one is missing, what is available, what one needs and, having no standards by which to judge, to criticise what one is given. While it is possible that the mothers felt intimidated by the interview situation or wanted to present as good and compliant respondents, it is also possible that the portrayal by participants of counsellors in a predominantly positive light may be evidence of positive therapeutic alliances having been established and one in which, believing the counsellors were being evaluated, the participants felt the need to protect them.

While particular interventions and issues seemed to have been remembered with clarity the details of visits (number, frequency and length) were remembered with varying accuracy, more often than not being overestimated. The mothers' inaccurate memory of the structure of the intervention may be the result of a combination of factors. The visits, in fact, followed a rather complicated structure and took place perinatally. This is a time when many mothers are likely to have been maternally preoccupied with their infants or when their anxieties about survival were such that logistical details about the intervention may not have mattered. The tendency to overestimate the length, time and frequency of the visits may reflect memories of a generally positive nurturing experience. The continuing presence of the counsellors in the community and their informal availability with the occasional "dropping in" may also have been experienced as an extension of the visits.

What we have not assessed was exactly what and how much of the fairly sophisticated knowledge about infant development was transferred by the counsellors to the mothers, and what was understood and retained by the mothers.

Due to the focus and limits imposed on this thesis I was not able to include the counsellors' perspectives gleaned from their interviews. This represents an important gap which still needs to be addressed.

7.2. Summary of results from interviews and process notes

7.2.1. What changed?

All 17 mothers interviewed believed that they had changed in the way they thought about and managed their children. Having observed how interactive and capable their infants were and having gained information and skills, they developed in their level of understanding of their infants' emotional needs, particularly the importance of building secure relationships, and the impact of separation and loss. They were more aware, thoughtful and more attuned to their infants' cues. Some expressed feeling better able to manage stressful situations, such as their babies' crying, without feeling overwhelmed. Many demonstrated affection and responded more sensitively in play and other means of communication with their infants. This was also observed in fathers, grandmothers, older siblings and others.

Improvements in interactions were, however, not always consistent. Intrusive, insensitive and, at times, even aggressive behaviour continued to be observed in some of the mothers.

Most of the mothers reported feeling happier and more confident following the visits and some spoke of being better able to assert themselves.

Conflict with others and support from partners improved for the duration of the visits.

7.2.2. What elements were valued and identified as having facilitated the process?

Without exception the visits were appreciated by the mothers and other family members. Certain elements of the intervention were particularly highly valued. These included being visited in their own homes as well as the counsellors' respect, accessibility, dependability and accommodation of the mothers' often intrusive and demanding circumstances. Mothers responded positively to the counsellors' neutral, accepting, open, non-judgmental stance, and the assurance of confidentiality, which quickly facilitated the development of trust and the freedom to talk, even about their "evil" and "mad" thoughts and feelings. Being heard in this way brought relief, particularly in the context of HIV/AIDS. One mother expressed how she had been "helped out of torture". Nevertheless, some behaviours and ideas felt too shameful to be shared and continued to be hidden by some mothers.

The counsellors were experienced as playing a caring and supportive "grandmothering" role to many mothers who expressed having felt lost and isolated. The mothers referred to them as "*my mother*", "*really a mother*", "*my only hope*" or "*your mother*". They were valued over friends and family who were seen as less caring and less knowledgeable.

A high value was placed on the support and encouragement the mothers received, as well as the concern demonstrated for them, as mothers, and for their infants. The care for one was experienced as care for the other. For one HIV positive mother it confirmed that her infant was loveable too.

Starting out with very little or no basic knowledge about caring for infants, mothers described how they valued the information and advice they had received. Observing their infants' capacities to interact with

their environment and the discussions that followed was a source of great amazement and insight to mothers and seemed to have changed their attitudes and behaviours towards their infants.

In the role of the benign witness the counsellors were informed about, and excitedly shown the successes and achievements of, mothers and their infants, as well as any negative or abusive behaviours that had occurred. Mothers reported how helpful it had been to have someone on their side. The stern approach and limits set by some counsellors seemed to have conveyed care and concern for all parties and provided containment at times of threat, anxiety and despair.

Financial or material assistance, occasionally required in dire circumstances which threatened to impact on maternal care or infant wellbeing, was greatly appreciated.

7.2.3. How had new ideas been introduced?

The counsellors were experienced as having responded with sensitivity and respect to mothers' cultural beliefs and practices, while promoting the infants' best interests. Mothers found the new information they received from counsellors very useful and did not feel it was disrespectful to their belief systems. This seems to have been possible through the counsellors' deep understanding and compassion for the mothers they visited, demonstrating what they were attempting to teach and offering suggestions that mothers could choose to implement without being intrusive.

7.2.4. How could the intervention be improved?

Mothers were unanimous in their beliefs that visits should begin as early as possible in order to limit potentially harmful maternal practices in pregnancy and for mothers to be better prepared for the birth and early parenting. They also unanimously believed that visits should be extended beyond the first year.

7.3. Links identified by the mothers between the intervention elements and changes they experienced

While we know that we cannot link what mothers said they valued of the intervention to specific changes, or to mechanisms of change, some mothers identified some of the specific elements of the intervention, which they felt linked to specific effects in their own minds.

Mothers described initially feeling isolated, abandoned and anxious that they would not be able to manage their infants alone. It was into this void, created by absent and unavailable maternal figures, that the counsellors stepped and fulfilled some of the functions of the motherhood constellation. The mothers linked the support, interest and care they received from the counsellors, to a feeling of having someone there on whom they could depend, as an ally and a support. Stern (1995) used the term "the good grandmother" transference to describe the relational needs of new mothers in the early months of motherhood. In the context of deprivation and a society in which the punitive parental state has so

influenced the emotional lives of people (Long, 2002), the mothers all expressed the realisation that they had experienced a relationship that was quite different in a positive, even idealised way, with “*an angel*”, “*really a mother*” and “*really like my parent*”. They experienced the counsellors as empathic, protective, caring, accepting and concerned and linked these characteristics with the fact that they could almost immediately trust them, even with their most vulnerable and shameful feelings and thoughts.

Mothers further linked being able to express their feelings to counsellors, who could listen and be “open” and non-judgmental, to feeling relieved, calmed and contained, and able to think more clearly. The powerful effect of being listened to, particularly in South Africa, has been addressed by Long (2002), who states how, “‘really being listened to’ for the first time recognizes the personal and political experiences of having previously been silenced” (p. 120).

Having been heard and understood, mothers felt better able to regulate their own emotions and those of their infants in less destructive ways. For example, a young mother, who having felt safe enough to express and discuss her own desperate and angry feelings with the counsellor, could then manage her own angry feelings better and, in turn, understand and help her infant regulate his angry and distressed crying.

Having felt initially quite unskilled, mothers also linked the knowledge and skills learnt through the information, discussions, observations and more directive advice and coaching, to an increased sense of competence, confidence and satisfaction in their roles as parents. They felt empowered and better able to understand the broad spectrum of their childrens’ needs, from the physical to their emotional and relational needs for communication and interaction. They expressed immense enjoyment and satisfaction with their infants’ new developments and responses to their environment. The mothers’ emotional responses to seeing their infants’ capacity to absorb and interact with their environment seemed to encapsulate profound moments of change in mothers, which shifted their perceptions, attitudes and behaviours towards their children in ways that promised a far more positive relational and developmental trajectory.

Mothers also linked the counsellors’ direct intervention in various conflict situations they experienced with partners to an immediate relief of the conflict. Knowing they were being watched and monitored seemed to help the partners, who were being neglectful or frankly abusive, to control these offensive behaviours, at least in the short-term. This is significant in a sector of society characterized by considerable violence and where there has been an absence of supportive and benign paternal influences, and where external authority remains unreliable and unpredictable (Ramphela, 2008).

7.4. Significant elements that connect to theory

In the early and demanding months after the birth of the infant the mother’s task is to create a reliable, predictable and responsive environment, and closely adapt to her infant’s needs in order to facilitate the development of a secure sense of trust and attachment. During this time it seems important that there be

someone reliable, predictable and responsive to tune in and respond to the mother's needs. The mothers interviewed suggest that this was indeed a role taken on by the counsellors. In the context of deprivation and extreme need, and at a critical stage of transition to early parenthood, caring "parental" counsellors arrived who provided, in a Winnicottian sense, close and attuned adaptation to the mothers needs.

With the provision of what the mothers needed, the distrust that might have dominated in different circumstances seemed to be absent. This facilitated the development of positive therapeutic relationships that proved transformative at least for some. The counsellors in the idealised parental transference may be thought of as having played an essential role, making use of the positive oedipal complex within what Stern (1995) described as the motherhood constellation. This positive alliance with older "mothers", who had implicit knowledge of their reality and provided a sense of acceptance and understanding, allowed for a high level of cooperation and openness. The counsellors as observers, witnessing and mirroring with excitement, new developments or achievements of the mothers and infants, provided validation and encouragement of the mothers role in caring for their infants. They encouraged the establishment and development of emotionally secure attachments. They represented a supportive matrix able to provide the protecting, benign support network the mothers needed. Finally, as maternal models, they seemed to facilitate the transformation and reorganization of the womens' identities as mothers. It is felt that this was achieved through their recognition, confirmation, approval, encouragement and support, particularly of new, young and isolated mothers who were taking up this role for the first time.

In their reports mothers indicate that through an exceptional relationship with a trusted and idealised attachment figure they experienced a different way of being. Along with their children, they experienced being valued, nurtured, cared about, and listened to, with respect. They felt thought about, remembered, and their feelings and experiences felt validated and understood. Nahum (1998) identified moving from not feeling understood to feeling understood as an important feature of moments of meeting also called special moments of authentic person-to-person connection and/or moments of reciprocal recognition, identified as a central mechanism of change (Tronick, 1998) and capable of altering both the implicit knowledge of herself as a mother and her models of relationships.

Being remembered week after week seemed to be an important factor particularly in a culture where people do just disappear, or leave without explanation. Partners find other girlfriends and leave, HIV positive women fear being cast out by family or abandoned by their partners, people die often with no explanation, children are sent to rural areas to be cared for by relatives. The frame seemed be important to provide a sense of being held in mind.

Olds (2008) described the passion with which counsellors deliver the intervention as perhaps the most essential feature of successful interventions. This was certainly reflected in our study. The counsellors' commitment to the programme, and their belief in their clients' capacities to overcome adversity, as they

believed they had done themselves, their valuing of the vital roles of mothers, as well as the interest, excitement and delight they expressed with each new development and success, seemed to constitute the affective charge required to shift present moments to the potentially transformative moments of meeting. This element appears to represent examples of what Fonagy et al. (2004) described as empathic affect-reflective gestures, which had the potentially strongly transformative and motivating effect on mothers.

The process of modelling sensitive and responsive maternal care seems to have been effective. Mothers spoke of how they watched and saw the counsellors interacting with their infants and were observed mimicking the counsellors' interactions with their infants. As a style of teaching it is very much in line with our approach of sensitive, non-intrusive support which offers mothers the choice of trying something new and effective that they might find more rewarding. In addition, in line with the principles of learning theory, were the positive effects reported by mothers of the encouragement, positive feedback and reassurance they received.

Many mothers reported affect expression to be culturally unacceptable. Although mothers were part of a culture where "*we don't talk about our feelings*", this did not mean that affects were not experienced, defined, modulated, or inwardly expressed. We were aware that emotional pain was often expressed as physical pain or as illness or other physical disease which received the attention required. When encouraged, through a client-centered and reflective approach, to express their feelings directly and outwardly, something seemed to shift for the mothers. Many expressed themselves openly for the first time and from the beginning, indicated a strong need to talk and share experiences, thoughts and feelings with interested, willing, non-intrusive and receptive counsellors. As mothers came to understand and accept how they really felt, their sense of agency seemed enhanced and their confidence in expressing themselves to the counsellors increased.

An important focus of the intervention was to sensitise mothers to the needs and communications of their infants. The evidence from mothers and the counsellors suggests that the counsellors' consistent attempts to direct the mothers' attention and thoughts to the meaning of their infants' behaviours and communications played an important role in the development of this capacity, which seemed to become quickly internalized by mothers and was evident even in the absence of the counsellors. This provided evidence that the mothers' capacity to mentalize had been enhanced (Fonagy et al., 2004). While this does not prove that lasting change has occurred, it provides support for the belief that short-term interventions can bring about change and that such change can occur at the level of both explicit and implicit relational knowledge.

7.5. Less obvious insights gained

I have attempted to remain focussed and grounded in the data collected. However, having fulfilled the roles of both clinical supervisor and analyst of results makes this, to a large extent, an insider account.

This creates compromises for objectivity in that it is difficult, if not impossible, to separate my own participation in the process from my interpretation of the data. Working within the psychoanalytically orientated approach, however, where the person of the researcher is key and reflection on their experiences, thoughts and feelings is a central requirement, allows for a layer of understanding of the data which comes directly from my experience of having been a participant in this process.

In this section I will therefore be dealing with insights that do not always point specifically to the data. It is for the reader to decide how disciplined I have been in using my own insider status as an implicit source of knowledge. This feels particularly pertinent with respect to my own feelings of how painful this intervention was, at times, for the counsellors and how pain felt like a constant underlying subtext.

7.5.1. The challenges to reflective listening

Since Rogers (1946), who was a trained and experienced analyst, introduced the technique of empathic and reflective listening as an attitude and approach to therapeutic process, the popularized Rogerian approach has been oversimplified, misled and debased as a technique. It is often naively taught and applied across the board, from counselling to politics, with little understanding of how complicated and emotionally demanding this approach is. Empathic understanding and reflection, or being able to “convey his deep understanding of the emotionalized attitudes expressed and his acceptance of them ... best conveyed by a sensitive reflection and clarification of the clients attitudes” (Rogers, 1946, p. 3), which resonates strongly with the concept of mentalization, as explained by Fonagy et al. (2004), is complicated largely because it requires the deliberate use of countertransference (Zepf & Hartmann, 2008). As such it has the potential to raise difficult, at times unbearable and unexpected, emotions and dynamics for the counsellor, challenging even the most qualified and experienced therapists protected by the reassuring frame of the consulting room. We know that profound attunement does not only resonate with benign thoughts, emotions and intentions, but is open to more negative, at times hateful and provocative affect. Furthermore, empathic listening requires the capacity to tolerate not knowing or holding difficult emotions for a while before these emotions and situations can be resolved. Despite our counsellors’ awareness of the importance of listening empathically and responding thoughtfully, there were many occasions when listening reflectively and empathically, in a marked way, was difficult for them to manage.

Whatever the purpose, the projection of powerful affects dominates the stage of early infancy (Bion, 1957; Segal, 1989; Winnicott, 1947, 1988). Working with mothers and their infants, therefore, requires the counsellor to have the capacity to bear enormously painful raw, unconscious, unprocessed, primitive infantile feelings. The power of these projections and the struggle to maintain boundaries in this work is exacerbated in the context of economic deprivation and trauma. When the interventions require home visits, counsellors are far more in touch with what Aragno (2008) described as the instinctive, unmediated mode of mirroring rather than drawing on the highly mediated and more cognitive and rational or marked

expressions of affect. Home visits increase the counsellors' exposure to the painful feelings and fantasies surrounding their own experiences of early infancy, loss and trauma that, more often than not, remain largely unspoken and unresolved. The need to protect themselves from these, at times, unbearable experiences, has the potential to undermine the integrity of empathic reflective responses.

In our intervention there were particular issues that tended to raise anxiety and interfere with the counsellors' neutrality and objectivity and the maintenance of their sense of separation and capacity to adopt an empathic listening and reflective stance. These included maternal ambivalence or threats of abuse towards infants, parental conflict and threats of violence to the mothers, an inability on the part of mothers to make the changes they wanted or needed to make in their lives, death, abandonment, separations and other losses, and the termination of the programme. When these issues arose there was a tendency to defend against these feelings by offering directive advice and solutions, effectively limiting opportunities to interrogate issues in more depth, thus limiting their understanding, interpretation of the data and, at times, their clinical judgment.

The intervention itself required that counsellors stand alongside the mothers and facilitate their gradual discovery of the infant by helping them to see and think about the infant, who they are, and how and what they might be communicating. This process involved learning to tolerate states of not knowing, rather than interpreting or judging prematurely and imposing some understanding because not knowing feels so unbearable. In the same way, the counsellors also needed to take on a similar thoughtful stance in reflecting on the needs of the mothers before prejudging the situation and imposing information or advice that might be out of tune with their needs. It feels important to remember that, as with many professionals in the field, lay counsellors may be drawn to help others as a result of unconscious wishes to repair earlier trauma in their own lives. They may thus be tempted to find solutions and attempt to rescue and fix problems for others rather than processing the feelings and faulty beliefs and allowing others to find their own healing. Van den Berg (2002) notes that the pressures, "both internal and external to produce solutions for clients" (p. 45) is very powerful and that in order to produce the best psychological intervention "more space needs to be given to thinking and reflecting, and not just action." (p. 45). There is therefore a strong imperative to provide and protect such a space and manage the beliefs, emotions and situations that have the potential to interfere with the counsellors' capacity to listen and reflect empathically and effectively.

Power issues also interfered with the maintenance of a reflective stance. Although power is held and used in various ways by all players in any situation, it has been pointed out by several theorists that no therapeutic approach is an equal, democratic or reciprocal process with respect to power (Fonagy et al., 2004; Gaylin, 2000; Modell, 1998). The asymmetrical nature of the therapeutic relationship and resulting power vested in the counsellor is particularly exaggerated in the context of early motherhood (Stern, 1995). Socially isolated and needy mothers deprived of benign maternal "grandmother" figures tend to

form intense idealised transferences with their counsellors which are a challenge to manage. Such idealized transferences are very helpful in establishing a positive working alliance and collaborative partnership in brief interventions such as ours. However there is always the danger that naïve counselors could be too easily seduced and unconsciously drawn into an idealised transference without understanding the consequences of this dynamic. Our counsellors often expressed feeling under unbearable pressure to provide the unprovideable and make things better for their mothers.

The lack of tertiary education and training was one of the limitations we found in employing community-based counsellors as a certain capacity to fully integrate and implement new concepts and a depth of knowledge and insight, which is taken for granted in therapists with rigorous academic and clinical training, could not be presumed.

7.5.2. The role of information and advice

Directive advice has generally been discouraged as a therapeutic approach by both the psychoanalytic and the Rogerian traditions. It is generally seen as undermining, intrusive and disempowering of the client who, given the space, will discover their own truths and solutions. It is important to keep in mind, however, that both the psychoanalytic and Rogerian traditions developed in the context of middle class resources. While information is broadly available many of the women we visited lacked the necessary resources, emotional and otherwise, to acquire this knowledge.

The very positive responses the mothers reported regarding the information and very directive advice they were given at times, and between which they did not seem to distinguish, may, to students steeped in the “Western” traditions which emphasize individual agency and self-determination, seem to some extent surprising.

Community interventions in South Africa take place in the context of a severe deprivation of basic resources and a tradition of hierarchical relationships in which there was a respect for and dependency on the knowledge and wisdom of elders. Furthermore, in South African society, which for many years was defined by oppression and authoritarianism, the issue of who has access to knowledge, and therefore holds the power to make decisions and act on whose behalf, was often closely and consistently questioned by progressive thinkers and community initiatives of the 1980s and 1990s. The tendency, amongst the most concerned professionals, was to overemphasize the valuable knowledge and skills held within oppressed and deprived communities and to undervalue or disavow their own knowledge and experience (Tomlinson & Swartz, 2002). These authors refer to Foucault’s argument that power and knowledge are inseparable and that for communities to become empowered they need access to knowledge. It is important to acknowledge that there are many kinds of knowing that come from experience and explicit information, all of which are important and empowering.

We heard that for many mothers, knowing what to do does not come naturally. This prompts us to rethink the potentially containing and helpful function of information and more directive advice and skills training. Van Rooyen (2009) has noted that in much of the community counselling literature there is a tension between the dominance of Rogerian, non-directive approaches on the one hand, and need within communities for information and advice on the other. She points out that many HIV counselling programmes, while nominally committed to non-directiveness, also in fact rely on a great deal of advice-giving. In the context of adversity and deprivation of basic needs therefore, for the counsellors not to provide useful resources and attempt to make better would have been counterintuitive. In this context the withholding of information and advice is like withholding something essential.

In our sample none of the mothers felt they had been imposed upon. Perhaps the counsellors' implicit knowledge of the culture and custom and ability to hold in mind both traditional and Western ways of thinking and doing helped to provide some acceptability to the information provided. They reported that what they heard was relevant and had made sense to them.

Like many parents at all levels of society, knowing what should be done does not enable them to act appropriately. Many parents simply do not have the words or the interpersonal skills required to act effectively and with agency in their lives. It seems too, that unless knowledge is accessible, in tune with and responsive to the mothers' specific needs, and offered within a supportive and reflective therapeutic relationship, it tends not to be sought out or utilised and is therefore ineffective.

Although more traumatised mothers may struggle with defensive and egocentric thinking, limiting consciousness about their infants, we can assume that some degree of mentalization or awareness of representations is present in most mothers. This allows the capacity for awareness of the individual needs, communications and minds of their infants to develop. Increasing mothers' knowledge and understanding of the sentient nature of their infants is likely to play an important role in the development of internal observers in mothers. By facilitating such a position mothers are likely to feel more accountable in the way they interact with their infants. More specifically, they may be less likely to consciously neglect or maltreat their children, creating the potential for more rewarding interactions and relationships between them and their infants.

7.5.3. The role of witness and setting of limits

Authoritarianism has been recognized as a dominant facet of our culture with historical links to the imposition of colonialism and apartheid but also to some African traditions of governance (Ramphela, 2008). Ramphela (2008) further links the experiences of children being brought up in an authoritarian home, beset with gender-based violence, with difficulties in becoming respectful democratic parents to their own children.

The often sudden, traumatic and repetitive losses experienced by children, through death, dislocation from, neglect or abandonment by their caregivers, tends to result in disruptions in interpersonal relationships and failure to develop the capacity for affect regulation, concern and compassion required for the healthy attainment of an internalised locus of control and self-discipline.

Through what Geeraert et al. (2004), called the “surveillance effect”, behaviour that threatened to become or had already become physically or emotionally abusive towards infants, partners or other family members was picked up. In these cases it was the watchful eye, firm limits and prescriptive intervention by counsellors that was perceived to provide a protective function. The counsellors, as benign authority figures acting as witnesses and holding in mind the knowledge of negative behaviours, seemed to have provided a protective external locus of control. This seemed to be experienced as helpful by partners and parents in gaining and maintaining better control of potentially abusive behaviours. The mothers’ perceptions that domestic conflict and violence had decreased presents a potentially profound finding given the strong association this factor has with child maltreatment in the literature. Daro and Harding (1999) concur that the presence of the home visitor in the home decreased the likelihood that children would be abused or neglected. It also increased the likelihood that if someone was abused, this would be seen and referred to the appropriate services.

7.5.4. Researcher reflectivity

Parker (1994) refers to researcher reflectivity as an important aspect of qualitative research in which the researcher’s personal subjective experiences, countertransference, insight, knowledge, values and assumptions need to be constantly kept in mind. This is particularly relevant as I, as an “outsider” to the community (white, English-speaking professional educated in the “Western” paradigm), also took on the role of the supervisor and interpreter of the material.

The impact of my involvement in the study and research on the dynamics of the interpersonal relationships between the counsellors and myself needs careful consideration. It was important to me that this work evolved as collaboration between the community and the professional researchers in which the voices of the counsellors would not be lost; however this proved less simple than I thought. The differences not only between me and the counsellors but between the counsellors themselves determined by our race, circumstances, experiences, training, reflectivity and values became evident from the start. I realized that I held very strong views that did not always accord with those of the counsellors. I felt far less tolerant of what I regarded as human rights violations than they did, and often felt the need to impose my views on the group. I attempted to deal with these and other important issues by openly stating my own point of view and encouraging the counsellors to do the same. This seemed to work well and lead to lively debates about often very difficult issues which included; women’s lack of control over their own fertility, rights to abortion, the roles of sangomas, traditional customs and religion, the use of traditional

“muthi” alongside Western medicine, women and child neglect and maltreatment, personal choice vs. community needs and others. This was very helpful in collaborating to find ways of approaching these issues with some consistency but it became evident that power dynamics similar to those observed between the counsellors and the mothers played themselves out between me and the counsellors. I was consistently aware of the power of my voice and I soon became aware of a positive or idealized grandmother transference developing between the counsellors and myself. At the same time I also seemed to represent a figure of authority from whom they required reassurance but also whom they were reluctant to disappoint or contradict. Despite encouraging a safe space in which the counsellors would feel free to share openly, there were times when I felt their voices were silenced. Personal difficulties were shared more easily with the auxiliary supervisor who had more implicit knowledge of their lives and circumstances than me, the “outsider”, and where they might have experienced less shame in sharing their difficulties. It was with this auxiliary supervisor, with whom I shared a positive and respectful collegial relationship that I would seek feedback on my understanding, decisions and approach to disagreements. Their experience of life and mothering in this community equipped the counsellors, far better than me, to tolerate and work with the many contradictions present in such communities in transition and in many cases I relied extensively on their judgement.

7.5.5. Ethical Dilemmas

The counsellors were, at times, caught up in ethical dilemmas. They struggled with the decision by the research team not to provide material support to families particularly when there was no food in the house. This was perceived as being contrary to principles of “ubuntu”, which refers to being an interdependent member of a sharing and caring community (Tutu, 1996). There were times when the decision was made by the group to help certain mothers but there were also occasions when the provision of clothes and food to poor mothers was hidden from me as the urgency was unbearable or possibly to avoid my possible criticism of their judgement. Another dilemma concerned the ethical and legal obligations to report neglect and abuse of women and children and the procedures that were required to be followed. This arose largely because reporting to the police often proved ineffective and the formal protective services for children were inefficient and often failed to act on reports. There were occasions when autopsies on babies who had died were not requested by police, even in suspect circumstances. This often left the counsellors feeling responsible for the safety of this vulnerable group and having to look for alternative solutions. This was one reason why they would step in and become very directive with a potentially abusive spouse. There was a time when women felt that the only way they could ensure their protection was by enlisting the support of local taxi drivers and the counsellors found themselves endorsing such action. When mothers were perceived to be acting in ways that were potentially harmful to their infants, they would visit more frequently, let the mothers know that they were aware of her behaviour, provide her with alternative ways of understanding and responding to the child and enlist other family members to support the mother

and the child where necessary. Nama and Swartz (2002) discuss some more general ethical issues arising from the trial in which this study was embedded. Core to all the dilemmas discussed is the issue of the imbalance between a relatively “wealthy” research project and women living in poverty.

7.6. Implications

While there is much that is inconclusive and remains unproved in the hypothetico-deductive sense, my participation and clinical understanding has led me to identify what I thought was key to the success of this intervention and the implications this has for the implementation, research and policy decisions concerning such interventions.

7.6.1. For practice

It is apparent from the mothers’ reports that Rogers’ core attitudes and skills of counselling, empathic listening, congruence, genuineness, non-judgemental positive regard, encouragement, respect and maintenance of confidentiality were recognized as important and valued qualities that seemed to facilitate a sense of trust and establish a positive working alliance. Over and above these however, other factors have been identified which I feel need further expansion.

7.6.1.1. Providing advice

When doing work in low income countries, which lie at the edge of theory, methodology, and the application of models of practice in high and middle income countries, one needs to think critically about theory and question the fundamentals which are often taken for granted. For example the role of giving advice is a more complex issue than it previously seemed and needs to be thought about carefully. It can be thought of as a form of resistance or defence on the part of the counsellor but it can also be thought about as a finely attuned response to a real need for knowledge and skills. Despite, and maybe because of the advice and direction they were given, even when offered defensively in lieu of empathic reflection, the mothers felt heard and attended to with interest and genuine concern and were left feeling more contained and less despairing, lost and alone.

7.6.1.2. Providing alternative motherhood constellation structures in the context of massive social transition

The mothers’ astounding receptivity and welcoming of the programme suggests that they had been aware that something essential had been missing for them. The support and affirmation they received from these older, more knowledgeable and wise grandmother surrogates seemed to affirm them as mothers and gave permission for many of them, legitimately, to become more preoccupied, attentive towards, and engaged with their infants.

7.6.1.3. The earlier the better

We know that the plasticity of the brain is greatest in the first three years of life and that unsatisfying early caregiving, if allowed to continue unattended, will lead to attachment insecurity, negative affect and behaviour and a poor capacity to cope later in life. It follows therefore that preparation and support should begin as early as possible, particularly for new, young and isolated mothers. This belief was indeed confirmed by the mothers themselves. The earlier parents engage with their pregnancies and their unborn child the more likely they are to provide protection from toxic uterine environments and experience their relationships with their infants as rewarding and facilitating of secure emotional attachments. While not guaranteeing immunity to life's traumas, secure attachments with caregivers make a positive relational and developmental trajectory more likely and enhance children's capacity to cope with the ongoing demands of living. Furthermore, more rewarding relationships between parents and their infants offer the protection from all forms of possible maltreatment, at least in the short-term.

7.6.1.4. Application and Adjustments to the programme

The resources and needs in communities differ tremendously so that interventions, particularly those imported from HICS, need to be carefully adapted with the cooperation of, and in collaboration with, the lay community counsellors involved, in order to meet the specific cultural conditions and needs of particular communities. In our study this became an integral part of the training and supervision process in which each new feature was debated and explored before it was agreed to and adopted.

7.6.1.5. The employment of untrained lay counsellors

While the search for the minimal requirements for the selection, training and supervision of previously untrained lay community workers awaits more rigorous randomised control trial evaluations, my participation in this process lead me to certain understandings regarding these aspects of the work. The interpersonal nature of this intervention, the dire contextual conditions and the complex dynamics that come into play create the need for careful selection of trainee counsellors, a thorough training with plenty of time for experiential work and discussion, and careful regular supervision and support.

On reflection, the emotional containment that the counsellors are expected to provide the mothers points to the need for the careful selection of previously untrained trainees for counsellor training. It seems important that from the start, we select trainees who are emotionally mature, genuinely empathic and caring, capable of reflecting on their own beliefs, thoughts and feelings, have implicit knowledge about the demands and dynamics of early parenthood and the community in which they work, are in attitude non-judgmental, supportive and encouraging, and willing to learn. All of these are qualities that cannot simply be taught. This has particular relevance in circumstances where jobs are few and in high demand and where, as a result, applicants might not be entirely suitability or appropriate. It also became clear that the trainees who had completed their schooling seemed better able to understand and effectively apply the more abstract concepts taught, to make thoughtful judgements in the difficult situations within which they

found themselves, and to provide adequately written records of their visits. These factors point to a school leaving certificate as an important criteria for selection.

The training itself evolved as a useful assessment tool for the selection of the counsellors. It was often only through the training that the trainees' reflective function, congruence, genuineness, empathy and ability to be with mothers and their infants in sensitive and non-intrusive ways, could be established. As a result the training has become an important part of the selection process involving a mid-course and final evaluation and feedback session with trainers before the final decision to appoint the trainee, who remains on probation for the first three months of employment.

I have also come to understand the importance of thorough, rigorous and ongoing training in order for lay counsellors to feel confident and act with competence in this type of intervention. To prepare trainees, with little or no formal training, for this demanding role required relatively extensive training, which comprised information and skills input. More importantly however, I believe that it is the experiential component of such training, which provides the opportunity for the development of self knowledge, a more empathic and less judgmental approach and enhances the capacity for emotional containment.

With counselling, as with other intimate relationships, attachments are formed based on internal working models or implicit relational knowledge from the past, and transference and countertransference dynamics are invariably played out between the counsellor and the client. In psychoanalytic work the transference and projections between therapist and client are core to the treatment. They are confronted, managed and worked with. While there is no attempt at in-depth interpretive work in client-centred and cognitive behavioural approaches used in community interventions such as ours, working within the field of early motherhood and infancy means having to manage the dynamics of transference and countertransference, receive and hold powerful and primitive projections and negotiate sometimes complicated boundary issues with which many of us, even when trained in the skills of psychoanalytic work, struggle. Very often in community interventions the dynamics that develop unconsciously between counsellor and client are not thought about or understood and tend therefore not to be constructively managed.

The need for a frame to maintain integrity, emotional engagement, and separateness, and to protect clients and counsellors from unconscious negative or destructive enactments is essential, yet challenging in community work. In this work one needs to think of a protective frame that is transportable and flexible. In this regard, Frenkel's (2003) metaphorical frame, which is at all times held implicitly in the mind of the counsellor, is very useful.

In my understanding regular and close reflective supervision was the primary structure that ensured and maintained the integrity of the intervention, reinforced the safe and supportive frame, provided emotional containment through a secure base, allowed the counsellors to manage their own affective states, monitored and managed the power dynamics in ways that protected all parties, provided perspective and

maintained the quality of services. Paradoxically the need for supervision in community work, which could be considered as presenting far more complex and demanding conditions for the counsellors than mental health professionals tend to confront in their practices, generally tends not to be talked about nor sufficiently appreciated. Two exceptions to this are; a collection of writings on reflective practice (Swartz, Gibson & Gelman, 2002), and a research report on the role of supervision in community clinic contexts (Revington, 2008).

There were times, in supervision, when powerful emotions needed to be held for a time, without immediately knowing what they were or what they meant. These needed to be thought about, discussed, processed and managed constructively and required the development of tolerance of the discomfort of not knowing. My own powerful countertransference to the counsellors' reports of visits often alerted me to emotions they were defending against or practices they had not questioned or thought about. Careful consideration of these powerful feelings of countertransference sometimes contributed constructively to the therapeutic relationship. For example when, through exploring these feelings, we were able to gain some understanding of the feelings of more uncommunicative, withdrawn or inaccessible mothers.

It is my belief that the training and supervision model should provide a relational experience for counsellors that encourages the process of reflective functioning and demonstrates the quality of sensitive and non-intrusive interaction that the counsellors are encouraged to provide mothers and mothers are, in turn, encouraged to provide their infants.

As a supervisor this intervention made me aware of my own need for regular debriefing and supervision, which I sought from the team at the Parent Centre. This was essential in helping me to process the many projections and transferences from the counsellors as well as my own countertransferences stemming from sometimes unbearable contextual circumstances that I began, unconsciously, to carry. There was a stage when I began avoiding the work and it was only when I shared this with my team that I became conscious of the negative affect I was carrying.

The role of the supervisor involves overseeing and containing the process and taking on the responsibility of thinking about the needs of the counsellors, the clients and the intervention as a whole. My experience of supervising this intervention has convinced me that while community counsellors do not necessarily require the depth of training and experience required by mental health professionals, the supervision of this work requires the training and experience of a trained clinical professional with an understanding of the potential challenges particular to parent-infant and community interventions.

7.6.2. Research

We still have a long way to go and all attempts, using qualitative and quantitative methods, should be made to fill in the gaps in knowledge. We should be making considered use of all the significant

knowledge at our disposal to begin to meet some of the urgent demands that confront us, whilst carefully documenting what we do as we go along.

Randomised control trials (RCTs) are essential research designs, or technologies, that can be applied in many contexts in order to prove that interventions are effective. They are very useful but no method (including the one used in this thesis) can tell us everything. By their nature they tend to gloss over local specifics and issues with no attempt to explore and understand the details of interactions and processes involved.

In the randomised control trial that we have recently published we say:

We based the intervention on an adaptation of a preventive intervention programme by health visitors devised for implementation in Britain, which itself closely follows the principles contained in *The Social Baby*.... We adapted this programme for the Khayelitsha project by incorporating the key principles of the World Health Organization's document *Improving the Psychosocial Development of Children*... The content and conduct of the intervention was specified in a manual, which was used to train the therapists. (This manual is available at www.reading.ac.uk/psychology/research/child-development/clinical-subgroup.asp). The aim of the intervention was to encourage the mother in sensitive, responsive interactions with her infant. A major aspect was the use of particular items from the neonatal behavioural assessment schedule...to sensitise the mother to her infant's individual capacities and needs. The intervention was delivered by four women, resident in Khayelitsha, who had been selected with help from the local community council. The women had no formal specialist qualifications, although all were mothers. Two had completed schooling. They received training over a four month period in basic parenting and counselling skills, as well as in the specific mother-infant intervention. An experienced community clinical psychologist (ML) provided them with group supervision throughout the study, on a weekly basis, offering session by session supervision. The intervention was delivered in participants' homes in hour long sessions. The women in the intervention group were visited, ideally, twice antenatally, weekly for the first eight weeks postpartum, fortnightly for a further two months, and then monthly for two months (that is, 16 sessions in total, ending at five months postpartum). Women in the control group received the normal service provided by the local infant clinic (as did the intervention group). This involved fortnightly visits by a community health worker, who assessed the physical and medical progress of mothers and infants, and encouragement of mothers to take their infant to the local clinic to be weighed, have their physical health assessed, and be immunised (pp. 3-4).

Written up in this form it all looks so simple. However, having become aware of the complexities and the micropolitics involved in our project has made me sceptical of claims by any project that this kind of work

is simple and straightforward. We need RCTs to prove outcomes, but the knowledge generated in the reporting of RCTs does not and cannot cover the theory and processes involved. RCTs tend to efface the sorts of factors and mediators which, from my theoretical understanding, formed the core of our intervention. They need to be complemented by the kind of theory and process information presented in this thesis.

It has taken a great deal of time and thought to develop this description of the processes that unfolded in the intervention in the hope that by paying close attention to the “soft” data a more nuanced, comprehensive and in-depth understanding of the intervention as a whole would be revealed, which can be used to further intervention studies. It is difficult, if not impossible, to prove the influence of this understanding on how I will work in future, but my theoretical understanding of what is at stake in psychological interventions supports my view that such attention to detail, and how recipients of interventions experience these interventions, will indeed be helpful. There is great value, and one is far more able to gain a more multi-dimensional perspective of interventions, when they are evaluated both quantitatively and qualitatively. The more we know about successful programmes, the more accurately we can replicate them. It follows then that it would be very valuable, as programme developers and clinicians, to get similar descriptions of other RCT interventions. Until then it remains very difficult to compare and replicate other empirically evaluated interventions.

The inclusion of an analysis of interviews with the counsellors would have provided further depth to our understanding, which would have completed the description provided. This remains a project for the future.

A further valuable study would be to explore the processes taking place between the counsellors and the recipient mothers through the use of video recordings of the visits in the home and immediate visual feedback of the visit, with the researcher exploring with the mother and counsellor the experience, perception and meaning, for both, of the interactions between them.

It would also be useful to explore, with parents in interviews, the extent to which the fairly sophisticated knowledge about infant development was transferred to the mothers, and how much of this was understood and retained by them.

On reflection I believe that had I sacrificed a degree of neutrality by conducting the interviews myself, I would have explored relevant areas of interest in far greater depth than the neutral interviewer was able to do. Despite this the important themes emerged.

7.6.3. Policy and funding challenges

Ramphela (2008) states:

Parenting is a daunting responsibility. Yet societies globally pay little attention to helping young adults prepare themselves for responsible parenthood ... Recognizing the importance of the family as the foundation of any society has to be accompanied by active measures to identify those most vulnerable and provide urgent psychological and material support to stabilize them. ... We are not investing enough in providing adequate social-work support to troubled families (p. 114).

In a new and struggling democracy, such as ours, it would seem to make sense for the State to invest in services that begin at the beginning in order to build capacity in children who are the future adults. While poverty alleviation strategies and housing are desperately needed, much could be done to reduce the stress experienced by struggling new parents in economically deprived communities to support their mental health and establish sensitive, mindful and non-intrusive parenting. The need for support and services for parents periodically make the headlines, usually following some horrific and traumatic event, yet seldom is there any effective follow-through in establishing these services.

Ideally, parents, particularly those overburdened by poverty, require reliable and predictable social structures and universal services that are able to support their adaptation to their roles as new parents (Richter, 2004). As no programme has proved sufficient and universally effective, programme planners need to remain thoughtful and flexible and responsive to the unique needs of each community, listening carefully to what needs are being expressed. As our study suggests, new knowledge, and change in general, take time to integrate. The principles imparted were not necessarily generalised to the older children in these families who, in any event, required additional knowledge and parenting skills more appropriate to limit setting and encouragement of separation, independence and confidence. Our mothers presented a strong case for ongoing support in order to maintain the gains they felt they had made and we know, from research, that this kind of intervention is seldom enough, and needs to be supported by further programmes on parenting as children develop. What is thus required is the need for more specific and specialised services, and for individual families to be assessed.

The lack of funding for this work remains a major challenge with the development and evaluation of this programme relying almost exclusively on dedicated funding from private donors. Where services are being considered or provided, there is constant pressure to find models of interventions that require maximum change in minimal time at minimal cost, however, the processes involved in identifying and evaluating these models are costly. Even when effective programme models are identified or found and which employ lay personnel at lower salaries to deliver the intervention, such as ours, the overall cost of the programme remains substantial. What is required is a substantial shift in attitude and priorities by the policy makers of the State in order to redirect state funding and invest in the early years for the future benefit of society.

An important aspect of culture is that it is a dynamic concept meeting the needs and circumstances of people as they change over time. However, change is often met with enormous resistance because new possibilities for self-expression and opportunities for new ways of being coexist with frightening and risky negotiations that threaten disappointment and confusion (Yates & Sclater, 2000). This ambivalent nature of cultures in transition provokes a “defensive cultural and psychological responses, characterised by a fear of change, the wish for greater mastery over the unknown, and increased rationalisation over all spheres of life” (p.135). It is really important to find ways of facilitating more reflective ways of being amongst South Africans who have had to endure substantial trauma for generations. There is no better place to start than at the beginning: by facilitating the capacity for reflection in the next generation through enhancing reflective capacity in mothers.

In the final chapter I will draw some conclusions about the meaning of this intervention in the context of low-income communities and poverty, and consider how to take this work forward.

CHAPTER 8

CONCLUSIONS

In the last three decades we have come to learn a great deal more about infant development and the factors that are involved in facilitating this process so that it culminates in competent and successful adulthood. We now know that environmental factors can alter the mechanisms of genetic expression and that children require antenatal and postnatal environments that are healthy, safe, sensitive and responsive, thereby facilitating the development of self-regulation, agency and attachment security.

We recognise that early parenting, even for the most economically advantaged and resilient parents, is difficult. It is the most demanding task, emotionally, physically and socially that we will ever undertake and for which we are not trained or ever sufficiently prepared. All new parents, in my experience, need support, first and foremost, and then help in not misreading the intentions of their infants, particularly in the often unpredictable early postnatal months. Fonagy et al. (2004) reminds us that at this time, “circumstance can temporarily undermine affectivity or at least make it difficult to sustain” (p. 466). These early months is a time when the impact of affect can be powerful and in the heat of the moment, perspective and the capacity for mentalized affectivity can be lost, giving rise to heightened arousal, confusion and paranoia. New parents are even more at risk in circumstances of poverty.

This knowledge makes it evident that the early stages of infancy should become a primary focus of interventions. Although many questions remain unanswered, and we do not yet have detailed knowledge of all the mechanisms involved in development, the application of what we know and still have to learn about therapeutic exchanges is unlikely to ever become a technically exact science. However we certainly know enough about the quality of facilitating relationships required and we are aware of many of the dominant risk factors that impair infants’ development to be able to take action and implement what we already know.

Barnard et al. (1993) refer to the need, even for basically secure mothers in social risk environments, first for transitional supportive interventions, which can then be followed by specific skills training which acknowledges and builds on their strengths, to buffer their infants from greater risk environments. In high income countries, early preventive parent-infant home-based interventions, delivered in most instances by professionals and paraprofessionals, have proved an effective approach in improving children’s lives, particularly in the context of depression and adversity. The situation in South Africa, as in many other low and middle income countries, dictates that financial and professional resources are simply not available to provide such services for the most needy. As a result, the employment of lay counsellors required exploration. This strategy has had its critics (Bolton et al., 2003; Olds et al., 2004; Rahman, 2007), however, since Rahman (2007) questioned the use of therapeutic techniques in sub-Saharan Africa, the

Khayelitsha intervention, delivered in an economically deprived community in Cape Town, proved that the use of counselling and psycho-educational principles by previously untrained lay community counsellors was indeed effective in bringing about fundamental changes in parental attitude and sensitivity and in increasing attachment security in the essential early months (Cooper et al., 2009).

While the randomised trial has been critical in proving the effectiveness of the intervention delivered by previously untrained, lay counsellors, this qualitative study set out to understand what meaning this successful intervention had for the recipient mothers and how they perceived its effectiveness. We wanted to know, in a more nuanced way, whether they had experienced change during this experience and whether they were able to link aspects of the intervention to the changes they experienced. We also wanted to understand more of the processes and dynamics involved, and attempted to understand and link some of what the mothers and counsellors described to theoretical concepts pertaining to both early infant development and therapeutic change.

Despite the possibility that in the context of such deprivation mothers would have inevitably appreciated anything they were given, our cohort of mothers made it very clear, having been provided the opportunity to express themselves, that they experienced this relatively brief encounter as valuable, meaningful and a very different experience. Their experience of trustworthy, reliable, caring, validating and thoughtful interactions by “maternal” counsellors seemed to have provided them with opportunities of now moments and moments of meeting, particularly around the infant, that seemed to have been transformative. This perception supports the belief that the experiential locus of change and growth was located in the fabric of the triangular relationship between the counsellors, the mothers and their infants. The importance of this relational experience, which is enhanced by a positive therapeutic alliance, is supported by the psychoanalytic tradition as well as the more recent models relating to change process, mentalization and empathy, all of which view maturation and change as occurring in the context of relational experiences throughout life.

The mothers valued the acceptance and recognition of their feelings as women and mothers. For many this was a novel experience and provided a sense of containment that allowed more thoughtful and mindful ways of responding to their difficulties. They valued the knowledge they gained which, they believed, made them more perceptive and aware of their infants’ needs, and provided them with an enhanced sense of agency. This intervention, although thought about in psychodynamic terms, was founded in a cognitive-behavioural frame, yet in line with more psychodynamic models of infant therapy, seemed indeed to have developed in the mothers’ minds a place for what was referred to by Berg (2007b) as their infants’ mental health. While not initially an explicit goal, mentalization as a construct turned out to be integral to the nature and structure of the intervention, as the counsellors attempted, through collaborative observation and thinking through, with parents, what their infants’ intentions might be, as expressed through their

behaviour. This enhancement of the capacity to mentalize in mothers has enormous potential to further improve this capacity in themselves as well as their children.

The positive results of the RCT, as well as the responses of the mothers, provided strong support for the successful delivery of interventions in low income countries to be delivered by previously untrained counsellors. However, in my opinion, this statement warrants some caution. I believe that it is only counsellors who have developed adequate and sufficient emotional capacity and who are able to offer interactional exchanges that are therapeutic to others. By this I mean women who have developed the capacity for concern, empathy and mentalized affectivity, and who are therefore able to attend and to attune to the affective communications of others and then to respond appropriately in a marked and thoughtful way. When such women are carefully selected they present excellent candidates for training in basic counselling skills and infant development and management training. They have the potential to provide an opportunity for mothers to experience themselves as thinking and feeling individuals within the minds of their counsellors and, in turn to provide this opportunity for their developing infants.

Several useful insights arose from the data analyzed which need to be taken into consideration when implementing primary preventive interventions in communities such as ours and for future research. These include: a) the emotional burden on the counsellors that comes from working in contexts of economic deprivation and providing validation and support to isolated mothers. b) the positive role that advice played in the context of need, which in more traditional approaches in resourced contexts, tends to be discouraged, c) the value of the benign witness for affirmation and the encouragement of growth, as well as for the protection from potential abuse, d) the struggle that lay community counsellors experience having to listen thoughtfully in the context of early parenthood and relentless insufficiency and despair and e) the value to mothers of being “kept in mind” by a concerned other.

In the design of programmes, while it is useful to know the curricula followed by other interventions, it is only by careful exploration and sharing of the process with all the parties involved that the real nature and more subtle dynamics and complexities of the intervention process can be understood and relevant feedback and knowledge be gained in each context. While it awaits further evaluation and proof, it is my belief, through my participation, that the careful and considered way we thought about and worked with the selection, training and supervision of the lay counselors in their emotionally demanding role, was key to the success of this intervention. This thoughtful process made us aware of the complexities involved in such a project and allowed us to respond constructively to the needs as they arose.

This qualitative study has shown us, and the mothers themselves have become aware of, their need for and capacity to make use of what has been offered through the intervention and the value of being heard. This implies that interventions of this type need not be thought of as “first world” or alien technology, but rather as attuned and meaningful interpersonal, intersubjective and transformative experiences for which

there is a hunger in poor communities so very far from where such therapeutic interventions were developed.

We are aware that many of the contributing factors that fail parents and children are endemic to poverty and that these factors require political and economic solutions which are, as yet, not forthcoming. We have, however, heard the voices of mothers and there is, therefore, some obligation on our part, despite not having all the answers and the necessary financial and political backing, to take this intervention to the next stage.

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Appendix I. Description of the cohort of 17 mothers.

This description is extracted from the group and individual interviews of the counsellors and recipient mothers as well as the supervision notes.

The Key informants interviewed for the study were 17 mothers selected by the counsellors from the cohort of mothers they visited. They were selected on the basis of, roughly, representing four key categories. These were selected in an attempt to capture the views of as representative a cross sample of experiences from this community as we could.

The four categories represented were:

- a).** Four mothers considered by the counsellors as having been cooperative, coping and rewarding to visit. (E)
- b).** Four mothers identified by the counsellors as having been distressed, depressed or difficult to reach. (D)
- c).** Five mothers considered by the counsellors as having been young, immature or in their teens. (T)
- d).** Four mothers with a confirmed diagnosis of HIV/AIDS. (H)

What follows is a brief description of each group and then a brief description paraphrased from the counsellors' notes, describing the life circumstances and particular stresses each of the mothers faced over the course of the intervention.

a). The sample of easy or rewarding mothers.

This group ranged in age from 24 to 36 with a mean age of 25.5 years.

One mother was self-employed, one had casual employment and two remained unemployed throughout. Three of the mothers were married and lived with their partners and fathers of the baby who were formally employed, and felt financially and emotionally supported by their partners. For two of the married mothers this was a second pregnancy, one planned and one unplanned. For the third married mother this was a third planned pregnancy. The fourth, a single mother, lived with her two children and had no support from the baby's father, who was casually employed. It was her third planned pregnancy. The single mother and one of the married mothers lived with their older children in the home, while the two other married mothers had children living with the maternal grandmothers in the Eastern Cape. The three married mothers had normal vaginal deliveries; two at the Midwife Obstetric Unit and one following a referral to a tertiary hospital. The single mother had a caesarean section.

Mother E1 was 36 years old and single. Her parents had died 5 years previously. This was a planned pregnancy and her third child. She lived with her brother, partner and two older children (18 year-old son and 11 year-old daughter) from different fathers, in a 3-bedroomed shack that belonged to her and her brother. Her partner and father of the baby was a national from a neighbouring country. She had hoped that her partner would marry and support her after the birth. She was a self-employed meat-seller. Her brother contributed to the household expenses, and her partner who had casual work was looking for regular and formal employment. She appeared depressed (low mood, thought she'd lost weight, was tired and was not sleeping). She was disappointed and angry at her partner's lack of support. She said that he "used to be a very sweet guy" but got tired of her pregnancy and would go off with his friends. He would drink and then

become abusive and use vulgar language. She felt stressed by her work and inadequate income. She had experienced a difficult pregnancy with nausea, swollen face, hands and feet and suffered abdominal pains. In the third trimester she refused to work. She felt inadequate and scared of the birth as she had previously had two caesarean sections, eventually having another caesarean with this baby.

At the third postnatal visit the counsellor was concerned that she was not coping. The house was very untidy, the bed was not made, floors not swept, the baby had a sodden nappy, was not bathed and looked untidy, and the children were on their own making food in the kitchen on a primus stove. She was struggling with her partner who drank, became abusive and provided very little support. She felt let down and tearful with the counsellor. While she seemed to be coping better by the seventh visit, she was still very angry. Her partner had come home drunk and she had given him a good hiding with a stick. She was still struggling to provide for her children by the time the visits ended. She seemed depressed and spoke about how when something preoccupied her she could not let it go.

When you have problems you think a lot, for example you even think that you may end up killing yourself, throwing yourself to a moving car. So when you talk about this to her (the counsellor) during the visits, you forget about that. Your wish that she would not go and always be with you talking to you. ... I felt well after talking to her. [6](E1)

She was selected for this group for the reason that, despite the stresses and difficulties she experienced, she was usually attuned and able to respond to her baby's communication, cues and needs. She followed the baby's lead and talked to her baby indicating her sensitivity to the baby's experiences. She asked questions and appreciated the information she was offered. The baby responded consistently well and she showed delight and excitement, clapping her hands and kissing the baby through the newborn assessment. She found the skill of problem-solving a useful tool and took initiative and found her own solutions to particular problems. She was always there waiting when the counsellor came for her visit. She was very appreciative, responsive and a rewarding mother to visit.

Mother E2 was 30 years old and married. She lived with her husband and daughters of 12 and 5 years in a 3-roomed shack. She saw herself as a "home executive". Her husband was employed as a garage attendant. The baby was planned and both parents were excited about the pregnancy. She struggled with abdominal pains and swollen arms and feet. Despite feeling supported by her partner and family she became "oversensitive" and reactive during the pregnancy. She stated,

... a pregnant person is like a child. Sometimes she thinks too much. Even a slight problem she takes it seriously. [6] (E2)

At the delivery she developed high blood pressure but was neglected and left to struggle alone throughout the labour. When she was about to deliver she called the staff. She explained to the counsellor how she had felt punished, "There was a nurse who left me in the middle of the process of delivering because I did push when she told me to stop. I could not help to, I had this feeling that I had to push, so she (the nurse) said 'I am leaving you now so you see what you can do', then at the time I was alone. Then there was another nurse who did empathise with me so she help me". She was able to accept the support of this more empathic nurse. After the birth her arm had swollen and become lame where the drip had been inserted. She had wanted a boy but

accepted a girl. She felt relieved after the birth, but struggled initially with the baby. She reported,

My heart was so sore because I was struggling with the baby. [2](E2)

Two months after the birth she was required to go back to the Eastern Cape to re-plaster the walls of her mother-in-law's house. She left her two older children with her husband in Cape Town. A month later the family were lucky to escape a fire that burnt most of the shacks around them. The family had applied, and were waiting, for a RDP house

This mother was selected as an easy mother as the counsellor felt that she could make use of the support she was offered and appreciated every visit, as had her husband and children. "They made me feel appreciated and valued every visit. I always looked forward to visits. ... She shared with me every problem she was facing. "

Mother E3 was a 28 year old married woman with an older daughter of 8 years, from a previous relationship, who lived with her maternal grandmother in the Eastern Cape. The pregnancy had been planned and she coped well. She felt happy after the birth. The counsellor noted that "her house was neat and tidy". She lived in a 4-roomed shack with her partner and a 16-year-old boarder whom mother had taken in as she was neglected by her own mother, and rejected by the family after her maternal grandmother died.

She was selected as she was a talkative, engaging and communicative person. When she experienced a problem she would ask and want to know what was going on. When she was concerned about the baby she shared her problem with the counsellor and made the counsellor feel useful. She was "always doing what I tell her to do." The counsellor felt that her input was taken seriously and respected. As a result she was able to continue to breastfeed even when she had a problem with one of her breasts, and breastfed until the baby was 2½ years.

Mother E4 was 24 years old and lived with the baby's father in a 2-roomed shack. She was single before the birth but by the second postnatal visit she was 'makoti' (married by traditional rites). She had a 4-year old child living with her own mother in the Eastern Cape. The pregnancy was not planned. The birth was induced at a tertiary hospital because of the threat of high blood pressure. She found the nurses supportive. When the baby was 2 months she was earning money by selling beers, cooldrinks, sweets and cigarettes. By the second last visit at five months she had secured domestic work for one day of the week. She seemed to be coping adequately.

This mother was experienced as having always been open to the counsellor who did not feel the need to ask her many questions. She expressed appreciation for the support she received and was always at home when the counsellor called. She did not have friends outside the immediate family.

b). The sample of 4 distressed, depressed or difficult to reach mothers.

We were aware that there were mothers who presented as depressed but, without adequate clinical skills to assess that they were clinically depressed, the counsellor considered them distressed mothers and mothers difficult to reach.

The mothers in this group ranged in age from 25 to 30 years with a mean age of 27.5 years. All were unemployed. Three were married and one was single. Two of the married mothers and the single mother lived with their partners and the fathers of their babies who were employed and whom they felt supported them financially and emotionally. All three of the married mothers had had previous births but this was the single mother's first pregnancy. The pregnancy was planned by the two married mothers and the single mother living with their partners but not planned by the married mother living alone with her two older children. All the older siblings lived at home with their mothers. All four mothers delivered normally, three at the Midwife Obstetric Unit and one mother delivered at home.

Mother D1 was married, 25 years old and lived with her husband 'a sweet and supportive man', 5 year old son, her brother-in-law and his wife who were supportive of her. She ran a 'spaza' shop from home. The pregnancy was planned. Like her own mother she suffered 'mental difficulties' known as 'amafufunyane'. During the pregnancy she had bad dreams of a stillbirth and other things going wrong. She feared that things could go wrong for the baby during the pregnancy and at the birth as a result of bewitchment by 'evil spirits'. She also feared that the bad feelings she'd experienced in her previous pregnancy would return and drank 'muthi' from the Sangoma, to keep alive and protect the baby. She experienced swollen feet and neck ache but felt better than she had in her previous pregnancy. At the birth she felt short of breath and was placed on a drip. She thought she was dying and felt weak. The notes revealed how the "mafufunyane" was holding her breath and she had heard voices. After the birth she was relieved that the 'mafufunyane' did not damage the baby inside her but appeared depressed, very anxious and at times quite paranoid with, what seemed like, auditory hallucinations. The notes described a frightening and disturbing voice she identified as "a quite calm one ... who tells you to kill yourself". These auditory hallucinations coexisted with a delusional understanding of her baby's abdominal hernia being the result of bewitchment.

She felt alone, distrustful, miserable and frightened. She was not in tune with her baby's emotional and social needs and development and was suspicious of her baby's behaviour. She would attend her sangoma, the clinic and the hospital and would administer both traditional 'muthi' and western medicines to her child and infant, at the same time. She struggled to understand and manage her older child's behaviour. The counsellor felt she needed more frequent visits and would take calls and visit in between scheduled visits. She was difficult to engage and found it difficult to open up about her fears and difficulties. She believed that her baby was possessed by something, like she is, and expressed the wish that he would be back to the womb where he belonged and would be protected and safe. By the 6th postnatal visit both mother and baby were ill. She was weak and dehydrated, had a stomach ache that she felt nearly took her life, forgetful and distracted. She'd lost weight, was not eating or sleeping at night, denied feeling tearful but the counsellor felt that she was close to tears when she talked to her. The prospect of hospitalizing her baby for a routine hernia operation terrified her. The counsellor felt great concern about how to reach her and how to help her to reach her baby who seemed to be very slow, failing to thrive, and who did not really feel yet to be in the world.

Mother D2 was a single unemployed mother of 25 years who felt isolated from family and friends. She lived in a one-roomed shack and had planned this first pregnancy. She developed boils during her pregnancy. She was financially and emotionally dependent on her partner whom she initially described as being supportive. While she expressed fear of her child being disabled, she struggled with trust and generally kept her difficulties and feelings to herself, showed little

interest in learning and made it difficult for her counsellor to engage with her. At the birth, when the nurses refused to believe that the birth was imminent and told her to go back to sleep, she was able to assert herself and insisted that they examine her. At three months after the birth she spoke, for the first time, about her partner's drinking and how, under the influence of alcohol he became aggressive, inconsiderate and stayed out late. When sober he became remorseful. She was able to stand up to him and wanted to leave him but the counsellor encouraged her to try to solve the problem first. The notes reveal that his behaviour changed when her sister arrived to visit but in the interview she ascribed the change to her partner knowing that she spoke about him to her counsellor. At the second visit their shack had burnt down as partner accidentally kicked over a paraffin stove but she managed to rebuild it. From the start mother interacted well with her infant.

Mother D3 was 30 years of age, married and had 2 older children of 11 and 7 years living with her in a one-roomed shack. This was her 3rd child and a planned pregnancy. She had a good relationship with her husband who was employed, as well as with her in-laws and friends who come around to help her regularly. She worried that she was large, struggled to walk and believed that the birth was a month overdue and that people would talk about that,

.... worried because people were going to talk, why has this woman not given birth. [1] (She felt very anxious). I was unhappy. I could not sleep. ... I had a very big tummy, I could not even walk, I had to stay at home. ... [2](D3)

She expressed gratitude for the support she had received from the nurses at the delivery despite being sent back home more than once before being admitted for the delivery. The counsellor described how this mother had thanked her for the advice she had received from her.

She was selected because, although she welcomed the visits and tended to interact lovingly and responsively towards her baby from the start, an attitude of ambivalence was evident in the form of neglectful behaviour, allowing her baby to cry for long periods despite the counsellor's advice to do otherwise. The counsellor found her, at times, to be resistant to advice and uncommunicative. She would hide her problems until the counsellor noticed that something was wrong. She was not rewarding as a client and did not leave the counsellor feeling appreciated.

Mother D4 was a 30 year old married mother. She lived alone with her sons of 11 and 7 years in a 2-roomed shack. Her pregnancy was unplanned. She had discontinued contraception when her husband left her to live with his girlfriend. The baby was conceived when her estranged husband moved back home for a short spell. He denied paternity and provided very limited and inconsistent financial support for his family who struggled financially with insufficient money for food, clothing and school fees. The younger child had been sent home from school as she could not afford the fees nor the uniform required. The older child struggled to concentrate on his school work and was beaten by his teacher. This mother appeared depressed, despairing and consistently anxious. She felt paralysed and powerless in the face of financial insufficiency and did not share her thoughts and feelings with others. She had initially planned to give the baby away.

When I heard I was pregnant, I planned to give this baby away. ... I thought I would not be able to bring him up without his father and I am unemployed. (D4)

Gradually, with guidance, she began to take action and managed to cope better.

c). The sample of 5 teen or young mothers.

Young, immature and/or teen mothers were strongly represented in the intervention. They seemed to have specific needs and represented specific challenges to the counsellors. Although they were not all in their teen years the two in their early twenties still saw themselves as learners.

This group ranged in age from 16 to 23, with a mean age of 19.2 years. All were single. Four were learners when they fell pregnant. Two of the group expressed their intention to complete their education. Three lived with the fathers of their babies in separate shacks and two lived with family. One mother sold vegetables to help her partner with the expenses. Four of the five mothers said that they felt emotionally and financially supported by their partners. Two of the fathers were in formal full-time employment, two worked part-time and one was unemployed. This was the first pregnancy for four of the mothers but the second for one who had previously lost her baby shortly after birth. Two mothers said that they had planned their pregnancies while three had not. One mother had a normal vertex delivery at the Midwife Obstetric Unit while four had complications (high blood pressure, a large baby, twins, premature delivery), and were transferred to tertiary hospitals. Three had Caesar deliveries.

Mother T1 was 20 years of age. She had lost her own mother at 17 years and still missed her, often lying awake at night thinking about her. She felt guilty and regretted having had to leave school in grade 10 when she fell pregnant. She felt she had let her parents down as they had hoped she would complete her education. Since falling pregnant she lived with her brother, who was casually employed, and his girlfriend in a large house that had belonged to her mother. Prior to that, she and her two siblings (9 years and 11 years) lived with a maternal aunt who worked as a “live-in” domestic worker in a distant suburb and cared for them. Her aunt had felt very angry and ‘hurt’ with the pregnancy as she saw mother as having “degraded her dignity to her own family as if she is a useless mother to her sister’s children”. Without explanation she cut off contact with the mother, who found herself having to manage alone and felt deeply hurt at her aunt’s withdrawal. She also feels very responsible for her younger siblings who continue to live with her aunt. In the pregnancy she felt tired and despondent and expressed fear of the birth. She described being in labour for nine days. Finally the baby was “too big” and needed to be delivered by Caesarean section. After the birth she moved in with her partner and the paternal grandmother. Two days after the birth she felt fragile and weepy. At two months she was weepy once more, hurt and angry about her aunts rejection and full of regret. She was heard telling her baby that she did not hate her. Her partner supported her as he could through casual employment. Two months after the birth her aunt convinced the paternal grandmother to send her home to her brother and his girlfriend. Once back with her brother, financial support from father was unreliable. Both her brother and the baby’s father bought clothes and food for the baby when they were able to do so.

This mother was selected, despite her age, as the counsellor felt she took on an important maternal role for this mother who seemed like a little girl; very naïve and uninformed. She looked to the counsellor to make decisions for her and her boyfriend. She felt very helpless and struggled to manage the baby and handed baby over for others to take over from her. Initially she wanted to sleep all the time, it seemed, to escape her reality.

Mother T2 was 18 years old. She was a scholar in Grade 7 when she discovered she was pregnant. The pregnancy was unplanned. She was living with her own mother who was caring for

eight other children. They lived in extremely stressed financial circumstances. She was never at home for the antenatal visits. She was shocked and overwhelmed when she delivered twin boys at the hospital and abandoned the weaker twin at the hospital. The maternal grandmother was unable to feed an additional two mouths so the paternal grandmother, unwilling to give the twins up for adoption, took mother and the twins into her home. The young father did whatever he could to support with the care of the twins. Two months after the visits began the notes indicate that she felt more in control. "The house is neat and tidy". She seemed to be managing the demands of both the babies and to use the help of the paternal grandmother and of others around her. This mother quickly developed good interactions with both her babies. At the tenth visit the counsellor noted that she was managing well on her own. By the twelfth visit she, her partner and the babies had been provided with their own accommodation and had moved out of the area into accommodation organized by father's work. When interviewed, mother T2 spoke about how, as the mother of twins, she saw herself as different and needing more support,

As I have twins, she came frequently even two times in a week. ... I felt like I was different from others.... I was worried when I got twins. [1](T2)

This mother was selected as she was a teenager, immature, overwhelmed and not coping.

Mother T3 was 16 years of age. She and her partner had planned the baby and were excited when she discovered she was pregnant. She lived with her mother who was shocked at first and then strongly supportive. The baby was born 3 months early following a physical attack by a drunken neighbour, which had traumatised her. She and her baby were kept in the hospital for the first 7 weeks while the baby gained weight. She was first visited at eight weeks. The father paid damages, was very supportive and his family bought clothes for baby. She breastfed throughout and interacted sensitively with her baby. She was selected as she was a young teen and had needed support and containment.

Mother T4 was 23 years of age and single. This was the couple's second baby. They were both very excited about the pregnancy but feared that they might lose this baby as they had lost their first baby a few hours after the birth. She was very young and inexperienced and would refer to the counsellor as her parent. She was on medication for high blood pressure and for that reason she was referred to a tertiary hospital. The birth was induced and then a Caesar performed. Following the birth she felt relieved that her baby was alive and well. She did not feel weepy or fragile and took charge of her life. At two months she spoke of her predicament of wanting to continue breastfeeding which the baby enjoyed but also wanting to complete her schooling the following year. She had made a few decisions; not to take her baby back to her mother in the EC as she would have missed her too much, to look for a caregiver in Cape Town, she had looked for a night school that offered the commerce subjects that she had been doing, not to go home for the December holidays as there was insufficient money to do so and to apply for a grant. At four months; she was receiving a grant, talked about looking for a job and had arranged for the 'next door' granny to look after her baby.

Mother T5 was 18 years old, single and a scholar in Grade 10. She lived with her maternal aunt. The pregnancy was not planned and she felt initially ashamed but by eight months had accepted the pregnancy and had bought clothes for the baby. She hoped to spend the first year caring for her baby and return to school to complete her schooling the following year. She felt frightened of the birth. At the first postnatal visit she told the counsellor that she had felt anger towards her baby for sleeping during the day and keeping her awake at night. She had been neglected as a

child by her biological mother, who had a history of alcohol abuse. She was also angry towards her mother, who had come to Cape Town to collect the 'damages' paid out by her partner, for neglecting the younger siblings left behind in the Eastern Cape. Alcohol abuse was a problem in the family both in Cape Town and 'back home' and she felt ashamed of the fighting that resulted. She discovered that the aunt with whom she lived had spent the food money on alcohol and in a drunken state this aunt had broken a bottle and stabbed her with it. Her partner was supportive. They both decided that it would be better for her to live alone in her own place so he built a shack for her. She sold vegetables to help him out financially and at four months she spoke of longing to go back to school and made plans with her partner to go back to school the following year. The counsellor states: "When I visited her she was living alone and needed lot of support which she appreciated and even after I terminated with her it was difficult for her not to see me."

d). The sample of 4 mothers with HIV/AIDS.

The routine antenatal screening women go through in pregnancy is the way most women discover, if they agree to being informed, that they are HIV positive. Not only do they face all the adjustments that come with being pregnant and having a newborn, they have to deal with the added trauma of adjusting and coping with a life-threatening illness. For some of these women the possibility that the baby has been infected and the threat of death, their baby's or their own, is very real.

In the intervention 22 mothers were believed to be HIV positive. They came to our notice either by disclosing their HIV+ status themselves or, within the context of a strict official policy of exclusive breastfeeding adopted nationally, by informing the counsellors that they had been told by the nurses not to breastfeed their infants. We did not know for sure how many mothers were HIV positive and we did not attempt to compare HIV positive mothers with others, nor do we suggest that this sample is representative of all HIV positive mothers in the community. However it seemed important to include this group who struggle with very real and particular circumstances.

The 4 mothers comprising the HIV positive subgroup all acknowledged to the counsellors that they were HIV positive. A fifth mother identified as HIV+ never acknowledged her HIV+ status so was included in another sample group. The ages of the HIV+ sample ranged from 21 to 27 years with a mean age of 23.5 years. They were all formally unemployed; however three were at various times casually employed. All were single, two lived with their partners, one lived with family and one lived alone. While all four fathers were employed, three of the mothers said they felt emotionally and financially supported by their partners. This was the first pregnancy for three of the mothers. The fourth mother had a daughter of 8 years who lived with her maternal grandmother in the Eastern Cape. None of these pregnancies had been planned and all were healthy normal vertex deliveries. All the mothers lived in inadequate accommodation comprising wood or corrugated iron shacks.

Mother H1 was a single mother of 27 years. She feared telling her partner that she was HIV+ as she feared being abandoned by him. She had overheard him saying that if he was tested and discovered that he was HIV positive he would commit suicide. The baby was unplanned. By the third trimester she had accepted her pregnancy but felt ill-prepared to care for her baby. She struggled with her baby's continuous health problems which tended to be fairly minor but required constant medical attention. She struggled financially and did not have the means she

needed to be able to travel back to the Eastern Cape to see her daughter who was in the care of her maternal grandmother who suffered with TB. She often did not have sufficient food in the house, yet was responsible for feeding her partner's brother who stayed with them and was unemployed. She worried about her father's health. Her partner was supportive but was only casually employed and abused alcohol. During the early months of pregnancy she sold vegetables but this only brought in insufficient money to cover the basic food, clothing and paraffin requirements for the family. At 4 months postpartum she found domestic work for two days of the week. By 6 months she had found casual employment in a restaurant and the baby was being cared for by a caregiver and the father, who had also secured permanent shift work at night. She considered sending her baby to the Eastern Cape where the father's family would have cared for her. She spoke openly of her HIV status to her counsellor during her first antenatal visit.

Mother H 2 was a single mother of 24 years. The pregnancy was unplanned. She struggled throughout the intervention with her own unstable health. In the early months she had to have a cyst removed and over the six months her skin changed colour, she lost weight, suffered from diarrhoea and her hair fell out. She was very worried about not being able to buy the nutritious food she needed to stay healthy. She was unemployed until she found work at a laundry. Her one-roomed shack was cold and had no ceiling and no electricity supply. An electric cable connected her shack to the neighbour's electricity supply and as a result of a short in the cable; the house was set alight and partly destroyed. At four months postpartum her partner left her, denied paternity and moved in with a new girlfriend. She had to fight to get him to provide maintenance and took him to court to prove paternity. She worried constantly about who would care for her baby when she died. Her mother was HIV+ and in prison and her sister of 15 years for whom she was responsible had left school and had become involved with a group of gangsters. She was difficult to engage initially. The counsellor describes her as loud, insensitive to her baby's needs and rough with baby. "She laughed when it was suggested that that she not wake her baby up too suddenly. She disclosed that she had been diagnosed as HIV+ at the second postnatal visit and said that she would be taking her baby in to be tested too. She expressed feeling sorry for the baby and seemed to want him to grow up fast. Shortly after the visits ceased, this mother was attacked and stabbed in the hand by three men who attempted to rape her. She fought them off and escaped.

Mother H 3 was a single mother of 21 years. It took her a while to accept the unplanned pregnancy. She seemed fairly resilient and did not report major problems in her life. Her partner was caring and supportive of her and the baby. She had lost her parents in a motor vehicle accident four years before and experienced some sadness that her parents were not there to help her and spoke of missing them but pushed these thoughts from her mind. She initially lived with an aunt who drank a great deal and was unreliable but was later able to move in with another aunt. She expressed fear of the birth process but it was uncomplicated. At four months postpartum she experienced severe abdominal pain and a 'swollen tummy' that made it difficult for her to walk. She explained to her counsellor that she had 'poison in her system'. The medication she was given did not help and she was referred to hospital. Her family believed that if they left her at that particular hospital she would die. They took her instead to a Sangoma who relieved her of the pain but as the visits drew to an end the abdominal problems recurred and she began losing weight. By the last visit the mother had found work at a pub for three days of the week. Months after the visits ended she would stop her counsellor in the street to tell her how things were going.

Mother H 4 was a single mother of 22 years who lived with her sister, two brothers and five children. The pregnancy was not planned. She had missed her appointment at the clinic and as a consequence of a break in contraception she fell pregnant. She felt guilty as she was completing grade 12 at the time. She planned to return to school the following year. She never actually spoke about her wish to abort the pregnancy, but created the impression in the mind of other people that it had been a considered possibility. She talked about her mother warning her not to kill the baby. She admitted to drinking two or three beers a day but promised the counsellor she would stop. She had a problem with her brothers who drank and came home drunk in the early hours. None of the adults in the home were formally employed. She sold vegetables and her sister sold beer. Her mother, who owned the house, was a pensioner and lived in the Eastern Cape and her father was deceased. Her main concern and source of much anxiety was that her partner, a soldier, who was initially supportive, withdrew from her towards the end of the pregnancy. He abused alcohol and when drunk became jealous and aggressive and provoked fights. He had been temporarily suspended from duty as a result and she feared that he would lose his job. It was only in the third month postpartum that he began, once more, to provide support for her and the baby. She was open about her HIV status to the counsellor. She had told her partner that she was HIV+ but he had refused to have himself tested. She received treatment for HIV and her health was stable.

APPENDIX II.

Mother-Infant Intervention Programme for the Khayelitsha Treatment Trial

Antenatal Visit 1

Agenda for this visit:

- i. Introductions to the intervention.
- ii. Contracting for: the structure of the visits.
- iii. Contracting for: time and setting of the visits.
- iv. Contracting for: confidentiality.
- v. Discussion and input: the mother's current pregnancy.
- vi. Ending off and arrangements for the next visit.

Building trust

The main purpose of the first antenatal visit is to start to build a trusting relationship with the mother so that she feels that **you are absolutely on her side, understand her point of view, and are supportive of her**. For that reason try to arrange time alone with the mother during this visit. This might require some negotiating, as the mother probably did not know when you would be visiting her for the first time. It is important to be accepting of the mother, whatever you may feel about her or her circumstances. **Make it very clear that you are not there as an authority figure who checks up on mothers and evaluates them.**

NB

You need to adopt a counselling attitude of listening and reflecting her feelings. Stay with her and follow her lead throughout the visit and only once you feel you have established a trusting relationship do you begin, gradually and with sensitivity, to introduce your own agenda for the session. *This applies to all future visits.*

AGENDA:

i. Introductions

Introduce yourself to the mother and explain who you are in relation to the study.

Tell her a little about yourself. (For example, that you are a mother, how many children you have and their ages, that you have a special interest in the support of new parents and their infants and that you understand that adjustment to parenthood is not always easy. You should say that you live in the community, but it is best, at this stage, not to give out your address.)

Explain that you are visiting pregnant women in the community at their homes antenatally and for the first 6 months after the birth of the baby.
Explain how you came to know about her.

Explain that **your role will be to support her and that your focus will be on her and her experience with her baby. You will be helping her to learn about her baby.** For example you will be demonstrating her baby's individual qualities and interactive capacities which enable her baby to communicate with her and the rest of the outside world, to make sure his/her needs are met as they should be.

Explain that the programme is designed to help a mother have the best possible experience with her baby.

Explain that parenting is challenging for most parents, but that there are various factors that make it even more difficult for a mother to form an attachment to her baby ("bond" with her baby) and care for her baby. These include:

- Her pregnancy is unwanted or unplanned and she may have considered having an abortion.
- She has had stressful events in her life in the past year, for example, retrenchment, loss of home, loss of someone close.
- She has experienced a lack of emotional and financial support from her partner.
- She has been involved in incidents of domestic violence.
- She has experienced abuse in the past, for example, physical, emotional, sexual, rape.
- She has experienced a lack of support and practical help from family and friends.
- She has a poor, unsupportive relationship with her own mother.
- She experienced a miscarriage, stillbirth or the death of a child.
- She has had a serious depressive episode in the past.
- She is a teenage mother.
- She is a single-parent.

Suggest to the mother that perhaps one or some of these might be relevant to her. (She may start to open up to you or she may just nod in agreement or she may just stare back at you. Do not put her under pressure to open up.)

Explain that when a mother has had any of these experiences, she needs a lot of support and our home visits can provide her with some support.

ii. Contracting for : the structure of the intervention

You should explain what your involvement with her over the following months will be. This includes:

- There will be **2 visits before the birth** (including this one).
- Each visit will last **an hour**.
- **Fourteen further visits will follow postnatally** until her infant is 6 months of age. For the first two months the visits will be weekly, then for the next two months the visits will be every second week, and for the last 2 months the visits will be monthly.

iii. Contracting for: time and setting of the visits

Try to **set up a time** in the week when it would best suit both you and the mother to visit.

Arrange with the mother that when you visit, you and she will have private space where you would both feel free to talk without being interrupted by the radio or family, friends or neighbours. **This is very important.**

iv. Contracting for: confidentiality

It is very important that you explain to the mother how you will be working within a team, under supervision, and that anything discussed with her will be kept confidential within the team.

v. Discussion and input: Mother's current pregnancy

a. Ask the mother to tell you about her pregnancy:

Explore how she has been feeling physically and emotionally and whether she has experienced any problems in this time that are of concern to her.

b. Explore whether this pregnancy has been planned and the feelings related to this:

The very young mothers are unlikely to admit that they planned their pregnancy. Where mothers still feel unsure about the pregnancy, just allow them to speak about it. Don't try to reassure or convince them either way. It is their feelings we are concerned with.

c. If the baby, planned or unplanned, is now much wanted:

If the mother is an adolescent herself she might be dealing with very angry and disappointed parents. She may feel as though she is not allowed or can't be seen to show interest in her pregnancy, and might value an opportunity to talk about and validate her own feelings of disappointment, guilt, anticipation and excitement.

Some questions you could ask the mother:

- Does she have particular thoughts and feelings about her baby?

- Does she have any impressions about the baby so far (e.g. Is the fetus active? Does he or she react to particular external events or the mood of the mother? Can the mother sense some kind of routine in this activity? etc.).
- Does she (or anyone else) have a preference about the sex of the baby?
- Explore any concerns or fears that the mother may express. (e.g. particular fears in relation to whether the baby will survive, might be imperfect/handicapped, have positive or negative personality characteristic, etc....?)

d. Explore whether the mother has experienced any previous pregnancies, births, miscarriages, abortions, stillbirths or deaths of children or any other close family members.

Encourage the mother to talk and express her feelings about such experiences, as she will be close to these feelings in this pregnancy.

vi. Ending off and arrangements for the next visit

- Arrangements must be made for the next visit.
- The mother should be asked if she would like you to meet her partner (or any other important figure in her life who might be involved with the care of the baby).

It is vital to provide private time for the mother to speak about issues she would **not** address in front of other family members, including her partner. But we also want to support the relationship between the baby and his/her father, as well as the relationship between the mother and other people who are part of her support structure.

- Make an arrangement with the mother to get a message to you should the baby arrive sooner than expected. Many mothers are unclear about their dates. You might want to give the mother a phone number where someone could call to let you know.

Agenda for this visit:

- i. Tuning in to mother.
- ii. Discussion: mother's support structures.
- iii. Discussion and input: the labour and birth.
- iv. Discussion: employment.
- v. Discussion: the mother's partner / the baby's father.
- vi. Ending off and arrangements for the next visit.

AGENDA:**i. Tuning in to mother**

On this visit you may meet the woman's partner and / or other family members.

1. Enquire in an open-ended way how the mother has been since last seen and **listen and reflect on any concerns that the mother may raise.**

Be aware that sometimes a mother who has been very open with you during the first session, might be much quieter during this session, perhaps fearing that she has revealed too much about herself, too soon.

2. When you feel that the mother has had sufficient time to express her **concerns**, gradually and with sensitivity, introduce your own agenda for the session.

ii. Discussion: mother's support structures

The fact that the visit is being conducted in the home allows you to enquire more easily about the housing situation and the household, including the availability of support. Try to cover the following questions -

- Whether she and the father of her baby are still together and if so: What his feelings are about this pregnancy. Does she feel cared for and supported emotionally and financially by him?

- Is her own mother present? How did she respond to the pregnancy? Is she supportive?
- Is her mother-in-law present? Is she supportive? What are her feelings about this pregnancy?
- Does mother have friends? Are they supportive?

iii. Discussion and input: the labour and birth

This visit will focus to a large extent on the mother's feelings about the birth and on how she will manage, and the mother's experience of previous pregnancies and births.

iv. Discussion : employment

Try to find out about work issues. For example, are there pressures to go back to work? Have arrangements been thought about? If the mother is unemployed and she has no other financial support, ask about her **plans to support herself** once her baby is born.

v. Discussion : the mother's partner / the baby's father

If the partner is seen, a number of points should be kept in mind. The main aim should be to encourage a mutually supportive relationship between the two partners. If the couple are in harmony, you should reinforce the partner's support and emphasise the value of his contribution for both the mother and the child.

If the partner communicates his own vulnerability and anxiety, this can also be used to strengthen the link between the couple, in that it can be noted that this is a very big emotional event for both of them. The father may find it useful to have you acknowledge his feeling that everyone is focusing on the mother, but that he too may need attention. Thus, you should convey the feeling that both partners receive consideration and that diverse points of view can be heard, despite the primary focus being on the mother at this stage.

You should be aware of potential competition between the woman and her partner and the possibility that one or both of them may wish to create a situation where each individual is concerned to have you see them as the "good" partner, and the other as the "bad" one. In such situations, it will be important to find a way of supporting both partners, reflecting back the perspective of each, but doing so in a way that does not ally you with one individual. **It is especially important that the mother's feeling that you understand and sympathise with her is preserved.**

vi. Ending off and arrangements for the next visit

- Arrangements must be made for the next visit.
- Make an arrangement again with the mother to get a message to you should the baby arrive sooner than expected.

Postnatal visit 1 - Day 3

Agenda for this visit:

- i. Tuning in to mother.
- ii. Discussion and input: the birth.
- iii. Discussion and input: the blues.
- iv. Discussion: concerns for the baby.
- v. Note and comment on: infant social responsiveness.
- vi. Note and comment on: infant behaviour.
- vii. Wider concerns.
- viii. Ending off and arrangements for the next visit.

AGENDA:

This visit, to be held as near as possible to the third day after the birth, will focus to a large extent on the mothers' detailed account of the birth and any joys and disappointments should be shared.

i. Tuning in to mother

1. Enquire in an open-ended way how the mother has been since last seen and **listen and reflect on any concerns that the mother may raise**.
2. When you feel that the mother has had sufficient time to express all her **concerns**, gradually and with sensitivity, introduce the other issues on your own agenda for the session.

ii. Discussion and input: the Birth

Invite the mother to tell you her story of her experience of labour and birth in her own words. **Listen and reflect** on any concerns that the mother may raise.

Once she has told her story gently explore some of the areas she might not have covered. Encourage her to talk about:

- How she felt she was cared for.
- How she felt she managed the process of labour and birth.
- Did she want and was she allowed a birth attendant to accompany her.
- What were her feelings and thoughts as she saw her baby for the first time.
- What would have improved the experience for her.

iii. Discussion and input: the blues

You should enquire whether the mother has found she feels fragile and weepy, (has she had “the blues”)? ***If so, be as supportive as possible and*** focus on any anger or sadness she may be feeling. You should point out that these feelings are common, experienced by nearly all women, and that they will usually quickly settle down. It should be acknowledged that having the baby provokes strong feelings; and any particular issues that came up to the surface should be aired. If the blues continues for more than a few days, be aware that the mother may be postnatally depressed.

iv. Discussion: concerns for the Baby

The mother may have had anxieties and concerns about the baby in pregnancy. These should have been shared with you in the antenatal sessions. The fact of the baby’s presence gives an opportunity to return to these concerns and, in particular, to focus on relevant aspects of the infant’s behaviour and functioning. For example, the mother may have concerns about the baby’s being damaged by the birth. Listen carefully to the mother and if you are equally concerned about an aspect of the infant identified by the mother, refer her back to the MOU for the problem to be assessed.

v. Note and comment on: Infant Social Responsiveness

The full Behavioural and Interactive Assessment of the Baby will not be done until postnatal session 2 at 6-10 days. However, if the infant’s behaviour gives any opportunity to comment on the infant’s responsiveness to, say, the mother’s voice, face or smell, you should exploit this by specifically pointing it out.

vi. Note and comment on Infant Behaviour

You could use the opportunity to talk about the infant’s behavioural state. If you suspect that this may be an irritable/sensitive infant, it may be appropriate for you to say a little about individual differences in babies, and to introduce the idea that some infants are more sensitive than others, and that these babies need more support to help them regulate their state. The aim should be to prevent any belief that, if the infant shows behaviour which the mother finds problematic, this is somehow the mother’s fault.

The mother might highlight aspects of the baby's behaviour which concern her. For example, a mother might be anxious that her baby does not sleep at night. These concerns need to be discussed and placed in the context of normal infant capacities and development.

vii. Wider concerns

You should be alert to the mother's general circumstances and, in particular, to the kind of support she has available. Issues that were raised in pregnancy should be aired again, and strategies to help make most effective use of resources discussed.

viii. Ending off and preparations for the next visit

The mother should be reminded that, at the next visit, you will be carrying out the Behavioural and Interactive Assessment of the Baby. You should discuss with her whether her partner, or older children, or any other important figure in her life who might be involved with the care of the baby, could be present.

Postnatal visit 2 - Day 6- 10

Agenda for this visit:

- i. Tuning in to mother
- ii. The Behavioural and Interactive Assessment of the Baby
- iii. Discussion and input: sleeping
- iv. Discussion and input: crying and consolability
- v. Wider concerns
- vi. Ending off and arrangements for the next visit.

AGENDA:

i. Tuning in to mother

1. Enquire in an open-ended way how the mother has been since last seen and **listen and reflect on any concerns that the mother may raise.**
2. When you feel that the mother has had sufficient time to express all her **concerns**, gradually and with sensitivity, introduce the other issues on your own agenda for the session.

At all times be aware and ready to recognize, point out and praise any positive, sensitive, responsive, loving, attuned, observant, emotionally expressive communication and interaction between the mother/caregiver and the child.

iii. The Behavioural and Interactive Assessment of the Baby (BAIB)²

The main agenda of this visit will be you and the mother (and father and the potential caregiver, if they are present) **thinking together about the baby as a person.**

a. The role of the PICC when demonstrating the Behavioural and Interactive Assessment of the Baby:

- You will have to judge whether the mother is accepting of your undressing and assessing the baby before the umbilical cord has dropped off. Some mothers have strong feelings about this and you might have to wait until the cord is off before going ahead with this assessment.
- The assessment should be administered in a way that actively, and in a supportive manner, involves the mother (and other caregivers, if they are present).
- It is important to be aware that **your interactions with the baby during the assessment will be a model for the mother.** You therefore need to be especially sensitive to cues from the baby. Very importantly, you should demonstrate a pace of talking that is not so fast that it cuts across the baby's initiatives, nor so slow that you lose the baby's attention.
- You should give a careful explanation of what the various components of the assessment reveal about the baby.
- You should point out to the mother that a particularly effective way of entraining baby in face-to-face engagement is to monitor the baby's own expressions and gestures and then respond, either through imitation or affirming the baby's initiative. This serves to give the baby immediate feedback about his/her own behaviour.
- You should be alert for any opportunities to facilitate sensitive communication between the mother and her baby, pointing out to the mother, her baby's responses to her. *

Summary of the Behavioural and Interactive Assessment of the Baby (BAIB)

1. 6 infant behavioural states
2. Ability to shut out intrusive light and sound while asleep.
3. Uncovering and undressing and placing in supine.
4. Ventral suspension.
5. Crawling.
6. Defensive movements (cloth over face).
7. Crying and consolability.
8. Cuddliness.
9. Social interactive package.
10. Imitation, responsiveness and reciprocity.
11. Intrusiveness.
12. Rooting and sucking

² This assessment is derived, in part, from the Brazelton Neonatal Behavioral Assessment Scale, *Clinics in Developmental Medicine*, No. 137, T.B. Brazelton and J.K.Nugent, 1995, and from *The Social Baby*, L.Murray & L.Andrews, 2000.

*Such sensitivity to the baby, and the early active involvement of the baby in this two-way process of communication, in which his attention is maintained on a focus for prolonged periods, has been found to be highly predictive of the baby's later cognitive development.

- With regard to social interaction, remember to inform, and possibly show the mother that, within the first five days, her baby will turn towards her smell rather than another woman's smell. Similarly, he/she will quickly come to prefer the sound of her voice to that of any other person. He/she will also look more to her face than to the face of another woman.

These behaviours are probably biologically programmed to help the mother feel that her baby is connecting with her and to foster or encourage a sense of a special relationship between them. This, of course, is just what the baby needs for optimum (best) psychological development.

- Also with regard to social interaction, remember to inform the mother that within the first few weeks (usually by around four to six weeks) babies show an intense interest in becoming engaged in prolonged (drawn out) interpersonal communication.

If the mother gives the baby good head support and places her face at the optimal distance for the baby's vision (about 22cms), the baby will watch intently and, if the mother is responsive, can be drawn into a "conversation".

Babies of this age will use their mouth and tongue actively, with wide, open, shaping, or protrusions of the tongue over or into the lips (so-called 'pre-speech').

If the mother can be helped to see that this behaviour is not random, but a purposeful effort at communication, they can join in with the baby and together experience a two-way dialogue (referred to as 'proto conversations'). This is typically intensely satisfying for mothers, giving them the feeling that they are really in contact with their baby.

- You should give a running commentary to the baby of what is happening between you and him/her. Watch the baby's response to your commentary. For example, you might say to the baby "You really like talking these days" and then watch the response. This will help the mother to see which strategies elicit and sustain the baby's engagement. Once you have demonstrated this, explain to the mother what you and she have just learned about the baby, and how she could implement this.

If you were insensitive and caused the baby to be avoidant, draw the mother's attention to it and explain to her what has just happened. For example, you might say "Did you just notice that? When I laughed suddenly he turned away from me. I think I overloaded him and came in too forcefully".

- At this stage, do not point out weaknesses such as the baby being low in tone and floppy, or some delay in the baby's response to situations. Keep your concerns in mind and monitor development with time. If you continue to feel concerned about an aspect of the baby's development it is likely that the mother has noticed it too. Affirm her observation and if you are sufficiently concerned and judge it to be necessary,

refer her to the appropriate service. If you are concerned, but the mother is not either aware or concerned, bring your concerns gently to her attention and then refer.

- Once you have completed the assessment, you should give a review of how any difficulties which emerged in the assessment might be displayed during ordinary family care giving (e.g. when changing a nappy, undressing for a bath, putting the baby down to sleep). Also help the mother; father or potential caregiver who is present, think about managing these difficulties.

b. Helping mothers who experience difficulties in engagement:

There are four groups of mothers who need special help engaging with their babies.

1. Mothers who are severely depressed, emotionally flat and unresponsive

Some mothers, especially those who are severely depressed, are emotionally flat and unresponsive. Their babies will typically try to draw them into engagement, fail, and then withdraw. These mothers need to be helped to engage with their babies. A number of strategies can be used.

First, the mother will need to be encouraged to talk to and play with her baby.

Second, the assessment must be used to draw the mother's attention to her baby's individual characteristics and social capacities. It is especially important that you highlight instances of the mother behaving sensitively towards her baby, as well as instances of the baby responding to the mother.

Finally, 'modelling' (that is, your demonstrating sensitive engagement) should be used to give the mother an idea of what sort of adult behaviour her baby finds engaging.

2. Mothers who overload their babies and are not sensitive

Another form of difficulty is where a mother overloads her baby by a constant stream of talk, without any sensitivity to the baby's own perspective.

Since the baby is overwhelmed by the bombardment of stimulation, to protect himself, he may withdraw or become distressed and, consequently, will not engage properly.

These mothers can be helped by slowing the mother down. They should be advised that the baby is having difficulty keeping up with them; and that it would be useful to see how the baby responds to the mother's remaining quiet and only responding to an initiative of the baby. By encouraging the mother to imitate the baby's communicative gestures and commenting upon them, she will be drawn into a meaningful engagement with her baby.

3. Mothers of babies whose motor control is rather poor

A mother who has a baby who has poor motor control (is either, jerky, tremulous (unsteady or shaky), tense or flat and sluggish) need help to achieve satisfying face-to-face engagements.

For example, the latter group of babies may need additional head support to help them keep eye-to-eye contact.

Those who are jerky and tense may find it distressing to be in a situation that babies with better motor control find optimal for social contacts (such as lying supine during a nappy change). These babies are also likely to benefit from a supportive holding environment in order to be able to be fully interpersonally engaged.

The assessment can inform you about the characteristics of the individual infant and the most effective strategies for facilitating a good state; and this information should be used to promote the best possible experience of face-to-face engagement for mother and baby.

4. Mothers who have babies who are irritable and sensitive

Mothers of babies who are irritable / sensitive, and who therefore have difficulty in regulating their state in relation to environmental stimulation, need particular help.

These babies tend to startle at slight events, becoming rapidly disorganized and finding it hard to return to a stable calm state.

In order to achieve and sustain such a baby's positive involvement in face-to-face interactions, the mother should be made particularly aware of the role her responses can play in helping to support the regulation of the baby's state.

Stimulation that is pitched strongly, which may not disturb other babies, will in the case of one who is sensitive, be likely to contribute to the baby's state becoming disorganized.

Mothers of such babies should also be made aware that it will be helpful to pay attention to the context of their interactions. Thus, laying the baby in supine undressed may mean that the baby's spontaneous gross movements are more likely to destabilise a state of calm alert. Providing a more physically supportive environment, where the baby is held, for example, on her lap, may help the baby feel contained.

iv. Discussion and input: sleeping

New parents often have two main concerns about their baby's sleep:

1. They want to help their baby develop a clear distinction between night and day with prolonged sleep during the night.
2. They will want to establish procedures for settling their baby off to sleep in a manner that is peaceful for the baby and that does not place enormous demands on them (by, for example, spending prolonged periods rocking a pram, or walking up and down with the baby in their arms).

The way in which you can help the mother is:

a. Listening

Listen to her, allowing her share her concerns and challenges regarding her baby's sleeping.

Try to understand the expectations the mother has in terms of sleep, both for herself and the baby. Be aware that she may or may not be realistic about what she expects from her baby.

You should bear this in mind when thinking through strategies with the mother.

b. Giving her information about sleeping behaviour in young babies

- During the first few days after birth babies typically spend considerable amounts of time in an awake, alert state, more time in fact than they will do for the next three weeks.

These periods of alertness, cycling with sleep states, give the parents frequent opportunities to engage in direct personal contact with the baby, and to observe how the baby's state and behaviour change in relation to the environment. (it provides an opportunity for them to get to know their baby).

- In the beginning the sleep cycle of the baby and that of his parents are quite disparate or dissimilar. (e.g the baby can be wide awake during the night, a time during which his parents usually are asleep).

Gradually, their sleep cycles become synchronised (happen more or less at the same time) through the parent responding in a way that helps the baby to make the transition to sleep. Also, quite naturally, through the course of ordinary life, exchanges take place that help the baby adapt to his parents rhythms and day-night cycles. For example, having the baby sleep in a crib next to his parent's bed (or in his parent's bed) gives him and his parents repeated opportunities through the night to sense each other's rhythms through changes in breathing and state.

There is some evidence that the first ten days may be an optimal time for establishing the initial co-ordination between the baby and the caretaking environment. Babies who have had care that is unresponsive in the first ten days are more difficult to manage in the subsequent two weeks than babies whose care has been responsive from the start.

- All babies wake frequently during the night. Most babies wake every 45 to 90 minutes throughout the night. Some wake up into a very light sleep or drowsy state but do not wake fully, and if they do wake up, they are able to go back to sleep on their own. Others, however, wake up, but are unable to make the transition back to sleep on their own and need external support, such as being rocked.

c. Helping her to understand her baby's behaviour patterns and rhythms and way of making the transition to sleep

Each baby comes with his own unique rhythms of activity and quiescence (calm) and manner of moving between the six different infant behavioural states.

With regard to particular advice, the best approach to achieving both the aims of settling to sleep and establishing a day-night cycle is founded upon a close observation of the unique behaviour patterns of each baby, and in particular an understanding of the

individual baby's capacity to regulate his state, including how the baby uses his environment (personal or physical).

The Behavioural and Interactive Assessment of the Baby will give you and the mother the opportunity to observe how smoothly the baby is able to shift from each of these states to the other, and how much, and what kind of environmental support the baby may need.

Helping the mother to see the distinct states the baby experiences and what her baby needs to regulate his state will help her manage her baby's sleep in a way sympathetic to his own nature. This is to everybody's benefit because the *research evidence shows that where infant care fits in with a baby's own rhythms and is responsive to that baby's behaviour, babies are generally less distressed, and day -night differences in sleep patterns are established earlier than in those whose care is managed less responsively.

Some babies have the capacity to move smoothly from one state to the next without a great deal of support. Others find transitions from awake to sleep states hard to manage themselves and need much more direct help.

d. Encouraging her to read her baby's cues for moving to a sleep state

Ideally, parents should become aware, from observations of the baby over the first few days, of the very first signs that their baby is becoming tired. These might be, for example, the baby's becoming avoidant or unavailable, moving to state 3 or becoming drowsy; or it could be shown in fussy or irritable behaviour.

Again, based on observation of the individual baby, it may then be possible for the parents actively to arrange the environment to support the baby's transition to a sleep state as soon as the baby shows a sign that he is tiring.

The effectiveness of a particular intervention is maximal when it occurs at a point where the baby is shifting from one phase in his rhythm to the next. For a particular intervention to become a cue for the baby to use in the future to help him make a transition to sleep, it should be used repeatedly by the parent at a particular phase in the baby's state cycle (For example, when the mother observes that her baby is tired she then lays him in his cot. She has learnt that he falls asleep easier when the radio is playing softly in the background. She lays him in his cot and puts the radio on softly when she notices that he is tired. This then becomes the baby's cues for sleep).

* The best text, which is the most accurate in relation to the research evidence, is 'Sleep: the secret of Problem free Nights' by Beatrice Hollyer and Lucy Smith. It is endorsed by the Health Visitor's Association.

e. Helping her to devise interventions that are based on her baby's unique behaviour pattern and rhythms, that help him to make the transition into sleep

Babies vary widely in what will help them make the shift to sleep state. A range of strategies is listed below, from those for babies who find it relatively easy to settle to those for babies who experience real problems. In highlighting these strategies, consideration has been given to the fact that most parents will want to find a method of settling their infant that will not involve their having to be directly physically involved with the infant until he is asleep (as, for example, in patting the baby on his back, or rocking or feeding him to sleep).

- **Visual stimulus**

Some babies may need relatively little direct support and may be calmed by, say, engaging visually with the environment. If the mother has noticed this she may subsequently, as soon as she notices the first sign that the baby is getting tired, try putting her baby in his crib under a mobile with distinct visual contrasts and edges (placed 22cms above his head if on his back), or arranging similar patterns on the inside of the crib if placed on his side.

- **Auditory stimulus (e.g lullabies)**

Another, similarly easily settled baby, may be able to use an auditory stimulus, a tape of lullabies for example, or the noise of a vacuum cleaner (!) to make the transition to a sleep state.

- **Active stimulation (e.g touch, sucking)**

Other babies prefer rather more active stimulation through touch to help them go to sleep, perhaps sucking on something. It is easy for mothers of such babies, and particularly those who are breast feeding, to misread these babies' cues and imagine that the baby is actually hungry. The mother in this situation may well offer the breast; and, indeed, the baby might suck, become less distressed, and fall asleep. The potential problem with establishing this pattern is that the baby will become adjusted to it, and might subsequently always need to suckle on the breast in order to be able to move to a sleep state. Some families may not find this problematic, but mothers should be aware that this might not be a pattern she would like to establish. In such cases it is advisable to help the mother check first whether the baby is genuinely hungry. This can be done by seeing if the baby will root and suck strongly on a finger, and by noting the quality of the cry. If, of course, the baby is genuinely hungry he should be fed. However, it is possible that such a baby's behaviour does not specifically indicate hunger so much as a need for oral comfort. Some babies who find sucking helpful are comforted by sucking on their own fist. Some might be able to achieve this by themselves. Others might only be able to find their fist if they are wrapped so that their fist is in position near their mouth. If the baby cannot achieve this kind of self-control, and sucking seems to be an important way in which this particular baby regulates his state and calms himself to sleep, then the mother might wish to consider using a dummy for this purpose.

- **Direct physical support (e.g swaddling)**

Other babies may require more direct physical support to make the transition to sleep. Such babies may have rather poor motor control, and startle themselves

easily out of a drowsy state into an alert one. In these cases, firm swaddling in a thin cotton sheet may be helpful to contain the baby's movements, and generally calm and soothe them. Some babies might require substantial ventral contact or physical support. It is obviously important if advising on swaddling to explain the issues of overheating.

- **Intensive support (e.g rocking whilst walking around)**

In spite of trying out the strategies outlined above, some babies who become rapidly very disorganised and distressed when needing to sleep may need even more intensive support to become calm and sleep. These babies are usually highly sensitive to slight environmental changes and place great demands on parents. Parents may be helped considerably by having an understanding of the baby's difficulty in regulating their state themselves, and in this way the parents may be able to tolerate giving the kind of support such babies require much more willingly. The baby might, for example, need input from several modalities to contain them: for example, ventral contact and movement, such as in actively rocking the baby.

- **Reducing stimulation**

Alternatively, there are babies who also become disorganised and distressed when needing to sleep, but who require a reduction in stimulation. Trying to intervene actively with such babies may make them even more agitated, and it may be observed that these babies will calm better if all stimulation is cut right down.

Whichever strategy is used to help the baby move into a sleep state, he may find it helpful to have next to him a cloth or cover that has been in contact with his mother and which therefore carries her smell.

v. Discussion and input: crying and consolability

a. Understanding crying

Crying is normal for babies. All babies cry. It is a clear form of communicating needs and is essential for survival. A baby does not cry because s/he is "naughty" but because of one of the following reasons:

- Hunger
- Tiredness
- Over-stimulation
- Discomfort caused by a dirty nappy; digestive disturbances such as cramps, bloating, reflux; indigestion, constipation, diarrhoea, over-feeding, medical conditions, allergies, being too hot or too cold.
- Feeling lonely- the need to be touched, soothed and spoken to

Babies differ in how much they cry. Some babies cry for an hour altogether in a whole day whilst other babies cry for a couple hours unceasingly.

Research has shown that there can be quite a big difference in how much a baby cries and how much the mother expects her baby to cry. There can also be quite a big difference in how much the baby is **actually crying** and **how much the baby seems to**

be crying. For example, a baby may be crying for 1 hour altogether in a day but it might seem to the mother that the baby has been crying the whole day.

Crying evokes powerful emotions. It can evoke joy (e.g. when the mother hears her baby crying for the first time). It can also evoke anger; frustration; rage; disappointment, etc.

How a mother copes with crying and how much crying it takes to push her to the point of desperation, also differs from one mother to the next.

All mothers want to settle their babies as quickly as possible.

b. Strategies for consoling a crying baby

The principles that apply to the management of the transition to sleep apply similarly to baby crying. That is, there should be careful observation of the individual baby's behaviour in order to build up a picture of the circumstances that both provoke and relieve crying. Strategies found to be effective for settling the baby to sleep are also likely to be relevant to relieving crying. However, whereas parents may often want to avoid getting in to a pattern of having to intervene directly with the infant through the transition to sleep, this will almost certainly not be an issue with consoling the infant. The following strategies, therefore, while using the same understanding of the infant's use of different stimulation for regulating their state, involve direct personal intervention by the parents. **They progress from minimum to maximum direct intervention.**

CRYING AND CONSOLABILITY

Minimum

Intervention



Maximum intervention

1. Using voice alone.
2. Presenting face and voice.
3. Assisting with use of hand to mouth, or dummy.
4. Placing a steady hand on the baby's front.
5. Placing hand on baby's front and holding one or both
6. Picking up and holding.
7. Swaddling, holding and rocking.
8. Dummy or finger to suck, and swaddling, holding and rocking.

It is important for the mother to be aware that, as with sleep strategies, some infants may become more distressed with additional stimulation. In such cases, as for sleep, the infant may be better calmed by being left in a quiet semi-dark environment, checking of course to make sure that the baby is all right.

Decisions about the best strategy to try will be most effective when based on detailed observation of the individual baby's responses. There are no universal rules, other than that the mother must be guided by the unique patterns of behaviour of her baby.

vi. Wider concerns

You should be alert to the mother's general circumstances and, in particular, to the kind of support she has available. Issues that were raised in pregnancy should be aired again, and strategies to help make most effective use of resources discussed.

vii. Ending off and preparations for the next visit

Arrangements must be made for the next visit.

Postnatal visit 3 - Day 17 - 21

Agenda for this visit:

- i. Tuning in to mother
- ii. Completion of Behavioural and Interactive Assessment of the Baby
- iii. Discussion and input: sleeping
- iv. Discussion and input: crying and consolability
- v. Wider concerns
- vi. Ending off and arrangements for the next visit.

AGENDA:

i. Tuning in to mother

1. Enquire in an open-ended way how the mother has been since last seen and **listen and reflect on any concerns that the mother may raise.**
2. When you feel that the mother has had sufficient time to express all her **concerns**, gradually and with sensitivity, introduce the other issues on your own agenda for the session.

ii. Completion of the Behavioural Interactive Assessment of the Infant

While you will not on this occasion formally perform the Behavioural Interactive Assessment of the Baby, you might want to complete certain items of the assessment that could not be completed in the previous session.

iii Discussion and input: sleeping

Discuss the baby's sleeping.

Refer to the Postnatal visit 2 notes on sleeping.

iv. Discussion and input: crying / consolability

Discuss the baby's crying and how the mother is managing with it.

Refer to the Postnatal visit 2 notes.

v. Wider Concerns

You should be alert to the mother's general circumstances and, in particular, to the kind of support she has available. Issues that were raised in pregnancy should be aired again, and strategies to help make most effective use of resources discussed.

vi. Ending off and preparations for the next visit

Arrangements must be made for the next visit.

Remember to arrange for the next visit to be at bath time so that you can demonstrate baby massage for the mother.

You should discuss with her whether her partner, or older children, or any other important figure in her life who might be involved with the care of the baby, could be present.

Postnatal visit 4 – 4 weeks

Agenda for this visit:

- i. Tuning in to mother
- ii. Discussion and input: sleeping
- iii. Discussion and input: crying and consolability
- iv. Wider concerns
- v. Ending off and arrangements for the next visit.

AGENDA:

i. Tuning in to mother

1. Enquire in an open-ended way how the mother has been since last seen and **listen and reflect on any concerns that the mother may raise.**
2. When you feel that the mother has had sufficient time to express all her **concerns**, gradually and with sensitivity, introduce the other issues on your own agenda for the session.

ii. Discussion and input: sleeping

Discuss the baby's sleeping.
Refer to the Postnatal visit 2 notes on sleeping.

iii. Discussion and input: crying / consolability

Discuss the baby's crying and how the mother is managing with it.
Refer to the Postnatal visit 2 notes.

iv. Wider Concerns

You should be alert to the mother's general circumstances and, in particular, to the kind of support she has available. Issues that were raised in pregnancy should be aired again, and strategies to help make most effective use of resources discussed.

v. Ending off and preparations for the next visit

Arrangements must be made for the next visit.

The mother should be reminded that at the next visit you will be carrying out the Behavioural Interactive Assessment of the Baby again.

You should discuss with her whether her partner, or older children, or any other important figure in her life who might be involved with the care of the baby, could be present.

Postnatal visit 5 – 5 weeks

Agenda for this visit:

- i. Tuning in to mother
- ii. The Behavioural and Interactive Assessment of the Baby
- iii. Discussion and input: sleeping
- iv. Discussion and input: crying and consolability
- v. Wider concerns
- vi. Ending off and arrangements for the next visit.

AGENDA:

On this visit the Behavioural and Interactive Assessment of the Baby will be repeated. As arranged during the previous visit, you should include mother's partner, co-habiting grandparent or older children in this visit.

i. Tuning in to mother

1. Enquire in an open-ended way how the mother has been since last seen and **listen and reflect on any concerns that the mother may raise.**
2. When you feel that the mother has had sufficient time to express all her **concerns**, gradually and with sensitivity, introduce the other issues on your own agenda for the session.

ii. Behavioural and Interactive Assessment of the Baby

This assessment should be repeated in full.

The baby's development over the weeks can be seen and should be highlighted. In the light of these changes, you should review with the mother strategies for care giving.

Give special attention to the social interaction items. Emphasise any social responsiveness shown to the mother.

iii. Discussion and input: sleeping

Discuss the baby's sleeping.

Refer to the Postnatal visit 2 notes on sleeping.

iv. Discussion and input: crying / consolability

Discuss the baby's crying and how the mother is managing with it.

Refer to the Postnatal visit 2 notes.

v. Discussion: Wider Concerns

You should be alert to the mother's general circumstances and, in particular, to the kind of support she has available. Issues that were raised in pregnancy should be aired again, and strategies to help make most effective use of resources discussed.

vi. Ending off and preparations for the next visit

- Arrangements must be made for the next visit.

Postnatal visit 6 – 6 weeks

Agenda for this visit:

- i. Tuning in to mother
- ii. The Behavioural and Interactive Assessment of the Baby – only the social interactive package and imitation, responsiveness and reciprocity
- iii. Discussion and input: sleeping
- iv. Discussion and input: crying and consolability
- v. Wider concerns
- vi. Ending off and arrangements for the next visit.

AGENDA:

i. Tuning in to mother

1. Enquire in an open-ended way how the mother has been since last seen and **listen and reflect on any concerns that the mother may raise.**
2. When you feel that the mother has had sufficient time to express all her **concerns**, gradually and with sensitivity, introduce the other issues on your own agenda for the session.

ii. Behavioural and Interactive Assessment of the Baby – items 9 and 10 only

On this visit items 9 (social interactive package) and 10 (imitation, responsiveness and reciprocity) of the Behavioural and Interactive Assessment of the Baby will be repeated.

As the visits progress, the emphasis needs to focus more and more on the social interactive items of the assessment – the imitation, sensitive responsiveness on the part of the mother or father towards the baby, reciprocal games and other conversations or communications, and thinking and reflecting on how you understand the baby's behaviour.

You will need to model face-to-face interactions in the form of reciprocal and sensitive exchanges with the baby and look for opportunities to comment on the mother's and father's sensitive and reciprocal face-to-face interactions with the baby when they occur.

You may also need to help the mother to position the baby to facilitate engagement during feeding and at other times.

iii. Discussion and input: sleeping

Discuss the baby's sleeping.

Refer to the Postnatal visit 2 notes on sleeping.

iv. Discussion and input: crying / consolability

Discuss the baby's crying and how the mother is managing with it.

Refer to the Postnatal visit 2 notes.

v. Wider Concerns

You should be alert to the mother's general circumstances and, in particular, to the kind of support she has available. Issues that were raised in pregnancy should be aired again, and strategies to help make most effective use of resources discussed.

vi. Ending off and preparations for the next visit

Arrangements must be made for the next visit.

Remember to arrange for the next visit to be at bath time so that you can demonstrate baby massage for the mother.

You should discuss with her whether her partner, or older children, or any other important figure in her life who might be involved with the care of the baby, could be present.

Postnatal visit 7 – 7 weeks

Agenda for this visit:

- i. Tuning in to mother
- ii. The Behavioural Interactive Assessment of the Baby
- iii. Discussion and input: sleeping
- iv. Discussion and input: crying and consolability
- v. Wider concerns
- vi. Ending off and arrangements for the next visit.

AGENDA:

i. Tuning in to mother

1. Enquire in an open-ended way how the mother has been since last seen and **listen and reflect on any concerns that the mother may raise** as a result of the issues raised in the previous visit.
2. When you feel that the mother has had sufficient time to express her concerns, **gradually and with sensitivity, introduce your own agenda for the session.**

At all times be aware and ready to recognize, point out and praise any positive, sensitive, responsive, loving, attuned, observant, emotionally expressive communication and interaction between the mother/caregiver and the child.

ii. The Behavioral Interactive Assessment of the Baby

Repeat aspects of the Behavioral Interactive Assessment of the Baby, especially those highlighting infant social responsiveness.

iii. Discussion and input: sleeping

Discuss the baby's sleeping.

Refer to the Postnatal visit 2 notes on sleeping.

iv. Discussion and input: crying / consolability

Discuss the baby's crying and how the mother is managing with it.

Refer to the Postnatal visit 2 notes.

v. Wider Concerns

You should be alert to the mother's general circumstances and, in particular, to the kind of support she has available. Issues that were raised in pregnancy should be aired again, and strategies to help make most effective use of resources discussed.

vi. Ending off and preparations for the next visit

- Arrangements must be made for the next visit.

Postnatal visit 8 – 8 weeks

Agenda for this visit:

- i. Tuning in to mother
- ii. The Behavioural and Interactive Assessment of the Baby
- iii. Discussion and input: sleeping
- iv. Discussion and input: crying and consolability
- v. Wider concerns
- vi. Ending off and arrangements for the next visit.

AGENDA:

i. Tuning in to mother

1. Enquire in an open-ended way how the mother has been since last seen and **listen and reflect on any concerns that the mother may raise** as a result of the issues raised in the previous visit.
2. When you feel that the mother has had sufficient time to express her concerns, **gradually and with sensitivity, introduce your own agenda for the session.**

ii. The Behavioural and Interactive Assessment of the Baby

Run through the full assessment for the last time. Ask the mother to tell you about all the changes she has seen and pointing out how much development you have noticed.

iii. Discussion and input: sleeping

Discuss the baby's sleeping.

Refer to the Postnatal visit 2 notes on sleeping.

iv. Discussion and input: crying / consolability

Discuss the baby's crying and how the mother is managing with it.
Refer to the Postnatal visit 2 notes.

v. Wider Concerns

You should be alert to the mother's general circumstances and, in particular, to the kind of support she has available. Issues that were raised in pregnancy should be aired again, and strategies to help make most effective use of resources discussed.

vi. Ending off and preparations for the next visit

Arrangements must be made for the next visit.

Remind the mother or caregiver that as from next week your visits will only be every second week and then once a month from the fourth month. Explore and allow her to express her feelings about this change of routine.

Postnatal visit 9 – 9 weeks

Agenda for this visit:

- i. Tuning in to mother
- ii. Encouraging social interaction between mother / caregiver and baby
- iii. Discussion and input: sleeping
- iv. Discussion and input : crying and consolability
- v. Wider concerns
- vi. Ending off and arrangements for the next visit.

AGENDA:

i. Tuning in to mother

1. Enquire in an open-ended way how the mother has been since last seen and **listen and reflect on any concerns that the mother may raise** as a result of the issues raised in the previous visit.
2. When you feel that the mother has had sufficient time to express her concerns, **gradually and with sensitivity, introduce your own agenda for the session.**

ii. Encouraging social Interactions between mother and baby

The focus of the visits now shifts substantially to encouraging social interactions between the mother or caregiver and the baby.

Take advantage of the infant's pre-speech developing at this time and his or her fascination with mother's face and eyes. You will model face-to-face interactions and sensitive reciprocal exchanges in the form of verbal and non-verbal conversations with

the baby. Comment to the baby about what is going on around her or him and reflecting on how baby might be experiencing this.

Try to find an opportunity to see the mother interact face-to-face with the baby. Help the mother to position the baby to facilitate social engagement.

iii. Discussion and input: sleeping

Discuss the baby's sleeping.

Refer to the Postnatal visit 2 notes on sleeping.

iv. Discussion and input: crying / consolability

Discuss the baby's crying and how the mother is managing with it.

Refer to the Postnatal visit 2 notes.

v. Wider Concerns

You should be alert to the mother's general circumstances and, in particular, to the kind of support she has available. Issues that were raised in pregnancy should be aired again, and strategies to help make most effective use of resources discussed.

vi. Ending off and preparations for the next visit

Arrangements must be made for the next visit.

Remind the mother or caregiver that as from next week your visits will only be every second week. Explore and allow her to express her feelings about this change of routine.

Agenda for P10 – 15 visits:

- i. Tuning in to mother
- ii. Encouraging social interaction between mother / caregiver and baby
- iii. Discussion and input: sleeping
- iv. Discussion and input : crying and consolability
- v. Wider concerns
- vi. Ending off and arrangements for the next visit.

Postnatal visits 10 – 15

Postnatal visit 10 –11 weeks

Postnatal visit 11 – 13 weeks

Postnatal visit 12 – 15 weeks

Postnatal visit 13 – 17 weeks / 4 months

Postnatal visit 14 – 21 weeks / 5 months

Postnatal visit 15 – 25 weeks / 6 months

Additional input:

Postnatal 12 visit:

Remind the mother that after your P13 visit you will be visiting her on a monthly basis. Explore and allow her to express any feelings regarding this change.

Postnatal 13 visit:

Discuss changes in the baby's social responsiveness with the increase in maturity. Remind the mother that you only have two more visits before this programme comes to an end. The baby's eyesight has developed and the baby can now see better at a distance. This will mean his interest will shift away from just playing face-to-face, to events and objects further away. The mother's understanding this shift and noticing the baby's new interests, will allow her to respond sensitively in new ways: following the infant's interest, starting to play simple body games, such as, 'peek-a-boo' and 'round and round the garden'.

Postnatal 14 visit:

Remind the mother at the beginning of this session that you only have one visit left before this programme comes to an end. Now the baby will be able to reach out and grab things nearby; again if the mother follows the baby's cues, she can use this new development to have different social experiences with her baby that will hold the baby's interest and give enjoyment.

Despite the best preparation there will be mothers who will have very strong feelings of abandonment and sadness about this ending. You need to be aware of this even though this may not be conscious in the mother or

expressed openly to you. Remind the mother that as part of the study there will be further assessments of her and her baby and this will provide her with further opportunities to express any concerns she may have.

Postnatal 15 visit:

You will need to say goodbye to the mother and her baby and the others with whom you have worked in the household. It might be helpful to review, with the mother, what this has meant to her and what she feels she has learnt through the process.

APPENDIX III. Interview Guide for interviewing mothers..

Mother's Name: _____ **Address:** _____

(Preamble: We would like some feedback from mothers who have been through the intervention as we are planning to develop it further and would like to know, from your point of view, what would improve the programme.)

1. How many times did your counsellor come to visit you at home?
 - a) Before the birth _____
 - b) After the birth _____
2. How long did each visit last?
3. What did you think and how did you feel after each visit? (Encourage the mothers to describe her feelings and her experience of these visits as far as possible.)
4. What did you find helpful about the visit?
5. What did you think about what you were shown and the information you were given at the visits?
6. Did the information you were given conflict with your beliefs? If they did, how was this dealt with?
7. Did you ever feel that foreign ideas were being imposed on you?
8. Have the visits changed the way you think about babies and children? How?
9. Has the new knowledge been relevant and useful in the way you manage your baby?
10. Have these visits made a difference to; a) your partner (baby's father), b) your other children, c) your baby, d) other family members?
11. What did you value most about the visits?
12. What was the most useful thing the counsellor did during the visits?
13. What would have improved the visits for you? What would you change?
14. Would you encourage your friends with babies to agree to such visits if it was offered to them?
15. How early do you think these visits should start? Why?
16. How long should they continue? Why?

Appendix IV.

Improving quality of mother-infant relationships and infant attachment in socioeconomically deprived community in South Africa: randomized controlled trial.

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BMJ

Improving quality of mother-infant relationship and infant attachment in socioeconomically deprived community in South Africa: randomised controlled trial

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Improving quality of mother-infant relationship and infant attachment in socioeconomically deprived community in South Africa: randomised controlled trial

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ABSTRACT

Objective To assess the efficacy of an intervention designed to improve the mother-infant relationship and security of infant attachment in a South African peri-urban settlement with marked adverse socioeconomic circumstances.

Design Randomised controlled trial.

Setting Khayelitsha, a peri-urban settlement in South Africa.

Participants 449 pregnant women.

Interventions The intervention was delivered from late pregnancy and for six months postpartum. Women were visited in their homes by previously untrained lay community workers who provided support and guidance in parenting. The purpose of the intervention was to promote sensitive and responsive parenting and secure infant attachment to the mother. Women in the control group received no therapeutic input from the research team.

Main outcome measures Primary outcomes: quality of mother-infant interactions at six and 12 months postpartum; infant attachment security at 18 months. Secondary outcome: maternal depression at six and 12 months.

Results The intervention was associated with significant benefit to the mother-infant relationship. At both six and 12 months, compared with control mothers, mothers in the intervention group were significantly more sensitive (6 months: mean difference=0.77 (SD 0.37), $t=2.10$, $P<0.05$, $d=0.24$; 12 months: mean difference=0.42 (0.18), $t=-2.04$, $P<0.05$, $d=0.26$) and less intrusive (6 months: mean difference=0.68 (0.36), $t=2.28$, $P<0.05$, $d=0.26$; 12 months: mean difference=-1.76 (0.86), $t=2.28$, $P<0.05$, $d=0.24$) in their interactions with their infants. The intervention was also associated with a higher rate of secure infant attachments at 18 months (116/156 (74%) v 102/162 (63%); Wald=4.74, odds ratio=1.70, $P<0.05$). Although the prevalence of maternal depressive disorder was not significantly reduced, the intervention had a benefit in terms of maternal depressed mood at six

months ($z=2.05$, $P=0.04$) on the Edinburgh postnatal depression scale).

Conclusions The intervention, delivered by local lay women, had a significant positive impact on the quality of the mother-infant relationship and on security of infant attachment, factors known to predict favourable child development. If these effects persist, and if they are replicated, this intervention holds considerable promise for use in the developing world.

Trial registration Current Controlled Trials ISRCTN25664149.

INTRODUCTION

Extensive research over the past three decades has shown that when infants experience reliable care that is sensitive to their developmental needs over the first year or so of life, they are likely to develop a secure attachment to their principal carer, usually their mother,¹ and that this security of attachment endures through to adulthood.²⁻⁵ In turn, security in the infant's key attachment relationship is associated with better outcomes in several domains of development, in both the short term and the longer term. In early and middle childhood, the benefits of a secure attachment are principally shown in good peer relationships and socio-emotional adjustment^{6,7}; in adulthood, associations are consistently found with lower rates of mental health problems.¹ Notably, emerging evidence also indicates benefits of secure attachments for physical health, including lowered rates of failure to thrive in infancy and early childhood, fewer chronic and recurrent health problems, and better health and lifestyle practices in adulthood (for example, in relation to smoking, drug use, and sexual behaviour), and these benefits are reliably associated with lower health costs.⁸

The capacity of parents to provide the kind of care that promotes security of attachment in infancy and good developmental outcome in childhood can be severely compromised in adverse conditions such as poverty, particularly when mothers have depression.⁹⁻¹¹ This is of particular concern in

populations in the developing world, where rates of poverty and of maternal depression after childbirth are high.¹² Research in Khayelitsha, a peri-urban settlement in South Africa, where a high prevalence of maternal depression was found, also showed, for example, marked impairments in mother-infant interactions compared with those seen in populations in the developed world.¹³ A recent extension to this work showed that these early parenting difficulties were associated with longer term insecurity in the mother-infant attachment relationship.¹⁴ Interventions in the developed world have been successful in bringing about improvements in mother-infant relationships and infant attachment when they are focused on difficulties in parenting behaviours,¹⁵ and an urgent need exists to develop such interventions for developing world contexts. Moreover, given the marked limitation in healthcare resources, interventions in the developing world that capitalise on locally available resources are a particular priority.

A small case series in Khayelitsha, in which local mothers from the community were trained to give support to mothers of young infants, produced promising evidence of an improvement in mothers' capacity to interact sensitively with their infants.¹⁶ The study reported here was a randomised controlled trial of this intervention, which aimed to determine not only whether short term improvements could be brought about in mother-infant interactions but also whether a reduction could be achieved in rates of insecure attachment later in infancy. We had the secondary objective of determining whether the intervention would confer benefits in terms of maternal mood. With regard to

mother-infant interactions, as well as the general characteristic of sensitive responsiveness, we also sought to reduce rates of highly intrusive parenting. We had found that this type of parenting difficulty, in which parents impose their own agenda and cut across, or interfere with, the infant's behaviour, is particularly common and extreme in Khayelitsha; moreover, extensive research has shown that intrusive parenting is a major risk factor for those poor childhood outcomes that are of particular concern in such communities, such as conduct disorder and gang violence.^{17 18} These same childhood behavioural problems are also associated with particular kinds of attachment insecurity—namely, those in which the infant fails to treat the parent as a source of comfort and trust and instead either avoids contact with them when distressed (the avoidant insecure pattern) or else responds in a confused and dysregulated fashion (the disorganised attachment pattern).¹⁹ When considering attachment outcome, therefore, we were particularly concerned to reduce rates of these two forms of insecurity.

METHOD

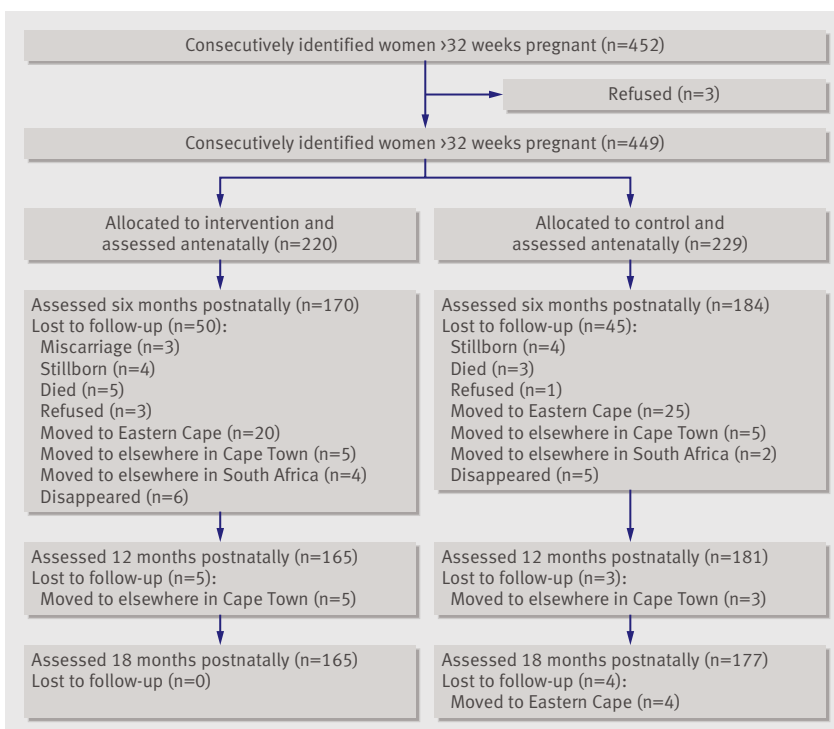
Protocol, design, and objectives

The study was a randomised controlled trial, in which we randomly assigned pregnant women to an intervention group or a no treatment control group. We made independent assessments, blind to treatment groups, before treatment, at the end of treatment, and at 12 months and 18 months postpartum.

The study took place in two adjoining areas of Khayelitsha (SST and Town II), a peri-urban settlement of between 500 000 and 750 000 people on the outskirts of Cape Town, South Africa. SST is an informal settlement of shacks characterised by particularly high levels of unemployment and poverty; most shacks are without running water, and considerable overcrowding exists. Many of the inhabitants are recent migrants from rural parts of South Africa. Town II, into which SST merges, is characterised by a somewhat better standard of living. Dwellings are supplied with electricity, most have an indoor water supply, and increasing numbers are served by an indoor waterborne sewage system. Since the election of the ANC government in 1994, a concerted nationwide effort has been made to improve housing conditions; during the study period, much of SST was razed and the inhabitants were accommodated in better housing nearby, similar to that in Town II.

Sample size

Our own epidemiological work in Khayelitsha showed that most (58%) of the mothers were rated as being insensitive to their infant during play interactions (compared with a rate of 25% in a British sample of non-depressed mothers²⁰).¹³ If the intervention was to effect an improvement by six months in the quality of the mother-infant relationship of at least one third (the same order of improvement as effected by interventions in developed countries¹), this improvement



Flow of participants through study

Table 1 | Characteristics of sample. Values are numbers (percentages) unless stated otherwise

Characteristic	Intervention group (n=220)	Control group (n=229)
Area:		
SST	124 (56)	121 (53)
Town II	96 (44)	108 (47)
Major depressive disorder	36 (16)	36 (16)
Unplanned pregnancy	89 (40)	83 (36)
Married/cohabiting	133 (60)	140 (61)
First child	83 (38)	83 (36)
Male child	106 (48)	110 (48)
Housing—shack	185 (84)	199 (87)
Mean (SD) age (years)	25.5 (5.23)	26.2 (5.84)

could be detected ($\alpha=0.05$, 80% power) with two samples of 145 each. A similar degree of improvement in intrusiveness would also be detectable with such samples. (This estimate is conservative, because we intended to analyse the mother-child interaction variables as continuous variables and this would probably mean increased power).

Participants

Over a period of 22 months, we made efforts to identify and recruit unselected women living in SST and Town II who were in the last trimester of their pregnancy (on the basis of the accounts of their gestation that women had received from the antenatal clinic). Throughout the recruitment period, over three week cycles, a research assistant visited all the homes in both areas to inquire whether anyone had become pregnant or a pregnant woman had moved into the area and to invite identified women to participate in the study.

We anticipated a substantial loss to follow-up, particularly after women had delivered their infants, because many women from rural areas come to the city to use the obstetric services and then return to their rural homes. We identified a consecutive series of 452 women as pregnant within the study area and invited them to take part in the study. Of these, only three refused. After the women had given written informed consent, we made an antenatal assessment to obtain demographic details (such as age and marital status) and information on wider circumstances (such as obstetric factors and housing conditions); we also assessed mental state (see below). We then assigned the 449 women to the intervention or control group by using minimisation,²¹ balancing for antenatal depression, whether or not the pregnancy was planned (that is, factors known to be associated with adverse outcome¹⁴), and whether the mother was living in SST or Town II. We did not pay the women for their participation in the research, but at each assessment we provided a small gift for the infant (an item of clothing). Seven pairs of twins were born, of whom we included only the first born child in the study.

Assignment

The relevant information from the initial assessment was communicated by telephone to the trial manager

(MT), who ran the minimisation programme and communicated group assignment. The figure shows the progress of participants through the study. By the final assessment at 18 months postpartum, 107 of the 449 women were lost to follow-up, leaving 342 women (76% of the original sample); most of the losses occurred, as anticipated, in the six month period after delivery. This is consistent with the known high mobility within this community and equivalent to the proportion lost to follow-up in our previous study in the same two areas.^{13 14} The women lost to follow-up did not differ from those retained in terms of demographic characteristics (parity, marital status), apart from age; those lost were somewhat younger than those retained (mean 24.9 (SD 4.4) years versus 26.1 (5.8); $t=2.07$, $df=447$, $P<0.05$), and neither did they differ on any of the minimisation criteria or on area of residence.

Intervention

We based the intervention on an adaptation of a preventive intervention programme by health visitors devised for implementation in Britain, which itself closely follows the principles contained in *The Social Baby*.²² We adapted this programme for the Khayelitsha project by incorporating the key principles of the World Health Organization's document *Improving the Psychosocial Development of Children*.²³ The content and conduct of the intervention was specified in a manual, which was used to train the therapists. (This manual is available at www.reading.ac.uk/psychology/research/child-development/clinical-subgroup.asp). The aim of the intervention was to encourage the mother in sensitive, responsive interactions with her infant. A major aspect was the use of particular items from the neonatal behavioural assessment schedule,²⁴ to sensitise the mother to her infant's individual capacities and needs. The intervention was delivered by four women, resident in Khayelitsha, who had been selected with help from the local community council. The women had no formal specialist qualifications, although all were mothers. Two had completed schooling. They received training over a four month period in basic parenting and counselling skills, as well as in the specific mother-infant intervention. An experienced community clinical psychologist (ML) provided them with group supervision throughout the study, on a weekly basis, offering session by session supervision. The intervention was delivered in participants' homes in hour long sessions. The women in the intervention group were visited, ideally, twice antenatally, weekly for the first eight weeks postpartum, fortnightly for a further two months, and then monthly for two months (that is, 16 sessions in total, ending at five months postpartum). Women in the control group received the normal service provided by the local infant clinic (as did the intervention group). This involved fortnightly visits by a community health worker, who assessed the physical and medical progress of mothers and infants, and encouragement of mothers to take their infant to

Table 2 | Quality of maternal engagement with infant at six and 12 months

	Mean (SD)		Difference		t	P value
	Intervention group (n=153-9)	Control group (n=165-9)	Mean (SE)	95% CI		
Six months						
Sensitivity	15.35 (3.36)	14.58 (3.18)	0.77 (0.36)	0.048 to 1.492	2.10	0.037
Intrusiveness	6.51 (2.73)	5.82 (2.64)	0.68 (0.36)	0.093 to 1.278	2.28	0.024
12 months						
Sensitivity	5.74 (1.88)	5.31 (1.51)	0.42 (0.18)	0.058 to 0.797	-2.04	0.043
Intrusiveness	6.41 (7.27)	8.17 (8.34)	-1.76 (0.86)	-3.466 to -0.058	2.28	0.023

the local clinic to be weighed, have their physical health assessed, and be immunised.

Outcomes

The primary outcomes at six and 12 months were those aspects of the mother-infant relationship previously found to be associated with both socioeconomic adversity and maternal depression (that is, maternal sensitivity and intrusiveness); at 18 months the primary outcome was infant attachment. The secondary outcome was maternal depression (a dichotomous variable for depressive disorder and a continuous variable for depressive symptoms) assessed at six and 12 months.

Assessments took place in a custom-made prefabricated research unit adjoining a local well baby clinic and women's health project, to which the research team brought mothers and infants. The building included a playroom with a one way mirror and an adjoining observation room. Mothers and infants were assessed at six and 12 months postpartum, when mother-infant interactions were observed, and at 18 months postpartum when infant attachment was formally assessed (see below). At six and 12 months postpartum their mental state (see below) was assessed. Mothers and infants in the intervention and controls groups visited the research unit on an equal number of occasions and for equivalent lengths of time, and their experience of the assessment procedures, including the video recording, was similarly equivalent.

Mother-child interactions

We used age appropriate measures to assess the quality of mother-child interactions at six months and 12 months, by scoring with established, reliable scales. At six months the mothers and infants were filmed in a 10 minute free play interaction, in which we asked mothers to interact with their infants as they would if

they were at home. We rated episodes with the parent/caregiver involvement scale, which measures the responses of the mother to her infant's needs and initiations.²⁵ In view of the literature and our own earlier findings in Khayelitsha,^{14,21} our focus was on whether the intervention significantly improved the sensitivity of maternal interactive behaviour and reduced maternal intrusiveness. Accordingly, a trained rater, blind to both treatment group and maternal mental state, scored the videotapes on the five dimensions of "physical involvement," "verbal involvement," "responsiveness," "positive statements," and "control over child's activities," each rated on a five point scale for the "quality" and "appropriateness" of maternal behaviour. We calculated sensitivity as the sum of ratings for the first four dimensions and intrusiveness as the sum of ratings for the last dimension (with codes reversed). We assessed inter-rater reliability on 20 tapes and found it to be uniformly good ($\kappa=0.81$ for sensitivity and $\kappa=0.85$ for intrusiveness).

At 12 months the mother and child were observed in a structured play situation.^{26,27} This comprised two three minute episodes, in each of which the mother was asked to play with the infant by using novel toys—a set of stacking rings and a form board. Each typically requires infants of this age to be given support by an adult, so they provided an opportunity to observe how well the mother was able to facilitate the child's play. A trained rater, who was blind to treatment group, maternal mental state, and the interactions at six months, scored maternal behaviour from the videotapes on measures of sensitivity and intrusive-coercive control. We used an established measure to rate sensitivity on a five point scale^{26,27}; scores were summed across the two tasks. We established intrusive-coercive control by counts of the defined behaviour.²⁷ A second trained rater, also blind to group and maternal mental state, scored 20 of the videotapes to establish inter-rater reliability: weighted $\kappa=0.91$ for sensitivity, and Pearson $r=0.83$ for intrusiveness.

Maternal depression

A trained black South African Xhosa speaking researcher interviewed mothers by using the major depression section of the structured clinical interview for the Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV) diagnoses.²⁸ The interview had been translated and then back translated

Table 3 | Infant attachment categories for intervention and control groups at 12 months. Values are numbers (percentages)

Attachment	Intervention group (n=156)	Control group (n=162)
Secure	116 (74)	102 (63)
Insecure:	40 (26)	60 (37)
Avoidant	17 (11)	31 (19)
Resistant	13 (8)	13 (8)
Disorganised	10 (6)	16 (10)

by following standard principles.²⁹ The interviewer and the second author (a clinical psychologist), both of whom were blind to treatment group, reviewed each assessment anonymously, using both tape recordings and the interviewer's notes. A collective decision was made about each of the relevant symptoms, on which the decision about the presence or absence of a DSM-IV major depressive disorder was based.³⁰ We also obtained a continuous measure of depressive symptoms by incorporating the 10 items from the Edinburgh postnatal depression scale, each scored 0-3, into the structured clinical interview for DSM-IV.

Infant attachment

At 18 months, we used the strange situation procedure developed by Ainsworth and colleagues to assess infant attachment.³¹ This is a structured, standard procedure, used extensively in research in both the developed and developing world. The assessment has good reliability and predictive validity.³² The infant was filmed through a one way mirror, in an unfamiliar playroom over a 21 minute period, during episodes of separation and reunion with the mother and in the presence of a stranger. MT, who had been trained for reliability and was blind to all other information about the infants and their mothers, rated the videotapes. He used the ABCD system^{31,33}, that is, infants were rated as securely attached or insecurely attached, the second of these being specified as avoidant, anxious-resistant, or disorganised. We confirmed reliability by assessing agreement between MT and a second trained rater on 16 tapes ($\kappa=0.96$).

Statistical analyses

We used SPSS 12.0 for Windows for descriptive and analytical statistical analyses. We investigated continuous variables for departure from normality by using Shapiro-Wilk's test and compared the treatment groups by means of two sample *t* tests or Mann-Whitney U tests, as appropriate. For dichotomous outcomes we used χ^2 tests to compare groups. We also expressed the differences between the intervention and control groups for the mother-infant interaction variables in terms of effect size by using Cohen's *d*.³⁴ As mothers from Town II and SST did not differ on any of the outcomes for either the intervention or the control group, we ignored this variable in the analyses reported below.

RESULTS

Three quarters of the women in the intervention group received the full 16 sessions, and less than 15% received fewer than 10 sessions (mean number of sessions=14.1, SD 3.92). Table 1 shows the characteristics of the sample. The randomisation process resulted in closely equivalent groups in terms of demographic variables.

Mother-infant interactions

Table 2 shows scores on the ratings of mother-infant interactions at six months and 12 months. At both time points, compared with mothers in the control group, those in the intervention group were rated as interacting with their children in a significantly more sensitive and less intrusive manner. Cohen *d* analyses revealed a small effect size for all variables (effect size for sensitivity of $d=0.24$ at six months and $d=0.26$ at 12 months; $d=0.26$ and $d=0.24$ for intrusiveness).

Infant attachment

Table 3 shows the distribution of classifications of infant attachment. A significantly greater proportion of infants of mothers in the intervention group than infants of control mothers were rated as securely attached at 18 months (74% v 63%; Wald=4.74, odds ratio=1.70, $P=0.029$). The principal difference between the groups derived from the higher rate of avoidant infants in the control group. The rate of disorganised attachments by infants was also higher in the control group, but not significantly so. We found no association between infant attachment status and the parenting variables. For example, although differing in the expected direction, the mean sensitivity ratings at 12 months for secure versus insecure infants were not significantly different (5.47 (SD=1.78) and 5.29 (1.52), $t=0.82$, $df=276$, $P<0.44$), and nor were the means for intrusiveness (7.77 (7.97) and 8.00 (8.80), $t=0.24$, $df=276$, $P<0.82$).

Maternal depression

As can be seen in table 4, the prevalence of depressive disorder for the mothers in the intervention group was lower than that in the control group at both assessments; however, the differences were not statistically significant ($\chi^2=0.85$, $df=1$, $P=0.36$ at six months; $\chi^2=1.16$, $df=1$, $P=0.21$ at 12 months). With regard to maternal depressive symptoms (the continuous Edinburgh postnatal depression scale measure; see table 4), the mean scores for those in the intervention group were lower at both assessments than were those for the control group, but the benefit of treatment was significant only at six months ($z=2.05$, $P=0.041$ at six months; $z=0.24$, $P=0.813$ at 12 months). Neither maternal depressive disorder nor maternal depressive symptoms were correlated with the parenting variables or infant attachment. For example, at six months postpartum the correlations between the Edinburgh postnatal depression scale score and sensitivity was $r=0.04$, and that between the depression scale score and

Table 4 | Maternal depressive disorder and depressive symptoms at six and 12 months for intervention and control group

	Intervention group	Control group
Depressive disorder—No (%)		
Six months	21 (12.4) (n=170)	29 (15.8) (n=184)
12 months	18 (10.9) (n=165)	28 (15.5) (n=181)
Depressive symptoms—mean (SD)	(n=170)	(n=184)
Six months	2.78 (4.54)	3.91 (5.80)
12 months	1.93 (4.54)	2.69 (5.86)

WHAT IS ALREADY KNOWN ON THIS TOPIC

Mother-infant interactions are adversely affected by both socioeconomic adversity and maternal depression

Such impaired interactions are associated with adverse psychological, social, and physical consequences for child development

Some evidence from Western countries shows that interventions directed at mother-child interactions can improve mother-child interactions and childhood outcome

WHAT THIS STUDY ADDS

A home based mother-infant intervention, delivered by trained lay therapists in the context of socioeconomic disadvantage, has positive benefits for both maternal responsiveness and children's emotional development

This low cost approach could be integrated within health systems at a population level to deliver interventions to mothers and their infants in the developing world

intrusiveness was $r=0.10$; the mean Edinburgh postnatal depression scale scores for secure (3.61, SD 5.34) and insecure (3.35, 5.59) infants were similar ($t=0.37$, $df=286$, $P<0.71$).

DISCUSSION

Compared with women who received no specific help or support, women in Khayelitsha who received a home based intervention interacted with their infants with greater sensitivity and with less intrusiveness, both shortly after completion of the intervention (six months postpartum) and at a longer term follow-up (12 months postpartum). The magnitude of improvement in parenting was of the same order as reported in studies in the developed world of supportive interventions that focused on sensitivity.¹⁵ At 18 months postpartum infants whose mothers had received the intervention were more likely to be rated as securely attached to their mothers than were infants of control group mothers. Given the reliable relation between early insecure attachment and later childhood behavioural problems, the fact that more than 10% fewer of those who received treatment were insecure compared with the controls means that early intervention could have the potential to make an important contribution to reducing the rate of subsequent childhood disturbance.

Although we found no difference between treated and untreated mothers in terms of the prevalence of depressive disorder, the intervention had some benefit in terms of maternal mood at six months (as measured by the Edinburgh postnatal depression scale). The limited effect of the intervention on maternal depression is consistent with other research showing that interventions principally directed at the mother-infant relationship do not necessarily bring about improvements in maternal mood.³⁵ Prevalence of depressive disorder in both the control and the intervention group in this study were somewhat lower than those found in our previous epidemiological study, possibly reflecting the steady improvement in living conditions in the intervening period, which may have alleviated a key source of distress in the women's lives.

The positive impact of the intervention on infant attachment is in line with the findings of previous research on the benefit of early mother-infant interventions, although, to our knowledge, this is the first demonstration of such a benefit in a developing world context. The effect size for maternal sensitivity is similar to the difference in sensitivity between depressed and non-depressed postpartum women living in conditions of adversity in the United Kingdom,^{13,20} a magnitude of difference that strongly predicts adverse cognitive development.³⁶ The absence of an association in our study between security of infant attachment and improvement in the specific features of the mother-infant interactions measured is not inconsistent with the previous literature³⁷; the intervention may have improved dimensions of parenting related to attachment that were not assessed in our study. Although the benefit of the intervention could have been merely a function of the women in the intervention group receiving more attention than women in the control group, this is unlikely as two recent reviews of early intervention studies have concluded that attention not directed specifically at mother-infant engagement has no impact on the quality of the mother-child relationship.^{35,38}

The findings of this study show that the benefits to the mother-infant relationship of an early intervention in developed world contexts similarly obtain in the deprived peri-urban conditions of Khayelitsha. The intervention was delivered by women from the local community who had no formal training, apart from that received from the study team for delivery of the intervention. In addition, they had a focused task (rather than responsibility for comprehensive community health), they were given appropriate support and supervision, and they had strong community support, all of which are regarded as essential for effective community health worker programmes.³⁹ This indicates that the intervention is potentially sustainable and that it could be "scaled up" in developing countries with relatively limited resources. Clearly, the design of the study precludes any discussion of whether similar, or superior, outcomes might have been achieved if a different form of intervention had been delivered.

Strengths and weaknesses

Despite the difficult developing world circumstances, we were nevertheless able to do a randomised trial of a mother-infant intervention in which rigorous trial procedures were followed: a standardised psychological intervention was delivered, and systematic independent assessments were made. Indeed, "gold standard" assessments were made of both the mother-infant relationship and outcomes in infants. We were able to train lay community workers to deliver the intervention to a high standard, and the intervention itself, conceived in a developed world context, was highly acceptable to the women receiving it, with very low dropout rates for those who did not move away. That we could not

investigate which aspects of the treatment were particularly effective was unfortunate.

Questions and future research

Our findings raise two important questions. Firstly, determining whether the improvements in the early mother-infant interactions and infant attachment are realised in subsequent positive developmental outcomes in children is important. The children living in areas such as Khayelitsha are at considerable risk of poor physical and emotional health, violence, educational failure, and a host of other associated adverse outcomes.⁴⁰ If the improvements in mother-infant interactions and infant attachment were shown to be of benefit in terms of these long term outcomes, this would be very important. The fact that rates of avoidant and disorganised attachment were especially low for infants in the intervention group is particularly encouraging, as these are forms of insecure attachment associated with subsequent conduct problems in children.⁴¹ Secondly, the positive results produced in this study arose in the context of a tightly delivered research intervention. That the intervention can be developed into a sustainable and widely available service that produces benefits similar to those obtained in this study needs to be shown. The fact that such positive outcomes were obtained by using lay therapists is particularly encouraging in this regard. This suggests that the intervention is not only sustainable but has the potential to be scaled up at low cost in resource constrained settings in developing countries.

We are grateful to the Parent Centre, a Cape Town based non-governmental organisation, for providing the infrastructure for the recruitment and training of the community workers. We thank Marjorie Feni, Nomabili Siko, Nokwanda Sikana, and Lephina Makhanya, the community workers in this study; Nosisana Nama and Busisiwe Magaze, who assisted in the assessment of the mothers and infants; Thulani Njengele and Agnese Fiori-Cowley for coding of the video recordings; and Timothy Freeth for help with data entry and general administration. We are especially indebted to the mothers and children who took part in this study.

Contributors: PJC designed the study and supervised its overall conduct, managed the data analysis, and took the lead in writing the paper. MT was the trial manager and trained and supervised the assessors. LS assisted in training the assessors. ML trained and supervised the community workers and assisted in drafting the treatment manual. CM assisted in setting up recruitment procedures. AS assisted in the development of the intervention and the overall supervision of the study. KMacP supervised the data analysis. LM developed the intervention manual and assisted in training the community workers, doing the assessments, and training the assessors. All authors took an active role in writing the submitted paper and approved the final version. PJC is the guarantor.

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Appendix V: Developments in the parent-infant work consequent to the Khayelitsha research.

In anticipation of the future dissemination of the programme, following the publication of the results of the study and also as a result of the Parent Centre's commitment to primary preventive services and belief in the value of this programme, we were inspired to roll out this programme in other economically deprived and needy communities served by the Parent Centre.

While the basic principles and structure of the intervention have been maintained, adjustments have been made to the content and presentation of the material.

Mothers' responses to visual material was so positively received that written material, diagrams and photographs, relevant to the input being provided at each session, was developed. This related to: the various aspects of pregnancy, foetal development in utero, the work of the placenta and umbilical cord, childbirth, breast-milk production and feeding, the stages of birth and the early days. These have had enormous impact on the mothers who were particularly fascinated by images of foetal development, which they had never previously been exposed to. As many of the pregnancies were reported to have been the result of failed contraceptive practices and a lack of free choice, we decided to include, antenatally, some input and discussion on family planning. As counsellors became aware of symptoms of depression and anxiety in pregnancy we introduced the Edinburgh Postnatal Depression Scale (EPDS), antenatally, in session 2. As parents requested help with issues of sibling adjustment to the birth of a new baby, input on this topic was also introduced.

Based on the work of Field (1995), which indicates that baby massage has a significant impact on calming distressed infants and helping with sleep and the physiological regulation of infants, as well as facilitating contact between distressed and detached mothers, baby massage was introduced and demonstrated to the mothers in postnatal sessions 4 and 7. The EPDS was re-administered and discussed with the mother postnatally, in session 3, and could be re-administered at any time a counsellor felt concerned about a mother's mental health. This proved helpful in tracking and discussing with mothers their mental health status.

Miscarriages, stillbirths, termination of pregnancies, loss of infants soon after birth and the loss of parents or children to HIV/AIDS-related diseases created a need for the counsellors to offer grief and trauma counselling, following such a loss, to the mother or other family members. Four sessions of grief counselling were thus offered by the parent-infant counsellors in these circumstances.

Despite a National Health policy that encourages birth attendants and the presence of fathers at the birth of their infants this is still actively discouraged by many of the staff at the state-run Midwife Obstetric Units. Following negotiation

with local health directors, the Parent Centre drafted a letter that mothers are given to take with them when they are admitted to the Midwife Obstetric Units for the birth. This letter informs the nursing staff the name of the person that will be accompanying the mother in the labour ward through the birth process. Information about child-support grants was also provided.

A particular need in communities where teen mothers tend to be overrepresented is that relationships between the counsellor, the mother and her own mother, with whom the mother often lives, needs to be sensitively managed. Grandmothers often end up caring for their grandchildren and some engage in ways that are controlling and undermining of their daughters. When grandmothers are involved as caregivers they need to be engaged in the intervention and provided with skills and knowledge in order to provide consistency for the infant and support for their daughters, as mothers. Similarly to that reported by Olds (1997) the counsellors needed to play an essential mediating role between often deeply disappointed, anxious, angry and punitive grandmothers and their daughters.

We have also had to make changes to the counsellors' training. On the basis of needs encountered in these particular communities and direct feedback from mothers, additional workshops were subsequently included, which added to the information given to and skills developed by the counsellors.

More recently we became aware and concerned that some of the new trainees were struggling with the concept of non-intrusive, sensitive engagement. We decided to record the counsellors, on video, in two face-to-face interactions with an infant (2- to 4-months old), followed by immediate playback with feedback and discussion. This visual feedback was experienced as so helpful that we have now introduced this into the main body of the training.

The rolling out of this intervention to other needy communities has required the training of counsellors from those communities and the training of supervisors to support the work. To date thirty-eight indigenous, previously untrained, women from eight economically deprived communities around Cape Town have been selected, trained and employed as parent-infant counsellors.

Due to a lack of state funding for this work private funding needs to be secured on an ongoing basis if the project is to continue. Unfortunately, no private funds have been sufficient to maintain the work consistently. As a result, over the years, the intervention had to be interrupted or suspended, only to be restarted when new funding was made available. In the process we have had to terminate the employment of trained and dedicated staff, who were then often unable to be reemployed by us when funds were subsequently made available as they had secured alternative employment.

Despite these disruptions there have been substantial gains in the skills and knowledge bases and confidence of many of the trained staff. Two of the original

Khayelitsha community parent-infant counsellors, who remain with the Parent Centre fourteen years on, have become involved in the training and basic supervision of new teams of parent-infant community counsellors. They have each regularly hosted community radio phone-in programmes on parenting issues. Thirteen counsellors have been trained to deliver regular clinic talks on early parenting to mothers awaiting services at local clinics. One of the original parent-infant counsellors is presently studying for a university degree in social work by correspondence. Five mental health professionals, psychologists and social workers, have been trained and worked as clinical supervisors of various teams. One of these professionals has subsequently taken on the role of programme manager and consults with an external consultant (myself) who is mentoring her. The material has also been adapted for another Parent Centre programme in which “teen-parenting” counsellors run groups at secondary schools for learners parenting their own children or younger siblings at homes in economically disadvantaged communities around Cape Town.

An added achievement is that in the course of the study, the wages earned by three of the community counsellors who lived in the community was put towards replacing their own shacks with block and mortar structures as seen below.

