

THE FOUNDATIONS OF AFFECTIVE DEVELOPMENT: PROACTIVE INVOLVEMENT
OF THE EDUCATIONAL PSYCHOLOGIST

THESIS

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of the University of Cape Town

by

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DEDICATION

This thesis is dedicated to my husband, John, without whose help I would never have got it done. It is also dedicated to my daughter, Ruth, who has put up with my being an absent mother for many weekends.

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I thank my supervisor, David Donald for his help. I am also grateful to the deputy medical officer of health, Dr Neulah Durcan, for giving me permission to do research in infant clinics, and for the sisters-in-charge and the health visitors of the clinics visited. I thank the mothers who participated in the groups that were run. I thank my husband, John for all his help, not only in reading through drafts and making comments, but also for doing double share of household tasks and child-minding.

ABSTRACT

In this thesis the foundations of affective development are discussed. The context of development is considered to be the relationship between infant and caregiver. The theoretical bases of developmental psychology and the practice of clinical psychology have been drawn on and applied to a model of promotive and preventive work. Affective development may be enhanced by early intervention by psychologists, and it is therefore important for them to consider promotion of mental health as well as more traditional ways of therapeutic intervention.

A survey was done in four infant clinics in Cape Town, and had the aim of establishing whether health care workers in this context were doing anything to promote affective development. There seemed to be minimal intervention in this regard. The second aim of the research section of this thesis addressed the question of whether there might be a place within the clinic structures for educational psychologists. To this end groups of caregivers were set up, and a pilot promotive programme was administered and evaluated over five sessions. In general the response of the mothers was positive.

In the final chapter some of the particular strains that are placed on South African families are considered. Finally recommendations and ideas for establishing programmes that seek to promote affective development in contexts other than clinics are discussed.

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CHAPTER ONE. INTRODUCTION TO AND DEFINITIONS OF AFFECTIVE DEVELOPMENT IN INFANCY

1.1 Why study affective development in infancy?

The question of why this thesis should consider affective development in infancy is comprised of two questions: why study affective development? and why study at the developmental level of infancy? Some of the answers to these questions are included in the writer's personal history and experience, but of more importance, there are felt to be sound professional reasons for choosing this area of study. Firstly the question of why affective development is important as an area of study, is considered.

1.1.1 Why study affective development?

In a sense it is a contrived exercise to separate out emotional or affective development from the rest of development. The relationship between affect, cognition and behaviour is a tight one, and in discussion of one of these aspects of development, the others must be mentioned. However, the primary focus of the affective aspect has been chosen because this seems to be the material with which therapy in large part has to work. It is not so much what a person experiences, but the meaning that a person has for the event that is important. The meaning of experience is given by and derived from an affective experience of the event. "Everyday experience as well as the clinical evidence from psychotherapy attest to the fact that the most important source of information guiding human decision making and behaviour comes not simply from the things we see, hear, smell, touch and taste. It is the nature and intensity of the affect generated by or in

connection with a particular event that determines one's behavioural reaction" (Basch, 1988, p. 65).

It might be argued that individuals exist in a psychological sense only in the context of relationships. To speak of affect as being separate from the context of relationships is somehow to ignore one of the most important dimensions of its meaning. In infancy we could not survive without a caregiving relationship and later in life relationships are also essential. "Intimate attachments to other human beings are the hub around which a person's life revolves, not only when s/he is an infant or a toddler, but throughout adolescence and the years of maturity as well and on into old age" (Bowlby, 1980, p. 442).

In this thesis, the context of affective development, that is the relationship between infant and caregiver, is considered to be of utmost importance. There is substantial evidence that supportive relationships promote health, provide buffers against the onset of known classes of disorder, and prevent the recurrence of major mental disorders. Conversely, non-supportive or stressful relationships have been implicated in the etiology of disorder (Sameroff and Emde, 1989).

Whereas previously (Mussen, Conger and Kagan, 1969) it was thought that the satisfaction of physiological needs was primary and affective needs were secondary to this, much clinical and experimental evidence exists to modify this view. The work of Bowlby (1980) shows how the development of attachment may be interfered with, even when physiological needs are met. There is

therefore ample reason for examination and discussion of the development of affect.

1.1.2 Why is the developmental stage of infancy important?

The second question is why to study at the developmental level of infancy. Infancy is generally considered to be crucially important to development and is seen as being formative. Therapy is often concerned with maladaptive patterns that were functional to survival in infancy, but that have survived intact into adulthood. Obviously it is only a privileged few who can afford the luxury of therapy, and so reconstruct the hurts and pains of early experience. What of the many people who have never received any kind of intervention to remedy or heal early hurts? Are ignorance and pain being handed on from generation to generation? How can professional health care workers intervene, and what is the most effective way of doing this?

Current psychological practice, although paying lip-service to the importance of preventative and promotive mental health care, in practice seems to be addressed at intervention when problems occur. There seems therefore to be a regularity in the kinds of problems that psychologists deal with year after year, and although many individuals may be helped by therapy, not much seems to be done to reach out to the great mass of people who will never be able or willing to commit themselves to therapy. It seems a reasonable proposition that if psychologists and other professionals started addressing their work to the earliest and formative years of development, much could be done to promote optimal functioning for further development, as well as preventing

some of the problems that are regularly addressed at later stages.

It would seem that the infant's affective development becomes manifest within the infant-caregiver relationship. In this relationship the availability of the caregiver is very important. What happens to the child's affective self if there is not an appropriate range of emotional availability in the early caregiving relationship?

"It appears that a deficit of emotional availability in the early caregiving relationship is associated with a restriction of experience and with a risk for the later development of narcissistic personality disorder. On the other hand, an inappropriate excess of emotions in the early caregiving relationship ... may be associated with warded-off affects and a risk of neurotic conflict structures of the sort found in parenting disorders of the next generation. Moreover, an increased risk of other kinds of personality disorder also seems likely" (Sameroff and Emde, 1989, p. 49). Surely to prevent these kinds of consequences, and to promote the converse, is good enough reason for psychologists to become involved in helping caregivers provide a solid affective foundation for their infants?

This is not to say that if all goes well in infancy, that all will continue to go well for the rest of life. Indeed Clarke and Clarke (1979) caution against putting too much weight on the early years, arguing that early experience, which is sure to be modified by later experience will not have any long-term

effects. They argue that the importance of infancy is only in terms of its having a function in the developmental chain. Of course all development is important, and much effective therapeutic work has been done beyond the stage of early development, but this thesis seeks to address the question of whether it might be effective for psychologists to become involved from the beginning of development.

In summary then, affective development in infancy is considered to be fundamental to later development. Its effects are considered to resound in many parts of life at later developmental stages. Because the beginnings of maladaptive affective development have implications for future pathology, it is important that the psychologist discover effective ways of promoting optimal affective development from the beginning.

1.2 The distinction between affect, emotion and feeling

The question arises as to whether there is a difference between affect, feeling and emotion. Is "affect" simply a technical word that psychologists use instead of the more commonly used "feelings" or "emotion"? Or does each word have a precise and circumscribed meaning? In the literature the three words seem to be used according to the writer's particular preference. In this thesis however, distinctions are made between affect, feeling and emotion, and the distinctions are seen as being a function of development. Basch (1988) describes the development of affect as having four stages -1. affect, 2. feeling, 3. emotion and 4. empathy. Initially, affective experience is a genetically encoded

reflex phenomenon. Affect is a visceral and vascular reaction carried by the autonomic nervous system and is used to denote a biological response to stimulation.

Feeling is used to mean a connection between an affective reaction and a concept of self. This comes into being when the child is about 18 - 24 months. At this stage the affective reaction is abstracted and objectified and the child would therefore be able to say , for example, 'I am sad'.

The next stage in affective development, according to Basch (1988) is emotion. By emotion he means the connection between feeling states and experience, which give meaning to complex concepts such as love or hate.

The last stage in affective development is empathy, when affective communication goes beyond the self-referential and allows the person to find a way into the experience of another.

The distinctions between affect, emotion and feeling are therefore related to a developmental layering process. Affect is fundamental to feeling, emotion and then empathy.

Izard, Hembree and Huebner (1987) define emotions as having biological, expressive and feeling components. For them, affect includes all motivational states, including drives and emotions. Drives have a more limited set of elicitors and are more stimulus bound than emotions, for example, hunger or pain. Basch (1988) does not refer directly to the expressive component in affective development. Nevertheless, in this thesis, his definitions are

adhered to, because they are developmentally very clear and logical. The expression of affect is discussed in another section of this chapter.

It is worth noting at this stage that affect is defined as the first, very early response to the environment, and is therefore a sensory, physiological, biological response. Because it is a pre-verbal response, there are interesting implications for caregivers and professionals working in the fields of infancy and in the development of affect.

1.3 The relationship between affect, behaviour and cognition in development.

As mentioned earlier it is a somewhat contrived exercise to separate affective experience from cognitive and behavioural experience. "The child grows not as a perceptive being, not as a cognitive being, but as a human being who experiences anxiety, joy and anger and who is connected to the world in an emotional way. The infant's engagement of the observable and manipulable world is not merely a cognitive engagement, but an affective engagement as well" (Sroufe, 1979, p. 462). However, development is an organized process, and just as cognitive development can be seen as an organized process, so too can affective development. Both affect and cognition organize the infant's behaviour.

What then are the cognitive factors that influence affect, and what is the influence of affect on cognition? Cognitive factors seem to underlie the unfolding of emotions. For example, it is

only with some development of causality, object permanence and intentionality, that there can be joy, anger or fear. Shame can only be experienced when there is some sense of self-awareness. Also the effects of sequence, situation and context on emotion, are surely mediated by cognition. Piaget and Inhelder (1969) in discussing cognitive development, argue that "There is no behaviour pattern, however intellectual, which does not involve affective factors as motives; but reciprocally, there are no affective states without the intervention of perceptions or comprehensions which constitute their cognitive structure" (p. 158).

Basch (1988) argues that the primary purpose of cognition is to protect the affective system against unnecessary stimulation and guard it from overreacting. "If affect were to remain an unmediated modality around which the brain organized its decision making, the results would be far from adaptive" (p. 96). The infant would become exhausted with his/her involvement in the affect of each moment, and also oblivious to environmental signals requiring modification of affective response. It is therefore the function of the neocortex to control tension. This process occurs without reflection or recall, but the infant learns to link signals in the environment with the meeting of needs, and can then modulate affective experience. For example, an infant may soon learn to link the presence of the mother with the sensation of being fed. So, when an infant cries out in hunger, the mother's stepping in the door may be enough to stop the distress, as there is an "expectation" that her presence will soon result in a nipple between the lips, and milk in the stomach.

The infant in this sensorimotor phase obviously does not have a clear conception of causality or self-awareness. Stern (1985) refers to these infantile adaptive generalizations as "RIGs" - Representations of Interactions that have been Generalized. These then are the beginnings of learning, and they have the function of protecting the affective system.

It is only fairly recently that more attention is being given to the influence of affect on cognition, rather than vice-versa. Escalona (1968) argued that affect is the infant's primary medium of communication and meaning, and that affect-laden exchanges are a major source of cognitive growth. It could be argued with justification that, especially for an infant, affective experience must be primary, and that it is through this experience that the infant's cognition develops. Piaget and Inhelder (1969) go so far as to say that without affect, problems would not be posed and there would be no intelligence. It has been shown that affective measures are useful predictors of cognitive performance. For example, Birns and Golden (1972) found that pleasure in the task was a better predictor of later cognitive performance than cognitive measurements made early in a child's life. It is surprising therefore that greater attention has been paid to the influence of cognition on affect, rather than concentrating primarily on affective experience.

In summary then, cognition, behaviour and affect cannot be separated easily, but are organized as co-operative systems within the infant's total development and context. In this thesis affect is seen as being particularly important in infancy.

1.4 How can one know about the existence of affect?

One can never really know what the subjective experience of another person is like, as one can never inhabit the being of another. Instead one depends on descriptions and imagination in trying to understand the affective experience of another. For the infant, without the benefit of being able to communicate with words, it is even more difficult to know the subjective world that he/she inhabits. Yet it is important to make the inferential leap to the subjective experience of the infant, the origins of psychopathology.

It seems that there are two main streams in psychology that are used in an attempt to grasp the subjective experience of the infant. These are developmental psychology and reflections on clinical practice. Stern (1985) describes these two streams as relating to the "observed infant" and the "clinical infant". Developmental psychology observes the infant and new information comes from naturalistic and experimental observations. Although developmental psychology seeks to develop as thorough and as accurate a data base as possible, still an inferential leap is required when speaking of the subjective experience of the infant. Complementary to the "observed infant", and coming from clinical practice, is the "clinical infant", which is reconstructed from memories and feelings of infancy within the framework of a theory of psychotherapy.

"Both of these approaches are indispensable for the present task of thinking about the development of the infant's sense of self.

The clinical infant breathes subjective life into the observed infant, while the observed infant points toward the general theories upon which one can build the inferred subjective life of the clinical infant" (Stern, 1985, p.14).

Within the stream of developmental psychology, or the "observed infant" there are different models that attempt to explain the development of affect. Lewis and Rosenblum (1978) outline four models. These are biological, socialization, cognition & affect and, in line with Stern's concept of the "clinical infant", affect and pathology.

First, there will be discussion of the biological model. Affect in infancy is very much a matter of physiology, and the biological foundations of affect have implications for the "clinical" and the "observed" infants.

1.5 The biological foundations of affect

To return to Basch's (1988) conception of the development of affect, he describes the affective experience of the infant as being a genetically encoded reflex phenomenon, a visceral and vascular reaction carried by the autonomic nervous system. In infancy, probably more than in any other stage of development, the biological foundations of affect are most evident.

No longer do we view the infant as being passive and undifferentiated, rather we conceive of the infant as having "biologically prepared active propensities and with organized capacities for self-regulation" (Sameroff and Emde, 1989). There seems to be a pre-adapted organized basis for guiding behaviour.

Affect is central to the experience of relationships, and the expression of affect by the infant is used by the caregiver in order to respond appropriately. For example, when the infant cries, the caregiver seeks to remove the source of inferred distress. So it would seem that we are biologically determined for regulating relationships through the expression of affect, from infancy. The means by which this is done is through the participation of infant and caregiver in social interaction. It is suggested that affect is central to relationships, and in infancy no less so. In the next chapter I discuss in much more detail the context of affective development; that is the relationship between infant and caregiver, whereas in this section an attempt is made to abstract the elements of affect. This discussion is therefore confined to how one can use signals of somatic changes in order to infer the presence of affect.

In speaking of affective behaviour, one implies that there is such a thing as non-affective behaviour. This does not however ring true, as one assumes that it is difficult to feel nothing. Perhaps what one is really saying is that affect and other modes of functioning are not easily separated, and when considering the biological basis of affect, one needs to key in to particular signals. Starr (1978) suggests that affect is a quality of behaviour that involves a change in state, and therefore one needs to examine the prior state of the infant, the transition reactions and then the expression of the affect. Starr (1978) argues that the variability and lack of consistency in infants' affective reactions may be due to a disregard of the sequential dependencies of affective states and therefore not enough attention being given to the infants' prior state. Firstly,

short-term within-individual changes in state need to be considered. These changes are keyed to variables such as sleep-wake cycles and health-related conditions. Secondly, between-individual differences need to be considered. This would be the issue of temperament. Thirdly, one would have to consider developmental differences in feeling and mood states. The transition reactions that Starr discusses, mediate changes in state, and then as an outcome of changed state, there is expression of affect. How then does one track physical and somatic changes through these three states in order to monitor affect?

Apart from the biologically based aspects of affect, the neurologically determined adaptive aspect discussed above, there are the biological correlates of affect. By this is meant how an external event is experienced and expressed physiologically. James (1978) defined emotions as the bodily changes that follow directly the perception of the exciting fact and our feeling of the same changes as they occur.

Emde, Kligman, Reich, and Wade (1978) argue that to index emotions by either physiological or situational correlates is unreliable. Rather, one should view emotions as expressions or non-verbal communications, and then what one presumes to call "emotional" communicates both feelings and messages for caretaking and social interaction. Emotional expressions, however, do not only communicate messages to others, they also reflect complex and changing organismic states. Biological adaptation therefore has resulted in not only a system of external regulation, but also of internal regulation, that is,

of both physiological and psychological systems.

In infancy behaviour is heavily influenced by the physiological context within which the stimulation occurs. Such contextual factors include enduring characteristics of the individual, i.e. temperament, as well as transient states of arousal. Whereas temperament, state and neurological maturation are important, interacting with experience, they become subordinated to other principles of developmental organization (Sroufe, 1979).

Expressive and communicative actions are seen to be organized as part of cooperative systems with other elements of the infants' physiology, cognition, behaviour and social environment. A systems approach presumes that order arises dynamically as a result of the interaction between the cooperating elements that are changing asynchronously, rather than as a result of centrally coordinated developmental change that is synchronous across domains. It is further assumed that the control parameter responsible for eliciting developmental change may be different, depending on age, context and task (Fogel and Thelen, 1987).

The question arises as to the relationship between the experience of affect and the expression of affect. Is there a one-to-one relationship between feeling and the expression of feeling? Oster (1978) argues that there is prima facie evidence to suggest that as early as three to four weeks of life, there are organized, non-random patterns of facial behaviour, and that these reflect the operation of at least primitively psychological perceptual, attentional and cognitive processes that are already intimately linked to affect. Saarni (1978) also refers to the varied and

complex facial expressions that infants produce, suggesting that these indicate that people are biologically programmed to produce coherency between facial expression and affective experience. One of the crucial steps in establishing coherency of affect and expression is the role played by the characteristic response given back to the infant after it has signalled expressively. The caregiver attributes meaning to the infant's expressive signals, and gradually an interpersonal feedback system develops in which the infant learns to know the meaning of his/her affective signals to others.

Saarni (1978) outlines a model for how affective experience differentiates simultaneously and interactionally with development in the individual's cognitive and communicative systems. The first part of this model refers to the biology of affective experience, whereas the second part touches on the coordination of affect and expression. Initially, primary and global affects are reflexively activated. They are accompanied internally by physiological changes and are externally expressed in facial, vocal and postural channels. These expressive channels show considerable, perhaps spontaneous, behavioural variation, which suggests a physiological competence for their expression, but the competence is not yet linked to specific affective criteria for their consistent performance. Gradually the reflexively activated affects are partitioned into an assortment of simple affects that become activated by increasingly specific situational releasers. An operant connection between expressive pattern and internal sensory feedback may be part of this gradual partitioning. In discussing the coordination of affect and expression, Saarni (1978) refers to the development of self-

awareness. As the infant's evaluation of incentive events becomes differentiated, there is a simultaneous increase in the range and kind of affective experience. As the infant becomes increasingly active in its impact on its social and physical environment, affective criteria are linked to and coordinated with encoding specific expressive patterns. The infant now expressively signals his/her affective experience to others in order to affect their behaviour toward itself. Constructing, maintaining and synchronizing communicative exchanges becomes a goal in itself.

Izard, Hembree and Huebner (1987) discuss research in which stability of individual emotion-expression was predicted, but argue that there were developmental changes in the relations between emotion-eliciting events and particular emotions. Differential emotions theory (Izard, 1979) argues for an innate concordance between emotion expression and emotion feeling. Whenever a specific expression is encoded, the corresponding feeling is assumed to be present. But the duration of the feeling is not accurately indexed by the duration of the expression. The feeling may continue after the expression disappears. The innate expression-feeling concordance obtains until maturation enables the child to regulate expression and until culture imposes attitudes towards emotions by socialization.

Lewis and Brooks (1978) argue that there is not necessarily a one- to- one correspondence between facial expression and either emotional state or emotional experience. However, in many infancy studies a synchronous relationship between expression and state, and expression and experience is implicitly assumed.

It seems clear that we are biologically determined to respond to the environment affectively. The expression of affect, whereas it may not always be perfectly correlated with the experience of affect, serves to regulate relationships. The affective experience of the infant is stored physiologically, and therefore has implications for therapy, in accessing the "clinical infant".

1.6 Therapeutic implications of affect development in infancy

The therapeutic implications for the study of the development of affect in infancy may be linked to Stern's (1985) conception of the "clinical" and the "observed" infants. The clinical infant is a reconstruction of infant experience, but undertaken in therapy through regression work, memories and work in the transference. Particular in a psychodynamic model this reconstruction of the "clinical infant" is a powerful and much used way of working. The "observed infant" has implications for preventative and promotive work, and as yet seems to be a fairly unexplored area in terms of how professionals might be involved in helping caregivers to promote optimal affective development.

If, as has been previously mentioned, the infant's affective experience is mainly physiological, is pre-verbal, and is stored, it means that the therapist often has to work in the realm of unlocking this experience. How does the therapist work with pre-verbal experience? How does the therapist access material that may be physiologically stored? These are fascinating questions that are answered by looking at the theories and practice of clinical psychology. These theories surely also reflect the values of those working with them. Dualistic conceptions of

people, with a split between body and mind, is felt to confound some of the work that may be done by therapists. Without this dualistic split, probably we would know far more about accessing infancy states through working with the body - using the signs and cues of characteristic postures and states in order to work with the affective material that these contain.

The aim of this thesis is not to consider clinical intervention and theory with regard to affective development in infancy. This has been covered by many writers particularly within the frameworks of object relations and psychoanalytic theory. Clinicians such as Winnicott, 1965; Mahler, 1975; Basch, 1988; The role of the educational psychologist in the domain of affective development in infancy seems to be more suited to the second kind of intervention, which is connected with the "observed" infant. In other words, rather than working in the transference with adults about their experience of infancy, to be working with infants and caregivers as they experience the relationship. Developmental theory is the primary framework for this kind of work, although clinical theory must also inform the kind of work that is done at this stage. Discussion therefore turns to early intervention and to some of the issues connected with this.

Infancy research on early intervention seems to be divided into two main positions. One position deals with those interested in enriching the environment to encourage early learning or to optimize child care and education within a framework of normal infant development. The other position is based largely on a deficiency model and deals with early intervention that is aimed

at providing compensatory stimulation to infants who are deprived of a normal environment. For example, ghetto children and premature infants have been the target of many such intervention programmes (Cornell and Gottfried ,1976).

This thesis is addressed to the former position of working within a framework of normal development and seeks to find ways of intervening in ways that promote affective development. It seems that there is very little investigation in this field. Korner (1979) comments that whereas there are reports that address themselves to the antecedents and consequences of parental attitudes and actions on the later development of the child, there is "little solid information about how the care requirements should change with the infant's growth and development. In practice, principles of childrearing as dictated by the developmental changes in the child are largely based on conviction, intuition, or on inferential reasoning from the findings of cross-sectional studies rather than on solid evidence from longitudinal work" (p. 771).

In the next chapter the importance of contingent responses by the caregiver towards the infant is discussed. There seem to be very few studies that address themselves to the changing requirements of caregiving behaviour as development proceeds, and how intervention might enhance the relationship between infant and caregiver.

Early intervention programmes have focused largely on cognitive development, rather than affective development. Beller (1979) reviews early intervention programmes, dividing them by their

target and their location. There have been home-based programmes oriented towards both parents and children, centre-based programmes oriented towards both parents and children, and parent-child centres. Most of the programmes that Beller mentions have as their aim the improvement of cognitive functioning, and there appears to be little difference with regard to results depending on whether the parents have been enabled to become better teachers, or whether the investigators have taught the children themselves.

One programme that dealt with affective development was the Houston Model (Beller,1979) which was based at a parent-child centre. This programme aimed to increase parental behaviours of warmth, autonomy-granting techniques,encouragement of verbal skills as well as the enhancement of self-esteem, emotional adjustment and cognitive development in the child. However, the programme started only when the child was a year old.

The Birmingham Model (Beller,1979), also based at a child-parent centre, aimed to promote the mother's active participation in the mothering role. The New Orleans Model aimed to increase children's emotional, social and intellectual development as a result of changes in the caregivers. Beller (1979) concluded that there have been positive results from these early interventions.

A question that is addressed in more detail in chapter five is how the educational psychologist might be involved in early intervention in order to promote optimal affective development in infancy. There is no doubt that the role of the educational psychologist has changed considerably over the years. In the late

nineteenth century, compulsory school education was introduced in England, and the work of the educational psychologist was to assess children's educational and intellectual development in order to utilize special classes appropriately. Cyril Burt was appointed as a psychologist to the London County Council and in many ways was the forerunner of educational psychology, developing concerns for children with learning and behaviour problems (Chazan, Moore, Williams and Wright, 1974).

More recently, the role of the educational psychologist has been extended and developed as the traditional boundaries between industrial, clinical and educational psychologists become more flexible. Education does not happen only in schools, and the psychological knowledge of the educational psychologist may be used to educate in homes, in business or in more traditional educational settings. This thesis sees the role of the educational psychologist in a broad way. The promotion of affective development would utilize the educational psychologist's skills and knowledge of both education and psychology, dealing with parents and children as well as having a clear conception of the systems in which this would take place.

The final chapter of this thesis discusses in more detail some of the therapeutic implications of working in the field of affective development. First, however, there needs to be discussion of the context of affective development, that is the relationship between the infant and caregiver.

CHAPTER TWO. THE CONTEXT OF AFFECTIVE DEVELOPMENT

2.1 Blame it all on the parents?

There is a widespread view that parents, and more particularly mothers, are almost entirely responsible for the way that their children turn out. Obviously parents are important in influencing the lives of their children, but this view tends to see the infant as a passive recipient of anything that the parents may give to the child, rather than seeing the child as an active participant in a reciprocal interaction.

The view that blames it all on the mother, generally focuses on maternal attitudes and behaviour, and holds these responsible for the mother being unable to discipline her child, respond empathetically, or shape the infant in some way that conforms with societal expectations. An example of the extraordinary influence attributed to the mother comes from the writing of Miller (1981): "Every child has a legitimate narcissistic need to be noticed, understood, taken seriously, and respected by his mother. In the first weeks and months of life he needs to have the mother at his disposal, must be able to use her and to be mirrored by her" (p. 49). Miller goes on to describe how the narcissistic personality develops as a result of the infant's lack of being mirrored by the mother.

Views such as the above, as well as ignoring the contribution that the infant makes to the relationship between infant and caregiver, also ignore much of the context in which the mother has her being. The mother's history, her needs and deficits, are

considered in terms of how they have been introjected by the child, and the helplessness, abandonment and powerlessness that the child was never able to feel in childhood, now becomes the material for therapeutic work.

In this thesis I also see that the history and early experiences of the caregiver are of great importance, and it seems indisputable that the unmet needs of the caregiver will make inroads of pain or distortion into the lives of her/his children. However, where I differ from writers such as Miller, is in the solutions seen for this fact of life. Rather than seeing the solution simply in terms of long-term therapy, important though this is, it is felt that there should be some attempt to work with the caregivers before they become parents, as well as during the early stages of parenthood. This kind of intervention is visualised as comprising a therapeutic element in which caregivers can become more aware of how their own experiences of being parented might influence the way in which they will parent. In addition to this therapeutic element, it seems that there would have to be an educational element, in which caregivers were given information about the development of infants and children.

In blaming the mother there is a conception of linear, rather than circular causality. Systems theory attempts to show that simple causal relationships are limited and that there needs to be a wider understanding of the relationships and interactions between many factors. It is simply not sufficient to state that, for example, a mother's insecurity will cause her infant to be fearful. Rather what would be required is consideration of the

infant's temperament, the historical and current influences on the mother, analysis of the development of the relationship between mother and infant, and then some formulation of how all these factors might interact.

Early studies of the effects of such drastic changes in caregiving as institutionalization with maternal absence led to the conclusion that the withdrawal of maternal care or of positive affective interchanges with a specific caregiver would lead to maladaptive development, depression or failure to thrive (Bowlby, 1951). However critics of these early studies pointed out the need for identifying the specific variables involved in maldevelopment.

There is growing awareness that it is the interaction that needs to be studied, rather than individuals in isolation. Lewis and Rosenblum (1974) state that this is a new field, raising questions about the point of entry as well as ignorance about either the limitations or the promise of measurements in this area.

In the next section of this chapter, I consider some of the characteristics of the infant that influence the relationship between him/her and the caregiver. Also, some of the characteristics of the caregiver are briefly discussed. This is as an introduction to the main purpose of this chapter, which is to examine the way in which infant and caregiver characteristics may develop into an interlocking relationship which forms the basis of affective development. More is said about the capabilities and characteristics of the infant than of the caregiver, because it is felt that there is a need to redress the

balance towards an awareness of the way in which the infant may affect the caregiver, rather than the bias which has in large part existed towards the influence of the caregiver on the infant.

2.2 The capabilities and capacities of the infant

The infant is born with biologically prepared active propensities and with organized capacities for self-regulation. These are manifest in sleep-wake cycles and in a highly complex organization for physiological homeostasis. More than this, the infant is biologically prepared for social interaction, with capacities for initiating, maintaining and terminating social interactions (Sameroff and Emde, 1989).

What are the characteristics of the infant that affect the infant-caregiver relationship? Consideration is given to some of the following which are felt to be important. The temperament of the infant, the gender of the infant, birth order, the state of the infant, responsiveness to tactile, visual and auditory stimuli and particular styles of behaviour, all influence the relationship between infant and caregiver, and are discussed briefly under those headings.

2.2.1 Infant temperament

The infant is not a tabula rasa onto which the parents stamp a particular character. Rather, the infant brings a particular temperament into the relationship with the caregiver, and this may affect the relationship beneficially or detrimentally. Some of the dimensions of temperament outlined in a study by Thomas,

Chess, Birch, Hertzog and Korn (1963) were activity level, rhythmicity, approach-withdrawal, adaptability, intensity of reaction, threshold of responsiveness, quality of mood, distractibility, attention span and persistence. In a longitudinal study Thomas et al (op cit) found that there were general consistencies over time, and no indication was found that these temperamental characteristics were caused by caregivers.

The variability of states related to stimulation affects relationships between infant and caregiver. Some infants may be easy to arouse, some may be difficult to arouse. Some infants may be easily soothed, while others may take a long time to respond to soothing. Infants who respond to any type of stimulation with rapid state changes may be highly responsive to stimulation generally, and may be easily overstimulated. Feelings of competence as a caregiver must surely be related to these variables.

According to Wolff (1979), the infant's behaviour influences the caregiver's behaviour as much as her/his past experience does. If just this were communicated to caregivers, there would surely be less desperate searches for the perfect way to bring up children, and less guilt associated with perceived failure, and in its place more freedom to perceive the infant as he/she really is. Usually the caregiver learns to accommodate and deal with the infant's states appropriately, but in rare cases the repertoire of states is inadequate, and then however appropriate the caregiver's ministrations, they will still be ineffective (Brazelton, Koslowski and Main, 1974).

2.2.2 The gender of the infant

How does the gender of an infant influence the relationship between infant and caregiver? Are there significant gender differences at birth and if so, do they make a difference? Korner (1974) writes that tentative results suggest that females are more receptive to certain types of stimuli, and are also more orally sensitized. Males may be stonger and more vigorous. These differences would result in caretakers treating boy and girl infants differently. Moore (1967) observed that female infants learned to orient more readily to sound than did male infants, and hypothesized that females were more sensitive to auditory stimuli generally, so reinforcing their own vocalizations, and eliciting more responses from others. Males, on the other hand, were more responsive to moving visual stimuli. Several studies have indicated that male infants are more irritable and difficult to soothe than female infants, and therefore more difficult to care for (Osofsky and Connors, 1979).

In the case of parents hoping for a child of a particular gender, preparing for this, but giving birth to a child of the opposite gender, one could imagine that simply the fact of the infant's gender might affect the relationship between that infant and the caregiver.

Osofsky and Connors (1979) conclude that the data on behavioural sex differences in infants are contradictory. Early differences related to gender are moderate, but not enough to be categorized according to magnitude. Also the presence of differences varies from sample to sample.

2.2.3 The auditory and communicative capabilities of the infant

What are the auditory and communicative capabilities of the infant? The infant's first cry may provide the mother with a sense of well-being and assurance that her infant is well. Crying later comes to have a communicative function, signaling discomfort. Cries are graded signals that vary in several perceptually salient acoustic features: gradations in these acoustic features communicate information that varies along a continuum of perceived intensity. Zeskind and Marshall (1988) conducted a study designed to determine whether increases in the pitch of infant crying, were related to how urgent, arousing, distressing or sick the cries were perceived to be, even when all the cries were in response to the same eliciting stimulus. They found that increases in several aspects of cry pitch were related to increases in intensity of adult perceptions, even when all the cries were in response to the same stimulus. They hypothesize that increased adult arousal and distress that is elicited by higher-pitched cry sounds, could contribute to the development of abuse or neglect.

Keller and Scholmerich (1987) classified infant vocalizations into four types according to their affective expression. They demonstrated that from birth, infants produce different kinds of vocalizations. Different interactional states led to different rates of vocalization. Positive vocalizations occurred most frequently during eye-contact, and were responded to by caregivers with verbal or vocal reactions. Physiological, negative and effort vocalizations primarily resulted in

caregivers' tactile and vestibular behaviours with concomitant verbalizing. Infants who expressed more positive vocalizations, received more verbal feedback. Keller and Scholmerich (op cit) hypothesize that this may have consequences for language acquisition. The communicative nature of the infant, and the way in which the caregiver responds, develops the interaction between infant and caregiver.

2.2.4 Visual capabilities of the infant

Infants appear to be inherently prepared for visual responsiveness within a few hours of birth. In the first hours after birth, infants have shown visual distinction and preference for human facial configurations as opposed to nonfacial configurations. Periods of infant visual attentiveness are very important, especially in the first few months of life when the visual field is limited due to the infant's immobility and extended periods of sleep. The amount of infant visual responsiveness is dependent on the amount of time spent in an alert state, and infants who are in an alert state more frequently than other infants are more capable of visual pursuit than other infants (Korner, 1974).

The infant contributes to the regulation of stimulation within the infant-caregiver relationship largely through the control of gaze. The infant's gaze initiates and terminates interaction as he/she engages or turns away (Stern, 1974).

Reissland (1988) conducted a study on new-born infants in the first hour after birth, in which the neonates were exposed to two modelling conditions. These were facial expressions with lips widened and lips pursed. It was found that neonates moved their lips significantly more often in accordance with the model's lip position than at variance with the positions. These results suggest that imitative capacity is present at birth.

2.2.5 The infant's capacity for emotional response

Thompson (1987) concludes that infants are neither indifferent to the emotional experiences of others, nor incapable of understanding them. This conclusion is based on the results of studies in three areas: reactive crying in new born infants, affective synchrony in mother-infant play and the onset of social referencing in infants. Studies have found that two-to four-day old infants produced significantly more reactive crying than did either the cry of a five-month old, a synthetic cry or white noise. In parent-infant play, which begins to occur regularly at about two to three months, positive "affective attunement" engages the infant emotionally, and may also contribute to a resonant emotional response in the infant. Over time, the association of maternal smiling and other social initiatives with the infant's own positive arousal may make the mother's expressions themselves potent cues for the infant's own positive expressions. This kind of emotional resonance may constitute the infant's major contribution to the establishment of affective synchrony between mother-infant play.

The third area of relevance mentioned by Thompson (1987) is the onset of social referencing. Evidence suggests that at about six months the infant makes active efforts to obtain emotional cues from others in order to assess an uncertain situation. The caregiver's emotional expressions will significantly influence the infant's response in an ambiguous situation. Thompson (1987) argues that there is evidence that infants are capable of emotional resonance or contagion, and that these are important precursors to empathy.

It is clear that the infant possesses many characteristics and capabilities which have a great influence on the relationship between infant and caregiver. No longer can we view the infant as being insensitive, chaotic or unpredictable, but rather as equipped with highly predictable behavioural responses to both positive and negative stimuli from the outside world (Brazelton, 1973). These responses in turn shape the responses of the adult caregiver to set up a mutual feedback system. I now discuss some of the characteristics of the caregiver that influence the interaction between infant and caregiver.

2.3 Characteristics of the caregiver

What are the characteristics of the caregiver that are brought into the relationship between him/her and the infant, and how does the history of the caregiver influence the infant? The relationship between infant and caregiver is not a symmetrical one because the caregiver brings so much more personal history

into each encounter with the infant. This personal history may affect to a great extent the caregiver's ability to perceive the infant clearly, and to enter into the infant's experience without distortion . Bettelheim (1988) refers to the importance of the caregiver's emotional involvement in the past, or anxieties about the future, and how these may act as distortions in viewing the infant's experience from his/her own frame of reference. He states that when the caregiver is able to understand how things look to the child, we are able "to participate in what happens - not as equals, which we are not, but as equally important partners in the common and most important enterprise of our lives, which is living as a family" (Bettelheim, op cit, pg. 54).

2.3.1 The attitudes and perceptions of the caregiver

A number of studies have investigated the attitudes and perceptions of caregivers to their infants. Fleming, Flett, Ruble and Shaul (1988), in a longitudinal study of first-time mothers, found that mild depression in mothers was significantly associated with reduced maternal feelings and affectionate behaviour. As well as this, the mother's mood also influenced the patterning of interactions between mother and infant. More contented mothers responded to their infant's vocalizations by vocalizing themselves and by engaging in caretaking activities. More depressed mothers, on the other hand, were less likely to vocalize in response to their infants, but vocalized in response to their infant's limb movements. Their caretaking activities were performed adequately. Fleming et al. (op.cit.) conclude that mother's mood is associated with caretaking attitudes and affectionate behaviour, but not with

caretaking behaviours or affectionate attitudes.

Brazelton, Koslowski, and Main (1974) state that most mothers are unwilling or unable to deal with neonatal behaviours as though they are meaningless or unintentional. Instead they endow the smallest movements with highly personal meaning and react to them affectively. "They insist on joining in and enlarging on even the least possible interactive behaviours through imitation. And they perform as if highly significant interaction has taken place when there has been no action at all." (p. 68) This phenomenon can work both positively and negatively. The well-used example of the mother who claimed that her two-week old infant "looked daggers at her", reveals far more about the mother than it does about her infant. In contrast to this, I have heard first hand accounts of birth experiences, in which mothers have attributed to their new-born infants, the ability to gaze directly into the mother's eyes with love.

Broussard and Hartner (1970) found that maternal perceptions measured in the immediate postpartum period were not correlated with later infant outcome. Initial perceptions seemed to be related more to the mothers' fantasies about their infants than to actual characteristics. When the infants were one month old, however, mothers' perceptions were related to subsequent determinants at four and a half years of age. This seems to indicate that either mothers did perceive their infants' characteristics accurately early in the relationship, or that the mothers' expectations became a self-fulfilling prophecy.

The birth of a first infant can be a very stressful time for the

mother. In hospitals very little opportunity is given for mothers and infants to develop their relationship. Packer and Rosenblatt (1979) note that mothers who deliver in hospital are much less likely to handle their babies in the first hour than mothers who have home confinements. Usually the first contact between mother and infant is not long or satisfying, and subsequent opportunities for developing the relationship are often dependent on the convenience of the hospital, rather than the needs of the mother or infant. Maternity care is advancing, however, and the practice of rooming-in seems to be becoming the norm. These changes in maternity care are in large part due to the demands of mothers.

Korner (1974) notes that too often mothers cannot or will not respond to their infants' cues, because of their own psychological needs, or because of convictions which they hold about what constitutes "good" childcare. These factors may seriously impede the formation of the mother-infant relationship and result in a mismatch of the pair.

The attitudes, perceptions and personal history of the caretaker are considered to be of vital importance to his/her ability to provide an environment which is conducive to a relationship that promotes optimal affective development. I see this whole area therefore as a very important target for early intervention in promoting affective development.

2.3.2 The behaviour of the caregiver

Several studies have been done on the effect of the facial expressions of the caregiver on the relationship between infant

and caregiver. Gusella, Muir and Tronick (1988) suggest that maternal expression is important in generating positive infant attention. When the mother is affectively positive and responsive, with animated or smiling face, smiling is elicited from the infant. Conversely, a sad or angry face seems to elicit a negative response from the infant. They conclude that the infant's affective response is a social one, showing great sensitivity to changes in the quality of the mother's affective expressions.

Haviland and Lelwica (1987) report that infants of ten weeks and older can respond differentially to three expressions of maternal affect when the presentation is simultaneously facial and vocal. These results were supported by a study in which infants were found to express more joy and to look longer at their mothers, when the mothers were expressing joy. In contrast infants showed more sadness, anger and gaze aversion when their mothers were expressing sadness (Termine and Izard, 1988).

Tronick, Cohn and Shea (1986) also demonstrated a clear relationship between the quality of maternal affective displays and the infant's behaviour. When maternal affect was experimentally depressed, infants organized their emotions very differently, and started looking depressed. The infants' depression persisted into the next period of time when the mother acted normally.

In an interesting cross-cultural comparison between Japanese and American mother-infant dyads, it was found that Japanese mothers were more likely than American mothers to punctuate their facial

expressions and vocalizations with looming upper-body movements and touches. They were also less likely to respond selectively to infant vocalizations. American mothers held their faces closer to their infants and provided primarily facial and vocal displays for the infant. Mothers seem to use culturally appropriate means to express affect: primarily non-verbal for Japanese mothers, and verbal for American mothers (Fogel, Toda and Kawai, 1988).

When the social relationship between mother and infant goes smoothly, positive emotions are generated. Mothers feel growing self-esteem, and infants develop a sense of competence. When the mother feels good about herself, it is likely that she will be more sensitive to her infant, and less likely to either under- or over-control the relationship.

2.4 Some dimensions of the interpersonal relationship between infant and caregiver with regard to affective development

In the discussion of characteristics of the infant and the caretaker, it has been almost impossible not to refer to the relationship between them. However, discussion now concentrates on the complex interaction between caregiver and infant, with particular reference as to how the infant's affective development proceeds within this relationship.

Winnicott (1965) stated dramatically that there is no such thing as a baby. By this he meant that the infant cannot be regarded apart from the caregiver. The facilitation of infant development is virtually synonymous with the facilitation of the caregiving relationship. The infant can survive physically and psychologically only if the caregiver is appropriately responsive. Perhaps it would be just as true to say that there is no such thing as a caregiver, indeed even more apt, as without someone to care for, there is no caregiver. In this reciprocal interaction how does affective development proceed, and how is affect transferred from caregiver to infant?

Regardless of the characteristics that caregivers and infants bring to the relationship, an appropriate match is necessary to foster an adaptive relationship. A number of terms has been used in the literature to describe the ingredients for positive interactions between infant and caregiver. Examples are: reciprocity or mutuality (Brazelton and Yogman, 1986), contingency (Greenspan and Lieberman, 1980), affect attunement (Stern, 1985) and emotional availability (Sameroff and Emde, 1989).

The Mutual Regulation Model (Tronick, Cohn and Shea, 1986) formulates that the infant attempts to control the social environment by using emotional signals. When the infant succeeds, positive emotions are generated and the infant gets a sense of being in control and able to affect the environment. However, when the infant fails, the converse happens, and the infant feels a sense of helplessness. Obviously, the infant's success depends to some extent on the caregiver's reciprocal response. "Emotions

are not magically transferred from mother to infant but rather the infant generates his own emotions as he processes the emotional input provided by the mother in relation to his own interactive goal" (Tronick, Cohn and Shea, op. cit., p.12).

The Mutual Regulation Model also applies to the caregiver. When the interaction goes well, the caregiver gains a sense of being in control; when she/he fails, she/he feels a sense of failure. The difference between caregiver and infant is in the caregiver's history and socialization, the caregiver having had so much more exposure to positive and negative influences. The infant's responses are for the most part affected by immediate external and internal stimuli, whereas the caregiver is affected by historical and social factors as well. "Thus the success or failure of mutual exchange generates emotional states in the infant which reflect not only the immediate situation but the effect of historical factors that impact on the mother's behaviour." (Tronick, Cohn, and Shea, op. cit., p.13)

Another way of expressing the interaction between infant and caregiver is in the concept of "mirroring" which is described by Winnicott (1965) amongst other writers. Winnicott describes the mother gazing at the infant in her arms, and the infant gazing at his mother's face and finding himself therein, provided that the mother is really looking at the unique, small, helpless being and not projecting her own introjects onto the infant. In the case of the mother projecting her own expectations, fears and plans for the child, the child would not find her/himself in the mother's face, but rather the mother's own predicaments. This child would remain without a mirror, and for the rest of his life be seeking

a mirror in vain.

Stern (1985) criticizes the concept of "mirroring", because he believes that the positive interactive process is much more than simply a reflecting back to the infant through a sharing of the infant's subjective experience. He defines affect attunement as "the performance of behaviours that express the quality of a shared affect state without imitating the exact behavioural expression of the inner state." (p. 142)

Thoman (1976) believes that the interdependency of maternal and infant cyclic or rhythmic behaviours are at the root of many positive interactions. Mutual modification of behaviour is characteristic of this process, which is psychobiological in nature, since both infants and mothers enter the relationship with characteristics that are developed before the infant's birth. Before there can be synchrony in the relationship however, the infant must be capable of signalling his/her needs and responding to maternal interventions, and the mother must be able to perceive the infant's cues and respond appropriately.

Emde (1983) discusses how from the emotions that are generated during social exchanges, an emotional mood and interactive pattern becomes internalized in the child. They become part of the infant's affective core or prerepresentational self. The affective core biases the infant's evaluation of a new situation and his/her interactive patterns even before the information arising from the situation has been processed. The infant whose affective core is one of depression or anxiety will evaluate a new situation fearfully and may even withdraw from it before

confronting it. The infant's affective core acts as an initial adaptive system, structuring the meaning of a situation and so regulating interactive behaviour (Tronick, Cohn and Shea, 1986).

Stern (1985) states that interpersonal attunement will "play an important role in the infant's coming to recognize that internal feeling states are forms of human experience that are shareable with other humans. The converse is also true: feeling states that are never attuned to will be experienced only alone, isolated from the interpersonal context of shareable experience. What is at stake here is nothing less than the shape and extent of the shareable inner universe." (pp 151 and 152)

Whatever the interactive process between infant and caregiver is called, there seem to be general principles that arise from most of the models that attempt to describe this process. Firstly, the stage of infancy is one in which it is developmentally appropriate for the infant to be helpless and dependent on the caregiver. It is therefore also the stage at which the caregiver has to be most responsive to the infant. Much of the literature, especially by writers with a clinical background, emphasizes the importance of the history of the caregiver in either helping or hindering her/him in being able to respond appropriately to the infant (Inter alia Basch, 1988: Stern, 1985; Emde, 1983; Miller, 1981;)

Another important principle that emerges from the interaction models is the contribution of the infant to the relationship between him/her and the caregiver. Both this, and the principle

of history given above, are seen as being very important in terms of early intervention to promote affective development. Caregivers may need to have therapeutic intervention addressed at making conscious their experiences of being cared for so that they do not project their own bad experiences onto their children. The second principle of how the infant contributes to the relationship, is one that does not seem to be communicated to caregivers to any great extent. It is felt that if this were made explicit to caregivers, that there would be less guilt and sense of failure involved when their infants did not conform with the books or with other caregivers' experiences. If caregivers were released from the sense that it was all dependent on them as to how the infant responded, it is felt that there would be an increased ability to perceive the infant and his/her needs as they really present, and perhaps an increased ability to respond to the infant appropriately.

2.5 What happens if affect is not appropriately transferred between infant and caregiver?

Although it is very unusual for there to be no interaffective sharing between infant and caregiver, there are different variations that hinder affective attunement. The first condition Stern (1985) calls non-attunement. This is probably encountered only in severe psychosis, when the caregiver is unable to respond to the affective experience of the infant. The child in this situation would probably grow up experiencing a deep sense of aloneness and a fear of intimacy.

The second condition that Stern (op. cit.) refers to is that of

selective attunement. Caregivers always have to make choices about what to attune to and what not to attune to. These choices are usually made out of awareness, and are very potent in shaping the development of the child's subjective and interpersonal world. The caregiver's bias, which is formed by his/her own personal history, creates a template for the infant's interpersonal world, determining what may be shared and what may not be shared.

Misattunements are another way in which the caregiver's behaviour shape the experience of the infant. Misattunements just miss the mark of being accurate attunements. Misattunements are used to change the infant's behaviour and experience, and also to "steal" the experience. The caregiver gets access to the infant's subjective experience by a number of attunements, but then covertly changes the experience so that it becomes lost to the infant.

Stern (op. cit.) also describes a position which he calls overattunement, which he describes as a form of "psychic hovering." The caregiver overidentifies with the infant and the boundary between them could be described as enmeshed. This is an intrusive position and may slow down the infant's development of independence. However, because overattunement cannot attune with accuracy to all of an infant's experience, it cannot interfere with the process of individuation.

One way of conceptualizing the relationship between infant and caregiver is in terms of the power relationship between them. The caregiver of course has the greater power and the infant is almost powerless. When the caregiver misuses power, the result

will be entrapment for both infant and caregiver. Kopp (1982) believes that power over others always results in both parties feeling trapped. He argues that it makes no difference whether the power is used benevolently or exploitatively, as the same result occurs, this being a symbiotic bargain in which both are trapped.

If the caretaker is unable to see that she/he is more powerful than the infant by virtue of age, and not because of any inherent inequalities, it may be that the relationship becomes an expression of the caregiver's perception of power, and this could distort the relationship in various ways. Kopp (1982) describes power illusions as being the result of early two-party contracts, in which "one of the signers is a person who feels he must take care of others, who comes to experience the desires for his own happiness as injurious to the feelings of someone else." The accomplice in this bad bargain is one with a reciprocal power illusion, insisting that "his own welfare depends on how the empowered first party lives his own life." (p. 60)

In this early contracting, the infant may become either the first or the second party. In other words, the child may introject the expectation that he/she is expected to care for the parents, rather than the other way around. These children know that it is their task to make their parents happy, and often sacrifice their own childhoods in being prematurely responsible.

The other side of the coin however, are parents who disempower their children, by not allowing them to experience discomfort and the consequent ability to control this discomfort by their own

efforts of changing the environment. These caregivers are those who are so "good" that the child would have difficulty in separating from this powerful caregiver who understands and fulfills every need, even before it is experienced by the child.

Basch (1988) categorizes his patients into four broad groups, regardless of specific symptoms. These are those who have experienced failure of affective bonding in early infancy, those who have learned to be ashamed of their affective responses, those who have had problems with affect attunement, and lastly those who have had difficulty during psychosexual development in the oedipal phase. The first three of these categories are relevant to this thesis and are all considered to be part of affect attunement, or the reciprocal process between infant and caregiver.

Failure of affective bonding interferes with basic tension control in very early infancy and results in either understimulation or overstimulation. Infants who have experienced such damage, according to Basch (1988), usually find productive or meaningful relationships very difficult, and may display borderline personality structures.

The next category is those who are ashamed of affect and this results from affective understimulation in infancy or from intolerance for the infant's affective expression on the part of the caregiver. Affect is experienced, but cannot be recognized and so the infant is unable to make the transition from affect to feeling. Instead the child learns to control affect by

withdrawing from it, and the results would be inability to identify or express affective reactions. (Basch, 1988).

Problems related to affect attunement stem from the infant's need to know that the caregiver is participating affectively with what he/she is doing, and so validating his/her competence. In infancy this may be seen as healthy narcissism, but if these needs are not met in infancy, they covertly govern all relationships consequently and contribute to the narcissistic character structure. The person may seem to be very self-reliant, but this is a defence against the pain of acknowledging the need for others to participate and share in subjective, psychological experience (Basch, 1988).

The consequences of relationships between infant and caregiver, such as those discussed above, must convince parents that they will never be good enough, and convince therapists that they will never be out of work! Apart from pointing out that there is a wide range of flexibility in normal development, I also feel that there is space for educating parents towards attunement, and for therapists to shift some of their work towards early, rather than later intervention in the form of preventative or promotive work. How and when this should happen is discussed in the last chapter of this thesis. In the next chapter, consideration is given to the work being done in infant clinics, with a particular focus on whether health care professionals are promoting affective development.

CHAPTER THREE. SURVEY CONDUCTED AT INFANT CLINICS TO INVESTIGATE THE PROMOTION OF AFFECTIVE DEVELOPMENT.

3.1 Rationale for conducting research in infant clinics

The primary aim of the research component of this thesis was to establish what was being done by primary health care services in the Cape Town metropolitan area with regard to promoting optimal affective development in infancy. This chapter is concerned with the research component. A secondary aim was to explore whether there might be a niche for educational psychologists to make a contribution in this regard and within the context of primary health care. Chapter 4 explores this notionally, while chapter 5 reports on a small scale intervention.

The two obvious places for investigation were maternity hospitals and infant clinics. It was beyond the scope of this thesis to cover both hospitals and clinics, and for the following reasons it was decided to investigate clinics and exclude hospitals. Firstly, maternity hospitals offer twenty four hour a day support while mother and infant are there. Second, the mother is not solely responsible for the care of her infant, and therefore may not be fully aware of the demands and changes required of her in this new role. Third, in the hospital, focus is largely on the more basic needs of physical health and care, rather than promoting the development of rhythms and attunement between mother and infant. Fourth, the times and quality of contacts between infant and mother in hospital may depend more on the convenience of the hospital than on the needs of the mother and infant.

Barnet, et al (1979) hypothesized that separation after delivery could have effects in three areas: commitment and attachment to the infant, the ability to establish an efficient care-taking routine and the development of confidence in mothering abilities. Although rooming-in is becoming more and more common, separation of infant and mother after delivery is still widely practiced. It was felt therefore that investigations of the infant-caregiver relationship in maternity hospitals was too soon after birth to establish what was being done to promote affective development.

By the time that mothers and infants come to the clinic, they have had some time to establish their own relationship, without the watchful eye of hospital nurses and doctors. They have been able to practice "going it alone", and are probably aware of some of the problems or areas in which they may not be coping.

It was decided, therefore to concentrate on an investigation of whether affective development was being promoted by infant clinics run by the Cape Town City Health Department.

One of the dilemmas of doing research into affective development at infant clinics, was the following: If the main purpose of the clinics is to provide primary health care, why should there be any attempt to promote affective development? In other words, the context of the clinic would define the type of service being requested by caregivers, as well as the type of service provided.

For four main reasons, it was decided that infant clinics were

nevertheless suitable as places to investigate whether anything was being done in regard to promoting affective development. These four reasons were: trends towards holistic medicine; the aims of community health ; the relationship between physical health and the development of relationships; and lastly, the investigation of whether infant clinics might be appropriate places for educational psychologists to become involved in promotive and preventive work.

There seems to be a growing awareness that it is not enough to treat physical symptoms in a patient. Dualistic conceptions which separate body from mind are no longer considered helpful. Rather, there is an emphasis on the person as a whole, with body, mind, emotions and behaviour working together as closely connected systems. Within this context of a trend towards holistic healing, it seems that medical and psychological professionals need to find ways of working in closer conjunction with one another, as they aim to treat the whole person. In this thesis, with its focus on affective development in infancy, I see potential for input from educational psychologists within the medical setting of infant clinics. Also, the educational psychologist could be enriched through knowledge of the medical input given to caregivers of infants.

The next reason given for justification of working in infant clinics, is the general aims and philosophy behind the work done by community health nurses. From the standard textbook for community health nurses (Vlok, 1981). it was interesting to see the emphasis on psychological factors and relationships. In my observations at clinics I wanted to establish whether these

principles were in fact practiced.

Several quotations from Vlok (op. cit.) have been extracted to illustrate the importance placed on the role of the community health nurse with regard to psychological development.

"Community nurses ... are in a favoured position to prevent mental ill-health and promote mental health amongst the youth. This can be done by teaching parents skills which will promote good parent/child relationships, thereby helping children to deal with the frustrations inherent in socialization." (Vlok, p. 194)

This principle is very much in line with what is envisaged by this thesis with regard to the role of the educational psychologist in early intervention. The question is whether this principle is applied in practice or not.

Another quotation from 'Principles Involved in Establishing Good Family Relationships' from Vlok's (op. cit.) textbook is as follows:

"The infant needs to have a trusting relationship with his parents while he is powerless and helpless. Trust can only be fully established where there is a continuity of the caring, need-satisfying parent/child relationship in order for the child to form an emotional bond and the parent to become a psychological parent. Bonding occurs as a result of the day-to-day physical care of the child being initiated by early postnatal contact between parents and infant." (Vlok, op. cit., p. 195)

Again, this quotation embodies much of what is envisaged in terms of how the educational psychologist might wish to intervene in infant clinics in order to promote affective development.

The third reason for locating research in infant clinics is

related to the connection between physical health and relationships. In infancy, perturbations of physical development such as feeding problems, minor illnesses and injuries, are omnipresent (Parmelee, 1989). However, developmental models usually assume uneventful physical development of healthy infants with perturbations being caused by developmental shifts, temperament or environment. One of the tasks of caregiving is to keep the child healthy, and it may be therefore that caregivers interpret minor physical illnesses as an indictment of caregiving ability, or as evidence that their infants are frail. It has been documented that feelings of inadequacy and concern can significantly interfere with caregivers' interactions with their infants (Parmelee, op. cit.). Therefore if health care workers could help caregivers to accept common disturbances of physical development as a normal part of infant life, and to manage them successfully, normal relationship development would be fostered.

Part of the difficulty for health care workers in doing this is that they may have a different understanding of health and sickness from that of caregivers. Health care workers focus on the biological and medical aspects of sickness, whereas caregivers focus more on the personal and social aspects of sickness. Because caregivers typically seek help for physical problems for their infants, often at clinics, it may be that health care workers actually reinforce caregivers' fears about the physical vulnerability of their infants and enhance concerns about their own competence (Carey and Sibinga, 1972).

In observing the interactions between health visitors and infant-caregiver dyads, research focused on whether relationship

dynamics between caregiver and infant were addressed, or whether focus was simply on the physical aspect of health. "Providers of both mental and physical health care can help parents understand the constructive aspects of physical problems and illnesses for children's understanding of relationships, self and other, and empathy" (Parmelee, 1989, p. 162). If health care workers in clinics are not helping caregivers in this way, perhaps this could be a role for educational psychologists in the clinic context.

This leads to the fourth reason for locating research in infant clinics, which is the question of whether there might be a niche for educational psychologists to become involved there. It seems that although the training of community nurses does put considerable importance on the promotion of mental health, and although the structures of infant clinics may in principle be committed to this, in practice it is physical rather than mental health that is the primary focus of the work of infant clinic.

3.2 The way in which clinics function and are structured

Infant clinics are part of national comprehensive community health centres, which aim to provide curative, preventative, psychiatric and midwifery services. These community health centres may provide a number of services including antenatal clinics, dental clinics, casualty services for Workmen's Compensation Act patients, tuberculosis clinics, family planning clinics, geriatric clinics, social assistance facilities and a pharmacy for dispensing medicines. Infant clinics, or "well-baby clinics" as they are called by the medical community, are part of

the comprehensive community health programme.

As part of this programme, especial emphasis is given to child care, in a programme called the "under-fives' clinic. The aims of this programme are:

- the early diagnosis and treatment of disease; health education
- the extension of low-cost curative and preventive care, encouraging regular visiting to the clinic
- supervision of the health of all children up to the age of five years
- prevention of malnutrition and diseases preventable by immunization
- simple treatments of diarrhoea, pneumonia and common skin disorders. Vlok, op. cit.)

Under-fives' clinics aim to offer the following curative and preventive services:

- health education of the mother by means of demonstrations and talks to groups of mothers
- the maintenance of records which are filled in by the staff on health cards
- immunization
- primary health care
- special services for severely malnourished infants.

The under-fives' clinic usually runs in conjunction with under-fives', preventive family health centres are run by local authorities. The following clinics usually comprise a preventive family health centre: well-baby clinics, family planning clinics, preventive geriatric clinics and genetic counselling clinics. The

focus of this thesis has been on well-baby clinics.

The preventive health centres are staffed by doctors and community health nurses. The community health nurse is a registered nurse and midwife with a post-basic qualification in community health, employed by a local authority. Her main responsibilities are the promotion of health by health education, and the prevention of ill-health in the family (Vlok, op. cit.).

At well-baby clinics hearing and vision tests are done on all infants. Mothers of children with genetic abnormalities are referred for genetic counselling at the State Health Genetic services. In Cape Town, and in other local authority wards, the community health nurse visits the home of every newborn baby within seven to fourteen days after birth. The parents are informed of the family health services and encouraged to attend clinics with their infant. At the well-baby clinic, help and advice with minor ailments is given, the immunization programme is conducted and mothercraft counselling is done.

The immunization programme requires that a compulsory BCG vaccine is given to every infant before the age of eight weeks by an employee of the State or Local Authority Health Services. After the BCG, vaccines against diphtheria, tetanus, pertussis and polio are given at two to three months and four to five months of age. The measles vaccine is given at six to nine months of age. The smallpox vaccine is the last infant vaccine, given at seven to twelve months of age.

According to Vlok (op. cit.) about a third of the contacts

between the community health nurse and the mother happen in the home rather than in the clinic. Reasons for this are that non-attending mothers are followed-up, if a mother has a problem and there is no clinic scheduled for that day, the community health nurse would visit her at home, and that emotional or marital problems are usually best discussed at home.

Within the community health nurse's role is dealing with abusing families, who are usually referred to psychiatric clinics, indigent mothers, who are often referred to Social Welfare, and single parents, who in the case of severe stress might be referred to appropriate agencies. The community health nurse is expected to support and educate the mother, not only with regard to the needs of her infant, but also with housekeeping and budgeting (Vlok, op. cit.).

In Cape Town the community health nurses, or "health visitors" as they are called, try to visit homes every three months, and encourage mothers to bring their infants to clinics at least every month, but more often if required.

In the four clinics that I visited, there appeared to be a standard procedure on the days that infant clinics operated. Caregivers report to reception and hand in their clinic cards. They then wait in a large waiting room until called by a nursing sister, who weighs the infant and establishes the purpose of the visit to the clinic. The intake-nurse gives the file to whichever professional she feels should see the caregiver and infant; this may be for the family planning clinic, for immunization or the health visitor. I chose to observe the health visitors

because their described role includes a counselling component, and it was in this context that I wanted to establish if anything was being done to promote affective development.

3.3 Research method

Permission was obtained to do work in infant clinics in the Cape Town metropolitan area. This was obtained from the Cape Town Deputy Medical Officer of Health, who also advised on which clinics should be visited. According to the Deputy Medical Officer of Health, (pers. comm.) it was immaterial which clinics were visited with regard to observing different standards of practice, because all clinics follow similar procedure.

A pilot study was conducted at the Wynberg and Mannenberg clinics on 6.6.90 and 13.6.90 respectively in order to observe how the clinics function and where I could best gather information. I spent two hours at each of these clinics spending time observing nursing sisters administering immunizations, speaking to the sister-in-charge, and observing the health visitors.

The health visitors have the role which includes counselling as part of the job description. As well as doing home visits in the community, the role of the health visitors on clinic days includes seeing all those who have requested help or advice, doing developmental screening of infants and handling all cases that the reception sister may deem necessary. In essence the health visitor sees clients who may be divided into two main categories - those who are coming to the clinic for a routine visit, and those who have come with a particular concern.

It was decided on the basis of the pilot investigations to observe the health visitors at work, because their role included

both psychological and educational components. It seemed likely that these were the clinic professionals most likely to be doing preventative or promotive work in the area of affective development.

Four infant clinics were then visited: these were situated in the suburbs of Mannenberg, Langa, Wynberg and Woodstock. The dates on which the clinics were visited were: 12.7.90, 11.7.90, 1.8.90 and 30.8.90 respectively. At each of the clinics, I spent three hours observing the health visitors at work. The health visitors work in private rooms and see each caregiver - infant dyad separately. I sat in the room and observed the exchange as well as taking written notes of some aspects of each exchange.

The factors that were recorded during the exchanges were:

time of entering the health visitor's office

age of infant

reason for attending the clinic

response of health visitor

time of leaving the health visitor's office.

The time spent with the health visitor was recorded as it was hypothesized that no significant promotion of affective development could be done within a short space of time. It takes time to assess the mental state of the caregiver and it takes time to assess the relationship between caregiver and infant. It was also considered important to observe whether there was a match between what the caregiver requested, and what the response of the health visitor was.

The reasons for attending the clinic were coded into two main categories: - routine visit requested by the clinic (R)
- voluntary visit to the clinic because of a particular concern (V)

It seemed likely that voluntary visits might be the ones in which the health visitors were required to probe more deeply into what was really being requested, and also the ones for which they might have to make a more therapeutic response.

The responses of the health visitors were coded into the following categories:

- medication prescribed (M)
- advice given (A)

Advice tended to be given in response to questions about feeding sleeping problems, for example on how to introduce solids into the diet.

- education/information given (E)

Although there was often a fine line between advice and education/information the main difference was that education tended to be unsolicited. An example of the education category response would be an explanation about contraceptive methods.

- counselling (C)

This included any response which was empathetic and non-directive, attempting to convey an understanding of the mother's feeling.

- screening (S)

Screening is routinely done at nine months and the hearing, sight, and developmental milestones of the child are screened.

- referral (R)

Referral refers to any case in which the mother was referred to

a doctor or other professional.

The results of the recordings of these factors for the four clinics are given in the next section.

3.4 Results

TABLE 1.

TOTAL NUMBER OF EXCHANGES PER CLINIC AND MEAN TIMES PER EXCHANGE

Clinics	Exchange totals	Mean times per exchange
Mannenbergl	24	6,8 minutes
Langa	13	6,5 minutes
Wynberg	12	8,3 minutes
Woodstock	3	10 minutes
TOTALS	52	Overall mean: 7,3 minutes

Mannenbergl clinic was the busiest of the clinics visited, with 24 exchanges occurring in three hours. Woodstock Clinic was surprisingly empty, with only three exchanges during the three hours of observation. Despite the fact that the health visitor at Woodstock could have taken nearly an hour for each exchange, the interactions had a mean time of only ten minutes, which is not much more than the mean times for the other clinics. It was hypothesized that no significant therapeutic work or promotion of affective development could have been done in short a short time span.

TABLE 2.
DISTRIBUTION OF EXCHANGES ACCORDING TO INFANT AGE

Less than one month:	4
One month:	4
Two months:	5
Three months:	3
Four months:	4
Five months:	1
Six months:	1
Seven months:	2
Eight months:	1
Nine months:	14
Ten months:	2
Eleven months:	2
Twelve months:	1
More than one year:	8

Modal age:	9 months
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The modal age of infants brought to the clinics was nine months old. This can be accounted for by the fact that at nine months infants are given a developmental screening. Other reasons for coming to the clinic are immunization and concerns about health. These are spread across a greater age distribution. There is no significant variation in age distribution apart from noting the modal age of nine months. One might have expected clusters around the ages of routine visits for immunizations, but this was not the case. In a bigger sample this might have been so, but in this case there were more voluntary than routine visits and that is probably why age clustering did not show up.

TABLE 3. RESPONSES BY HEALTH VISITORS DURING EXCHANGES

Responses	Wynberg	Langa	Mannenberg	Woodstock	Totals
A	1	1	3	1	6
E	1	0	1	0	2
S	4	1	0	0	5
M	3	1	7	1	12
R	0	0	1	0	1
C	0	0	3	0	3
A & E	2	4	0	0	6
S & R	1	0	3	0	4
S & A	0	2	1	0	3
A & M	0	1	1	0	2
S & M	0	1	1	1	3
S & E	0	0	1	0	1
E & R	0	0	1	0	1
A & C	0	0	1	0	1
A & S	0	0	1	0	1
S & A & E	0	0	1	0	1
R & E & A	0	0	1	0	1

Total number of responses: 53

Key to table:

M - medication prescribed	A - advice given
S - screening	E - education and information
R - referral	C - counselling

The most common response was to prescribe medication. Second to that, advice, and advice and education were the next most common responses. Counselling was a response in only three of the cases, and this in only one clinic. The prescription of medication was in response to voluntary visits only. It was thought that it was more likely that caregivers would have a hidden motive in voluntary visits, and even though they may present a concern about their child's health, what they were really wanting was reassurance for themselves. There seemed to be no attempt on the part of health visitors to probe below the surface or attempt to establish whether there was a hidden agenda or not. The three counselling responses were made in voluntary visits, but only because the caregivers were explicit about their needs for counselling.

Advice and information giving are certainly part of the health visitors' role, but as a common response, also seem to indicate a particular way of seeing the role. It would seem to reinforce the idea of health visitors being the experts and caregivers being the powerless, dependent ones. The responses of prescribing medication as well as the responses of advice and information giving, might seem to perpetuate the medical hierarchy, which excludes lay people from decision-making and self-determination. A more therapeutic attitude would obviously challenge this structure.

Because of the hypothesis that voluntary visits might elicit more counselling type responses, the responses of health visitors to voluntary visits were noted. These results are tabulated below.

TABLE 4. RESPONSES OF HEALTH VISITORS TO VOLUNTARY AND ROUTINE VISITS

Responses	Routine visits		Voluntary visits	
M	0	0%	12	32%
S	4	25%	1	2%
A	0	0%	6	16%
C	0	0%	3	8%
E	0	0%	2	5%
R	0	0%	1	2%
A & E	4	25%	2	5%
S & E	1	6%	0	0%
S & M	0	0%	3	8%
A & S	1	6%	0	0%
S & A	3	18%	0	0%
A & M	1	6%	1	2%
S & R	1	6%	3	8%
E & R	0	0%	1	2%
C & A	0	0%	1	2%
S & E & A	0	0%	1	2%
R & E & A	1	6%	0	0%
Totals:	16		37	

Key to table:

M - medication

S - screening

A - advice

C - counselling

E - education

R - referral

Because of the small sample, statistical treatment of the results would not be meaningful, however a rough comparison between the responses to routine and voluntary visits is possible. In response to routine visits, health visitors most commonly screened the child. This is to be expected as routine visits are in large part precisely for the purpose of screening. However, another twenty five percent of the responses in routine visits was advice and education while this response accounted for only five percent of the responses in voluntary visits. One might have expected these percentages to have been the other way around, with a greater proportion of advice and education being given in response to voluntary visits. Sixteen percent of the responses to voluntary visits was however in the form of advice. Prescription of medication is the most common response to voluntary visits, accounting for thirty two percent of responses. The results would seem to indicate that very little counselling or therapeutic work is being done by health visitors. There are no instances of counselling responses being made to routine visits, and only three occasions of counselling for voluntary visits.

3.5 Discussion

The quality of service given by the health visitors was impressive. They tended to be direct, efficient and reassuring to the caregivers, as well as showing empathy towards the infants. They also appeared to be sensitive to the needs of the communities in which they worked, or to have personal leanings for community issues. For example, in Mannenberg, almost every caregiver was advised about family planning, whereas in Langa the predominant concern was for nutrition of the infant.

The time spent in each exchange between health visitor and caregiver-infant dyad is partly dependent on the demand for time with the health visitor. It also seems to be a function of a fairly standard procedure that operates within the clinics.

Of interest was whether affective development could be in any way addressed or promoted in the short time given by the health visitor to the caregiver and infant. Although there was no direct attention given to this, the health visitors did model congruent communication both to caregivers and to their infants.

The clinics were visited in winter when coughs and colds are more prevalent than in summer. Many of the voluntary visits were because caregivers were concerned about their infants' coughs and colds. Perhaps this pattern would be different in summer. Nevertheless, it is felt that voluntary visits might actually be visits in which the caregiver requires something for herself rather than for the infant. These are also the visits in which it is felt that there might be room for further probing and therapeutic work.

As can be seen the most frequent response to voluntary visits was medication. There was only one exchange in which medication was coupled with advice, and no exchanges in which medication was coupled with counselling or education. Perhaps this can be seen as evidence of health visitors reinforcing caregivers' fears about physical vulnerability of their infant, and enhancement of concerns about caregiving competence (Parmelee, 1989).

As might be expected, no counselling was done in response to routine visits. It was surprising, however, at how little counselling was done in response to voluntary visits. (4 out of 37 exchanges) Even in a case of maternal depression, it was advice, rather than counselling, that was the response.

The question that this survey attempted to answer was whether anything was being done by health visitors to promote affective development in infancy. No direct attempts to do this were observed. The kind of responses envisaged as being possible within the clinic context were comments regarding affective attunement between caregiver and infant as observed in the clinic and questions as to how this was proceeding at home. Also it was expected that health visitors would enquire more about the state and mood of the caregiver as a way of gauging the state and mood of the relationship between caregiver and infant. Although health visitors did reassure caregivers about the physical health and milestones of their infants, no reassurance about affective development, or about individual differences was given. In conclusion the answer to the survey question of whether infant clinics were involved in promoting affective development, was negative.

This survey undertaken in infant clinics in the Cape Town metropolitan area was designed to answer the above question, and also to establish whether educational psychologists might be able to promote affective development within the context of infant clinics. It seemed that affective development was being almost entirely ignored and that there is scope for the involvement of educational psychologists within infant clinics. Chapter five

reports on a small intervention done with caregivers by the educational psychologist. In the next chapter discussion focuses on what the knowledge and skills of the educational psychologist are, and how these might be employed within the setting of infant clinics.

CHAPTER FOUR. THE KNOWLEDGE AND SKILLS OF THE EDUCATIONAL PSYCHOLOGIST AND HOW THESE MIGHT BE USED IN INFANT CLINICS.

In this chapter I discuss how the educational psychologist might be involved in infant clinics, but first it is necessary to consider what the knowledge and skills of the educational psychologist are, before proceeding to discuss how these might be applied.

4.1 The knowledge of the educational psychologist

The knowledge of the educational psychologist comes from two main sources - educational and psychological. In essence the foundation of knowledge which the educational psychologist should have is the whole field of the psychology and development of children, adolescents and adults as well as educational knowledge based on practical experience in schools and on educational theory. For the promotive intervention done with caregivers, reported on in chapter 5, the theory of Transactional Analysis was found to be particularly helpful. Transactional Analysis includes developmental theory, insights into healthy and pathological interactions and a conceptual model that is easily understood even by those with no psychological training (Stewart and Joines, 1987).

The educational knowledge which the educational psychologist has includes knowledge about educational theories and problems, cognitive development, theories of learning, school systems, classroom management, referral systems and sources and direct experience of the problems that teachers experience.

The psychological knowledge that the educational psychologist has includes knowledge of development over the lifespan, psychopathology of the child, adolescent and adult, personality theories, family systems, ethics, research methodology and current research issues, cognitive development, group dynamics and process, neuropsychology and techniques of assessment. The self-knowledge of the educational psychologist is also a very important source of knowledge, which guides and biases her/his work.

4.2 The skills of the educational psychologist

As with the knowledge of the educational psychologist, the skills of the educational psychologist are based on both educational and psychological theory and experience. The skills of the educational psychologist may be grouped into four main areas:

- communication
- gathering information
- effecting change and
- evaluation.

These skills relate to a wide range of people: children, teachers, parents, colleagues and other professionals, either individually or in groups.

4.2.1 Communication Skills

The educational communication skills that the educational psychologist needs are to be able to communicate with a wide range of people, of different ages, cultures, educational levels, etc. Some of the skills necessary to do this are the ability to establish rapport, the skill of expressing complex information in an appropriate way, report writing, liaison with colleagues,

being able to create an atmosphere that is conducive to learning, control and structuring, group skills and the communication of enthusiasm in order to motivate others.

The psychological communication skills include empathy, challenge, joining, containment, reflection, interpretation, tracking, establishing trust and rapport, listening, non-verbal communication, information-giving both written and oral, contracting and negotiating, counselling, advising, supporting and collaborating.

4.2.2 The Skills of gathering information

The educational psychologist needs to collect relevant, accurate and comprehensive information from a wide variety of sources. This involves specialist knowledge, skills and techniques. The educational psychologist needs to have systematic and objective procedures for observing behaviour and relationships in individual and group settings, both in structured and unstructured ways. The gathering of information includes the skills of hypothesizing and formulating, the application of psychotherapeutic interventions and the skills of assessment both through standardized testing and through other techniques. The educational psychologist also needs to be able to gather information from other people so that it provides collateral.

4.2.3 The skills of effecting and maintaining change

The educational psychologist needs to have the skills of effecting and maintaining change in individuals, in the work and methods of those who care for children and in adapting and developing the systems, contexts and organizations within which children operate. Some of the skills that are relevant to this

are an ability to analyze needs, the setting of goals, choosing appropriate methods, consolidation of activities, leadership skills, organization and planning, flexibility and motivating others.

Huggett (1988) argues that the skills of maintaining change contain the main core of the educational psychologist's work. Educational psychologists need to initiate change and maintain change by recognizing "the importance of a unifying theoretical approach, backed by materials and organizational structure."(p. 15)

4.2.4 The skills of evaluating change

Change in itself may not be an improvement, so the educational psychologist needs to be able to evaluate the change that has been implemented. This involves the skills of record-keeping, interviewing, experimental design, statistical analysis, case management, organizational and administrative skills, conflict resolution and decision-making.

4.4 How might the educational psychologist's knowledge and skills be used in an infant clinic?

4.4.1 Employment by clinic

One way in which an educational psychologist might be used, is to be employed by a particular clinic. The work that could be done by an educational psychologist would then depend on the role description given. Some aspects of this work could include dealing with referrals from the health visitors when they have perceived a psychological problem, running groups for caregivers

in which educational and therapeutic elements are covered, in-service training for nursing professionals and the production of educational videos or booklets.

Before such work could be undertaken in a particular clinic, it would probably be necessary to do considerable educational work to inform both staff and clientele of the opportunities and skills presented by the educational psychologist. This would have to be carefully combined with a needs assessment of the clinic and the community it served, in order to create an enhanced service.

As mentioned in chapter three, infant clinics aim to promote mental health by teaching the principles involved in establishing good family relationships, but in practice there does not seem to be much evidence of this principle being applied. It would seem therefore that the structures of the clinic, while supporting such promotive work, for various reasons cannot accommodate such work except as a by-product of the work currently being done. It may be that health visitors do not have the time, the knowledge or the training in order to implement such a principle. The educational psychologist would be able to get involved at various levels while still operating well within the general principles of the current structure of infant clinics. In chapter 5 the role of the educational psychologist in running groups for caregivers has been surveyed in a pilot study. Other roles for the educational psychologist that have not been investigated are the following.

4.4.2 In-service training

Another way in which the educational psychologist could be employed in order to be effective in empowering as many people as possible, would be to be involved in in-service training of community health nurses. Such training could involve several group training sessions covering such areas as current infancy research in psychology, diagnosis and treatment of inadequate parenting, and application of these areas to their work in the clinics.

4.4.3 Employment by several clinics

Thirdly, the educational psychologist might be employed to run groups with caregivers at several clinics with the aim of promoting affective attunement. Such groups would have an educational element covering such issues as developmental stages and tasks, as well as conveying in a simple way the issues arising from current developmental and clinical theory and research. These groups could also have therapeutic aims; the groups could serve as support groups for caregivers as they adapt to the changes elicited by their infants, and the educational psychologist's group skills would be used to facilitate the groups. The groups could also seek to address and make conscious in the caregivers their own experiences of being parented, and how this affects the way in which they parent.

4.4.4 Educational material

Lastly, the educational psychologist might be employed in a more educational way, by creating videos or booklets for use in clinics. In two of the clinics visited, a video on breast-

feeding and other issues were being shown to mothers in the waiting - room. Why not have the educational psychologist's skills employed in helping to produce a video on how caregivers might promote affective development? Such information could also be conveyed in booklet form. The educational psychologist could play an important part in deciding on what should be included in videos , pamphlets or booklets and how they should be displayed.

In summary, it would seem that there is scope for the educational psychologist to become involved in infant clinics with the particular task of promoting affective development. Obviously, infant clinics are not the only places where educational psychologists might be involved in early intervention programmes. In the next chapter there is a report on a promotive intervention done in infant clinics which attempted to promote affective development, and which used many of the skills and some of the knowledge of the educational psychologist.

CHAPTER FIVE. EVALUATION OF A PILOT PROGRAMME OF INTERVENTION FOR GROUPS OF CAREGIVERS

5.1 Rationale for conducting groups in a clinic setting

In order to test out whether the educational psychologist's skills could be usefully employed in a clinic setting, groups for caregivers were set up. Although this is only one small way in which the educational psychologist could be used to promote affective development, it was felt that this would give a fair idea of the needs that caregivers experienced as well as being a pragmatically simple way of slotting into the functioning of the clinics.

The aim of the groups was to intervene with regard to offering reassurance to caregivers by means of giving information with regard to individual differences, acknowledging particular stresses in the lives of caregivers and examining how the caregivers' experience of being parented affected their styles of parenting. In short then, the groups were envisaged as having two main functions - an information-giving function and a therapeutic function.

5.2 Method

Having received permission from the Deputy Medical Officer of Health to run groups in clinics, I discussed the project with the sister in charge of the Wynberg Clinic. She asked the health visitors to recruit mothers for the groups, informing them that the group was for the purposes of a thesis, that the group would

run over five sessions and that aspects of emotional development and parenting would be dealt with.

The groups were to be comprised of about ten mothers who had infants under one year of age. It was felt that the mothers themselves would be supportive to each other and could learn from the experiences of each other.

The health visitors had difficulty in recruiting mothers for a group at Wynberg. Part of the difficulty was related to the fact that there is no parking area close to the clinic and therefore the clinic is seen as being somewhat inaccessible. For the initial group only five mothers were recruited. As this was felt to be too small a sample, another group was recruited at Elfindale Clinic. Two groups were therefore set up, both to follow similar programmes.

The group sessions lasted for a period of one to two hours for each session. At the end of each session, each member of the group was given a questionnaire in order to evaluate the session (see appendix 1). The whole course was also evaluated by means of a questionnaire as well as by verbal feedback (see appendix 4). The Wynberg groups were held weekly on Wednesdays and the Elfindale groups were held twice weekly on Mondays and Thursdays. The Elfindale group had five sessions in all, and the Wynberg group had four sessions.

5.3 The programme for sessions

Session One was envisaged as being a time for introducing myself to the group, introducing the mothers and their infants to each other and to me, explanation of what my role and purpose was, what material we would cover and a time for contracting and negotiating content and process of the group. Finally, a questionnaire was administered in order to assess the needs of the group. The questionnaire covered the categories of the mothers' history of being parented, the amount of support that she received and from which sources this was received, perceived knowledge about affective development and the amount of support received from the clinics. (See appendix 1)

Session Two aimed to reassure the mothers that there is no one perfect way of bringing up a child. This was done by means of discussion of individual differences under the headings of temperament, gender, communicative abilities, visual capabilities and emotional response. The session then focused on how affective development proceeds from a physiological response to a complex emotion such as empathy. The concept of attunement was introduced and the mothers were given opportunity to discuss issues that were relevant to them in relation to the material presented.

Session Three began the more therapeutic element of the programme with the aim of making the mothers more aware of their own history of being parented. For this session concepts from Transactional Analysis were used. Transactional Analysis was chosen as a theoretical base as the theory is complex enough to embrace developmental theory- pathological and normal, and although complex, is very clear conceptually and therefore easily

understood by people who do not necessarily have a psychological background (Stewart and Joines, 1987). As well as these reasons, I have been trained both theoretically and experientially in Transactional Analysis. The mothers were taught about ego states and each mother drew up her own ego gram. After discussing the ego grams in pairs, each mother drew up an ego gram representing the ego states of her parents. Interesting similarities and differences were discussed.

Session Four continued the therapeutic function of the last session by introducing the concept of script from Transactional Analysis. The script matrix was explained and each mother then drew up her own script matrix. After discussion each mother then drew up what she would expect the script matrix for her infant to be. This meant that she had to identify the counterinjunctions, injunctions and program that both she and her husband were giving to the infant. The session concluded by discussion of the positive and negative consequences of each of the aspects of the script matrix.

Session Five was an unstructured session in which the mothers were able to bring any concerns, questions or unfinished business to the group for more informal discussion. It was also a time for me to receive unstructured feedback about the programme.

5.4 Composition of the groups

The group at Wynberg consisted of five mothers. The infants ages ranged from two to eleven months. Four of the mothers were married and one mother got married during the course of the programme. None of the mothers had tertiary education. Three mothers were first-time mothers and two had older children. Attendance at sessions was poor, most sessions having only two group members present. Only one mother attended all sessions. For this reason, the Wynberg group was treated as a pilot group in which material could be tested for length of time taken to present and response to the material.

The Elfindale group consisted initially of eleven mothers although the average attendance at sessions was seven members. Five of the mothers were first-time mothers and the other six had older children. Two mothers in the group had twins. Two mothers attended only the first session and did not come again. The ages of the infants ranged from two months to seventeen months.

The Elfindale group was very much more enthusiastic and committed to the programme than was the Wynberg group. The mothers asked more questions, spontaneously made connections between the material presented and their own lives and were more ready to discuss issues. Both groups impressed as being competent mothers who were not in need of depth therapeutic work or of fundamental information-giving. The programme that was presented therefore, was seen not so much in terms of preventative work, but rather in terms of promotive intervention.

5.5 Programme evaluation

5.5.1 Results of initial questionnaire

The responses of the Wynberg and Elfindale groups have been combined, giving a total of 16 respondents for the initial questionnaire. (See appendix 1).

TABLE 5. FREQUENCY WITH WHICH RESPONDENTS AGREED OR DISAGREED WITH QUESTIONS RELATED TO PARENTING AND OWN BACKGROUND OF HAVING BEEN PARENTED.

Categories	Frequencies				
	disagree		neutral		agree
	1	2	3	4	5
<u>Parenting</u>					
loved by parents				2	14
mother showed love				6	10
father showed love			1	5	10
supported by parents				2	14
understood by parents		1	2	7	6
space to develop	1	1	3		11
sense of belonging				1	15
will not make same mistakes	1	3	3	4	5
act in same way as mother		1	1	7	7
<u>Confidence about mothering</u>					
confident about being a good parent			2	7	7
know what is best for child		1	2	7	6
can meet needs of child			1	9	6
feel confused about right way to parent	4	5	1	3	3
know about emotional development	1	2	6	5	2

<u>Support</u>					
feel lonely and isolated	5	4		5	2
received support from others				2	14
receive support from husband		1		1	14
would like professional help	5	1	1	3	6
<u>Clinic support</u>					
bring worries and concerns to clinic	5	3		4	4
receive the right kind of help		1	2	6	7

n = 16

Because of the small sample size, it was not appropriate to apply statistical treatment to the results. However, the results in table 5 seem to indicate that the mothers had good experiences of having been parented themselves. Generally they also had supportive networks and were confident about their own ability to parent. There was a considerable spread for the item on wanting professional help and reassurance. The results of the initial questionnaire seemed to indicate that no deep therapeutic work was called for, and that the programme would be building on the strengths of the mothers and enhancing their knowledge of themselves and the relationships with their infants, rather than having to intervene to heal past experiences of having been parented.

The incomplete sentences did not reveal much further information and were very unclear regarding what was wanted in the group sessions. One mother wanted more information with regard to feeding, one mother said she wanted to learn more about her child, two mothers asked specifically to know more about emotional

development, one mother wanted to know how to develop her child as quickly as possible, one wanted reassurance, several mothers wanted to know how other mothers were dealing with problems and two mothers asked how to stimulate their babies.

5.5.2 Session Two Evaluation

This was based on a separate questionnaire (see appendix 2). The goals of this session were to reassure the mothers that there was no perfect way to care for a child and to explain how affective development proceeds.

TABLE 6. EVALUATION OF SESSION TWO

Categories	Frequencies				
	disagree 1	2	neutral 3	4	agree 5
helpful			1	2	6
interesting					9
learnt new things			1	5	3
feel more confident about mothering			1	2	6
feel more reassured			1	6	2
disappointed	8		1		
see infant in new way			3	3	3
did not deal with what I want to know	6	2	1		
learnt from other mothers				3	6
Daphne supportive				2	7

n = 9

Most mothers found the session helpful and interesting and they learnt new material. They also felt supported, both by the group leader as well as by the other mothers. The incomplete sentences

reflected a general sense of having been reassured, e.g. "I seem to be going in the right direction." and "There is no 'right' way to bring up a child."

5.5.3 TABLE 7. EVALUATION OF SESSION THREE

Categories	Frequencies				
	disagree		neutral	agree	
	1	2	3	4	5
interesting				2	6
difficult to understand	7	1			
learnt new things about myself	1			4	3
understand more about my script		1		2	5
brought up painful memories	3	1	2	2	
like to explore how script affects child				2	6
felt uncomfortable today	5	1	1	1	
did not see connection between material and how I care for my baby	7	1			
learnt from other mothers	1		1	4	2
Daphne supportive				1	7
n = 8					

Although this session made use of fairly advanced concepts from Transactional Analysis, the mothers reported that it was not difficult to understand. Only one mother had a score of 2 in responding to the item about understanding more about her script. It was of interest that the mothers found that the material tended to bring up painful memories for them, despite the fact that they had all reported good experiences of having been parented. Nevertheless, they all wanted to explore their own

scripts further and know the influence of their own script on that of their child's. In this session, as in the others, the mothers seemed to feel supported, more by the group leader than by each other. This was probably because the presentation of material took more time than was allowed for discussion among the mothers.

The incomplete sentences revealed that generally the mothers felt that they had more insight into themselves. One mother felt that it would be a good idea to involve fathers as well. Examples from the incomplete sentences are as follows:

"I learnt how my character is related to that of my parents."

"I have been opened up to new ideas and thoughts."

"The more you know yourself, the more you can pass on to your children."

5.5.4 FINAL EVALUATION OF WHOLE PROGRAMME

The final evaluation was done by means of ten incomplete sentences. (see appendix 4) Only one mother attended the final session at Wynberg and eight mothers attended the final session at Elfindale. The most meaningful way in which to report this is to take each of the questions and discuss them qualitatively in general terms.

1. The sessions were worthwhile because.....

The mothers reported that they felt more confident, able to change old attitudes, more conscious of how they thought and felt and that they knew themselves better as a result of the programme. Examples from the incomplete sentences are as follows:

"They helped me to have more confidence in my relationship with

my baby."

"They made me think of my upbringing and how I'm going to influence my children."

"They gave me insight into how complex the development of my child is."

2. The best session was

There was quite a spread over what was considered to be the best session. Generally the discussion around ego grams, script and script matrix seems to have been the most popular. One mother said that she liked all the sessions. One mother felt liberated by learning what the child brings into the relationship and one mother enjoyed the last session most because there was more discussion among the mothers.

3. The most interesting thing learnt was....

Again there was quite a spread across this item which corresponded with the last item on the best session. Generally the mothers had learnt most from the session that they considered to have been the best. Examples from the incomplete sentences are as follows:

"I learnt that there is no perfect answer."

"I learnt how my script and that of my parents can affect my child."

4. I feel more reassured about the way in which I care for my child because....

All the mothers reported that they did feel more reassured about the upbringing of their children. Reasons given were that they had been reassured that they were going in the right direction,

that they were now aware of their own dynamics and that they were able to consciously determine how to be with their children. Examples from the incomplete sentences are as follows:

"I have been given confidence that I am doing things correctly."

"I am more conscious of what to say and what to avoid saying to her."

5. The way in which the material was presented was.....

The mothers felt that the material was presented in a clear, interesting, relaxed and understandable way. For example:

"Very relaxed. Didn't feel pressurized. Could open up."

"Relaxed, efficient and very interesting."

6. I expect the consequences of having attended the programme will be.....

The responses on this item reflected greater insight, consciousness and thoughtfulness. Examples are:

"A more conscious effort not to inflict my hangups and lack of confidence on my child."

"That I will be more aware of ways of dealing with the emotional development of my child."

7. What would have improved the sessions?

A couple of the mothers felt that if they had been able to organize baby-sitters, they would have been freer to interact with the programme rather than having to be distracted by the needs of their babies. Two mothers felt that they would have preferred a bigger group. One mother said she wished that the sessions could have continued for much longer and one mother

wanted more group participation as well as input about mental stimulation.

8. Other suggestions, ideas or comments....

Only two mothers responded to this item. One mother commented that she felt the terminology was complex and that if a similar programme were presented to less well educated mothers, they would not understand. The other mother felt that the sessions were too vague in content and wanted more practical tips.

5.6 Discussion

As can be seen from the evaluation responses of the group members, there was generally a positive response to the programme. Words like 'conscious' and 'aware' were frequently used, and the impression received was that this is primarily what the programme had done - to make the mothers more aware of their upbringings and their own styles of parenting.

The programme operated very much as a promotive one rather than a preventive or remedial programme. This was because the mothers were competent, interested and committed to their children's well-being. No major therapeutic work had to be done. There were no major indications of pathology in mothers or infants. It seems likely however that there are caregivers who are not functioning as effectively as the mothers who attended the groups. Therefore, there would seem to be scope for further work in this area, although the programme would have to proceed far more slowly and carefully.

It is clear that such a programme is able to be accommodated

within the structures of the clinic setting. This particular programme was short and involved very few mothers, but further scope is seen for involving greater numbers of caregivers and for the presentation of ongoing and more varied programmes. Such programmes could be preventive and promotive.

One of the problems of structuring programmes of this nature is how to accommodate different levels of insight and knowledge within a group. This problem was evident in the Elfindale group, in which one mother reported that because she had three courses in psychology, she did not really gain much. In contrast, another mother said that the terminology would have to be made very much more simple for those not as well educated as themselves. If further programmes are to be run, this is one of the problems that would need to be addressed. Possibly there could be some initial questionnaire in order to determine levels of education and insight, and then groups could be constituted accordingly.

5.7 Limitations of programme

Limitations of this programme were that it involved only a small sample of mothers. None of them were in need of therapeutic work and none was experiencing any major stresses or life crises. The groups might have been very different and have had to have continued for a far longer time, had the mothers been in need of psychological help. Because this was a pilot programme, it was a short one. Any results from such a programme could not be expected to have lasting, long-term effects. However, given the indications of these results, a more extensive follow-up study would seem to be justified if similar programmes were to be instituted. Another way of assessing the effectiveness of such a

programme would be to have a control group, so that the effectiveness of the intervention could be more rigorously assessed.

In conclusion, running the groups on affective development was a very small part of how an educational psychologist might be involved in promoting affective development. However, the indications seem to be that the primary health services as offered by infant clinics, are able to accommodate such programmes and also that this seems to be a worthwhile undertaking.

CHAPTER SIX. CONCLUSIONS AND IMPLICATIONS

6.1 Themes so far

Before making conclusions or drawing out the implications of what has preceded this final chapter, a brief summary is given of the main themes that have been addressed. Infancy is seen as being a very important developmental stage in which the structure of personality is being formed. Affective development in infancy is considered to be fundamental to later development and its effects to resound in thinking and behaviour particularly in relationships throughout life.

The context of affective development is seen within the relationship between infant and caregiver. The two critical factors that influence this relationship, and that are seen as being critical for therapeutic intervention, are firstly the infant's characteristics and capabilities, and secondly the caregiver's personal history and experience of having been cared for.

Because of the importance attributed to affective development in infancy, and the implications of this development not going smoothly, the question of early intervention needs to be addressed. The role of the educational psychologist in preventative and promotive work is considered to have the potential of making a significant contribution in this area. Little seems to have been done in regard to promoting optimal affective development in infancy, but much clinical therapeutic work has been done in trying to reconstruct the consequences of non-optimal affective development. Early intervention programmes

have tended to concentrate largely on cognitive, rather than on affective development.

In perceiving a trend towards holistic health, and a trend away from dualistic conceptions, it was thought reasonable to investigate what was being done with regard to promoting affective development within the context of primary health services. Infant clinics were selected for this investigation, and it was found that there was much potential for early intervention and promotion of affective development. The knowledge and skills of the educational psychologist were thought to be able to be appropriately employed in this regard. In a small promotive programme the educational psychologist demonstrated that groups for caregivers, designed to promote affective development, were positively received.

Until this stage there has been no discussion of the wider issues that currently influence the family, the historical trends and the particular stresses or supports that families have available to them. Discussion therefore broadens in order to consider some of the issues of this wider context.

6.2 The social context of families

In several ways, families are under stress now, in ways that have never before been experienced so acutely. The increases in the numbers of single-parent families, especially as a result of divorce; adolescent parents; and working mothers contribute to psychological, economic and social instability. Brofenbrenner (1979) believes that the rapid changes which are being

experienced result in "a progressive fragmentation of the family and the isolation both of the child and of those primarily responsible for his care and development. The fact that such disruptive processes are taking place on a national scale and are occurring most rapidly for families with young children clearly poses questions about their consequences for the welfare and development of the young." (p. 838)

In South Africa there are particular problems that families face, and that have consequences for affective development. The South African divorce rate has shown a drastic increase over the last few years, and whites have one of the highest divorce rates in the world. The divorce figures for other population groups are less clear cut, but indications are that the number of separations and divorces in other population groups are also on the increase (Burman and Fuchs, 1986). There seems to be a very high rate of family breakdown in South African families, and this has been grossly exaggerated by factors such as migrant labour, influx control and shortage of housing. Of direct relevance to this thesis is the number of minor children whose parents undergo divorce. Burman and Fuchs (1986) state that if present trends continue, about 50% of white marriages will end in divorce. Two-thirds of white couples divorcing had minor children. Over the period from 1978 to 1982 the number of "coloured" and Asian children involved in divorces doubled, while the figures for whites increased by half (Burman and Fuchs, 1986). When the proposed interventions of this thesis are considered in the reality of South African divorce figures, it is naive and unrealistic to assume that the nuclear two-parent family is the norm. Early intervention programmes therefore need to take into account the fact of single-parenting.

One of the implications of single-parenting is that the primary caregiver often needs to be both breadwinner and caregiver. Caregivers, because of economic necessity, are often forced to leave their children in the care of others. "The inadequacy of creches and other formal child care arrangements means that this is often done at enormous physical and emotional cost to mothers who are subjected to considerable strain and anxiety. It also involves a cost to the young children who are left alone, or in the care of aged and infirm grandmothers, or with older children whose education is disrupted for this purpose, or with ill-equipped and often expensive childminders" (Cock, Emdon and Klugman, 1986, p. 66). The great comfort of working caregivers has been the much-used phrase "quality time". However, it is questionable whether someone who has worked a full day is capable of giving quality time. The implications of this for affective development are great. How can a caregiver be expected to be contingent and affectively attuned to the infant, when all that he/she needs is to relax and see to his/her own needs after a day's work?

Because this thesis has recommended that the educational psychologist might effectively be involved in promoting affective development within the context of primary health services, it is also necessary to consider what pressures and stresses are relevant to health services for children in South Africa. In the Western Cape thirty children out of every one thousand die of diarrhoeal disease in the first year, and this is often due to basic deficiencies in water supply, sanitation and housing

(Molteno, Kibel and Roberts, 1986). Overcrowding is one of the main factors in the causation of tuberculosis and in the Western Cape there are rising trends in tuberculosis among "coloureds" and blacks, with six people a day dying from tuberculosis, and 53 new sufferers being reported daily (The Weekly Mail, August 31 to September 2 1990). Fincham and Thomas (1986) found that the most important determinant of the nutritional health of the child was the organization of home life. For example, 62% of a sample of children with kwashiorkor were illegitimate, and 86% of the fathers were migrants. In contrast, 83% of a sample of well-nourished children lived in a family situation, in which only 5% of the fathers had deserted their children. Molteno et al. (1986) argue that the most important of the basic amenities for health is adequate nutrition.

There are very obvious and basic health needs for children in South Africa that have not been met. Provision of water, sanitation, housing and nutrition are not available for all, and there are obviously results in terms of bad health. It could be argued that to recommend promotion of affective development is an unrealistic luxury, until such time as the more fundamental health needs have been met. However, there is an acknowledgement in medicine of the importance of family and mental health. The World Health Organization defines health as a state of physical, mental and social well-being, with the aim of child health being to achieve optimal functioning of all children. In concluding a paper on childhood health in South Africa, Molteno et al. (1986) state that there should be a commitment by all concerned to maintain and strengthen the child-rearing unit.

It is the contention of this thesis that the promotion of affective development must address the issue of maintaining and strengthening the child-rearing unit, and that the promotion of affective development is therefore not an unrealistic luxury, but a matter of great urgency for this country. In South Africa there are, however, many forces and crises that threaten the existence of the family, and anyone wishing to promote family functioning, needs to take cognisance of the crises that are fragmenting family life.

In recommending ways to promote affective development, the wider social context should be kept in mind. Affective development is still considered a crucial issue, but the social context requires that anyone involved in this field, will have to work harder because of the structural and political forces that mitigate against promoting and strengthening affective development within families.

6.3 Issues of normality and pathology

This thesis has had as its focus "normal" affective development, but when writing of normal development, pathological development is always implied. If we describe attunement, we imply that there are failures in attunement. If we refer to reciprocity, then the implication is that there are situations where reciprocity does not occur. If we can describe contingent behaviours, it implies that we can detect noncontingent behaviours as well. This point needs to be made because it raises the question of whether the data from normal interactions can be used to define pathology and

to establish early intervention programmes. It also raises the question of how valid it is to work backwards from clinical pathological reconstructions in making implications for normal development. These questions relate to Stern's (1985) concept of the clinical and observed infants. Stern believes that it is necessary to work at the interface of these two concepts. Cramer (1986) also believes that such cross-fertilizations are possible, but subject to certain methodology issues.

Because infants do not talk, the assessment of infant-caregiver relationships must utilize observational methods that focus on the physical properties of social exchange, e.g. the timing, the direction, the duration and the modalities of interaction (Cramer, 1986). In contrast, clinical reconstructions of infant-caregiver relationships utilize verbal reports, and the therapist's main modality is that of listening. "...interactive research focuses on physical properties of social exchange in an attempt to describe them objectively, relying mostly on the visual modality. What is observed is a normal, adaptive interaction. The clinician, on the other hand, is called to intervene in cases of deviance, crisis or pathology. While he or she does observe, the tendency is to favour the expressivity of subjective experience. Beyond the overt interaction, the clinician seeks to unearth the fantasies, anxieties and conflicts that form the basis of relationships" (Cramer, 1986, p. 29).

Another way of conceptualizing the difference between the observed and the clinical infant is to see the data from observation, related to developmental psychology, as providing the "how" of the relationships between infant and caregivers. The

data from listening to verbal reports, related to clinical and abnormal psychology, provides the "why" of particular interactions between infants and caregivers.

It is felt that these two methods, with their particular modalities and focuses, are complementary, and that both need to be utilized when considering early intervention programmes that aim to promote normal affective development and to prevent pathological development.

Having said that both normal and pathological developmental approaches need to be used in formulating early intervention programmes, it is also important to note that promotive work, such as that visualized in this thesis, should emphasize normal, rather than pathological development. Promotive work is proactive, rather than reactive, and means furthering growth and therefore being concerned with health, supplying the encouragement for use of healthy coping mechanisms and supporting strengths, rather than waiting for problems and pathological conditions to develop. One aspect of promoting affective development involves the assessment of relationships between infant and caregivers, and this is discussed in the next section.

6.4 The assessment of infant-caregiver relationships

Firstly, within a promotive framework, the assessments of relationships in a family should be seen as a way of working with families in order to discover strengths, rather than imposing on families conceptions of how they may be wrong or pathological.

In order to assess relationships between infants and caregivers there are three main areas that need to be considered. These are: the current state of the relationship and its history; each of the partners as individuals and particularly the caregiver's history of significant relationships; lastly the family's socioeconomic circumstances, current stresses and social supports (Sameroff and Emde, 1989). These three dimensions are discussed in greater detail below.

6.4.1 The current state of the relationship

In assessing the current state of the relationship between infant and caregiver, the therapist observes the interactions between them in order to assess the quality of attunement in the relationship. According to Sander (1976) there are seven stages of developmental milestones in the relationship between infant and caregiver and at each stage infant and caregiver need to negotiate dyadic issues. The seven stages are: initial regulation, reciprocal exchange, initiative, focalization, self-assertion, recognition and continuity. These stages are thought to be a useful framework for assessing the current state of the relationship between infant and caregiver. In the first three months, for example, the therapist would focus on the regulation of behaviours surrounding physiological homeostasis and how effective infant and caregiver have been in establishing dyadic patterns of feeding, sleeping and physical well-being. In the next stage of reciprocal exchange, which happens between three and six months, interactions would be assessed in terms of regulating reciprocity. What is important is that the therapist should have a clear developmental framework, that can be clearly

communicated to the caregiver, so that strengths may be supported and so that inappropriate patterns may be rectified. It is also important that the relationship is assessed in different contexts which may include feeding, bathing, separations or bedtime. The domains of interaction include physiological regulation, social communication, control and inhibition, teaching and exploration and comfort and security (Sameroff and Emde, 1989).

The assessment of the current state of the relationship between infant and caregiver includes, therefore, observation of the degree of attunement between infant and caregiver, and seeks to answer the "how" questions of the relationship.

6.4.2 The individuals within the relationship and the caregiver's history.

The modality used for this kind of assessment is largely verbal report in which the "why" questions of the relationship are addressed. Caregivers can report verbally about their subjective experience of the relationship, making meaningful links between their representation of the child and their personal history, while the infant does not possess the tools to do this. In order to infer the subjective state of the infant we need to rely on gross behavioural signs in behaviour such as gaze aversion or motor behaviour, and the chances are that one will be adultomorphic. The caregiver, rather than the relationship itself, is being assessed in this way because of the asymmetry of responsibility and of expressive ability at this stage.

The way in which caregivers perceive their child is sometimes

embedded in unconscious processes that include memories of their own parents, their past griefs, anxieties and pleasures. The caregiver may relate to an imaginary construct of the child, and the actual relationship will be underpinned by this imaginary construct that is embedded in past relationships.

Cramer (1986) suggests three ways in which the caregiver may represent the child:

- as an important person in the caregiver's past
- as a reincarnation of a dead relative
- as a repressed part of the caregiver's own self.

When an infant is expected to be an important person in the caregiver's past, resemblances will be found between the infant and the important person, and the former relationship will be replayed in the present with the child as the new partner. In this way a ghost is between the parent and the infant, and the caregiver addresses the ghost while interacting with the infant.

"These former relationships may act as a screen that interferes with attunement to the real child, with contingency to the child's real needs, and with emotional availability to the child's real feelings. It is then that we see derailments of dialogue and interaction" (Cramer, 1986, p. 35).

The second kind of imaginary relationship occurs when the infant is expected to be a reincarnation of a dead relative and take the place of this relative. Often the child is given the same name and is expected to become a replica of the dead person. Of course the child can never produce a perfect copy, and again the interaction may be badly affected.

The third imaginary interaction is based on the caregiver projecting a repressed part of herself onto the child, and the infant becomes a reminder of the caregiver's inner conflicts. For example, a caregiver who has eating difficulties may see her infant's healthy appetite as over-eating, or a depressed caregiver may see her infant's calmness as depression.

6.4.3 The family's stresses and supports

It seems that little is known about the social and ecological factors that affect a caregiver's ability to respond contingently. But in assessing the relationship between infant and caregiver, the wider social context must be taken into account because this also provides answers to the "why" of the relationship.

Zarling, Hirsch and Landry (1988) argue that support, in the form of advice, physical assistance, emotional support and respite from caregiving, has a beneficial role on maternal and child outcomes. The availability of support is related to increased affectionate and socioemotional growth-fostering activities by mothers, and greater general infant development.

In a comparison between full term and very low birth mass infants, Zarling, et al. (1988) found that mothers of full term infants showed greater sensitivity than did mothers of preterm infants. Clearly, maternal sensitivity and infant responsiveness are related, but the differences remained even after controlling for differential rates of responsiveness. The authors argue that

the differences between the mothers in the two groups could be due to the social networks that are activated by the births of full-term and preterm infants. For example, friends and family of preterm infants may not know how to respond to the caregivers, and this could increase distress. Healthy infants however elicit certain network responses that may affect maternal sensitivity more positively.

Similarly, Fleming, Flett, Ruble and Shaul (1988) found that mother's perceptions of their social supports were important predictors of maternal feelings. The relationship between parents was also found to be an important predictor of feelings about caregiving at pregnancy and at three months postpartum.

In assessing infant-caregiver relationships the therapist must take into account the stresses and supports that surround the dyad in order to encourage the supports and understand the stresses which may distort the relationship.

Whereas assessment of relationships is part of the function of early intervention promoting affective development, there may be other ways in which the educational psychologist might structure a programme of early intervention.

6.5 A programme of early intervention

Any programme that aims to promote affective development in infancy needs to take account of the community in which the programme is to be applied. Principles underlying the programme include enhancement of family strengths, parenting skills and self-esteem, in order to help caregivers become more positively engaged in bringing up their children. Education is seen as an

important part of such a programme, in which caregivers are taught about developmental stages and needs, as well as about individual differences and variations. As well as this, the educational psychologist would need to be aware of and sensitive to the particular stressors for each family.

Huntington (1979) outlined six different types of programmes which are applicable to parents and young children:

- community organization
- interagency collaboration
- mental health education
- case and programme consultation
- training and continuing education
- combined community service, promotive and preventative programmes

These six kinds of programmes are thought to be relevant to a proposed programme that seeks to promote affective development, and are discussed below in more detail.

6.5.1 Community organization

It is seen as crucial to establish what the needs of a community are, and what the various groups within a community comprise. Therefore, before drawing up any kind of programme, a needs assessment must be done, and the appropriate kind of intervention for that community must be planned specifically to address particular needs.

6.5.2 Interagency collaboration

It is wasteful of resources to replicate services that are

already being offered. Therefore careful research into existing services should be done and referral networks need to be developed. No programme should aim to supply all services itself.

6.5.3 Mental health education

Mental health education is seen to be a very important component of a programme promoting affective development. This would involve courses, workshops, self-help groups and support groups, in which information about development in infancy, parenting and family life would be conveyed simply and appropriately to caregivers. Special issues might be covered, such as surviving as a single parent, or how to cope with divorce.

This component of mental health education could also involve education through the media of videos, pamphlets and posters.

6.5.4 Case and programme consultation

This component of the programme seeks to use the educational psychologist's skills of consultation in order to empower other professionals working in the field. For example, the educational psychologist may act as a consultant for community health nurses or pre-school teachers.

6.5.5 Training and continuing education

Not only would the educational psychologist act as a consultant, but teaching skills would be used as well. In order to empower other professionals or groups within the community, the educational psychologist could teach appropriately and creatively

to diverse groups within the community about affective development and its promotion.

6.5.6 Combined community service with promotive and preventative programmes.

There are various options and components of this kind of programme and the particular kind of programme that would be developed would depend on the factors mentioned above.

One of the programmes might be a caregiver-infant development programme, in which the relationship would be assessed in order to aid caregivers to appreciate the attributes of their infants, developing skills of attunement, and discovering how the history of the caregiver impinges on the present relationship. This could be done individually or in groups, and could run for the first year of the infant's life.

Home visits may be a necessary part of early intervention programmes. As mentioned earlier, health visitors of infant clinics undertake home visits as part of their work. The educational psychologist could help health visitors to address issues related to affective development, or be directly involved in home visits.

A programme that seeks to promote affective development would also need to have a therapeutic component built into it. This would be aimed particularly at the caregivers in order for them to understand how their history of relationships with significant others currently affected their relationship with their infant.

The therapeutic component of such a programme would seek to address the "why" questions related to the caregiver-infant relationship, and make conscious the psychological and unconscious forces that acted in the relationship. Therapeutic interventions could be conducted individually or in a group setting.

There are many variations of programmes that could be presented, but the aim of this thesis is not to present a definitive programme. Rather, the aim is to make general recommendations that can be adapted according to the needs of communities in which they may be applied.

6.6 Some recommendations and general principles

6.6.1 Where?

Although there are arguments in favour of locating a programme of promoting affective development within the context of infant clinics, there are also factors that may make this difficult. In favour of the location is the fact that the structure and philosophy of infant clinics favour a promotive health service in which mental health is seen to be an important part of physical health. Against the location of such programmes is the fact that infant clinics have a well-defined and standard way of operating, and there may be considerable inertia against implementing new ways of doing things.

Would maternity hospitals be an appropriate place to start the implementation of early intervention programmes? For several reasons this is not considered to be optimal. First of all, many mothers do not stay for more than a few days in hospital after the birth of their infant, and therefore time would be very limited. Secondly, hospitals run according to a medical/sickness model, which would be in direct contradiction to a programme of early intervention hoping to utilize a promotive model of mental health. As with clinics, it is expected that there would be opposition to new systems being introduced into already established ways of operating.

The Parent Centre in Cape Town offers services which fit the philosophy and principles suggested in this thesis. A programme of promoting affective development in infancy would seem to be able to fit comfortably into the existing structures of this centre. The Parent Centre promotes family life by offering the services of workshops, discussions, individual therapy/counselling and addressing specific issues such as parenting teenagers.

It is felt that a specific programme to promote affective development in infancy has to find its place within a wider context. Fees for service are rarely paid for promotive services, and this factor alone would mean that such a programme would have to receive funding through a larger organization.

6.6.2 What?

The contention of this thesis is that there are three major factors that need to be considered in a programme that seeks to promote

affective development in infancy. These are the objective, behavioural, developmental factors that are operative in the relationship between caregiver and infant, the unconscious psychological factors that affect the caregiver in the relationship, and thirdly, the wider issues of social context. All three factors need to be included and accounted for in a programme that aims to promote affective development in infancy through promoting the relationship between infant and caregiver.

The following aspects could be offered in a programme that aims to promote affective development:

- New behaviours for interacting with the infant.
- New understanding and awareness of infant needs and individual differences.
- Education about infancy, development and parenting.
- Socialization with and support from other caregivers.
- Development of the ability to verbalize feelings, and the use of this skill to enhance the relationship with the child.
- Enhancement of the caregiver's self-concept.
- Release from guilt about the infant's behaviour.
- Development of ability to set and follow limits.
- Development of ability to identify with infant's feelings and needs.
- Establishment of an empathic and effective relationship between infant and caregiver.

6.6.3 How?

Again this thesis cannot be specific, but seeks rather to outline general principles of how a programme might operate. It is important that a promotive programme views caregivers as

competent individuals who have the potential to offer what is best for their infants. Strengths and competencies need to be acknowledged and mobilized. Techniques and approaches would involve appreciating and acknowledging individual differences, needs and strengths. The emphasis would be on facilitating growth and competence, not on weakness or pathology.

The ways in which affective development are promoted are numerous and are dependent on the setting in which the educational psychologist operates. Direct involvement would be with the infants and caretakers themselves either in groups or individually, either in organizational settings or in the homes of the family. Indirect involvement would be through empowering others to facilitate affective development. In both cases the educational psychologist's skills of communication, teaching, group skills, and therapeutic experience would be utilized.

6.7 The final conclusion

This thesis has sought to work at the interface of developmental and clinical psychology, and to apply what has been learnt about affective development in infancy to a framework of promotive and preventive mental health. The field is a large and complex one, and this thesis of necessity has been limited to only some of the issues in the field. The limitations reflect the writer's particular bias and interests, and several areas are oversimplified and generalized. For example, this thesis has not addressed the issue of the ontogenesis of emotions or dealt with stages in the development of affect. This has been done before,

(e.g. Stroufe, 1979) and besides not wanting to replicate, there has been some controversy about whether stages of development should be considered as a useful concept or not (Stern, 1985).

The most salient feature of infant experience has to do not with the individual's state of adaptiveness, but rather with the caregiving relationship. That relationship frames all individual experience, and the facilitation of infant development is almost synonymous with the facilitation of the caregiving relationship. Because of the importance placed on the early caregiving relationship, and because of the implications for pathology if this relationship does not satisfy the infant's affective needs, this thesis has attempted to address the question of how the educational psychologist might be involved in promoting this relationship.

Traditionally psychoanalysis has been involved in the relationship by working individually with the client in the transference relationship. This thesis argues that whereas this is important, it is not enough. Affective development is far too important to be left to chance, and far too important to be remediated and healed through individual therapy only.

Rather what is called for is a proactive, promotive approach that seeks to reach out to empower as many people as possible to realize their strengths, overcome their difficulties and engage positively in the caregiving relationship. By promoting the caregiving relationship, it is not only affective development that will be positively influenced, but because all development is linked and inter-related, all development would be affected.

This is the goal: to help set in motion the process of optimal development, behavioural and cognitive as well as affective, so that future relationships may be marked by healthy psychological functioning.

APPENDIX 1.

QUESTIONNAIRE FOR FIRST SESSION

Please respond to each item by making a ring around one of the numbers. If you agree strongly with an item, mark the 5, if you disagree strongly with an item, mark the 1.

- | | | | | | |
|--|---|---|---|---|---|
| 1. I always felt that my parents loved me. | 1 | 2 | 3 | 4 | 5 |
| 2. My mother showed that she loved me. | 1 | 2 | 3 | 4 | 5 |
| 3. My father showed that he loved me. | 1 | 2 | 3 | 4 | 5 |
| 4. I felt supported by my parents. | 1 | 2 | 3 | 4 | 5 |
| 5. I felt understood by my parents. | 1 | 2 | 3 | 4 | 5 |
| 6. My parents gave me enough space to develop. | 1 | 2 | 3 | 4 | 5 |
| 7. I felt that I belonged in my family. | 1 | 2 | 3 | 4 | 5 |
| 8. I feel confident that I will be a good parent. | 1 | 2 | 3 | 4 | 5 |
| 9. I know what is best for my child. | 1 | 2 | 3 | 4 | 5 |
| 10. I can give my child what he/she needs. | 1 | 2 | 3 | 4 | 5 |
| 11. I felt lonely and isolated as a new mother. | 1 | 2 | 3 | 4 | 5 |
| 12. I received support from people around me when my baby was born. | 1 | 2 | 3 | 4 | 5 |
| 13. I feel confused about the right way in which to bring up my child. | 1 | 2 | 3 | 4 | 5 |
| 14. My husband is supportive of me. | 1 | 2 | 3 | 4 | 5 |
| 15. I would like professional help and reassurance about being a mother. | 1 | 2 | 3 | 4 | 5 |
| 16. I know about emotional development in children. | 1 | 2 | 3 | 4 | 5 |
| 17. Children from the same parents are very similar. | 1 | 2 | 3 | 4 | 5 |
| 18. I bring all my worries and concerns to the clinic. | 1 | 2 | 3 | 4 | 5 |
| 19. The clinic sisters always give me the right kind of help. | 1 | 2 | 3 | 4 | 5 |
| 20. I will not make the same mistakes as my parents. | 1 | 2 | 3 | 4 | 5 |
| 21. Sometimes I act in the same way as my mother. | 1 | 2 | 3 | 4 | 5 |

Please complete the following sentences.

22. I get most support as a mother from

23. I would like more support from.....
24. What I most need to know as a mother is
25. What I most feel as a mother is.....
26. The relationship between me and my child is
27. The frightening thing about being a mother is.....
28. The most wonderful thing about being a mother is
29. In the groups I would like to learn more about.....
30. What I want for my child is that he/she should grow up to be.....

APPENDIX 2.
EVALUATION OF SESSION TWO

If you agree strongly with an item, please ring the 5. If you disagree strongly with an item, please ring the 1.

- | | | | | | |
|---|---|---|---|---|---|
| 1. I found today's session helpful. | 1 | 2 | 3 | 4 | 5 |
| 2. I found today's session interesting. | 1 | 2 | 3 | 4 | 5 |
| 3. I learnt things that were quite new to me. | 1 | 2 | 3 | 4 | 5 |
| 4. I feel more confident about doing the 'right' thing for my baby. | 1 | 2 | 3 | 4 | 5 |
| 5. I was disappointed by today's session. | 1 | 2 | 3 | 4 | 5 |
| 6. Today's session did not deal with what I really want to know about. | 1 | 2 | 3 | 4 | 5 |
| 7. I feel anxious or uncomfortable about some of the material that was presented today. | 1 | 2 | 3 | 4 | 5 |
| 8. I feel excited by some of the material that was presented today. | 1 | 2 | 3 | 4 | 5 |
| 9. I learnt more about emotional development. | 1 | 2 | 3 | 4 | 5 |
| 10. I found that Daphne and the other mothers were a support for me. | 1 | 2 | 3 | 4 | 5 |
| 11. The most interesting thing that I learnt today was..... | | | | | |
| 12. A new thing that I learnt today was..... | | | | | |
| 13. I feel better/worse about being a mother after today's session because..... | | | | | |
| 14. What today's session brought up for me was..... | | | | | |
| 15. What I really think and feel about today's session is..... | | | | | |

APPENDIX 3. EVALUATION OF SESSION THREE

If you strongly agree with an item, please ring the 5. If you strongly disagree with an item, please ring the 1.

- | | | | | | |
|--|---|---|---|---|---|
| 1. I found today's session interesting. | 1 | 2 | 3 | 4 | 5 |
| 2. I found today's session difficult to understand. | 1 | 2 | 3 | 4 | 5 |
| 3. Today I learnt new things about myself. | 1 | 2 | 3 | 4 | 5 |
| 4. I understand more about my own script. | 1 | 2 | 3 | 4 | 5 |
| 5. I found today brought up painful memories. | 1 | 2 | 3 | 4 | 5 |
| 6. I would like to explore more of my own script and how it affects my child. | 1 | 2 | 3 | 4 | 5 |
| 7. I felt uncomfortable at times today. | 1 | 2 | 3 | 4 | 5 |
| 8. I do not see any connection between what we did today and how I might care for my baby. | 1 | 2 | 3 | 4 | 5 |
| 9. I learnt from the other mothers in the group. | 1 | 2 | 3 | 4 | 5 |
| 10. I found Daphne supportive in today's session. | 1 | 2 | 3 | 4 | 5 |
| 11. The most important thing I learnt today was..... | | | | | |
| 12. The most difficult thing about today was..... | | | | | |
| 13. I feel better/worse about being a mother after today's session because..... | | | | | |
| 14. The material presented today was..... | | | | | |
| 15. What I really feel about today's session is..... | | | | | |

APPENDIX 4. EVALUATION OF WHOLE PROGRAMME

1. I found the sessions worthwhile because.....
2. For me the best session was.....
3. The most interesting thing that I learnt was.....
4. I felt more reassured about the way in which I care for my child because.....
5. The way in which the material was presented was.....
6. I expect the consequences of having attended these sessions will be.....
7. Would you recommend such sessions to other mothers or friends?
8. What would have made the sessions better?
9. Was the group the right size?
10. Any other comments, suggestions or ideas?.....

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