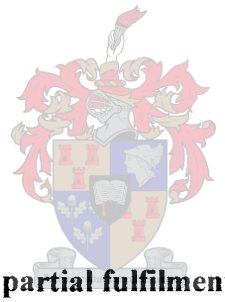
ROCKING THE HAND THAT ROCKS THE CRADLE:

Exploring the Potential of Group Therapy with Low-Income South African Mother-Infant Dyads

MAXINE F. SPEDDING



Assignment presented in partial fulfilment of the requirements for the degree of Master of Arts (Clinical Psychology) at the University of Stellenbosch

Supervisor

Prof Lou-Marie Kruger

April 2005

STATEMENT

I, the undersigned, hereby declare that the work contained in this assignment is my own original work, and that I have not previously in its entirety or in part submitted it at any university for a degree.

ABSTRACT

The transition to motherhood represents a critical period in a woman's life. It presents the mother with the opportunity for personal development, while simultaneously rendering her vulnerable to psychological problems. The South African low-income mother faces additional challenges in having to contend with a host of poverty-related stressors. The mother's at-risk status extends to her infant, who depends on her for the fulfilment of its needs. Current mental health policy does not consider the special needs of mother-infant dyads, despite its orientation to prevention.

The current paper seeks to explore the potential of group therapy with low-income mother-infant dyads. It outlines the possible theoretical underpinnings for psychotherapeutic group work with low-income mothers and infants, by making use of attachment theory, feminist theory and community psychology. It reviews the theories' individual contributions and explores their compatibility in considering group therapy with low-income mother-infant dyads. Further, it reviews empirical studies and interventions with mother-infant dyads, with a particular emphasis on group therapy interventions. It argues that group therapy may be a viable and effective approach to psychological work with low-income mother-infant dyads.

ABSTRAK

Die oorgang tot moederskap verteenwoordig 'n kritiese periode in 'n vrou se lewe. Dit bied die moeder die kans vir persoonlike ontwikkeling, terwyl dit haar gelykertyd kwesbaar maak vir sielkundige probleme. Die Suid-Afrikaanse lae-inkomste moeder moet boonop bykomstige uitdagings, in die vorm van 'n menigdom armoed-verwante stressors, die hoof bied. Die moeder se kwesbare status sluit ook haar baba in, wat op haar aangewese is vir die vervulling van sy/haar behoeftes. Huidige geestesgesondheids-beleid neem, ten spyte van 'n voorkomende oriëntasie, nie die spesiale behoeftes van moeder-kind pare in ag nie.

Hierdie werksopdrag beoog om die potensiaal van groepsterapie met lae-inkomste moeder-kind pare te ondersoek. Dit beskryf kortliks die moontlike teoretiese begrondings van psigoterapeutiese groepswerk met lae-inkomste moeder-kind pare deur gebruik te maak van bindings-teorie, feministiese teorie sowel as gemeenskaps sielkunde. Dit hersien die teorieë se onderskeidelike bydraes en ondersoek hulle aanpasbaarheid met betrekking tot die ondersoek van groepsterapie met lae-inkomste moeder-kind pare. Hierdie werksopdrag hersien dan ook verder empiriese studies en intervensies gemik op moeder-kind pare, met 'n spesifieke fokus op groepsterapie intervensies. Daar word geargumenteer dat groepsterapie 'n geskikte en effektiewe benadering tot sielkundige werk met lae-inkomste moeder-kind pare is.

ACKNOWLEDGEMENTS

My gratitude goes to:

Lou-Marie Kruger, for her patience and wisdom, and all the "after-hours" hours she offered up.

Suzanne de Villiers, for her insight, guidance, and accommodation of my urgency.

Heidi Burmeister-Nel, for exploring the possibilities of mother-infant dyad work with me.

My parents, for always supporting all I choose to pursue.

And Angela Cotterell, for everything…

TABLE OF CONTENTS

1. Introduction

1.1. Low-income mothers and their infants at psychological risk

The transition into motherhood has long been considered a crucial period in a woman's life. Not only does it present women with tremendous psychological changes and opportunities for personal growth, but also renders them vulnerable to myriad psychological and psychosocial problems. The transition for low-income women into motherhood is fraught with additional risks and challenges. These are related not only to the process of becoming a mother, but strongly related to the stressors associated with poverty. South African low-income mothers in the postpartum period are a group who have been largely neglected by the mental health profession, and are in dire need of psychological support and intervention.

Mothers are not alone in this vulnerable position, for their infants are fully reliant upon them for the fulfilment of their own physical and psychological needs. Winnicott (1971) underscores this in his contention that an infant does not exist on its own, but only in relation to the mother. As such, when the mother is at risk, her child, in being dependent on her, bears the same burden. Despite the psychological and social risks for both mothers and infants, mother-infant dyad interventions remain a non-prioritised concern in South African mental health policy.

1.2. The current status of mental health services in South Africa

The post-apartheid government has made great strides in making health services more accessible to the general South African population. Since the country's transition to democracy in 1994, the government has begun implementing policies aimed at making health services accessible on a primary level, such that communities have access to health services at their local clinic or day hospital.

Despite the fact that mental health care has been described as the health service's "stepchild" (Masilela, 2000), it too has been included in this trend. Patients who have been diagnosed with psychiatric disorders may receive limited treatment from the community clinic, which is serviced by a mental health nurse, as opposed to being

treated at a tertiary institution (Strachan, 2000). The mental health nurse is one member of a mental health team, which may also comprise a psychiatrist and, where possible, a regional psychologist. However, these regional mental health teams service thousands of patients at a number of clinics and as a result, are limited in their ability to provide services other than evaluation, diagnosing, and dispensing of medication.

Resources are so limited that the Mental Health Care Bill of 2001 permits the district or primary health care nurses to assume many of the mental health nurses' duties. The primary health care nurses then only refer to the mental health nurse in cases they may be ill equipped to manage. This allows the mental health nurse to reduce the number of consultations with patients, from once a month, to once every six to 12 months (Strachan, 2000). The purpose of this bill is to allow the mental health team more time to focus on education and prevention of mental illness, as the aim of current government policy is to promote prevention of psychiatric disorders on a primary level so as to minimise the need for tertiary intervention.

It is clear that "mental health services in South Africa provide limited mental health care to a small percentage of the population that actually need services" (Thom, 2003). Moreover, psychological services are still considered to be a luxury reserved for the elite; those who have the financial means to access mental health care in the private sector. South Africa's history of Apartheid has ensured that the population's division along racial lines directly corresponds to a division along economic lines, implying that the 'elite' who have access to privatised services are generally the 'white' middle classes (Foster & Swartz, 1997).

The most current estimates indicate that the ratio of public sector psychologists to the general population is approximately one to every 141 000 people, making public sector resources scarce (Health Systems Trust, 2003). With unemployment rates, using the official definition, currently estimated to be at 41,2% (Statistics South Africa, 2003), the reality is that the general South African population scarcely have the resources to ensure adequate housing, or education for themselves or their children, much less access private psychological resources.

1.2.1. Mental Health Care for Mothers, Children and Women

South Africa's oppressive past has not only left it with residues of racial inequity, but inequality along gender lines also. Current statistics indicate that 56,2% of South African women aged between 15 and 24 are illiterate, while 34,4% of South African men within the same age range cannot read or write (World Bank Group, 2000). The result is that women face a far greater disadvantage in the labour market. This is mirrored in the unemployment statistics for South African people of the same age group, with almost 33% more women than men unemployed (World Bank Group, 2000). The HIV/AIDS infection statistics reveal similar inequalities: 11,3% of South African men between the ages of 15 and 24 are infected with the virus, while statistics for their female counterparts are more than double at 24,8% (World Bank Group, 2000). These statistics reflect the social disempowerment experienced by a large portion of South African women.

Gender inequality extends into the field of mental illness. The World Health Organisation (2000) cites, among other issues particular to women's mental health, "Data from the World Bank study revealed that depressive disorders accounted for close to 30% of the disability from neuropsychiatric disorders amongst women in developing countries but only 12.6% of that among men" (p.1). It goes on to suggest that "a gender-based, social-model of health needs to be adopted to investigate critical determinants of women's mental health with the overall objective of contributing to improved, more effective promotion of women's mental health" (World Health Organisation, 2000, p.2).

Mothers, children and women comprise 73% of the South African population (South African Department of Health, 1995). For this reason the Department of Health proposed specialised care for mothers, women and children in its "Maternal, Child and Women's Health Draft Policy" (South African Department of Health, 1995). It advocates the development of health services for this group with its primary focus on: achieving equity, by providing services to populations most affected by "the past", and, health problems that result in the highest mortality and morbidity. The policy recognises the need for mental health services for mothers, children and women, but descriptions of these are limited and vague. Of some interest is that this policy was

drafted in 1995. In 2000, the Department of Health released the "Progress Report on Ten Points Operational Plans: Year 2000-2001". In this document, the reasons cited for the government's inability to promulgate and implement the policy included "lack of money for printing of the National Maternal, Child and Women's Health Draft Policy document" (p.5) and "lack of co-operation and support from other sub-directorates within the cluster" (p.5). The policy draft has since been abandoned.

General health care policy particular to women in South Africa is focused on reproductive health, contraception, family planning, domestic violence, ante- and postnatal medical care, maternal morbidity and mortality rates, and the prevention of mother-to-child-transmission of HIV/AIDS (South African Department of Health, 2004). Little to no attention is given to mental health issues pertaining to women, despite the Health Minister's identification of this as an area in need of attention in a parliament address (South African Department of Health, 2001b). In Thom's (2003) expansive review of articles on and references to South African mental health services, she found: "There were no specific references to research on women and mental health issues" (p31).

With regard to mental health services for children and adolescents, Thom (2003) also found that "epidemiological studies conducted locally as well as internationally indicate there is a great unmet need for services for children and adolescents, and a gross lack of resources for this vulnerable group" (p27). The Department of Health has identified adolescents (aged 15 to 19 years) as a high-risk group for health concerns (South African Department of Health, 1998). Among the health risks identified were those associated with early sexual activity, such as teenage pregnancy, sexually transmitted diseases, and substance abuse. The report records that 16,4% of adolescent girls have been pregnant, while 13,2% are mothers. Excluding pre-abortion counselling, there is no indication of public mental health interventions aimed at assisting young women in the difficult transition to motherhood.

Despite the Department of Health's (1995) clustering of these three populations under the umbrella term of "mothers, children and women", the "Maternal, Child and Women's Health Draft Policy" appears to regard the three groups as separate entities. It disregards issues that may pertain to the impact they may have on one another.

There is no evidence of any efforts to consider relationships that may exist between mothers and children for example, except in the issue of prevention of mother-to-child-transmission of HIV/AIDS. This is in spite of the government's recognition that nearly 35% of all children under the age of 15 years reside with their mother only (South African Department of Health, 1998).

1.3. The aims of the current paper

In light of current mental health policy pertaining to mothers and children, the need for interventions with both of these groups, and the lack of resources available to provide effective intervention, one possible solution is the provision of community-based mother-infant psychotherapy groups.

Numerous researchers and clinicians have proposed group therapy for low-income mothers. Druiff (2001), in her literary exploration of low-income women and psychotherapy, argues that group therapy interventions provide a cost-effective format from which to offer psychodynamic therapy. She asserts that psychodynamic therapy is a therapeutic approach that has long been denied to low-income women for reasons including financial expense.

Belle and Doucet (2003) have proposed the use of support groups for economically impoverished mothers as a "powerful antidote to guilt and depression" (p.109). Hanna, Edgecombe, Jackson and Newman (2002) report on the long-term benefits of groups for first-time mothers, which provide expanded social support, whilst dissipating the stress associated with first-time motherhood, in addition to increasing self-confidence. Richter (2001) highlights the effectiveness of group work with low-income mothers in addressing mother-infant dyad issues for the prevention of later difficulties.

Jarret, Diamond and El-Mohandes (2000) report that group formats have resulted in improved parenting behaviours for populations of adolescent mothers, parents at risk for child abuse and neglect, and foster and adoptive parents. Bumagin and Smith (1985) assert that group therapy for low-income mothers provides a unique therapeutic opportunity for mothers to identify with one another's needs, experiences

and concerns, thereby diminishing feelings of isolation. Finally, Puckering, Rogers, Mills, Cox and Mattsson-Graff (1994) concur, citing group therapy as a powerful tool for the empowerment of disempowered mothers.

The current paper has the following aims:

(1) to explore the possible theoretical underpinnings for psychotherapeutic group work with low-income mothers and infants, by making use of attachment theory, feminist theory and community psychology; and,

(2) to review existing reports of group therapy work with mother-infant dyads.

In the first brief chapter of the paper, the author will provide conceptual clarification with regard to the concept of group therapy. The second chapter briefly explores motherhood as an important transitional time for women, with a particular focus on the psychological challenges encountered by low-income mothers.

In the third chapter the focus will be on theory. While the major assumptions of attachment theory, feminist theory, and community psychology will be briefly summarized, the emphasis will be on the implications of each of these theories for psychological work with low-income mothers and infants. As such, the theoretical overviews provided do not reflect an exhaustive review of each approach, but rather the basis for arguing the potential of group therapy with low-income mother-infant dyads. It will be contended that despite the fact that these theories are often thought to be incompatible, each of them actually underscores different psychological needs of low-income mothers and their infants, and are therefore crucial to the design of interventions. The choice of attachment theory, feminist theory and community psychology as contributors to the formulation of the argument reflects the author's own theoretical orientation. The author will show how group therapy work with mother-infant dyads can incorporate central aspects of each approach.

This theoretical justification for group work with low-income women will be followed by a comprehensive review of the empirical studies in the fourth section. The conclusion will provide the reader with a summary of the argument, contending for the compatibility of the aforementioned theoretical approaches, in interventions aimed at low-income mother-infant dyads within a group psychotherapy format. An outline

of social contructionist theory provides a metatheoretical context for the integration of the major theories. Finally, the implications of the argument for psychological services and future research are outlined.

2. Conceptual clarification of group therapy

Since the current paper seeks to explore the potential of a group format approach to psychotherapy with low-income mother-infant dyads, a clarification of the concept of group therapy is required. The therapeutic factors described by Yalom (1995) form the basis of this paper's description and definition of group therapy, as they have been shown to form the central organising principle to the process of therapeutic change. This brief chapter provides an outline of these therapeutic factors that are central to the group therapy process.

Numerous terms have been given to the psychotherapeutic work conducted in a group format. These include group counselling, group therapy, self-help groups, support groups, and psycho-education groups (Corey, 1995). Each of these terms represents a differing approach to the group format. Many of these formats may be utilised, or incorporated into other therapies, by therapists adhering to differing theoretical orientations (Corey, 1995; Yalom, 1995). Yalom (1995) asserts that despite the heterogeneity of approaches to group work, even those groups that are not formally classified as therapy groups may be considered therapeutic. This is because they frequently "straddle the blurred boundaries between personal growth, support, education, and therapy" (Yalom, 1995, p.xii). He argues that groups that appear to have major differences in their external form, may rely on identical mechanisms of therapeutic change. Yalom (1995) posits that therapeutic change occurs through a complex and delicate interaction of human experiences, which he terms "therapeutic factors". It is these therapeutic factors that provide the basis for defining the concept of group therapy in this paper.

Yalom (1995) identifies 11 therapeutic factors that facilitate therapeutic change in the group therapy process. The first is the *instillation of hope*, which refers both to the mechanism that keeps clients in therapy, as well as clients' faith that the intervention

will help to effect change in their lives. *Universality* is a factor that reduces clients' feelings of isolation in their experiences, as they come to hear other group members disclose similar difficulties, concerns, fantasies, impulses, thoughts, feelings, and so forth. It provides clients with the sense that they are not alone or unique in their experiences, which often provides relief.

Yalom's (1995) third therapeutic factor is that of *imparting information.* As a therapeutic factor it may include didactic instruction from the therapist, or advice and guidance offered by the therapist, and possibly by other group members. A therapeutic factor that may conceptually follow from this is that of *altruism.* Altruism refers to the clients' experience of receiving through the act of giving in the form of advice, reassurance and support. This has the potential to generate the experience of being important to others and increasing self-esteem.

Yalom (1995) asserts that the therapy group, in many of its facets, may frequently bear resemblance to a family. The dynamics of relationships resembling those clients may have experienced in their families of origin, are frequently played out in the relationships that develop amongst group members, as well as in relation to the therapist. This provides clients with a *corrective recapitulation of the family group*, the fifth therapeutic factor identified by Yalom (1995). He goes on to propose that the *development of socialising techniques* is a therapeutic factor in operation in all therapy groups, where social learning is largely an indirect process. A therapeutic factor related to the development of socialising techniques, is that of *imitative behaviour.* This factor suggests that group members come to imitate certain behaviours of the therapist and other group members, such as support and self-disclosure. It also refers to the benefit a client may receive in observing the therapeutic process of another group member.

Interpersonal learning is a therapeutic factor Yalom (1995) considers to be unique to the process of group therapy. It is a complex factor involving the recognition of the importance of past interpersonal relationships. This provides clients with insight into how those relationships influence their current functioning within the social microcosm of the group. Clients' reproduction, within the group process, of behaviour patterns developed from past experiences, affords the opportunity for a corrective

emotional experience. The corrective emotional experience allows for the differentiation between the clients' behaviour and self-concept, facilitating enhanced self-observation, self-awareness, and openness to feedback from others.

Group cohesion is the term Yalom (1995) uses to describe the quality of relationships within the group, including the therapist. In this sense it denotes the group's solidarity. Yalom (1995) writes, "It refers to the condition of members feeling warmth and comfort in the group, feeling they belong, valuing the group and feeling, in turn, that they are valued and unconditionally accepted and supported by other members" (p.48). *Catharsis* is a therapeutic factor that relies heavily on group cohesion, due to the role it plays in the ongoing interpersonal process. In and of itself, the open expression of emotion is of little therapeutic value. However, within the context of other therapeutic factors, it is considered a vital aspect of the group therapy process.

Several issues are presented in the last of Yalom's (1995) therapeutic factors, a cluster entitled *existential factors*. These issues include "responsibility, basic isolation, contingency, the capriciousness of existence, the recognition of our mortality and the ensuing consequences for the conduct of our life" (Yalom, 1995, p.88). This therapeutic factor reflects clients' deeper exploration of themselves, and promotes a more thoughtful and insightful approach to life.

As is evident in the overview of these therapeutic factors, Yalom (1995) emphasises the interconnectedness of all of the factors. He highlights the arbitrariness of their division and proffers them as provisional guidelines for effective group therapy. These therapeutic factors form the basis of the definition of group therapy in this paper. It should be noted that despite their therapeutic value, groups that rely solely on the use of the self-help, psycho-educational or support formats, for the purposes of this paper, are not considered to fall under the umbrella of group therapy. The term 'group work' is used in this paper to denote the use of a group format that encompasses, as at least one of its components, the concept of group therapy as defined above.

3. Motherhood in context

"If a community values its children it must cherish its parents" (Bowlby, 1951, p.84).

This portion of the paper seeks to garner an understanding of women's experience of motherhood. This includes the psychodynamic changes that occur and the psychological challenges that are encountered by mothers. It briefly reviews literature pertaining to the transition into motherhood as an important period in a woman's life, a period offering a vital opportunity for emotional and psychological growth. However, this critical time bears threat to a woman's psychological well-being, rendering her vulnerable to mental illness and other psychosocial problems, a threat that is amplified for mothers in poverty who must contend with its associated ills. Here it is argued that low-income mothers represent not only a vulnerable portion of the population with special needs and concerns, at high risk for victimisation and the development of psychological disorders, but a group that has been marginalized and underrepresented in the South African academic literature of psychology. Further, it will be contended that low-income mothers are a group that will greatly benefit from psychological intervention.

3.1. The psychological importance of motherhood for mothers

Literature available on the research of women's experiences of motherhood indicates several important factors that make this a crucial period in a woman's life. The pre- and postpartum period is marked by major transitions for women and their families (O'Hara, 1995). Pregnancy and motherhood are often seen as a process of growth (Raphael-Leff, 1991) and development (Breen, 1975), a maturational period in need of crisis resolution (Levy & McGee, 1975), or a transitional period (Deutsch, Brooks-Gunn, Fleming, Ruble & Stangor, 1988). It entails a reorganisation of the self in a time of personal growth and emotional rebirth (Lederman, 1996; Raphael-Leff, 1991). Past emotions that are reactivated during pregnancy, allow for the resolution of infantile psychological emotions and conflicts relating to the woman's internal parents. In turn it permits the reintegration of more mature and realistic evaluations of the real parents (Raphael-Leff, 1991; Stern, 1995). Often, growth stems from the re-

evaluation of the self (Lederman, 1996), and from a process of integrating contrasting parts of the woman's self or the re-incorporation of facets of her self that have been split off, neglected or disowned (Raphael-Leff, 1991).

The changes and development women undergo have also been equated with a paradigm shift (Lederman, 1996; Leonhardt-Lupa, 1995). A woman's current paradigm, her constellation of beliefs, behaviour patterns, values, problem-solving skills and way of viewing people and the world, is reassessed (Leonhardt-Lupa, 1995). Elements that no longer maintain their feasibility are replaced, resulting in a shift that entails a change in perception (Lederman, 1996). Stern (1995) terms this new and unique psychic organisation the "motherhood constellation", which determines "a new sense of action tendencies, sensibilities, fantasies, fears, and wishes" (p.171). Winnicott (1956) refers to a unique psychological condition; "a very special state of the mother" (p.301) he terms "primary maternal preoccupation". Thus, women are thought to actively construct their identities as mothers through seeking out relevant information and visualizing themselves as mothers during pregnancy (Lederman, 1996).

Lederman (1996) considers the main goal of mothering as the identification with the idea of themselves as a "woman-with-child", and no longer as a "woman-without-child". She asserts that this identification takes the form of a timely, unfolding process whereby the first-time expectant mother's thoughts move away from her single self and towards the baby-mother unit. The process is finalised in a move towards recognising the separateness, uniqueness and individuality of the baby. The process involves significant changes, which require motivation to assume the motherhood role (Lederman, 1996).

Universal motives for women's reproductive choices cannot be assumed, as each woman's individual and unique life situation has a significant influence on her childbearing motivation (Brazelton & Cramer, 1990). These diverse meanings and motivations often reflect the woman's cultural context, as well as her expectations, dreams, fears, hopes, and fantasies regarding childbearing and motherhood (Raphael-Leff, 1991). Motivations may be altered by previous personal experience; experiential accounts of friends and family, in addition to her own knowledge of pregnancy, birth

and the experience of motherhood. A mother's appraisal of her competence to mother; and her desire to nurture are of further influence to her motivation (Lederman, 1996).

Women with severe doubts about motherhood tend to find it difficult to identify with the motherhood role or to make necessary changes in life-style that are implied in the transition (Lederman, 1996; Leonhardt-Lupa, 1995). The way a mother feels about herself and about her infant is of crucial importance to the infant's development. Leonhardt-Lupa (1995) states that, as the primary caregiver, the mother forms the foundation of her infant's emotional self-image. She postulates: "The baby absorbs not only her milk, but her smell, warmth, touch, sound of her voice, her gaze and her disappointments, and desires, her social status and self-image and her concept of her newborn baby" (Leonhardt-Lupa, 1995, p.7-8).

Leonhardt-Lupa (1995) writes in depth about the experiences of mothers and their desires to be 'good' mothers. She asserts that mothering requires a great deal of self-assurance, involving a delicate balance of confidence in her competence to cope in most situations, as well as an awareness of her own fallibility. However, often the differentiation between efforts to be a good mother and the wish to be a perfect mother is blurred, such that mothers frequently issue severe prescriptions for themselves. The search for the best possible manner in which to mother may become an exhausting preoccupation, besieged by perfectionism and self-reproach.

According to Leonhardt-Lupa (1995) this devotion to perfectionism may cause women to become intolerant, judgemental and incapable of overlooking mistakes or unable to forgive themselves. She cites the cultural idealisation of motherhood as a contributing factor to a mother's insecurity and drive for perfectionism. She goes on to describe the characteristics of the idealised mother as "loving, caring, comforting, passionate, understanding, creative enthusiastic, devoted, unselfish, conscientious, and very educated and skilful in child care matters. She is never domineering, selfish, depressed, bored, hot-tempered, scheming, impatient, unempathic, tired or bitchy" (Leonhardt-Lupa, 1995, p.36). She contends that the competency and success of a mother is judged according to how efficient, productive, and intelligent she is, as measured by the child's progress or success.

These socially constructed standards of motherhood sabotage any attempts to acknowledge the strengths mothers already possess as individuals (Leonhardt-Lupa, 1995). They destroy self-confidence, forcing women to set unrealistic ideals for mothering that are difficult, if not impossible live up to, causing mothers to feel inferior, incompetent and inadequate (Leonhardt-Lupa, 1995). As Parker (1995) states:

> Sometimes mothers use other mothers as mirrors. Each mother scrutinises the other in pursuit of a reflection of her own mothering. They look for differences from their own style of mothering and they look for sameness. But above all they look for confirmation that they are getting it right, in the face of fears that they are getting it hopelessly wrong. To the outsider, especially to the child-free observer, exchanges between mothers seem to be carried out in a language of measurement and invidious comparison, but the desired outcome is not so much a victory as a search for deeply-needed reassurance. (Parker, 1995, p.1)

It is these cultural expectations that may also be to blame for the mothers-to-be proclivity to emphasise the needs of the infant at the expense of their own needs for care and nurturance (Leonhardt-Lupa, 1995). It is vital that mothers learn to care for themselves equally as well as they care for the developing foetus and infant, in order to function optimally and provide appropriate care for their children (Leonhardt-Lupa, 1995). Thus, caring for the foetus or infant is not exclusive of a mother's care for and giving to herself.

Contrary to what socially idealised perceptions of motherhood would propose, not all mothers want to be mothers, and even those who do, experience intrapsychic conflict about the role. Stern (1995) argues that the motherhood constellation is neither innate nor universal, and that socio-cultural conditions play a dominant role in determining how it will manifest in a mother. Parker (1995) asserts that all mothers experience feelings of maternal ambivalence, but that cultural ideals prohibit explorations of these experiences, effectively concealing the contribution to creative mothering maternal ambivalence can make. Further, Parker (1995) believes the experience of maternal ambivalence is essential:

> Maternal ambivalence signifies the mother's capacity to know herself and to tolerate traits in herself she may consider less than admirable – and to hold a

> more complete image of her baby. Accordingly, idealisation and/or denigration of self and, by extension, her baby, diminish (Parker, 1995, p.17).

However, due to socio-cultural expectations and pressures that forbid mothers from feeling anything but love for their children, mothers are consumed with guilt and anxiety for the experience of ambivalence. It is the management of these feelings, Parker (1995) contends, that becomes problematic for many mothers.

For adolescent mothers, these feelings may be complicated further. In addition to the experiences described above, many young women experience unexpected pregnancy as disastrous, a crisis, and a period in which primitive anxieties are revived (Pines, 1988). For these young women, as for other mothers, voicing ambivalence, fears, concerns and negative feelings towards themselves, their partners and other important figures is of crucial importance. This is not only to prevent these feelings from being projected onto the foetus (Pines, 1988), but for the expansion of her own consciousness (Parker, 1995).

3.2. The impact of poverty on motherhood

From the above literature review it is clear that the experience of motherhood poses both psychological and emotional challenges for women. For the majority of women in the first world, these difficulties may become overwhelming. Even more so for the impoverished and socially disempowered women of South Africa, where need may not only encompass the psychological and emotional, but also the concrete and physical. However, little is said of low-income women's experience of motherhood in academic literature. Wagner and Menke (1991) note that mothers in poverty have largely been ignored by scientific literature; while Kruger (2000) argues that low-income women have been silenced in psychological research.

Despite widespread recognition of their vulnerability to psychological distress, low-income women have received scant attention in both psychological research and practice (Belle, 1985; Druiff, 2001; Reid, 1993). Of the limited literature available pertaining to the experiences and needs of low-income mothers, the majority is international, largely American-based research. As such, this review of the

experiences and needs of low-income mothers is also limited in that it does not represent the voices of South African low-income mothers.

Arguably, one of the greatest stressors facing South African mothers today is that of poverty. In addition to intrapsychic burdens, impoverished South African mothers must contend with a poorly developed medical infrastructure with little access to pre- and post-partum care by trained personnel (Rao, Harrison & Bergström, 2001). This results in problems remaining undetected and untreated.

In their individual capacities, low-income mothers are faced with myriad poverty-related potential social problems, including, unemployment, homelessness, (Wagner & Menke, 1991); health problems and reduced life expectancy; increased infant mortality and morbidity rates (Becker, Kovach & Gronseth, 2004); elevated exposure to crime (Belle, 1997); extremely high rates of violent victimisation (Salomon, 1996); and, social discrimination (Belle & Doucet, 2003). Studies have shown that these women report higher levels of stress (Middlemiss, 2003); have a reduced capacity for coping with stressful events (Wagner & Menke, 1991); and, are at increased risk for the development of mental illness, especially depression (Belle & Doucet, 2003). Research indicates that impoverished women who have experienced repeated failures in their ability to cope with stress often turn to palliative coping strategies such as self-medicating by means of drug or alcohol abuse (Belle & Doucet, 2003).

In her review of literature pertaining to the difficulties faced by low-income women, Druiff (2001) submits that women in poverty are more likely to have experienced significant childhood losses, and to have suffered childhood sexual or physical abuse. They are also more likely to have discordant intimate relationships, and to be single parents (Druiff, 2001). Salomon's (1996) study highlights that psychological distress is common amongst low-income mothers: "not surprisingly, these women were severely distressed, as reflected in elevated rates of depression, posttraumatic stress disorder, substance abuse, acute and chronic medical problems" (p.486).

Belle and Doucet (2003) identify poverty as "one of the most consistent predictors of depression in women, probably because it imposes considerable stress while attacking many potential sources of social support" (p.101). They go on to posit that "long-term

economic hardship is associated with a diminished sense of efficacy, while increases in household income, regardless of their source, are associated over time with increases in the sense of personal efficacy expressed by women who head households" (Belle & Doucet, 2003, p.104). Druiff (2001) echoes this in her assertion that women in poverty appear to experience "an objective sense of personal powerlessness, which is felt subjectively as low self-esteem, inadequacy, shame, humiliation and guilt" (p.2).

Several studies have reported on the social support systems available to, and utilised by, low-income women, and their importance (Belle & Doucet, 2003; Hall, Williams & Greenberg, 1985; Middlemiss, 2003; Wagner & Menke, 1991; Stevens, 1988; Zachariah, 1994). Zachariah (1994) notes the lack of attention given to young, single, low-income, high-risk, first-time mothers. This is in spite of the academic corroboration for the importance of social support in the moderation of stressful transitions, such as those experienced by this group. A study conducted by Middlemiss (2003) found that poverty is significantly related to decreased access to community and social support in their role as parents. Stevens (1988) documents the importance of informal and formal social ties for low-income mothers in the development of adequate parenting skills.

Belle (1982) has written extensively on poverty-related stress and the limited social support available to low-income women. She identifies social isolation as a considerable risk factor for the development of mental health problems in low-income mothers, and purports that the availability of a confidant acts as an important buffer against depression. Belle's (1982) study found that the more social support low-income mothers receive, the greater their sense of control over their lives. With regard to the composition of the mothers' social network, all participants living with husbands or boyfriends identified them as sources of support, while a significant number of participants named their own mothers as one of the most important people to them. Relatives and neighbours were also found to comprise further sources of social support. Zachariah's (1994) study corroborates this finding, with young, low-income mothers identifying their partners and mothers as most significant sources of support.

However, Belle (1982) found that social support proved to be "a two-edged sword" (p.143) for most low-income women. It is associated with important forms of emotional support and assistance, but simultaneously associated with distressing worries, concern and upset. In her study of social support networks amongst low-income mothers, Stack (cited in Belle, 1982) found that mothers in poverty created such networks to assist each other when the inevitable crisis arose. She noted that this, essentially involuntary interdependence of low-income mothers generated bitterness and hostility, but also love and trust. Belle (1982) contends that poverty reduces women's freedom of choice about interpersonal relationships, as well as coercing women to foster relationships they may otherwise have avoided. Elaborating on the unfavourable cost-benefit ratio she writes, "one cannot receive support without also risking the costs of rejection, betrayal, burdensome dependence, and vicarious pain. This is probably especially true amongst the poor, whose relatives, friends, and neighbors, are likely to be stressed and needy themselves" (Belle, 1982, p.143).

From the above it is clear that mothers in poverty are in psychological need, and if a mother is at-risk, the infant, who is dependent on the mother's ability to care and nurture, is also at risk. As Halpern and Larner (1987) state:

> Chronic economic insecurity, dilapidated housing, a disorganised or isolated community environment, and lack of personal support can overwhelm parents' intentions to provide the best for their children, to give those children the warm, nurturant, and consistent parenting that they themselves may not have received (p.132).

The physical and social hardships faced by low-income mothers are, in turn, encountered by their children. The implications of a mother's psychological distress can be detrimental to the development of her child. It has been established that poverty-related experiences of stress and low levels of social support are implicated in the development of negative parenting behaviour (Middlemiss, 2003). The strong relationship between poverty and maternal depression (Belle & Doucet, 2003) dramatically increases the risk of social, emotional, cognitive, behavioural and physical disturbances in the functioning of children of low-income mothers (Hall, Williams & Greenberg, 1985).

McGroder's (2000) study found that children of low-income mothers with depressive symptomology (in this case, 47% of the sample were classified as clinically depressed) show poorer developmental outcomes. Zachariah (1994) proposes that, due to a lack of developed support systems, limited parenting models, diminished self-worth, and high levels of stress and social isolation, low-income mothers are at high risk for abusing and neglecting their children. Lazarus (2003) asserts that the stress associated with poverty can give rise to extreme parental behaviours, such as harsh physical punishment and inadequate supervision and the exposure to domestic violence.

Lyons-Ruth, Connell, Grunebaum and Butein (1990) contend that low socio-economic status predicts low cognitive scores beginning in the second year of life, poor language development, and school failure, in addition to psychopathology in school years. The stressors associated with poverty can pose severe challenges to a mother's ability to responsively and sensitively engage and interact with her child. However, poverty alone does not predict a mother's ability to successfully bond with her infant. The brief review of attachment theory in the fourth chapter of this paper provides a useful understanding of the factors that contribute to the disruption of attachment and the implications thereof for the development of children.

3.3. Implications for interventions with low-income mother-infant dyads

Based on the literature reviewed it is evident that the transition into motherhood involves a complex interplay between intense intrapsychic processes and socio-cultural expectations and pressures. The intrapsychic processes include a reorganisation of the self (Lederman, 1996; Raphael-Leff, 1991); identity reformulation (Stern, 1995; Winnicott, 1956); and, ambivalence concerning the role of motherhood (Parker, 1995). Socio-cultural expectations and pressures dictate to mothers how motherhood 'should be done' (Leonhardt-Lupa, 1995; Parker, 1995). During this time, women are presented with a pivotal opportunity for psychological growth and yet simultaneously made vulnerable to mental health problems.

Low-income mothers are faced with additional stressors and challenges, associated not only with motherhood, but poverty and its correlates, such as reduced capacity for

coping with stressful events (Wagner & Menke, 1991), diminished sense of self-efficacy (Belle & Doucet, 2003), personal powerlessness (Druiff, 2001), and, decreased access to community and social support (Belle & Doucet, 2003; Middlemiss, 2003; Stevens, 1998).

Clearly, with depleted emotional, psychological and social resources, low-income mothers are a group who could benefit enormously from psychological interventions. These interventions may focus on providing the opportunity to express and therapeutically address both intrapsychic and socio-cultural concerns; offering emotional and psychological support; and facilitating greater access to social resources. Group therapy may offer particular benefits for low-income mothers in its provision of a safe and accepting environment in which they may voice their experiences, feelings, needs, fantasies and thoughts. Mothers may receive and provide guidance, information, and advice, enhancing their self-esteem and generating the sense of belonging and importance. In this therapeutic context, mothers may learn from each other, provide support to one another, and establish valuable relationships that may serve as important sources of social support.

4. Theoretical contributions

4.1. The contributions of attachment theory

In this section the assumptions of attachment theory are outlined, with the view to providing a foundation to the understanding of mother-infant bonding, and its implications for the psychological well-being of both mother and child. An overview of attachment theory is provided; including a description of four attachment style categories identified by Ainsworth (1978) and, Main and Solomon (1986). The implications of infant attachment styles for adult functioning will be discussed, with a specific focus on the aversive effects of an insecure attachment for both children and adults. It will be argued that addressing issues pertaining to mother-infant attachment is crucial to the prevention of adult psychopathology and other psychosocial problems. Finally, the implications of attachment theory's contribution to therapy with low-income South African mothers and infants will be considered.

4.1.1. Attachment Theory: An Overview

With its roots in Kleinian object relations theory (Fonagy, 2001), John Bowlby (1958) conceptualised attachment as a biologically evolutionary principle. Attachment behaviours are considered to increase the probability of mother-child proximity, lending themselves to genetic selection by providing an increased likelihood of protection and survival advantage to the off-spring (Cassidy, 1999). In essence, Bowlby conceived of attachment behaviours as serving both protective and instructive functions: in the presence of potential danger, the child is protected by the mother's close proximity. When there is no threat to the child's safety, the instructive function comes into play, as the mother becomes a safe base from which the child can explore its world (Peluso, Peluso, White, & Kern, 2004). Bowlby believed that while the primary goal of attachment behaviours is proximity, the subjective aim is felt security (Hopkins, 1990).

Bowlby (1969) proposed that attachment behaviours are organised into an "attachment behavioural system", discarding the view of attachment as a product of 'drive' or fundamental processes as theorised by traditional psychoanalytic ideas (Kobak, 1999). As Cassidy (1999) states: "Children are thought to become attached whether their parents are meeting their physiological needs or not" (p.5). When a parent is unresponsive or inaccessible, the infant develops strategies to elicit the desired response from the parent, and so enhance the feeling of security (Fonagy, 2001; Sroufe, 2000).

Over time, a child's organisation of the attachment behavioural system becomes stable, due to repeated exposure to behaviours that will enhance proximity, and hence safety, in relation to the mother across varying contexts (Cassidy, 1999). This has been termed the "internal working model"; a complex set of cognitive mechanisms that comprise a representational system (Fonagy, 2001) of the way an individual perceives themselves, others, and close relationships in general (Belsky, 2002). As such it provides a basis from which all future relationships are understood and conducted (Kobak, 1999).

While attachment behaviours are broadly classified as secure or insecure, the extensive research conducted by Ainsworth and her colleagues using the "Strange Situation" laboratory test lead to the postulation of three descriptive categories of attachment style (1978). These are secure attachment, insecure-avoidant attachment, and insecure-ambivalent/resistant attachment. The classifications are based on the attachment behaviour observed when an infant is reunited with its mother after a brief period of absence. This is due to Ainsworth's recognition that the infant's appraisal of the mother's departure in the context of her expected behaviour is what accounts for the infant's response (Fonagy, 2001). It is these reactions that are considered indicative of the nature of the child's security (Hopkins, 1990). Main and Solomon (1986) later described a fourth, more infrequent attachment pattern, which they termed the disorganised-disoriented attachment.

These attachment styles or patterns comprise not only behaviours that serve to maintain a minimum experience of safety, but also involve direct defensive strategies against experienced anxiety (Sandler, 2003). The degree to which the caregiver is available and responsive to the infant's needs determines the degree of security in the infant's attachment to the caregiver (Fonagy, 2001).

The first category of attachment is the *secure* attachment, and is characterised by an infant's ability to restore feelings of safety relatively rapidly (Sandler, 2003) upon reunion with the mother. A securely attached child has a mental representation of his or her attachment figure as available and responsive when needed (Cassidy, 1999). This is not to say that a securely attached infant does not experience or exhibit anxiety upon separation from the mother, however, this child has developed a confidence in the availability of the mother (Kobak, 1999), and so is able to express emotions appropriately upon reunion. Further, this child is able to recover from anxiety more rapidly than insecurely attached infants (Ainsworth, 1988). Mothers of securely attached individuals are more or less consistently responsive, available and comforting when a stressor or threat presents itself. This mother acts as a buffer against psychological distress, and facilitates early experiences that generate a basic trust in the world and the self (Pielage, Gerlsma, & Schaap, 2000).

Insecurely attached children may exhibit attachment behaviours, upon re-engaging with their mothers, that fall into the remaining three categories. These insecure patterns are viewed as organised strategies for maintaining proximity to unresponsive parents (Kobak, 1999) and are considered to reflect a lack of confidence in the mother's responsiveness and availability (Belsky & Fearon, 2002).

A child with an *avoidant* style of attachment is likely to experience distress when separated from the mother, but does not express this distress freely, possibly as a function of a denial defence against the anxiety experienced (Sandler, 2003). A limited range of behaviours is exhibited upon re-engaging with the mother, epitomised by withdrawal (Watson, 2001). These children have learned to expect rejection from their mothers and have adjusted their attachment behaviours accordingly. By avoiding her, the conflict or rejection that is anticipated following the separation is reduced (Kobak, 1999). According to Hopkins (1990) these children typically have mothers who are restricted in their expression of emotion and are averse to physical affection, such that the child's attempts to obtain comfort are consistently rebuffed.

Children who demonstrate *ambivalent/resistant* attachment styles experience intense anxiety and distress when separated from their mothers. However, upon the mother's return, the child's response is ambivalent: the child seeks physical proximity and comfort, and yet simultaneously appears to be angry and preoccupied (Hopkins, 1990; Sandler, 2003). These infants have learned to be uncertain about their mothers' response. They exhibit behaviour marked by angry resistance or passivity upon reunion with her, which serve to increase proximity to the mother (Kobak, 1999). These mothers generally provide erratic physical contact, and frequently offer it to assuage their own needs rather than as a response to the child's needs (Hopkins, 1990).

The fourth category of attachment behaviour, the *disorganised-disoriented* attachment pattern, was later described by Main and Solomon (1986). It refers to a pattern that involves less consistent strategies for dealing with stress than either of the other two insecure attachment patterns (Hopkins, 1990). Parents of these infants are either "frightened or frightening" (Main & Hesse, 1990); some are abusive, others suffer

from unresolved grief (Hopkins, 1990). This attachment pattern was initially described in light of a growing awareness of child physical and sexual abuse, and child neglect, which began in the 1970s and 1980s (Kobak, 1999). Main and Hesse (1990) had observed that infants who had been unpredictably frightened by their parents became caught in a conflict: not only are they are exposed to threats to the attachment figure's availability, but they must also manage the possibility that the attachment figure has become a source of danger (Kobak, 1999):

> The situation is irresolvable because rejection by an established attachment figure activates simultaneous and contradictory impulses both to withdraw and to approach. The infant cannot approach because of the parent's rejection and cannot withdraw because of its own attachment. The situation is self-perpetuating because rebuff heightens alarm and hence heightens attachment, leading to increased rebuff, increased alarm, and increased heightening of attachment...In other words, by repelling the infant the mother simultaneously attracts him. (Main & Weston, quoted in Hopkins, 1990)

Although this infant may display typical secure and insecure attachment strategies, these strategies are often marked by temporary lapses, patented by fear, freezing and disorientation (Kobak, 1999). They may exhibit a variety of behaviours that demonstrate an inability to cope in a stressful situation (Hopkins, 1990). Behaviours upon reunion with the mother such as, immobility, falling down, disorientation and tic-like stereotypies are frequently observed (Sandler, 2003; Kobak, 1999).

As research into Bowlby's theory progressed, researchers and theorists began to consider the variables that influence the quality of an infant's attachment to its mother. As evidenced in the attachment styles described above, the notion of maternal sensitivity and responsiveness had always been of prime importance to Bowlby. He believed these to be critical to the determination of attachment system security (Fonagy, 2001). More recent developments in attachment theory research have considered other variables that are considered to play a role in the determinants of attachment security or insecurity, and the continuity or discontinuity thereof over time. In brief, these variables include, a mother's own attachment history and internal working model (Fonagy, Steele, & Steele, 1991); parental characteristics and child characteristics (Belsky, 1984); the contribution of mother and child characteristics in dyadic interactions (Shulman, Becker, & Sroufe, 1999); infant temperament (Fonagy,

2001); the mother's consistency of care-giving (Waters et al, 2000); maternal depressive symptoms (Easterbrooks, Biesecker, & Lyons-Ruth, 2000; Pesonen, Räikkönen, Strandberg, Keltikangas-Järvinen, & Järvenpää, 2004); conditions of economic impoverishment (Vaughn, Egeland, Sroufe, & Waters, 1979); an individual's life experience (Hamilton, 2000); and, exposure to stressful events (Pielage et al., 2000), to name but a few.

Another development in attachment theory has been concerned with the concept of emotion-regulation. While Bowlby recognised the importance of affect regulation to the theory, making reference to observations he had made concerning affect regulation in close relationships, and about the role of cognitive or defensive processes in the regulation of negative affect, his conceptualisation of attachment did not include a detailed theory of emotion-regulation (Waters, Crowell, Elliot, Corcoran, & Treboux, 2002). Current conceptions of attachment theory regard the regulation of emotion as central (Belsky, 2002). According to Sroufe (2000), the extreme helplessness and dependence of infants in the early months means that they require enormous assistance from caregivers in order to be well regulated. The infant's expression of distress and contentment is reliant upon caregivers to be able to read these signals, whether intentional or not. He posits that infants are not capable of self-regulation, only 'co-regulation' or 'mutual regulation', and that to be well-regulated infants need responsive and sensitive caregivers (Sroufe, 2000):

> By effectively engaging the infant and leading him or her to ever longer bouts of emotionally charged, but organised behavior, they provide the infant with critical training in regulation. Within the secure, "holding" framework of the relationship, infants learn something vital about holding themselves, about containing behavior and focusing attention. (p.68)

This dyadic exchange is thus believed to be crucial to development of emotion-regulation and the emergence of the self (Sroufe, 2000).

Much research has been conducted concerning how the attachment styles discussed above impact upon later functioning, both in childhood and adulthood. It has remained an area of contention amongst various schools of thought. Many studies support the hypothesis that infant attachment patterns are generally stable across the

lifespan (for example, Waters, Merrick, Treboux, Crowell & Albersheim, 2000), while others have yielded results suggesting that discrete attachment behaviours are not necessarily stable over time (for example, Masters and Wellman, 1974). Innumerable studies have been conducted to verify and demonstrate the link between the quality of infant attachment experiences and later outcomes.

Fonagy (2001) points out that the evidence available in support of quality of attachment as a foundation for later adaptation is neither consistent nor reliable, and cites numerous studies to support this. In this review he concludes that the early relationship environment is crucial, not because it predicts the quality of subsequent relationships, for which there is a lack of evidence; but because it equips the child with a "mental processing system". The mental processing system later generates mental representations that include those for subsequent relationships (Fonagy, 2001).

Belsky (2002) proposes that the contradictions in evidence regarding the continuity of attachment styles may reflect researchers' varying interpretations of and approaches to attachment theory, such that differing methods are utilised and inconsistent results are rendered. Belsky (2002) states:

> Indeed, given that the association between individual differences measured using the AAI (Adult Attachment Interview) and those assessed by means of social psychological self-reports is only modest, there is the real possibility that findings relating to the developmental antecedents of attachment security as measured by developmentalists and those pertaining to psychological and relationship correlates of attachment styles as measured by social psychologists are virtually unrelated to each other. (p.169)

Consedine and Magai (2003) agree with this assertion, identifying measurement issues between researchers as key to the inconsistencies in the results of various studies.

Sroufe (2000) provides another explanation for the inconsistencies in research regarding continuity of attachment patterns. After providing a substantial review of research confirming the predictive nature of the early attachment patterns, he proposes that the relationship between early attachment and later "self organisation" is best considered in terms of dynamic systems rather than linear-causality. He suggests that

life experience, the environment, and social circumstances play important roles in directing an individual's development, such that early patterns or internal working models may be altered as life experiences or circumstances are altered. This view is supported by Belsky (2002), who responds to critics of attachment theory by addressing the incorrect presumption that an internal working model is fixed once established. He highlights Bowlby's original conceptualisation of the internal working model as being just as its name suggests: *working*. The study conducted by Waters et al (2000) confirmed Bowlby's belief that individual attachment patterns were generally stable across "significant portions" of the lifespan; yet remain revisable under altered life experiences.

The Waters et al (2000) study addressed the inconsistencies located in results yielded from the Masters and Wellman (1974) study, which concluded that there was little evidence to support consistencies in correlations across discrete attachment behaviours over time. Waters and his colleagues conducted a twenty-year longitudinal study, reassessing 60 subjects who had been observed in Ainsworth's Strange Situation test as infants. Their aim was to "clarify issues raised" by the Masters and Wellman study. An analysis of reliability suggested that most of the discrete behaviours found by Masters and Wellman were too rare to enable a reliable estimation of an infant's typical behaviour from brief episodes. The data that was generated provided strong support for Bowlby's hypothesis that individual differences can be stable across the lifespan, and that real experience can offer the opportunity for revisions to attachment representations (Waters et al., 2000). Waters, Hamilton and Weinfield's (2000) study of three different samples also showed that security discontinuity in adult representations of attachment was due to negative life experiences and circumstances. Researchers in the field of attachment have achieved consensus on the position that early infant attachments influence later outcomes in life. However, the mechanisms and variables that enable continuity, or cause discontinuity, across the lifespan remain hotly debated (Fonagy & Target, 2001).

The four attachment patterns, and the factors implicated in their establishment and continuity or discontinuity constitute the basis of attachment theory in which it is argued that the infant attachment patterns are crucial to the understanding of later child, as well as, adult behaviour and functioning. The following is a review of some

of the studies that have explored the correlation between infant attachment styles and subsequent functioning at specific intervals throughout the lifespan, but more particularly, during both childhood and adulthood.

4.1.2. The role of attachment in development

Infant attachment styles are believed to influence development and functioning across the lifespan (Waters et al., 2000). Secure attachment in infancy, while not necessarily stable over time, at the very least provides the child with confidence in the availability of an attachment figure, as well as the confidence that they are at least minimally competent in forming meaningful and satisfying relationships (Karen, 1994). According to Renn (2002), an insecure attachment "undermines the child's capacity to reflect on and integrate mental experience" (p.305). Lacking insight into the representational basis of human interaction and intentionality, these individuals resort to concrete solutions to interpersonal and intrapsychic problems. In so doing, they attempt to "control their subjective states and self-cohesion through physical experience such as substance misuse, physical violence and crime" (Renn, 2002, p.305).

With regard to secure attachment styles, Sroufe (2000) outlines several longitudinal studies indicating that infants with "effective dyadic regulation of arousal and emotion" (p.72) are later able to better self-regulate. Others rate these individuals as having higher self-esteem, being more self-reliant, and better equipped to manage emotions and impulses. Further, they are more able to express emotions appropriately, positively engage with others, and demonstrate empathy (Sroufe, 2000). Securely attached toddlers have been shown to be highly sociable, co-operative, and strongly oriented towards peers, while secure infant attachment has been found to predict social competence at age 10 (Weinfield, Ogawa & Sroufe, 1997). This is believed to be as a result of positive social expectations based on experiences with responsive caregivers, a learned reciprocity of social interactions, and a sense of self-worth and efficacy (Weinfield, Ogawa & Sroufe, 1997).

Studies show that securely attached adults have greater flexibility and increased openness in style of emotion regulation, suggesting that they have access to a wider range of emotions. Secure attachment in adulthood is further associated with the capacity to participate in successful intimate relationships (Cassidy, 2001), as well as less depression, anger and hostility than the other attachment styles (Consedine & Magai, 2003).

While insecure infant attachment styles are open to revision in the light of life experience (Waters et al., 2000), insecurely attached individuals have a greater predisposition to later psychopathology, poor social relationships, and other psychosocial difficulties.

The study conducted by Wood, Emmerson and Cowan (2004) found that children carry early relational expectations and styles forward into preschool peer relationships. Their research indicates that the degree of early attachment security is significantly related to acceptance and rejection by preschool peers. In their study, lower attachment scores at age three were predictive of peer rejection and lower acceptance scores at age four to five. The exploratory path models employed to explore the link between early attachment security and subsequent peer rejection and acceptance suggest that externalising and internalising behaviours are the mediating variables. The interpretation these researchers proffer is that the frustrations resulting from an early inability to have needs met by significant attachment figures leads to increased psychosocial adjustment problems, such as social withdrawal and aggression. These behaviours, in turn, are likely to impact upon subsequent peer relationships, leading to either rejection or acceptance (Wood et al., 2004). In a cohort study of 68 male juvenile delinquents, Elgar, Knight, Warren and Sherman (2003) found that those individuals with insecure attachments were most likely to report peer and social difficulties. It was concluded that insecure attachment characteristics are correlated with behavioural problems, substance use, and poor family functioning (Elgar et al., 2003).

Sroufe's (2000) review notes that children with anxious/resistant attachment histories are more easily frustrated, have difficulty sustaining successful interactions with others, demonstrate less resilience under stressful circumstances, and often fall prey to more aggressive peers. Studies suggest that these children frequently demonstrate

social withdrawal in middle childhood and anxiety disorders in adolescence (Green & Goldwyn, 2002). Resistant toddlers ignore bids from peers for social interaction and are often highly distressed by these interactions, while their preschool counterparts often show passive and withdrawn behaviour in peer group interactions (Weinfield et al., 1997). As adults they are hypervigilant to cues of rejection and distress; they exhibit higher levels of anxiety, and lower self-confidence (Consedine & Magai, 2003).

According to Sroufe (2000), children with avoidant attachment patterns tend to be isolated from other children, are generally over-controlled, antipathetic, and even aggressive. These children frequently demonstrate a marked lack of empathy towards distressed peers, and have the proclivity to behave in hostile and aggressive ways (Renn, 2002). They are described as aloof, asocial, avoidant of close relationships, as demonstrating more interest in the object world, and having diminished capacity for interpersonal sensitivity (Weinfield et al., 1997). Avoidant toddlers have been shown to be active in their interactions with peers, however the nature of their interactions is negatively oriented (Weinfield et al., 1997). Avoidant patterns have been associated with later antisocial and externalising problems (Green & Goldwyn, 2002). As adults, those with dismissing/avoidant styles of attachment are thought to be more defensive and hostile (Consedine & Magai, 2003).

Perhaps the strongest empirical support for the continuity of attachment is found in those studies examining the short- and long-term effects of the disoriented/disorganised pattern of attachment. Fonagy's (2001) review of research lead him to conclude that the disorganised/disoriented category of attachment style has the strongest predictive significance for later psychological disturbance, while the remaining three attachment patterns are not as strongly related to later measures of psychopathology. The disorganised/disoriented attachment style appears to be the least vulnerable to positive environmental influences and life experiences (Fonagy, 2001).

A longitudinal study conducted by Lyons-Ruth, Alperna and Repacholi (1993) examined the relationship between maternal and infant attachment measures at 18 months infant age, and child behaviour problems at age five in 62 low-income

families. It was ascertained that the strongest single predictor of deviant levels of hostile behaviour towards peers was early disorganised/disoriented attachment. Seventy-one per cent of aggressive preschoolers were classified as disorganised/disoriented in attachment as infants. As an independent factor, hostile and aggressive behaviour was shown to be predicted by the severity of mothers' psychosocial problems, such as depressive symptoms and hostility. In Gauthier's (2003) comprehensive review of studies on aggression, she notes that disorganised attachment in infancy is a major predictor of aggressive and violent behaviour later in life. She contends that individuals who have failed to develop adequate emotion regulation as infants due to a lack of empathic care-giving, also fail to develop the capacity for empathy and the control of aggressive impulses (Gauthier, 2003).

Green and Goldwyn's (2002) review of literature on disorganised attachments suggested that preschoolers, who were identified as falling within this category in infancy, were observed to demonstrate controlling and non-reciprocal interactions with their parents. Often, these behaviours were hostile and coercive in nature or bore the characteristic of solicitous reversal of care. They further refer to studies that demonstrate that disorganised children at age five to seven, have reduced mathematics ability at eight years, as well as impaired self-regulation and formal operational skills at age 17, difficulties which are posited to stem from low self-esteem and confidence in their own abilities (Green & Goldwyn, 2002).

4.1.3. Psychotherapy from an attachment theory perspective

Attachment practitioners and researchers have recognised the powerful preventative and remedial tool in attachment-oriented work (Fonagy, 2001). Clinicians vary in their application of attachment theory to therapeutic work, depending on their aims and objectives. Remedial attachment work with disrupted infant attachments is more commonplace, while preventative attachment work has more recently enjoyed growing attention (Fonagy, 2001). Therapy with adults based on attachment theory is largely curative, except in those instances when the focus is upon improving attachment security between parents and their children, or preventing the disruption of early attachment.

Berlin and Cassidy (2001) suggest that an intervention aimed at enhancing early parent-child relationships must be centred upon two tasks. The first is in facilitating parents' identification of their child's needs and their own responses to those needs. The second involves facilitating the development of parents' insight into how their states of mind with regard to attachment, influence their parenting behaviours, and consequently, the development of their children. Fonagy (1998) posits that all clinical interventions with infants are preventative in essence. However, in utilising a model such as the one described by Berlin and Cassidy (2001), an added advantage to the intervention is the remedial effects for the parents, by affording an opportunity to therapeutically deal with their own childhood attachment problems and, consequently, current attachment problems.

Just as the parent is exhorted to be a "secure base" from which the child can explore the world, clinical applications of attachment theory position the therapist as the secure base from which the client may explore his/her self (Eagle, 2003; Berlin & Cassidy, 2001). Bowlby (1988) asserts that one of the primary functions of the therapist is:

> To provide the patient with a secure base from which he can explore the various unhappy and painful aspects of his life, past and present, many of which he finds it difficult or impossible to think about and reconsider without a trusted companion to provide support, encouragement, sympathy, and, on occasion, guidance. (quoted in Eagle, 2003, p.27)

Lieberman (cited in Berlin & Cassidy, 2001) takes this one step further in proposing that the therapist's relationship with the parents must not only serve as a secure base, but also as a model of supportive and empathic care-giving:

> Parents learn, often for the first time, ways of relating that are characterised by mutuality and caring...Because of its power to change negative expectations and create a new and more trusting experience...the therapeutic relationship can be regarded as a corrective attachment experience (quoted in Berlin & Cassidy, 2001, p.69).

According to Berlin and Cassidy (2001), raising individuals' awareness of their internal working models, and of how these models influence current behaviour, is the means by which ineffectual patterns can be reversed. Thus, the most important themes

to be explored in therapy are those relating to early family relationships, current significant relationships, and the links between them (Berlin & Cassidy, 2001). In Selma Fraiberg (1980) and her colleagues' significant work with mother-infant dyads, the importance of parents' remembering their own childhood experiences, so as to prevent the repetition of these experiences in the relationships with their own children, is highlighted:

> The baby in these families is burdened by the oppressive past of his parents from the moment he enters the world. The parent, it seems, is condemned to repeat the tragedy of his own childhood with his own baby in terrible and exacting detail. (Fraiberg, Adelson & Shapiro, 1980, p.165)

Acknowledging that not all parents with histories of childhood abuse or neglect are destined to repeat their past with their own children, the authors go on to state:

> In remembering, they are saved from the blind repetition of that morbid past. Through remembering they identify with an injured child (the childhood self), while the parent who does not remember may find himself in an unconscious alliance and identification with the fearsome figures of the past...Our hypothesis is that access to childhood pain becomes a powerful deterrent against repetition in parenting, while repression and isolation of painful affect provide the psychological requirements for identification with the betrayers and aggressors. (Fraiberg et al., 1980, p.195, ellipses added)

While Fraiberg and colleagues approached their interventions with troubled mother-infant dyads from a psychoanalytic perspective, their work also comprised parental psycho-education with regard to the psychological and physical development of their children. Their approach was in consulting with the dyad, either through home visitation or consultation at the clinicians' offices (Fraiberg et al., 1980).

4.1.4. Implications for interventions with low-income mother-infant dyads

Disruptions in infant attachment can lead to severe psychosocial problems and even psychopathology. In a society where mothers are the primary caregivers, the quality of an infant's attachment to its mother remains the strongest predictor of later functioning (Hopkins, 1990). While these attachment styles are open to revision in light of life experience (Waters et al., 2000), children's early relationships with their mothers provide a blueprint for the way in which they construct their perceptions of

themselves, others and the world. These perceptions are, for the most part, carried with them into adult life (Belsky, 2002; Kobak, 1999; Waters et al., 2000). With the quality of early attachment during infancy playing a pivotal role in the individual's functioning throughout life, psychotherapy with low-income mother-infant dyads requires an emphasis on fostering improved attachments between mothers and infants, with the broader focus being on the prevention of later psychosocial problems (Fonagy, 2001).

Just as the theory's primary assertion underscores the importance of the mother as a secure base from which the child may explore his or her world, possibly the most essential feature of psychotherapy from an attachment perspective is in the therapeutic provision of a secure base from which the client may explore his or her own intrapsychic world (Bowlby, 1988; Eagle, 2003). Attachment-based psychotherapy with low-income mother-infant dyads does not merely require the facilitation of deepened awareness of the infant's needs and the development of the mother's ability to be a secure base for her child. It also exhorts the therapeutic exploration of the mother's attachment history. This is in order to foster an awareness of her own internal working model and the ways in which it manifests in her current relationships, including her relationship with her infant (Berlin & Cassidy, 2001). The therapy seeks to provide a corrective attachment experience for the mother and a means by which ineffectual patterns may be reversed. However, it also seeks to provide a model of supportive and empathic care-giving, such that the mother herself is mothered through the process of therapy (Berlin & Cassidy, 2001).

Group therapy has a particular contribution to make to an intervention based on attachment theory. Providing support and acceptance, a therapy group may provide a mother with a secure base from which to explore her intrapsychic and social world. Further, with therapy groups frequently exhibiting relational dynamics that resemble familial relationships (Yalom, 1995), mothers may have the opportunity to become aware of their own attachment styles in relation to one another and the effects they may have on current relationships, as is likely to be evident in the group process. This provides the opportunity for the exploration of attachment histories, in addition to a corrective attachment experience. Group therapy may also afford mothers the opportunity to vicariously and directly learn from one another (Yalom, 1995) about

providing a secure base for her infant. In addition it may afford an opportunity for didactic instruction about mother-infant attachment (Yalom, 1995). The implications of psychotherapy with low-income mother-infant dyads are thus two-fold: the infants benefit from increased prevention of psychological distress throughout life (with implications for their own abilities to later parent), and the remedial and preventative effects of psychotherapy generated for the mother.

4.2. The contributions of feminist theory

"In every story there is a silence, some sight concealed, some word unspoken, I believe. Till we have spoken the unspoken we have not come to the heart of the story" (Coetzee, 1986, p.141).

"The eyes of others our prisons; their thoughts our cages" (Woolf, 1944, p.21)

Thus far women's experiences of motherhood have briefly been explored, arguing the need for intervention with low-income mothers in particular. A review of the major theoretical assumptions of attachment theory has underscored the importance of psychological interventions with low-income mother-infant dyads. In this section an overview of postmodern feminist theory is provided, followed by a brief review of the feminist perspective of motherhood, and then an outline of feminist psychotherapy. Here it will be argued that feminist theory directs attention to the necessity of listening to mothers' voices, while the feminist oriented approach to psychotherapy provides an imperative opportunity for their voices to be heard. Further, the tenets of feminist theory and psychotherapy are contended to have vital implications for psychological interventions with low-income mothers and their infants.

4.2.1. Brief overview of feminist theory

Feminist theory comprises diverse philosophical, political, theoretical and pragmatic tenets and approaches (Biever, De Las Fuentes, Cashion & Franklin, 1998). As such the emphases on varied principles have resulted in feminist theory being divided into

several feminist schools of thought, including liberal feminism, postmodernist feminism, radical feminism, romantic feminism, socialist feminism, lesbian feminism, and, cultural and ecofeminism (Biever et al., 1998). While these approaches to feminism represent distinct views, many of their tenets and principles overlap (Biever et al., 1998). A thorough examination of each of these divisions in feminist thought is beyond the scope of this paper, but for the purposes of clarification it should be noted that the author assumes a largely postmodern feminist viewpoint.

Born in socio-political response to gender biases in accepted societal norms and practices, feminism may broadly be defined as "a form of oppositional knowledge" (Hare-Mustin & Maracek, 1997, p.524) that seeks to challenge accepted dogma and call dominant social discourses into question (Hare-Mustin, 1997). With its roots in post-modernism, and in its association with the intellectual movements of constructivism and deconstruction (Hare-Mustin & Maracek, 1997), one of postmodern feminist theory's primary epistemological positions is that the mind, the self, and knowledge are socially constituted and subjects of the socio-cultural contexts in which they are founded (Flax, 1990).

Feminist theory stands in opposition to modernist and positivist science, which maintains that truth and reality are objectively observable and measurable (González, Biever & Gardner, 1994). It contests the notion that knowledge is the product of factual study, and in its essence poses questions as opposed to providing answers. Feminism is grounded in the supposition that knowledge is culturally and socially bound, and thus relative to the contexts in which it is located (Hare-Mustin & Maracek, 1997). In so doing, it refutes biological determinism of gender differences and instead locates the origins thereof within socialising processes (Hare-Mustin & Maracek, 1997). Hare-Mustin and Maracek (1997) explain, "the size and direction of gender differences in social behaviours...often vary according to the norms and expectations for men and women that are made salient by the setting in which the behaviour takes place" (p.24, ellipses added).

From a feminist standpoint, dominant social discourses reflect the prevailing hegemony of a particular cultural and social context, and are reproduced to maintain and serve the ends of oppressive patriarchal ideologies (Hare-Mustin, 1997). Feminist

theory, within its postmodern context, maintains that meaning, as constructed through the medium of language, is socially and historically situated, with language symbolising the ways in which meanings are negotiated and controlled by those in power (Hare-Mustin & Maracek, 1997). This is a particularly salient feature in respect of the historical theorising and practices of clinical psychology, whereby distress and illness have been, and continue to be formulated according to dominant social discourses (as evidenced in the medical model) based on gender stereotypes (Unger & Crawford, 1996). This is highlighted in the words of Maracek and Hare-Mustin (1991), "the dominant discourses in clinical psychology have taken white males as the norm, and thus white women and people of colour have been viewed as deviant and inferior" (p.524). In this respect, woman's mental health is spoken for in the voice of patriarchy, while her own voice has been silenced.

4.2.2. A feminist perspective on motherhood in brief

Even within the confines of this paper's review on motherhood, which sought to delineate the processes that women undergo in the transition to motherhood, there exists a discourse about what motherhood 'should' look and feel like. While some theorists, such as Parker (1995) and Stern (1995), have argued that the cultural and social idealisation of motherhood serves to repress important intrapsychic processes, others, while appearing to champion for the needs and experiences of mothers, merely reproduce dominant patriarchal discourses. As Suleiman (cited in Parker, 1995) has succinctly stated: "Mothers don't write, they are written" (quoted in Parker, 1995, p.8). Feminist theory seeks to question and deconstruct what has been written of motherhood in dominant discourse that serves to reinforce oppressive gender biases and maintain patriarchal hegemony.

One such discourse is found in the socially sanctioned idealisation of motherhood. Flax (1997) proposes that the deification of motherhood reflects repressed cultural fantasies of a "benign force" that will always protect and ever be available to satisfy needs. Echoing an earlier contribution from Hare-Mustin and Broderick (1979), Kruger (2003) describes the "myth of motherhood" in Western society. It concerns the contention of motherhood as the ultimate goal for all women, as well as a rigid circumscription of the motherhood role. Kruger (2003) contends that when women's

subjective experiences of motherhood are attended to, intensely ambivalent feelings about motherhood frequently emerge. She concludes that women's narratives of motherhood recurrently reflect attempts to silence their own ambivalent voices. According to Kruger (2003) this is done in an attempt to obtain a sense of control and coherence, and results in a reproduction the dominant ideology of motherhood. Flax (1997) contends: "Motherhood is a heterogenous and conflictual set of experiences, wishes, fantasies – some of which have nothing to do with the child...Maternity is not an essence, nor does it exhaust categories of woman or the feminine" (p.320, ellipses added).

In her paper, Flax (1990) addresses the socially held view of motherhood as innate to women, and provides an explanation for the origins of psychological gender differences. In support of Chodorow (1983), Flax (1990) proffers a formulation of how women are socialised to become caregivers:

> The sexual and familial division of labor in which women mother and are more involved than men in interpersonal, affective relationships produces in daughters and sons a division of psychological capacities that leads them to reproduce this sexual and familial division of labor. Women as mothers produce daughters with mothering capacities and the desire to mother. These capacities and needs are built into and grow out of the mother-daughter relationship itself (p.162).

Hare-Mustin (1997) continues along this line, describing dominant discourses that socialise women into becoming nurturers with the promise of reward for assuming this position:

> For a women, love equals self-lessness. The discourse of equality makes a woman uneasy if she focuses on herself, her interests, her needs. Instead...she measures herself by her commitment to others, hoping that this will make her loved and respected. (p.568)

Feminism argues that it is not so much the intrapsychic processes that make women vulnerable to psychological distress in the postpartum period, but is a function of the way in which motherhood and its associated meanings are socially constructed. Unger and Crawford (1996) address this issue, and in the discussion of a study that found the

most commonly depressed individual being a woman living in poverty with a young child, they note: "When we look at social context, it is difficult to view depression as an indicator of psychopathology unless it is the psychopathology of society rather than that of individual women" (p. 564). They later go on to question the factors that make the postpartum period a psychologically vulnerable time for women and conclude that parenting of young children may be the source of tremendous stress, irrespective of gender, noting that men who are primary caregivers for young children have been shown to suffer from depression more severely than women (Unger & Crawford, 1996).

Flax (1990) provides a stronger social assertion in her discussion of the "domestication of women", stating, "the family is the source of women's oppression because under patriarchal domination it is the agency in and through which women and men are engendered – replicating men who dominate, women who submit" (p.145). As such, feminism conceptualises the role of motherhood as a social construction that serves the purposes of patriarchal domination, and women's experience of psychological distress in this role as a symptom of oppression, rather than a function of intrapsychic conflict.

4.2.3. Feminist psychotherapy outlined

Over the years, feminism has had a long and ambivalent relationship with psychotherapy (Rowley & Grosz, 1990). Maracek and Hare-Mustin (1991) underscore the tension between feminism's emphasis on social change and clinical psychology's focus on the individual, noting that one feminist psychologist went so far as to proclaim the term 'feminist therapy' an oxymoron. Psychoanalytic theory in particular, has faced a barrage of criticism from feminist thinkers, who assert that

> Psychoanalytic ideas about women were served up as scientific evidence for reinstating women in their "proper" domestic place. These ideas included interpreting women's ambition as penis envy, blaming mothers for an extensive array of difficulties and disorders of childhood and adult life, and equating heterosexuality, marriage and motherhood with psychological maturity (Maracek & Hare-Mustin, 1991, p.523).

Psychodynamic theories have been criticised for overemphasising the influence of early experiences and individual personality at the expense of acknowledgment of economic conditions, social role conditioning, and historical change (Hare-Mustin & Maracek, 1997). Horney (1967, cited in Rowley & Grosz, 1990) declared that girls' penis envy was realistic, given that the phallus symbolised social superiority and privilege not afforded to her because of her lack of a penis, a notion supported by de Beauvoir (1972). In this way, Freudian psychoanalysis was held responsible for defining women as the other (Rowley & Grosz, 1990) and for the dissemination of 'mother-blaming' (Maracek & Hare-Mustin, 1991). Many feminist therapists regard the utilisation of intrapsychic theory as an antithesis to the political commitment of feminism (Kruger, 2000), while Unger and Crawford (1996) assert that "a psychodynamic orientation leads inevitably to the neglect of social context" (p.579).

Despite psychotherapy being criticised as a patriarchal institution (Rowley & Grosz, 1990), feminist psychoanalysis has emerged as a school of feminist thought in its own right. The critical contributions of feminist thinkers such as Nancy Chodorow, Juliet Mitchell, and Jacques Lacan, called feminists to reconsider the insights of psychoanalytic theory (Rowley & Grosz, 1990). Mitchell (1974) argued that psychoanalytic theory does not advocate a patriarchal society but provides an analysis of it and the psychic processes that serve to reproduce it. In addition, Kruger (2000) addresses these criticisms by pointing out they are based on the assumption that the individual is separate from the social. The implication is that they neglect to consider the social as constructed by the individual, and the meaning the individual makes of their world as informed by the social (Kruger, 2000). She goes on to assert that object relations theory provides an intersubjective analysis of how components of social structures are internalised by the individual:

> Not as a direct translation of external interpersonal relations, but as a process, mediated by fantasy and conflict. These fantasies and conflicts are also shaped by the sociocultural and economic circumstances the individual has been exposed to. (Kruger, 2000, p.5)

In this way, feminist object-relations theorists have sought to bridge the gap between feminism and psychoanalytic theory.

Feminist psychology, within its heterogeneity of philosophies and approaches (Biever, De Las Fuentes, Cashion & Franklin, 1998), endeavours to empower not only women's voices, but all voices that have been marginalized by patriarchal governance. It protests against their subjugation and promotes social action and transformation to engender equality (Flax, 1990). According to Maracek and Hare-Mustin (1991), feminist psychoanalytic approaches venture to "disrupt the blatant sexism of orthodox psychoanalysis and to rewrite the account of women's development in an affirmative, woman-centered way" (p.529). The focus of feminist clinical psychology practice is on increasing awareness of gender roles and stereotypes, as well as gender discrimination (Biever et al., 1998). Biever et al (1998) suggest that the feminist approach to psychotherapy aims to increase clients' consciousness of the socio-political context of their behaviour, with the primary therapeutic goal of advancing empowerment and efficacy. According to Worell (2001), feminist psychology, since its inception, has emphasised the promotion of empowerment, personal strength, and resilience, in the face of past, present and future adversity.

4.2.4. Implications for interventions with low-income mother-infant dyads

In light of the needs and experiences of low-income mothers outlined in a previous section, in addition to the feminist perspective on motherhood briefly described above, low-income mothers of South Africa may be ideal candidates for feminist psychotherapy. A feminist approach to psychotherapy seeks to empower women in their daily lives in order to effect broader social and political change (Flax, 1990), and undermine the patriarchal discrimination that oppresses them (Biever et al., 1998; Worell, 2001). Its premises uphold the consideration of the low-income mother in her socio-cultural context and seek to challenge the dominant discourse of socially constructed roles that serve to reinforce the capitulation of women and the dominance of men (Hare-Mustin, 1997).

For the marginalized and unheard voices of low-income mothers in South Africa, the feminist approach to psychotherapy advocates the facilitation of self-empowerment and self-efficacy (Biever et al., 1998). Broadly speaking, therapy with low-income mothers requires the deconstruction of socially- and culturally-bound meaning, and an

exploration of how components of social structures have been internalised, such that the mothers become able to speak with their own voices and construct their own meanings (Hare-Mustin, 1991; Kruger, 2000).

A group therapy approach may provide a unique format for the aims of feminist psychotherapy to be achieved. Since groups often develop into social microcosms of group members' social worlds (Yalom, 1995), group therapy with mother-infant dyads, more than individual therapy, will allow for a deeper consideration of socio-cultural and political context. An empathic and supportive group context may permit mothers to explore and deconstruct the socio-culturally dominant discourses about motherhood. It may offer the opportunity for mothers to voice their experiences for themselves, and so begin to construct their own meanings and identities beyond the socially sanctioned and patriarchal definitions that have silenced them. Through the giving and receiving of support, advice and reassurance, mothers may be empowered, increasing their self-esteem and efficacy. Important networks of social support may be generated through this, thereby facilitating mechanisms for the promotion of social action.

4.3. The contributions of community psychology

Umtu ngumtu ngabantu (A person is a person because of another person) – Xhosa proverb

"Communities are means by which social groups can adapt to the demands posed by life" (Fernández-Alvarez & Nicemboim, 1998).

In this section of the paper, the origins and major premises of community psychology will be outlined. It will be argued that the principles of community psychology endorse the socio-political empowerment of low-income women as an oppressed group, as well as the interventions aimed at the prevention of later psychological distress. The implications of community psychology for therapy with low-income mother-infant dyads will also be discussed.

4.3.1. The origins of community psychology in South Africa

Community psychology was born as a result of heightened awareness of the advantages of collective action; awareness that was primarily promulgated in response to oppressive systems and restrictions of civil rights in the United States in the 1960's (Naidoo, Shabalala & Bawa, 2002; Pretorious-Heuchert & Ahmed, 2001). With mainstream psychology's capitalist origins and individualistic focus, the pioneers of community psychology criticised traditional approaches for various reasons. These criticisms included traditional approaches being elitist; intervening at inappropriate levels; emphasising the individual's responsibility and discounting the role of socio-cultural context; and, serving the ends of oppressive systems by maintaining a curative rather than preventative approach (Naidoo, 2000; Naidoo et al., 2002).

With South Africa's long history of colonialist oppression, the emergence of community psychology in South Africa, at a tumultuous period in its past, was destined to become a powerful tool for political and social reform. At the time, mainstream psychology in South Africa was profoundly aligned with the apartheid system, partly evidenced by the absence of local psychological training for black students (Naidoo, 2000). The South African majority had little to no access to mental health services, which were reserved for the minority, white, middle and upper classes.

With community psychology's emphasis on the prevention of mental disorders, the aetiology of which is viewed as "external forces operating at a higher level" (Naidoo et al., 2002, p. 2), its principles demanded action and intervention at the source of the problem: the apartheid government. Since the demise of separatist rule, community psychology has continued to make great strides, despite being a paradigm not yet fully realised (Naidoo, 2000), yet social action and the empowerment of marginalized groups remain core tenets of the theory.

4.3.2. Briefly defining community psychology

Theorists are divided concerning a single definition for the theory of community psychology, a heterogeneous derivative of psychology, comprised of at least four

varying approaches. These include the mental health model, the social action model, the ecological model, and the organisational model (Pretorious-Heuchert & Ahmed, 2001). According to Trickett (1996), a premise central to the theory of community psychology is "the importance of developing theory, research, and intervention that locates individuals, social settings, and communities in sociocultural context" (p.209). This places emphasis on the interaction between the individual and their environments, and considers entire communities rather than individuals (Pretorious-Heuchert & Ahmed, 2001).

Naidoo (2000), in reflecting upon community psychology theory, provides the following definition: "Community psychology is a comprehensive helping framework of intervention strategies and services that promote the personal development and well-being of all individuals and communities" (p.9). Edwards (2002) broadly defines community psychology as "the science of community behaviour concerned with improving all forms of community life" (p.302).

Lazarus and Seedat (1995) identify community psychology's four primary purposes within the South African context as 1) extending mental health services to all citizens, and in particular the historically oppressed sectors of society, 2) transforming the way in which aetiology and development of psychosocial problems are conceptualised and understood, 3) including a contextual analysis that acknowledges social issues, in order to transform mental health service delivery to include preventative initiatives, and, 4) redefining the psychologist's role to embrace functions of advocacy, community mobilisation and policy formulation (Lazarus & Seedat, 1995).

Perhaps the difficulty in isolating a comprehensive definition for community psychology is found in the attempt to identify principles and premises with the propensity to be generalised globally. Community psychology theory insists upon the acknowledgement of "the reciprocal relationships between individuals and the social systems with which they interact" (Bennett, Anderson, Cooper, Hassol, Klein, & Rosenblum, 1966, p.7), and is directed by the precept to be culturally relative, with respect for diversity (Rappaport, 1977).

As such, perhaps globally applicable definitions for this modality remain elusive in defiance of endeavours to identify a universal approach, which would effectively relegate these central tenets. Surely communities themselves, whether on a macro or micro level, are responsible for shaping definitions of community psychology, relative to their needs and concerns, within their unique contexts? As Lazarus (2003) points out: "Little of what has been written internationally seems relevant to the overwhelming need and very specific circumstances of the South African poor" (p. 32). Perhaps community psychology resists definition for this very reason: being "of, with and for the people" (Edwards, 1998, p.79), it relies on the communities it was born to serve to give it purpose and meaning.

Despite disparities between theorists' definitions of community psychology, consensus concerning community psychology's emphasis on prevention as its primary defining feature appears to have been achieved (Orford, 1992; Freeman & Pillay, 1997; Blair, 1992). The broader aim is thus to reduce incidence by preventing the development of new cases of a disorder, with the target population being those people who are considered to be most vulnerable, or at high risk for developing a particular disorder: "What is peculiar to prevention is its future orientation. It aims to prevent something which has not yet occurred..." (Orford, 1992, p.155).

Community psychology theorists concur, asserting that in order for national health policies to manage psychiatric disorders, as well as their consequences for society, it is imperative that greater emphasis is placed on prevention. If preventative measures are to be designed, they must consider and recognise both personal and environmental factors that contribute to the occurrence of disorders (Fernández-Alvarez & Nicemboim, 1998). In spite of broad definitions such as those referring to community psychology as being "of, with and for the people" (Edwards, 1998, p.79), points of differentiation from mainstream psychology are clearly evident. These are seen in community psychology's orientation to making psychology accessible to all spheres of society, whether operating within systems or upon them; in addition to its emphasis on prevention.

4.3.3. Critique: Community Psychology and the Psychodynamic Approach

As noted above, community psychology was developed in opposition to mainstream, traditional approaches to psychology. Particularly in South Africa, it was born out of critique against modalities that were considered individualist, elitist, decontextualising, and fraught with inequalities along racial, social, economic and gender lines (Naidoo, 2000; Naidoo et al., 2002; Foster & Swartz, 1997; Druiff, 2001). It is thus not surprising that community psychology has long been at odds with psychodynamic approaches to community interventions. As Lerner (1972) fervently contends:

> From its inception, psychoanalytic therapy has been, in essence, a medicine for mandarins, designed and prescribed primarily for mildly to moderately disturbed middle and upper class individuals...Mildly or moderately disturbed middle and upper class people are good clients; severely disturbed and or lower class people are poor ones, rejected by and rejecting of professional therapy and therapist (quoted in Druiff, 2001, p. 8).

Community psychology has not escaped its own share of criticism from other schools of psychological thought. Lazarus (2003) delivers valid critique against community psychology in a review that considers several of its more debatable features, including its failure to develop a theory that adequately identifies the interface between society and the individual. In addition, speaking of the theory's advocacy for understanding psychopathology as resulting from external pressures, she quotes Swartz (1991): "If Africans are consistently spoken of as 'victims' of pressure, this tends to lead discussion away from the possibility of their own role as agents in their psychopathology, but also, by implication, in their lives" (quoted in Lazarus, 2003, p. 33).

This externalisation, while removing 'blame' from the individual for psychological disturbances and placing it on the shoulders of 'oppressive society', may have the undesired effect of engendering further disempowerment, an issue that has always been of highest concern to community psychologists. It is possible that this may serve to deepen a power differential in society that community psychology seeks to eradicate.

4.3.4. Application of Attachment Theory to Community Work

While attachment theory has its origins in psychodynamic thought, and more particularly in Kleinian object relations, it is perhaps the only psychodynamic approach that has delivered a theory underpinning definitive and empirically measurable concepts (Fonagy, 2001). This provides attachment theory with the invaluable capacity to plan, implement and measure the efficacy of interventions, designed specifically for the unique needs of a particular community.

In addition, its departure from traditional psychodynamics is found in its rejection of primitive drive theory, and its concern for environmental factors that influence the quality of attachment (Sroufe, 2000). Attachment researchers and theorists have repeatedly acknowledged the importance of understanding individuals, not only in the context of their attachment histories, but also in the context of their social environments and life experiences (Waters, Weinfield & Hamilton, 2000; Fonagy & Target, 2001; Hamilton, 2000; Sroufe, Duggal, Weinfield & Carlson, 2000; Weinfield, Sroufe & Egeland, 2000; Fonagy, 2001).

With its emphasis on understanding and improving the attachment between mother and infant, attachment theory's potential for providing direct preventative intervention is a feature that further differentiates it from other psychodynamic approaches, which have a greater orientation towards remediation. Fonagy and Target (2001) state:

> Attachment theory is of interest to prevention researchers principally because of the model it provides for the integration of early childhood experience with later development, particularly the emergence of psychopathology. If we are going to provide early intervention with the aim of boosting prevention, we have to choose a domain that is likely to provide an opportunity of influencing the future course of development. (p.310)

Fonagy (1998) charges mental health practitioners and researchers with the following task:

> To persuade society and its agents, the politicians and the administrators of mental health budgets, to invest in the mental well-being of infants, to accept

> and internalise what we all believe to be a fundamental truth of our field, that the preservation of the mental health of infants is the key to the prevention of mental disorder throughout the lifespan. (p.126)

In refuting drive theory, attachment theory has effectively eradicated the role of reductive instincts within the individual, removing the 'blame' from the individual, and rendering attachment interventions more capable of implementing direct intercession for prevention at an environmental level.

What attachment theory lacks however is culture-sensitive definitions of "responsive" and "sensitive" care giving, as well as those definitions concerning various infant responses at separation. It fails to acknowledge cross-cultural differences that may exist regarding the concept of adequate mothering, and assumes universality, largely based on Western ideas, despite the origins of Ainsworth's (1967) work being in Uganda. Her observations and deductions make no reference to culture-specific practices regarding mothering or acceptable norms and customs concerning an infant's separation from its caregiver. Middlemiss (2003) asserts that differences in parenting behaviour across ethnicity are generally accepted in academic literature.

This is important when considering South Africa's cultural diversity. Berg (2003) provides a case in point. She describes a South African mother-infant dyad intervention based on attachment theory, which failed due to insufficient knowledge and understanding of the dyad's cultural context. The case tragically resulted in attempted infanticide. Even so, Berg (2003) concludes that attachment interventions have the potential to be effective, viable and meaningful across cultures, but only when essential factors have been accounted for. She identifies these factors as team work with people from the community, who speak the language and have an understanding of the culture; the team's consistent and reliable presence in the community; and, the practitioner's openness to and awareness of cultures, different to his/her own (Berg, 2003).

4.3.5. Implications for interventions with low-income mother-infant dyads

At its core, community psychology advocates the prevention of mental illness (Orford, 1992); personal development and empowerment of all individuals and

communities (Edwards, 1998); and, the extension of mental health resources to all sectors of society, but particularly those who have historically been oppressed (Lazarus & Seedat, 1995). As a therapeutic framework it seeks to reduce socio-political power differentials, both in society and within the therapeutic relationship, by relegating the role of the psychologist from 'expert' to facilitator (Lazarus & Seedat, 1995). Further, it exhorts consideration and awareness of the individual in socio-cultural context (Bennett, Anderson, Cooper, Hassol, Klein, & Rosenblum, 1966; Rappaport, 1977). Psychological interventions with low-income mother-infant dyads from a community psychology vantage point would thus stress the importance of an awareness of both mother and infant within a socio-cultural context. In addition they would seek to activate appropriate social resources, facilitate empowerment, whilst emphasising prevention of psychological distress.

A group therapy approach to work with low-income mother-infant dyads has several advantages with respect to the aims of community psychology interventions. In terms of cost effectiveness, the group therapy format offers greater access to psychological services for more people. Further, a therapy group may more adequately reflect socio-cultural context, making it more immediate and accessible to the consideration of the individual mother within this context. Mothers may receive and provide support and advice to one another, reducing power differentials in the therapeutic context. Further, it may facilitate individual and group empowerment and development, which may enable to mothers provide support to one another beyond the group therapy context, to non-members. A therapy group may facilitate the prevention of mental illness, by providing an environment in which difficulties, concerns, fears, thoughts and interpersonal experiences may be explored.

5. A review of empirical studies and interventions with low-income mother-infant dyads

The need for psychological intervention with low-income mother-infant dyads was contended in the section outlining the psychological experiences of mothers, as well as in the section underscoring the importance of attachment quality for later development. An overview of feminist theory brought the importance of considering socio-cultural context and the empowerment of marginalized women to light. The

major premises of community psychology have reiterated the need for the empowerment of oppressed groups, calling attention to the necessity of preventative interventions. In this portion of the paper, various interventions with mothers and mother-infant dyads will be described, drawing attention to the outcomes achieved for both mothers and infants.

Due to the strong recommendations for a group therapy approach, proffered by mental health professionals in their work with both low-income women and low-income mother-infant dyads (Belle & Doucet, 2003; Bumagin & Smith, 1985; Druiff, 2001; Hanna et al., 2002; Jarret et al., 2000; Puckering et al., 1994), in addition to the cost-effectiveness of the group format, the focus in this section is upon the outcomes that have been achieved in group work with low-income mothers and infants. Here it will be argued that a group psychotherapy format is an effective intervention for low-income mother-infant dyads, providing opportunity for intrapsychic issues to be explored and addressed; generating important sources of social support for the mothers; facilitating the prevention of psychological disturbance; and, fostering a renegotiation of socially accepted roles with the view to empowerment.

Druiff (2001) contends that low-income women are discriminated against with regard to access to psychotherapy, highlighting the paucity of literature pertaining to low-income women and psychotherapeutic interventions. She contends that low-income women often receive substandard psychological treatment and are infrequently the subjects of concern for researchers (Druiff, 2001). Similarly, there exists an enormous gap in literature relating to therapeutic interventions with low-income mothers, especially in South Africa.

Psychological interventions with their focus on mothers are largely directed at the treatment of mental illness. Exceptionally little is written of interventions with low-income mothers who have not been diagnosed with psychiatric disorders. In contrast, a proliferation of literature exists regarding treatment interventions for mothers with psychiatric illnesses, particularly those diagnosed with post-natal depression (for example, Kersting, Fisch & Arolt, 2002; Beeber, Holditch-Davis, Belyea, Funk & Canuso, 2004; Reid, Glazener, Connery, Mackenzie, Ismail, Prigg & Taylor, 2003). The following review represents reports on interventions with mother-infant dyads,

and group work with mothers and infants, who have not been diagnosed with psychiatric disorders (though they may exhibit signs and symptoms), but may have been identified as high-risk for the development of psychosocial problems.

5.1. A review of caregiver-infant dyad interventions

A substantial number of interventions with mother-infant dyads take place by means of home visitations or combination approaches involving home visits and group interventions. Halpern and Larner (1987) report on the Child Survival / Fair Start programme in the United States, which focussed on providing home visits to families that were identified as high-risk for the development of poverty-related psychosocial problems. Lay workers, who were members of the community, were responsible for making the visitations. They received training and ongoing supervision from professionals, including professional nurses, social workers, and child development specialists. Among the aims of the project were those of facilitating improved parent-child relationships, and providing psycho-education to parents regarding the appropriate developmental expectations of the children. Beginning during the mother's pregnancy with the "target child", lay workers made biweekly to monthly visits until the child reached the age of two. Lay workers were responsible for providing general support, by listening to the mother's immediate concerns and assisting in the formulation of appropriate problem-solving strategies. In addition, suggestions were offered concerning various exercises and tasks to stimulate the infant's development. The programme's success was found in its proactive contact with at-risk families. It provided helping interactions in a less threatening way, with sustained relationships between families and lay workers affording the early detection of problems, and as a result, facilitating the prevention of psychosocial problems (Halpern & Larner, 1987).

A similar intervention was implemented in South Africa, under the direction of Richter (2001), funded by the South African Department of Health. The pilot programme was aimed at populations in areas where no such services were available. Its primary goal was the promotion and development of healthier caregiver-infant relationships. It was developed as a violence prevention strategy based on the premise that children who experience healthy attachments to their primary caregiver are less

likely to engage in violent behaviour later in life. Community workers were trained and supervised by practicing psychologists, to provide several services to mothers at four community sites in semi-rural / rural areas in both the Western and Eastern Cape provinces. The services provided were based on an assessment of needs of mothers in each community. These services included home visitation and caregiver groups, providing support, information, and other social services. Despite many obstacles, the pilot project was considered to provide important direction for future interventions, highlighting the effectiveness of groups for mothers, as platforms for the provision of psycho-education and support (Richter, 2001).

Cooper, Landman, Tomlinson, Molteno, Swartz and Murray (2002) report on a pilot study intervention delivered to low-income mothers and infants in a peri-urban South African community. The intervention was specifically designed to target mothers exhibiting signs and symptoms of depression, in order to combat the adverse effects of maternal depression on the mother-infant relationship. Four community workers were trained to deliver the intervention, by means of home visits, to 32 mothers and their infants. They found that while maternal mood remained impervious to the intervention at six months post-partum, significant improvements were seen in interactions between the mother-infant dyads (Cooper et al., 2000).

While the interventions described above did not encompass the strategies for mother-infant dyad interventions proposed by Bowlby in dealing with mothers' attachment histories and current attachment statuses, each report varying degrees of success, noting that long-term outcomes are difficult to assess.

In Fonagy's (1998) review of preventative studies and interventions, he refers to two large randomised control trials with high-risk families. They revealed that home visitations providing social support and education only, show no long-term benefits for mothers or infants. He goes on to discuss the "Elmeira Project", the premise of which assumed "interdependence among social systems that operate simultaneously at the level of the parent-child dyad, the family as a whole, and the larger socio-economic influences of the community" (Fonagy, 1998, p.129). Home nurse visits were conducted throughout the first two years of life, with high-risk families and their infants. Visits took place weekly for the first six weeks and then tapered to once

every six weeks, during which parents were provided with education regarding risk behaviours, parenting techniques, enhanced social support and advice. Significant results were evident, including a dramatic reduction in child abuse and neglect. However, while some long-term benefits were noted, such as the number of infant injuries and toxic ingestions, child abuse and neglect increased once the home visits were ceased. Fonagy (1998) suggests that the strongest effects may have resulted from structural changes in the lives of the mothers (such as finding employment or terminating an abusive relationship), because of the home visits, that continue to impact upon the development of their children.

Fonagy (1998) purports that an integral component of successful prevention is a relationship-based approach as the fostering of an affectionate mother-infant relationship has been shown to reduce children's problem behaviours at older ages. He reviews several studies that show long-term advantages for mother-infant attachment where the focus was on highlighting infant cues, providing feedback, and developing the mothers' skills and self-confidence (Fonagy, 1998).

Marvin, Cooper, Hoffman and Powell (2002) implemented an intervention they called "Circle of Security", aimed at parents of at-risk toddlers and preschoolers. This 20-week group-based, parent education and psychotherapy intervention was designed to alter insecure patterns of caregiver-infant interactions to more adaptive and appropriate patterns. Small groups (approximately six members) of parents met once a week with a therapist to review edited video vignettes of their interactions and exchanges with their children. Parents were introduced to attachment theory, and psycho-education and therapeutic discussions, individualised to the specific attachment patterns presented by group members, were provided and facilitated. The methodological decision to focus on parents was based on the premise that adults have "greater degrees of freedom" in changing dysfunctional patterns (Marvin et al., 2002). The authors assert that the aim is not to attribute the cause of disruptions to parents:

> Rather the implication is that even for a preschooler or an older child, a most effective intervention for problematic attachment-caregiving patterns may be to focus directly on the caregiver, and work toward shifting the caregivers patterns of behavior and/or IWMs of attachment-caregiving interactions with this particular child. This shift could then lead to a change in patterns of

> parent-child interaction, and in turn shift the child's patterns of attachment- and exploratory-behavior toward a more adaptive developmental pathway. (Marvin et al., 2002, p115-116)

Preliminary results from this study suggest significant shifts in attachment style from insecure to secure, in both the parents and their children (Marvin et al., 2002).

An intervention that sought to place greater emphasis on the mother is described by Heinicke, Fineman, Ruth, Recchia, Guthrie and Rodning (1999). The intervention yielded positive results for both mothers and mother-infant attachments. Its primary goal was "to offer the mother the experience of a stable trustworthy relationship that conveys understanding of her situation, and that promotes her sense of self-efficacy through a variety of specific interventions" (Heinicke et al., 1999, p356). In this randomised control study targeting mothers with the primary risk characteristics of both poverty and a lack of social support, both home visitations and a weekly mother-infant group formed the basis of this intervention format. Both were implemented by mental health professionals, with weekly home visits beginning in the third trimester of the women's pregnancies, tapering to fortnightly in the second year, and telephone and follow-up contacts in the third and fourth years. Results from the study suggest that the mothers benefited from continuing support from their partners and extended families. They were shown to be better able to deal with personal problems, thereby enhancing feelings of self-efficacy, especially with regard to their abilities to parent. With regard to mother-infant interactions, mothers were observed to show greater responsiveness to the needs of their infants, as well as encouraging greater autonomy and task involvement. In comparison to the control group, the children of these mothers demonstrated greater security, autonomy and task involvement (Heinicke et al., 1999).

5.2. Group interventions with low-income mothers

Group interventions for mothers are often limited to postnatal support classes for middle-class mothers, whose focus is primarily on providing education and information pertaining to breastfeeding, physical conditioning exercises to facilitate physical recovery from pregnancy, parenting skills, infants' developmental milestones, soothing and calming techniques, and infant massage (Metzger &

Shocker, 2002). Low-income mothers in South Africa often do not have access to adequate professional and basic medical postnatal care and support (Rao, Harrison & Bergström, 2001), much less access to postnatal classes. However, group psychotherapy interventions for mothers provide unique therapeutic features and advantages that may represent a promising approach to work with low-income mothers and their infants.

Jarret et al (2000) describe a randomised control study for which low-income mothers who had received little prenatal professional support were recruited. The control group received standard social services. The intervention group received weekly visits for the first four months post-partum, and the combination of bi-weekly home visits and group intervention services from the fifth month until the first year. The "Pride in Parenting" group programme consisted of 16 ninety-minute structured sessions, which were divided into a forty-five-minute developmental playgroup, and a forty-five-minute support group for the mothers. In the former, mothers and infants participated in a playgroup, which focused on the importance of developmental play and providing information to the mothers as to what to expect with regard to their infants' development. During the support group session, only the mothers were in attendance, while care workers looked after the infants. Topics of discussion were structured and prepared from literature that was deemed relevant to the group. These topics included self-esteem, baby health care, women's and infants' nutrition, coping and stress, limit-setting, relationships, physical exercise, and substance abuse. At the conclusion to the programme, the mothers were asked to rate the features most valuable to them. The mothers indicated that the professional and social support offered, as well as informational and educational aspects, were the most meaningful features (Jarret et al, 2000).

Puckering et al (1994), make a compelling case for group psychotherapy with mothers. Their group-based "package" intervention for mothers with severe parenting difficulties rendered significant changes in participants' interactions with their children. The intensive four-month programme comprised several components. The mothers attended a psychotherapeutic group session in the mornings, facilitated by a clinical psychologist, social worker and care worker (while the children were tended to by care workers), with the emphasis on drawing links between past and current

relationship experiences and current feelings. At lunch, the mothers, staff and children ate together and participated in activities together, providing mothers with an opportunity to practice new interactions with their children and enjoy their children's company. A second group contact took place in the afternoon, with discussions centred upon parenting concerns and the review of video footage of the mothers interactions with their children, recorded prior to the group's commencement. The results suggest significant increases in mothers' positive affect and decreases in negative affect, as well as significant increases in measures of warmth, sensitivity and effective control. The authors note several features of the intervention, which are likely to have facilitated the changes. Among these was the clinicians' repudiation of the "expert model", promoting respect for the women's individuality and autonomy as a therapeutic medium. Identification with each other's experiences, fears and difficulties additionally provided a powerful therapeutic tool for the mothers. At a six-month follow-up, the mothers continued to report positive changes not only in their feelings towards and perceptions of their children, but in the children's and their own behaviour. The authors go on to report: "It was striking that none of the members ascribed the help they felt they received to the group leaders. Without exception, mothers cited giving and getting advice from other women as the most important factor" (Puckering et al., 1994, p.306).

Bumagin and Smith (1985) discuss a group therapy intervention directed solely at the psychological needs of low-income mothers residing in a housing project in the United States. The group ran for three years and was open to any mother who wished to attend. Group members were free to meet alone with one or both therapists as frequently as was needed. Pre-group meetings were conducted in the community clinic office or at the member's home. Home visitations, though not forming part of the intervention design, proved to be useful to the clinicians in gaining an understanding of the client's world. Group discussions were flexible in their format, at times focused on psychodynamic issues, and at other times with greater emphasis on an informational and educational format. The authors describe how the mothers' needs for personal attention came to the fore during the sessions, such that discussing concerns about child-rearing became of secondary importance to the group process. Group members developed increased capacities to make psychodynamic links between present difficulties and past experiences. This resulted in the development of

greater insight, decreased externalisation, and improved behavioural controls. Significant changes became evident in the lives of the mothers:

> The ongoing group process helped improve self-esteem and self-understanding while diminishing masochistic inclinations and passive-dependent approaches to relationships. The possibility of defining aspects of self other than via motherhood – of adding an identification as women in relation to each other – created an opportunity for members to expand their understanding of communication and interpersonal gratification. Psychodynamically and cognitively, the group addressed an assumption that its members were bad – bad children, bad mothers, bad citizens. (Bumagin & Smith, 1985, p.282)

5.3. The outcomes of group interventions with low-income mother-infant dyads

The interventions described above generally report positive outcomes for both mothers and infants. However, those studies that utilised a group approach appear to have had added advantages for the mothers and infants. Perhaps the most striking outcome of interventions involving a group-based approach is that of the benefits of increased social support (Bumagin & Smith, 1985; Jarret et al., 2000; Puckering et al., 1994). In a group format mothers are able to identify with one another's experiences and difficulties, provide support and advice to one another, thereby facilitating their empowerment and self-efficacy (Puckering et al., 1994).

Increased autonomy, individuality and responsive mothering have also been seen to result from this improved sense of self-efficacy (Heinicke et al., 1999; Puckering et al., 1994). The generation of social support not only extends mothers' support networks, but has been shown to enable mothers to improve upon their existing social support networks, in relationships with their partners and family members (Heinicke et al., 1999).

Psychotherapeutic groups afford the opportunity for psychodynamic issues to be explored and addressed, facilitating increased self-awareness and insight, improved self-esteem (Bumagin & Smith, 1985). They also provide corrective attachment experiences, with positive implications for both the mother's current relationships, and the quality of attachment between mother and infant (Marvin et al, 2002).

Significant changes from insecure to secure attachment styles in both parents and children are also reported (Marvin et al., 2002), with changes in mothers' perceptions of themselves and of their children fostering improved relationships between them (Bumagin & Smith, 1985).

While sustained effects and long term preventative outcomes are difficult to assess, some short term follow up studies have suggested continued evidence of positive outcomes (Bumagin & Smith, 1985; Puckering et al., 1994). In addition, therapy groups allow for the expression of definitions of the self that are not solely related to that of being a mother (Bumagin & Smith, 1985). Decreases in mothers' negative affect and significant increases in measures of warmth, sensitivity and effective control are other notable outcomes (Puckering et al., 1994). Psycho-educational and informational aspects form another important and valued aspect of group-based interventions for mothers, generating group discussions regarding parental concerns and difficulties, and assisting improved capacity for coping with stress (Bumagin & Smith, 1985; Heinicke et al., 1999; Jarret et al., 2000; Puckering et al., 1994).

While many of the studies and interventions described above are centred upon high-risk parent groups (the primary criterion for being qualified as 'high-risk' being economic impoverishment), their essential features are in addressing mother-infant or caregiver-infant interactions, with the emphasis on promoting improved infant development. Very few interventions speak of attending to the mother's needs as the fulfilment of these being the primary end in itself. As such, it is the infant's psychological development and well being that assumes first priority, and very rarely, the mother's needs. While these may be addressed during the course of the intervention, the motivation for addressing them is principally for the infant's sake and not the mother's.

It is generally accepted by attachment theorists and researchers, and even those professionals who do not strictly adhere to attachment theory, that in successfully meeting the mother's needs, at least in part, or successfully resolving her insecure attachment patterns, the infant will benefit from the results (Fonagy, 2001). The potential implication of this approach is that the mother receives the clear message that her own needs are only important in as far as they impact upon her infant. Thus,

the mother's needs become of secondary importance. Perhaps infant mental health professionals would argue that this is as it should be. However, this message to the mother may only serve to endanger the infant's development further.

Since there is little evidence of the long-term outcomes for sustained effects and long-term prevention in the lives of mothers, it is difficult to assess whether their needs were indeed met. If the mother's needs are fulfilled as a secondary measure to the promotion of the infant's development, it may be argued that while her immediate needs were met during the course of the intervention's duration, deeper intrapsychic needs may cease to receive attention once the intervention is over. In the long term, the mothers' needs may then not have truly been met. If the mother's needs remain unfulfilled, not only does she remain disempowered and bound to socio-cultural ideals that continue to oppress and marginalize her needs, but it may also be concluded that her infant becomes the beneficiary of mothering that may be limited and even affected by those needs.

6. Conclusion

6.1. Summary of the current paper

The transition into motherhood represents a crucial period for women. It offers the opportunity for psychological growth and development (Breen, 1975; Raphael-Leff, 1991), simultaneously leaving women vulnerable to psychological distress (Leonhardt-Lupa, 1995; Parker, 1995; Pines; 1988). For low-income mothers the challenges associated with this transition are complicated by a host of poverty-related stressors, rendering them at greater risk for victimisation (Salomon, 1996), social isolation (Belle, 1982), and the development of mental illness (Belle & Doucet, 2003; Druiff, 2001; Salomon, 1996; Wagner & Menke; 1991). When the mother is at risk, her infant, in its dependency on her for the fulfilment of physiological and psychological needs, suffers the same vulnerability (Halpern & Larner, 1987; Lyons-Ruth et al., 1990; McGroder, 2000). Thus the need for psychological intervention with low-income mother-infant dyads was argued. The aims of the paper were to explore the theoretical underpinnings of psychotherapeutic group work with low-income

mother-infant dyads, utilising attachment theory, feminist theory and community psychology. Further, it sought to review existing reports of interventions with low-income mother-infant dyads, with a view to arguing for the unique potential of group therapy interventions as a an effective approach.

6.1.1. Theoretical contributions revisited

The major contributions of attachment theory, feminist theory and community psychology underscore the diverse needs of low-income mother-infant dyads, in their distinctive approaches to psychotherapeutic interventions. The following is a summary of their major assumptions and contributions to psychotherapeutic approaches.

Attachment theory highlights the importance of mother-infant attachment quality for later development (Belsky, 2002; Hopkins, 1990; Waters et al., 2000), and as such recognises the importance of early preventative interventions (Fonagy, 2001). Psychotherapy from an attachment perspective seeks not only to prevent disruptions in attachments between mothers and infants (Fonagy, 1998, 2001), but advocates the therapeutic facilitation of a corrective attachment experience for the mother (Berlin & Cassidy, 2001) with the therapist's provision of a secure base from which to explore the intrapsychic world (Eagle, 2003). This enables an awareness of how current internal working models were developed, and continue to affect current relationships, offering a remediation of insecure attachment styles, and the facilitation of improved attachments in current relationships, with the infant and other significant people in her life (Berlin & Cassidy, 2001).

Feminist theory, with its diverse schools of thought, views motherhood as a socially constructed role that oppresses women and serves the ends of patriarchal domination (Flax, 1997; Hare-Mustin, 1997; Hare-Mustin & Broderick, 1979; Kruger, 2003). The postmodern feminist approach to psychotherapy with low-income mothers thus places emphasis on their socio-political and personal empowerment with the aim of exploring the components of social structures that have been internalised (Kruger, 2003), disrupting dominant social discourses (Biever et al., 1998; Maracek & Hare-Mustin, 1991), allowing mothers to construct their own meanings and so speak for

themselves (Hare-Mustin, 1991; Kruger, 2003). It highlights the importance of viewing the individual within the context of her socio-political environment, and increasing women's consciousness of their behaviour within this context (Biever et al., 1998).

The major premises of the community psychology approach to psychological interventions are focused upon the prevention of psychological disorders (Orford, 1992; Freeman & Pillay, 1997; Blair, 1992). By definition, community psychology exhorts the acknowledgement of individuals within the context of their communities, and the reciprocal relationship that exists between them (Bennett et al., 1966; Pretorious-Heuchert & Ahmed, 2001; Trickett, 1996). It endorses the extension of mental health services to all sectors of society, particularly those who have suffered the oppression of an unjust system, and promotes the personal empowerment and development of all individuals and communities through the generation of social support resources (Edwards, 1988; Naidoo, 2000).

6.1.2. The compatibility of attachment theory, feminist theory and community psychology

The descriptions of the major assumptions of attachment theory, feminist theory, and community psychology outlined in this paper, reveal their distinctive approaches to psychological interventions with low-income mother-infant dyads. The selection of these three theories for their contribution to psychotherapeutic interventions with low-income mother-infant dyads may be considered contentious. On the surface it would appear that their disparate tenets are in conflict with one another (though some congruence is evident between the principles of community psychology and feminist theory). However, here it will be argued that it is their disparities that may lend themselves to an effective psychological intervention with low-income mother-infant dyads, each considering unique aspects of work with mothers and infants that may have been neglected otherwise.

Commonalities in the assumptions of community psychology and feminist theory include the view and consideration of the individual within socio-political and socio-cultural context (Biever et al., 1998; Orford, 1992), and the emphasis on the

importance of empowering the oppressed individual to effect social and political change (Edwards, 1988; Worell, 2001). Both seek to redress social and political inequalities, and promote social action (Flax, 1997; Hare-Mustin & Maracek, 1997; Lazarus & Seedat, 1995; Pretorious-Heuchert & Ahmed, 2001).

Broadly speaking, these two theories largely hold society responsible for mental illness, both in the conceptualisation and the expression thereof. From a community psychology perspective mental illness is largely regarded as resulting from society's oppression of marginalized communities of individuals (Rappaport, 1977). From a feminist theory standpoint, mental illness is generally regarded as a consequence of society's promulgation and support of patriarchal discourses that serve to oppress women (Hare-Mustin & Maracek, 1997). However, both theories extend this contention to the formulation and conceptualisation of psychiatric illness by the traditional Western medical model, contending that it serves to reinforce the control and power of the prevailing hegemony (Lazarus & Seedat, 1995; Maracek & Hare-Mustin, 1991).

In this way, community psychology and feminist theory appear to be more compatible with one other than with attachment theory. Due to the emergence of both community psychology and feminist theory as oppositions to traditional approaches, they share common criticisms of traditional psychodynamic theory. From both perspectives, psychodynamic theory has been the recipient of criticism for its subservience to oppressive ideologies (Pretorious-Heuchert & Ahmed, 2001; Rowley & Grosz, 1990), favouring the sectors of society deemed superior (Flax, 1997; Rappaport, 1977), neglecting to account for social context (Lerner, 1972; Maracek & Hare-Mustin, 1991), maintaining the status quo, and propagating the ideals of the dominant dogma (Lerner, 1972; Maracek & Hare-Mustin, 1991).

In its defence, attachment theory, within the broader framework of psychodynamic theory, provides a detailed account of human psychic development (Fonagy, 1998), which neither community psychology nor feminist theory have fully embraced. However, feminist object relations theory, as one school of feminist thought has given greater attention to psychic development (Flax 1997; Kruger, 2000). Community psychology has been criticised by psychodynamic theorists for its failure to develop a

theory that adequately identifies the interface between society and the individual (Lazarus, 2003). Attachment theory departs from traditional psychoanalytic ideas in that it renounces drive theory and actively considers the individual within their environmental context (Sroufe, 2000), and while its consideration of context may not bear the political weight of community psychology and feminist theory's assumptions, it makes a valuable contribution to the understanding of the relationship between the individual and their social world (Cassidy, 1999; Fonagy, 2001; Pielage et al, 2000; Waters et al., 2000).

Further, attachment theory, like community psychology, places a strong and growing emphasis on the prevention of mental illness (Fonagy, 1998, 2001; Fonagy & Target, 2001). Attachment theory may be criticised by feminist theory for "mother-blaming"; reinforcing patriarchal discourses about motherhood and placing unequal responsibility for the infant's development on either parents' shoulders (Flax, 1990). Attachment theory places great emphasis on the responsive and sensitive caregiving of the mother and little mention is made of the father's contribution. However, as Mitchell (1974) suggested, in an effort to dissuade feminist thinkers from dismissing psychoanalytic theory in its entirety, perhaps this inequality is not reflective of an attempt to reinstate women "in their 'proper' domestic place" (Maracek-Hare-Mustin, 1991, p.523), as much as it is a reflection of accepted societal practices engendered by patriarchal domination. Attachment theory readily acknowledges that a caregiver, other than the mother, may be the primary attachment figure to an infant (Bowlby, 1958; Fonagy, 1998), however the reality in most societies is that mothers are generally the primary caregivers. Attachment theorists are more concerned about the quality of care-giving a child receives than who gives the care. In addition, attachment practitioners and researchers are paying increased attention to the roles of both parents, designing interventions for "caregivers" rather than mothers alone (Fonagy, 2001; Hopkins, 1990; Marvin et al., 2002).

Feminist theorists may contend that a maintained focus on the mother (despite its mere reflection of accepted societal practices), may serve to maintain and reinforce dominant discourses of motherhood by designing interventions primarily aimed at mothers. Perhaps the strongest response from attachment theory would be in highlighting the outcomes of reported group therapy interventions with low-income

mothers and their infants, which demonstrate an empowerment of low-income mothers, and not a subjugation of their needs. An examination of the outcomes of the empirical studies and interventions reported in this paper also provides clear indication that the major psychotherapeutic propositions of each of the three outlined theories are represented and achieved in group-based work with low-income mother-infant dyads.

Finally, attachment theory, feminist theory and community psychology are not so diverse in their assumptions as to prevent them from being understood and assimilated under the metatheoretical umbrella of social constructionist theory.

6.1.3. Social constructionism as a metatheory

It is clear that attachment theory, feminist theory and community psychology each have valuable theoretical contributions to make to the design of interventions with low-income mother-infant dyads. Their compatibility may best be understood within the broader theoretical context of the social constructionist view. According to Willig (2001), social constructionism is concerned with emphasising that "human experience, including perception, is mediated historically, culturally and linguistically" (p.7). As such, the ways in which reality is experienced is not an ahistorical given, but may vary between historical periods and cultural systems. It is argued for this reason, that perceptions and experiences must be understood as a particular reading of social conditions, rather than merely a reflection of social conditions (Willig, 2001). Social constructionists argue that the "terms in which the world is understood are social artefacts, products of historically situated interchanges between people" (Gergen, 1985, p.267).

It must follow then that there is not just one body of knowledge that can be called "the truth". The implications of this are not to refute the existence of knowledge, but to highlight the existence of "knowledges" (Willig, 2001) that continue to be constructed within and across cultures, and throughout time. As such social constructionism, within the broader framework of postmodernism, promotes the acceptance of pluralism, contextualism, and eclecticism (Biever et al., 1998). González et al. (1994) assert that "according to this viewpoint, there are no universal truths, no 'right' way of

thinking or behaving: rather there are multiple outlooks which are considered equally valid" (p.516).

The theory of social constructionism posits that meanings of the world are obtained from social interactions. As such, meaning is determined by the social and cultural contexts in which individuals operate (González et al., 1994). Since social interactions largely consist of conversation and dialogue, social constructionism gives particular attention to its ontological status, as the primary means by which reality is constructed (Willig, 2001). Through language, psychological theories thus reflect differing constructions of meaning, which are socially and culturally based. As Scarr (1985) states: "We do not discover scientific facts; we invent them. Their usefulness to us depends both on shared perceptions of the 'facts' (consensual validation) and on whether they work for various purposes, some practical and some theoretical" (quoted in González et al., 1994, p.517).

In this way, social constructionism provides a backdrop for the integration of attachment theory, feminist theory and community psychology in conceptualising the therapeutic needs of low-income mother-infant dyads. Each theory reflects a differing construction of meaning and understanding that is socially and culturally bound. They are "knowledges" (Willig, 2001) that may share commonalities, but have unique contributions to make to the formulation of psychotherapy with mothers and infants. Revisiting the outcomes of recorded groups with low-income mother-infant dyads gives emphasis to this point.

6.2. The outcomes of group interventions revisited

The review of available empirical studies and interventions with low-income mother-infant dyads revealed important implications for the utilisation of a group therapy format. It demonstrated many of Yalom's (1995) therapeutic factors at work, in yielding positive results. Further, it revealed that the major psychotherapeutic tenets of three diverse theories, namely attachment theory, feminist theory and community psychology may be in operation under the metatheoretical umbrella of social constructionism. Revisiting these outcomes highlights some of the major benefits of group therapy with low-income mothers and infants.

One of the major benefits of the group work described was in the generation and extension of important resources of professional and social support (Bumagin & Smith, 1985; Jarret et al., 2000; Puckering et al., 1994). This is an important feature of both the community psychology and feminist theory approaches to psychotherapy. The extension of social support systems is important for facilitating improved coping mechanisms, increased self-worth, and empowerment. Increased access to professional support may lend itself to prevention and early detection of psychological problems. Several of Yalom's (1995) therapeutic factors are evident in this outcome, including group cohesion and altruism. Therapy groups offer a unique vehicle for the promotion of social support, with factors such as universalism and catharsis in operation.

Mothers' experience of personal empowerment and self-efficacy (Puckering et al., 1994), as well as increased autonomy and individuality (Heinicke et al, 1999) resulting from the group processes, are psychotherapeutic aims of attachment theory (Marvin et al. 2002), feminist theory (Worell, 2001; Flax, 1997) and community psychology (Edwards, 1988). They reflect the instillation of hope and existential factors as therapeutic factors in operation (Yalom, 1995). The outcomes of increased self-awareness, insight and self-esteem for mothers (Bumagin & Smith, 1985) are significant to attachment theory (Berlin & Cassidy, 2001), feminist theory (Biever et al, 1998) and community psychology (Naidoo, 2000). These reflect therapeutic factors such as interpersonal learning and the role of existential factors (Yalom, 1995), within the group process.

A mother's improved psychological functioning is not limited to positive outcomes for only herself. In the review of group work mothers showed greater responsiveness to the needs of their infants (Heinicke et al., 1999), increased warmth and sensitivity (Puckering et al., 1994), and greater awareness of how their own internal working models impacted upon their relationships with their infants and significant others (Bumagin & Smith, 1985; Marvin et al., 2002). These are important aspects of attachment theory, as well as feminist object relations theory.

Despite the support for a group therapy approach to interventions with low-income mothers and infants (Belle & Doucet, 2003; Bumagin & Smith, 1985; Druiff, 2001; Hanna et al., 2002; Jarret et al., 2000; Puckering et al., 1994), there is an enormous paucity of literature describing group interventions or studies involving low-income mother-infant dyads. For this reason, it is not possible to generalise the outcomes reviewed above, as features of all such interventions. In addition, a lack of follow up studies makes the assessment of preventative effects and outcomes difficult. However, bearing the results of attachment theory research in mind, preventative effects for the infant are likely to be evident.

Limitations particular to this paper include the lack of attention given to the potential outcomes of other psychotherapy formats, such as individual psychotherapy. In addition, since the purposes of this paper were not to provide an exhaustive review of the three major theories presented, it fails to provide a comprehensive examination of their assumptions and theoretical intricacies. It does however; provide some promising insights into the potential of group therapy with low-income mother-infant dyads, drawing from attachment theory, feminist theory and community psychology.

6.3. Implications for services

Therapy groups for low-income mother-infant dyads may offer a cost-effective means to providing much needed interventions with this vulnerable and marginalized population. In addition, its potential for the prevention of psychiatric illness may have major long-term implications for the well-being of low-income South African society, providing individual and community empowerment. With possible reductions in the incidence of mental illness and other psychosocial problems, there may be less need for public mental health services at tertiary level, reducing the expenditure of limited economic and human resources.

Increased and expanded access to community and social support resources, generated by group interventions, may empower mothers to assist other mothers. A group therapy intervention with low-income mother-infant dyads may train and utilise community volunteers as co-facilitators. In time and with training, volunteers may run support groups or psycho-education groups for mothers. The professional input of

nurses, occupational therapists, social workers, and other professionals may be included in these group programmes. Home visits may be incorporated as an additional aspect of the intervention. These may facilitate greater awareness of the mothers' world, in addition to functioning as an additional source of support.

6.4. Implications for future research

The paucity in literature pertaining to South African low-income mothers' experiences of motherhood is indicative of the marginalisation of their voices (Kruger, 2003). The need for further research in this area is crucial for the design of appropriate and effective interventions with this vulnerable group. Similarly, studies to investigate the potential of group therapy with low-income mother-infant dyads in South Africa is necessary if mental health services seek to emphasise prevention in the form of primary health care. Studies investigating the long-term outcomes of these interventions are needed to ascertain their potential for prevention. Finally, the empowerment of oppressed sectors of society requires investigation into the empowerment effects of group interventions with low-income mothers, who represent a substantial portion of the South African population. The feasibility and potential of group therapy as a therapeutic tool with South African low-income mother-infant dyads must be explored.

References

Ainsworth, M.D.S. (1967). *Infancy in Uganda: Infant care and the growth of love.* Baltimore: John Hopkins Press.

Ainsworth, M.D.S. (1988). *On security.* Retrieved October 28, 2004 from the World Wide Web: http://www.psychology.sunysb.edu/attachment/online/online_2/online2_index.html

Ainsworth, M.D.S., Belhar, M.C., Waters, E., & Wall, S. (1978). *Patterns of attachment: A psychological study of the strange situation.* Hillside, NJ: Erlbaum.

Becker, J., Kovach, A.C., & Gronseth, D.L. (2004). Individual empowerment: How community health workers operationalize self-determination, self-sufficiency, and decision-making abilities of low-income mothers. *Journal of Community Psychology, 32*(3), 327-342.

Beeber, L.S., Holditch-Davis, D., Belyea, M.J., Funk, S.G., & Canuso, R. (2004). In-home intervention for depressive symptoms with low-income mothers of infants and toddlers in the United States. *Health Care for Women International, 25*, 561-580.

Belle, D. (1982). *Lives in stress: Women and depression.* California: Sage Publications.

Belle, D. (1985). Inequality and Mental Health: Low income an minority women. *Women and Mental Health Policy.* (pp.135-159). New York: Sage.

Belle, D. (1997). *Perceptions of poverty: Research and public discourse about low-income women.* Paper presented at the Jessie Bernard Memorial Address at the annual meeting of the Association for Women in Psychology. Pittsburgh, USA.

Belle, D., & Doucet, J. (2003). Poverty, inequality, and discrimination as sources of depression among U.S. women. *Psychology of Women Quarterly, 27*, 101-113.

Belsky, J. (1984). The determinant of parenting: A process model. *Child Development, 55*, 83-96.

Belsky, J. (2002). Developmental origins of attachment styles. *Attachment and Human Development, 4(2)*, 166-170.

Belsky, J., Fearon, R.M.P. (2002). Early attachment security, subsequent maternal sensitivity, and later child development: Does continuity in development depend upon continuity of caregiving? *Attachment and Human Development, 4*(3), 361-187.

Bennett, C., Anderson, L., Cooper, S., Hassol, L., Klein, D., & Rosenblum, G. (1966). *Community psychology: A report of the Boston Conference on the Education of Psychologists for Community Mental Health.* Boston: Boston University.

Berg, A. (2003). Beyond the dyad: Parent-infant psychotherapy in a multicultural society – Reflections from a South African perspective. *Infant Mental Health Journal, 24*(3), 265-277.

Berlin, L.J., & Cassidy, J. (2001). Enhancing early child-parent relationships: Implications of adult attachment research. *Infants and Young Children, 14*(2), 64-76.

Biever, J.L., De Las Fuentes, C., Cashion, L., & Franklin, C. (1998). The social construction of gender: A comparison of feminist and postmodern approaches. *Couselling Psychology Quarterly, 11*(2), 163-179.

Blair, A. (1992). The role of primary prevention in mental health services: A review and critique. *Journal of Community and Applied Social Psychology, 2*, 77-94.

Blatt, S.J., & Levy, K.N. (2003). Attachment, psychoanalysis, personality development, and psychopathology. *Psychoanalytic Inquiry, 23*(1), 102-151.

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

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

Bowlby, J. (1988). *A secure base: Parent-child attachment and healthy human development.* New York: Basic Books.

Brazelton, T.B., & Cramer, B.G. (1990). The prehistory of attachment. In *The Earliest Relationship.* United Kingdom: Addison-Wesley Publishing Company, Inc.

Breen, D. (1975). *The birth of a first child: Towards an understanding of femininity.* London: Tavistock Publications.

Bumagin, S., & Smith, J.M. (1985). Beyond support: Group psychotherapy with low-income mothers. *International Journal of Group Psychotherapy, 35*(2), 279-294.

Cassidy, J. (1999). The nature of the child's ties. In J. Cassidy, & P.R. Shaver (Eds), *Handbook of attachment: Theory, research, and clinical applications* (pp. 3-20). New York: Guilford Press.

Cassidy, J. (2001). Truth, lies, and intimacy: An attachment perspective. *Attachment and Human Development, 3*(2), 121-155.

Chodorow, N. (1983). Family structure and feminine personality. In L. Richardson, V. Taylor, & N. Whittier (Eds), *Feminist Frontiers* (5th ed.).(p.175-190). New York: McGraw-Hill.

Coetzee, J.M. (1986). *Foe*. New York: Penguin Books.

Consedine, N.S., & Magai, C. (2003). Attachment and emotion experienced in later life: The view from emotions theory. *Attachment and Human Development, 5*(2), 165-187.

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

Cooper, P. J., Tomlinson, M., Swartz, L., Woolgar, M., Murray, L., & Molteno, C. (1999). Post-partum depression and the mother-infant relationship in a South-African peri-urban settlement. *British Journal of Psychiatry, 175*, 554 – 558.

Corey, G. (1995). *Theory and Practice of Group Counseling* (4th ed.). California: Brooks-Cole.

De Beauvoir, S. (1972). *The second sex*. Harmondsworth: Penguin.

Deutsch, F. M., Brooks-Gunn, D., Fleming, A., Ruble, D. N., & Stangor, C. (1988). Information-seeking and maternal self-definition during the transition to motherhood. *Journal of Personality and Social Psychology, 55*(3), 420 – 431.

Druiff, P. (2001). *Psychodynamic therapy with low-income women: The "talking cure" as a desirable and alternative intervention*. Unpublished masters thesis, University of Stellenbosch.

Eagle, M. (2003). Clinical implications of attachment theory. *Psychoanalytic Inquiry, 23*(1), 27-53.

Easterbrooks, M.A., Biesecker, G., & Lyons-Ruth, K. (2000). Infancy predictors of emotional availability in middle childhood: The roles of attachment security and maternal depressive symptomology. *Attachment and Human Development, 2*(2), 170-187.

Edwards, S.D. (1998). The Zululand community psychology story. South Africa beyond transition: Psychological well-being. *Proceedings of the Third Annual Congress of the Psychological Society of South Africa* (pp.79-81). Johannesburg: Psychological Society of South Africa.

Edwards, S. (2002). Evaluating models of community psychology: Social transformation in South Africa. *International Journal of Behavioural Medicine, 9*(4), 301-308.

Elgar, F.J., Knight, J., Worrall, G.J., & Sherman, G. (2003). Attachment characteristics and behavioral problems in rural and urban juvenile delinquents. *Child Psychiatry and Human Development, 34*(1), 35-48.

Fernández-Alvarez, H., & Nicemboim, E. (1998). Prevention of mental disorders: Steps toward community interventions. *Journal of Community Psychology, 26*(3). 205-217.

Flax, J. (1990). Feminisms: Stories of gender. In J. Flax (Ed.), *Thinking Fragments: Psychoanalysis, Feminism, and Postmodernism in the Contemporary West* (p.135-221). Berkeley: University of California Press.

Flax, J. (1997). Forgotten forms of close combat: Mothers and daughters revisited. In M. Gergen & S. Davis (Eds.), *Toward a New Psychology of Gender* (pp.311-324). New York & London: Routledge.:

Fonagy, P. (1998). Prevention, the appropriate target of infant psychotherapy. *Infant Mental Health Journal, 19*(2), 124-150.

Fonagy, P. (2001). *Attachment Theory and Psychoanalysis*. New York: Other Press.

Fonagy, P., Steele, H., & Steele, M. (1991). Maternal representations of attachment during pregnancy predict the organisation of infant-mother attachment at one year of age. *Child Development, 61*, 891-905.

Fonagy, P., & Target, M. (2003). Early intervention and the development of self-regulation. *Psychoanalytic Inquirer, 22*(3), 307-336.

Foster, D., & Swartz, S. (1997). Introduction: Policy considerations. In D. Foster et al., *Mental Health Policy Issues for South Africa*, pp.1-22. Cape Town: MASA.

Fraiberg, S., Adelson, E., & Shapiro, V. (1980). Ghosts in the nursery: A psychoanalytic approach to the problems of impaired infant-mother relationships. In S. Fraiberg, *Clinical Studies in Infant Mental Health*, pp.164-196. New York: Basic Books.

Freeman, M., & Pillay, Y. (1997). Mental health policy – plans and funding. In D. Foster et al., *Mental health policy issues for South Africa*, pp.32-54. Cape Town: MASA.

Gauthier, Y. (2003). Infant mental health as we enter the third millennium: Can we prevent aggression? *Infant Mental Health Journal, 24*(3), 296-308.

Gergen, K. (1985). The social constructionist movement in modern psychology. *American Psychologist, 40*, 266-275.

González, R.C., Biever, J.L., & Gardner, G.T. (1994). The multicultural perspective in therapy: A social constructionist approach. *Psychotherapy, 31*(3), 515-524.

Green, J., & Goldwyn, R. (2002). Annotation: Attachment disorganisation and psychopathology: New findings in attachment research and their potential implications for developmental psychopathology in childhood. *Journal of Child Psychology and Psychiatry, 43*(7), 835-846.

Hall, L.A., Williams, C.A., & Greenberg, R.S. (1985). Support, stressors and depressive symptoms in low-income mothers of young children. *American Journal of Public Health, 75*, 518-522.

Halpern, R., & Larner, M. (1987). Lay family support during pregnancy and infancy: The Child Survival/Fair Start initiative. *Infant Mental Health Journal, 8*(2), 130-143.

Hamilton, C.E. (2000). Continuity and discontinuity of attachment from infancy through adolescence. *Child Development, 71*(3), 690-694.

Hanna, B.A., Edgecombe, G., Jackson, C.A., & Newman, S. (2002). The importance of first time parent groups for new parents. *Nursing and Health Sciences, 4,* 209-214.

Hare-Mustin, R.T. (1997) Discourse in the mirrored room: A postmodern analysis of therapy. In M.Gergen & S. Davis (Eds.). *Toward a New Psychology of Gender* (pp. 553-574). New York: Routledge.

Hare-Mustin, R.T., & Broderick, P.C. (1979). The myth of motherhood: A study of attitudes toward motherhood. *Psychology of Women Quarterly, 4*(1), 114-128.

Hare-Mustin, R.T., & Maracek, J. (1997). Gender and the meaning of difference: Postmodernism and psychology. In M. Gergens & S. Davis (Eds), *Toward a New Psychology of Gender* (pp.22-64). New York: Routledge.

Health Systems Trust. (2003). Health statistics. Retrieved October 27, 2004 from the World Wide Web: http://www.hst.org.za/healthstats/94/data.

Heinicke, C.M., Fineman, N.R., Ruth, G., Recchia, S.L., Guthrie, D., Rodning, C. (1999). Relationship-based intervention with at-risk mothers: Outcome in the first year of life. *Infant Mental Health Journal, 20*(4), 349-374.

Holmes, J. (1993). *John Bowlby and attachment theory.* London: Routledge.

Hopkins, J. (1990). The observed infant of attachment theory. *British Journal of Psychotherapy 6*(4), 460-470.

Jarret, M.H., Diamond, L.T., & El-Mohandes, A. (2000). Group intervention as one facet of a multi-component intervention with high-risk mothers and their babies. *Infants and Young Children, 13*(1), 15-24.

Karen, R. (1994). *Becoming attached: First relationships and how they shape our capacity to love.* New York: Oxford Press.

Kendell, R. E., Chalmers, J. C., & Platz, C. (1987). Epidemiology of puerperal psychoses. *British Journal of Psychiatry, 150*, 662 – 673.

Kersting, A., Fisch, S, & Arolt, V. (2003). Outpatient psychotherapy for mothers – A new treatment. *Archives of Women's Mental Health, 6*, 65-69.

Kesner, J.E., & McKenry, P.C. (1998). The role of childhood attachment factors in predicting male violence toward female intimates. *Journal of Family Violence, 13*(4), 417-432.

Kobak, R. (1999). The emotional dynamics of disruptions in attachment relationships. In J. Cassidy, & P.R. Shaver (Eds), *Handbook of attachment: Theory, research, and clinical applications* (pp. 21-43). New York: Guilford Press.

Kruger, L. (2000). "Shut up and shut out": The "talking cure" as an under-used psychotherapy modality in low-income communities. Paper presented at the South African Association of Marital and Family Therapy 8th International Conference. Cape Town.

Kruger, L. (2003). Narrating motherhood: The transformative potential of individual stories. *South African Journal of Psychology, 33*(4), 198-204.

Lazarus, J.A. (2003). *Small meetings: The application of psychodynamic thought in community work with South African children.* Unpublished masters thesis, University of Stellenbosch.

Lazarus, S., & Seedat, M. (1995). *Community Psychology in South Africa.* Paper presented at the Fifth Biennial conference of the Society for Community Research and Action, University of Illinois, Chicago, United States of America.

Lederman, R. P. (1996). *Psychosocial adaptation in pregnancy: Assessment of seven dimensions of maternal development.* New York: Springer Publishing Company.

Leonhardt-Lupa, M. (1995). *A mother is born: Preparing for motherhood during pregnancy.* London: Bergin and Garvey.

Lerner, B. (1972). *Therapy in the ghetto: Political impotence and personal disintegration.* Baltimore: John Hopkins University Press.

Levy, J. M., & McGee, R. K. (1975). Childbirth as a crisis. *Journal of Personality and Social Psychology, 31*, 171 – 179.

Lyons-Ruth, K., Alpern, L., & Repacholi, B. (1993). Disorganized infant attachment classification and maternal psychosocial problems as predictors of hostile-aggressive behavior in the preschool classroom. *Child Development, 64*, 572-585.

Lyons-Ruth, K., Connell, D.B., Grunebaum, H.U., & Botein, S. (1990). Infants at social risk: Maternal depression and family support services as mediators of infant development and security of attachment. *Child Development, 61*, 85-98.

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

Main, M., & Hesse, E. (1990). Parents' unresolved traumatic experiences are related to infant disorganized attachment status: Is frightening and/or frightened parental behaviour the linking mechanism? In M.T Greenberg, D. Cicchetti & E.M. Cummings (Eds.), *Attachment in the preschool years.* (pp. 121-160). Chicago: University of Chicago Press.

Maracek, J., & Hare-Mustin, R.T. (1991). A short history of the future: Feminism and clinical psychology. *Psychology of Women Quarterly, 15*, 521-536.

Marvin, R., Cooper, C., Hoffman, K., & Powell, B. (2002). The circle of security project: Attachment-based intervention with caregiver-pre-school child dyads. *Attachment and Human Development, 4*(1), 107-124.

Masilela, T. (2000). Editorial. *Health Systems Trust Update, 50*, 3-5.

Masters, J., & Wellman, H. (1974). Human infant attachment: A procedural critique. *Psychological Bulletin, 81*, 218-237.

McGroder, S.M. (2000). Parenting among low-income, African-American single mothers with preschool-age children: Patterns, predictors, and developmental correlates. *Child Development, 71*(3), 752-771.

Middlemiss, W. (2003). Brief report: Poverty, stress, and support: Patterns of parenting behaviour among lower income black and lower income white mothers. *Infant and Child Development, 12*, 293-300.

Mitchell, J. (1974). *Psychoanalysis and feminism.* New York: Random House.

Naidoo, A.V. (2000). *Community psychology: Constructing community, reconstructing psychology in South Africa.* Inaugural Lecture. University of Stellenbosch.

Naidoo, A.V., Shabalala, N., & Bawa, U. (2002). Community psychology. In L. Nicholas (Ed.), *Psychology: An introduction.* Cape Town: Van Schaik.

O'Hara, M. W. (1995). Childbearing. In M. W. O'Hara, R. C. Reiter, S. R. Johnson, A. Milburn, & J. Engeldinger (Eds.), *Psychological aspects of women's reproductive health* (pp. 26 – 48). New York: Springer Publishing Company.

Orford, J. (1992). Community psychology: Theory and practice. New York: John Wiley & Sons.

Parker, R. (1995). *Torn in two: The experience of maternal ambivalence*. London: Virago Press.

Peluso, P.R., Peluso, J.P., White, J.F., & Kern, R.M. (2004). A comparison of attachment theory and individual psychology: A review of the literature. *Journal of Counseling and Development, 82*, 139-145.

Pesonen, A.K., Räikkönen, K., Strandberg, T.,L., Keltikangas-Järvinen, & Järvenpää, A.L. (2004). Insecure adult attachment style and depressive symptoms: Implications for parental perceptions of infant temperament. *Infant Mental Health Journal, 25*(2), 99-116.

Pielage, S., Gerlsma, C, & Schaap, C. (2000). Insecure attachment as a risk factor for psychopathology: The role of stressful events. *Clinical Psychology and Psychotherapy, 7*, 296-302.

Pillay, J. (2003). "Community Psychology is all theory and no practice": Training educational psychologists in community practice within the South African context. *South African Journal of Psychology, 33*(4), 261-268.

Pines, D. (1988). Adolescent pregnancy and motherhood. *Psychoanalytic Inquiry, 8*, 234 – 251.

Pretorious-Heuchert, J.W., & Ahmed, R. (2001). Community psychology: Past, present and future. In M. Seedat et al. (Eds.), *Community Psychology: Theory, Method and Practice,* pp.17-36, Cape Town: Oxford University Press.

Puckering, C., Rogers, J., Mills, M., Cox, A.D., & Mattsson-Graff, M. (1994). Process and evaluation of a group intervention for mothers with parenting difficulties. *Child Abuse Review, 3*, 299-310.

Rao, K. B., Harrison, K. A., & Bergström, S. (2001). Organisation of maternity care in developing countries. In J. B. Lawson, K. A. Harrison, & S. Bergström (Eds.), *Maternity Care in developing countries* (pp. 21 – 36). Glasgow: Cromwell Press.

Raphael-Leff, J. (1991). *Psychological processes of childbearing*. London: Chapman and Hall.

Rappaport, J. (1977). *Community psychology: Values, research and action*. New York: Holt, Rinehart & Winston.

Reid, M., Glazener, C., Connery, L. Mackenzie, J., Ismail, D., Prigg, A., & Taylor, G. (2003). Two interventions for postnatal support. *British Journal of Midwifery, 11*(5), 294-298.

Reid, P. (1993). Poor women in psychological research: Shut up and shut out. *Psychology of Women Quarterly, 17*, 133-150.

Renn, P. (2002). The link between childhood trauma and later violent offending: The application of attachment theory in a probation setting. *Attachment and Human Development, 4*(3), 294-317.

Richter, L.M. (2001). *Final report: Development and implementation of a primary care model to promote interactions between caregivers and young children in the Eastern and Western Cape Provinces.* Unpublished document.

Rowley, H., & Grosz, E. (1990). Psychoanalysis and feminism. In S. Gunew (Ed.), *Feminist Knowledge: Critique and Construct* (pp.175-204). London: Routledge.

Sagi, A., Koren-Karie, N., Gini, M., Ziv, Y., & Joels, T. (2002). Shedding further light on the effects of various types and quality of early child care on infant-mother attachment relationship: The Haifa study of early child care. *Child Development, 73*(4), 1166-1186.

Salomon, A. (1996). Welfare reform and the real lives of poor women: introduction. *American Journal of Orthopsychiatry, 66*(4), 486-489.

Sandler, J. (2003). On attachment to internal objects. *Psychoanalytic Inquiry, 23*(1), 12-27.

Shulman, S., Becker, A., & Sroufe, L.A. (1999). Adult-child interactions as related to adult's family history and child's attachment. *International Journal of Behavioral Development, 23*(4), 959-976.

South African Department of Health. (1995). *Maternal, child and women's health policy draft.* Retrieved October 28, 2004 from the World Wide Web: http://www.gov.za/department/clus_maternal-f.html.

South African Department of Health. (1998). *South Africa demographic and health survey.* Retrieved October 26, 2004 from the World Wide Web: http://www.doh.gov.za/facts/sadhs-f.html.

South African Department of Health. (2001a). *Mental health care bill.* Retrieved October 28, 2004 from the World Wide Web: http://www.gov.za/bills/2000/20848.pdf.

South African Department of Health. (2001b). *Second reading of Mental Health Care Bill – Minister Manto Tshabalala-Msimang.* Retrieved October 30, 2004 from the World Wide Web: www.doh.gov.za/docs/sp-f.html.

South African Department of Health. (2004). *Cluster Maternal, child and women's health and nutrition.* Retrieved October 28, 2004 from the World Wide Web: http://www.doh.gov.za/department/clus_maternal-f.html.

South African Department of Health. (2004). *Progress report on ten points operational plans: Year 2000-2001.* Retrieved December 27, 2004 from the World Wide Web: http://www.doh.gov.za/department/clus_maternal-f.html.

Sroufe, L.A. (2000). Early relationships and the development of children. *Infant Mental Health Journal, 21*(1-2), 67-74.

Sroufe, L.A., Duggal, S. Weinfield, N.S., & Carlson, E. (2000). Relationships, development and psychopathology. In A.J. Sameroff, M. Lewis, & S.M. Miller (Eds.), *Handbook of Developmental Psychopathology*, pp.1-17. New York: Kluwer Academic / Plenum Publishers.

Statistics South Africa. (2003). *Census in brief.* Retrieved October 29, 2004 from the World Wide Web: http://www.info.gov.za/otherdocs/2003/census01brief.pdf.

Stern, D. (1995). *The motherhood constellation.* New York: Basic Books.

Stevens, J.H. (1988). Social support, locus of control, and parenting in three low-income groups of mothers: Black teenagers, black adults, and white adults. *Child Development, 59*, 635-642.

Strachan, K. (2000). Mental health legislation – The new Mental Health Care Bill. *Health Systems Trust Update, 50*, 5-6.

Thom, R. (2003). Mental health systems research review: Final report. Retrieved October 27, 2004 from the World Wide Web: http://www.hst.org.za/publications.

Trickett, E.J. (1996). A future for community psychology: The contexts of diversity and the diversity of contexts. *American Journal of Community Psychology, 24*(2), 209-235.

Unger, R., & Crawford, M. (1996). *Women and gender. A feminist psychology.* USA: McGraw-Hill.

Van IJzendoorn, M.H., & Hubbard, F.O.A. (2000). Are infant crying and maternal responsiveness during the first year related to infant-mother attachment at 15 months? *Attachment and Human Development, 2*(3), 371-391.

Vaughn, B., Egeland, B., Sroufe, L., & Waters, E. (1979). Individual differences in infant-mother attachment: Stability and change in families under stress. *Child Development, 50*, 971-975.

Wagner, J., & Menke, M.M. (1991). Stressors and coping behaviours of homeless, poor, and low-income mothers. *Journal of Community Health Nursing, 8*(2), 75-84.

Waters, E., Crowell, J., Elliot, M., Corcoran, D., & Treboux, D. (2002). Bowlby's secure base theory and the social/personality psychology of attachment styles" Work(s) in progress. *Attachment and Human Development, 4*(2), 230-242.

Waters, E., Hamilton, C.E., & Weinfield, N.S. (2000). The stability of attachment security from infancy to adolescence and early adulthood: General introduction. *Child Development, 71*(3), 678-683.

Waters, E., Merrick, S., Treboux, D., Crowell, J., & Albersheim, L. (2000). Attachment security in infancy and early adulthood: A twenty-year longitudinal study. *Child Development, 71*, 684-689.

Waters, E., Weinfield, N.S., & Hamilton, C.E. (2000). The stability of attachment security from infancy to adolescence and early adulthood: General discussion. *Child Development, 71*(3), 703-706.

Watson, J.S. (2001). Contingency perception and misperception in infancy: Some potential implications for attachment. *Bulletin of the Menninger Clinic, 5*(3), 296-320.

Weinfield, N.S., Ogawa, J.R., & Sroufe, L.A. (1997). Early attachment as a pathway to adolescent peer competence. *Journal of Research on Adolescence, 7*(3), 241-265.

Weinfield, N.S., Sroufe, L.A., & Egelang, B. (2000). Attachment from infancy to early adulthood in a high-risk sample: Continuity, discontinuity, and their correlates. *Child Development, 71*(3), 695-702.

Willig, C. (2001). *Introducing Qualitative Research in Psychology: Adventures in theory and method.* Buckingham: Open University Press.

Winnicott, D.W. (1956). *Through paediatrics to psycho-analysis.* London: Karnac.

Winnicitt, D.W. (1971). *Playing and reality.* London: Tavistock.

Wood, J.J, Emmerson, N.A., & Cowan, P.A. (2004). Is early attachment security carried forward into relationships with preschool peers? *British Journal of Developmental Psychology, 22*, 245-253.

Woolf, V. (1944). *A haunted house*. Great Britain: The Hogarth Press.

World Bank Group. (2000). *World Bank Group statistics*. Retrieved January 9, 2005 from the World Wide Web: http://worldbank.org/data/countrydata/countrydata.html.

World Health Organisation. (2000). *Women and mental health*. Retrieved October 28, 2004 from the World Wide Web: http://www.who.int/mediacentre/factsheets/fs248.html.

Worell, J. (2001). Feminist interventions: Accountability beyond symptom reduction. *Psychology of Women Quarterly, 25*, 335-343.

Yalom, I.D. (1995). *The Theory and Practice of Group Psychotherapy* (4th ed.). New York: Basic Books.

Zachariah, R. (1994). Perceived social support and social network of low-income mothers of infants and pre-schoolers: Pre- and postparenting program. *Journal of Community Health Nursing, 11*(1), 11-20.