What can be learnt from observing

a 5-week baby massage group in a Parent Infant Mental Health Service?

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ABSTRACT

The thesis presented below is the account of a qualitative research project conducted in a Parent Infant Mental Health Service (PIMHS) by a Child Psychotherapist.

The project explores the learning experience of setting up and conducting a small research study about an early intervention, a baby massage group delivered in PIMHS within a large NHS trust.

The thesis consists of literature review of the cultural and historical context of baby massage, baby massage research and relevant psychoanalytic concepts such as containment and holding; a methodology section comprises of the research methods section, ethics and grounded theory and observational methods are also described; the grounded theory analysis and findings are also presented and a discussion of the findings and psychoanalytic concepts is given. The findings are grouped in four thematic categories: Roles of the Facilitators, Group Dynamics, Changes and Developments and Touch and Bodily Communication. The conclusion explores learnings for practice.

Key words:

baby massage group

child and adolescent psychotherapy

containment/holding

group psychodynamics

psychoanalytic observation

parent-infant mental health

Chapter 1 Introduction

The thesis presented is part of a Professional Doctorate in Child and Adolescent Psychoanalytic Psychotherapy. The report is an account of a qualitative research project carried out in fulfilment of the academic requirements of the 4-year Professional Doctorate in Child and Adolescent Psychoanalytic Psychotherapy.

The project is the account of an observational study of a 5-week baby massage course delivered in a Parent Infant Mental Health Service (PIMHS). The PIMHS is part of the Child and Adolescent Mental Health Service (CAMHS) within a large National Health Service (NHS) mental health trust. The project links to the clinical field of Child and Adolescent Psychotherapy by virtue of the principal investigator's professional background as well as the fundamental importance attributed to the earliest relational experiences within psychoanalytic thinking and practice. Having spent most of my working life working with children, adolescents and their families, I have first-hand experience of the long-term consequences of what it means in later life when for example the effects of earlier miscarriages are ignored; when the impact of a traumatic birth is not thought about during infancy; when a feeding problem is not addressed. To name just a few issues that my young patients and their mothers had experienced which were not treated at the most opportune time. The links to Child Psychotherapy and the origins of my thinking about this area of research also stem from the life-long interest in the earliest relationship between the infant and the mother, the internal world, and the study of the unconscious.

From a professional and academic point of view, I was interested in finding out what early intervention might look like under the aegis of Child and Adolescent Mental Service provision. This is also why I thought it would be of particular interest to observe a baby massage group, in order not only to observe the development of an early intervention but also to reflect on what sort of observable effects this kind of close physical and skin stimulation might have on the mother-baby dyad.

The aim and purpose of the study was to carry out a qualitative research project to explore an early intervention. Amongst other definitions of early intervention in mental health, Davis et al use the following two in their literature review of early interventions in the mental health of young people:

> Early intervention is a term now used broadly to refer to a broad range of experiences and supports provided to children, parents and families during the pregnancy, infancy and/or early childhood periods of development (Dunst, 1996 cited in Davis et al, 2000) and
>
> Early intervention can be defined as some form of helpful input provided shortly after a need has arisen. Its aims are to reduce distress, shorten the episode of care, minimise the intervention required and reduce costs. Beyond this there are the issues of minimising dependency and enhancing hope (Gardner, 1996 cited in Davis et al, 2000).

Baby massage fits into these categories well and I was interested in finding out what the experience might look like and in the time-honoured tradition of learning from experience, what it might feel like as an observer.

Baby massage groups are an intervention offered in the Parent Infant Mental Health Service, amongst others, such as parent-infant psychotherapy. To my knowledge there is no historical study or comprehensive data about the introduction of baby massage within the NHS. However, there is some historical context in the origins and introduction baby massage, its origins and introduction to the United Kingdom. I have gathered information about the specific programme at the NHS trust where the baby massage group that I observed was delivered.

Historically and culturally, infant massage is understood to be an ancient tradition that has its origins in cultures that are thought of as the global South or East. The PIMHS massage instructors' handbook refers to the following information:

> For centuries in many diverse cultures, mothers have massaged their babies.
>
> The ancient art of baby massage is a beautiful and simple way to express love and to establish a deeper emotional parent infant bond.
>
> In India babies are massaged between one and six months of age.
>
> Russian mothers believe massage develops the nervous system.
>
> Maori mothers massage leg joints to help a child's suppleness and gracefulness.
>
> Balinese, Mongolians and Australian Aborigines massage to relieve headaches and stomach aches.

> Zinacantecos of Mexico believe a baby must be massaged and embraced frequently or he will lose his soul.
>
> Cuban mothers massage babies' abdomens with oil and garlic to ease stomach upset.
>
> In Korean culture it is believed that massaging the baby's legs routinely will encourage growth and make the babies tall.
>
> Nigerian mothers massage their babies in belief it will promote their health and wellbeing.
>
> In South Asia mothers perform daily baby massage in the belief that it will install fearlessness, harden bone structure, and enhance movement and limb coordination.
>
> In China they believe that even babies can benefit from increased blood flow to different parts of the body through massage.
>
> After birth the Samoans usually massage the baby with blood from the placenta or the umbilical cord.
>
> In Fiji, parents massage the baby as a night-time ritual.
>
> (from direct email communication from PIMHS service lead)

This information shows a widespread belief that massaging infants is beneficial for the infant. It seems to relate to long-established customs and is included here to add to the cultural context of baby massage.

The longest-established organisation is the International Association of Infant Massage (IAIM). The colleagues who deliver the course that I observed trained

in infant massage at IAIM. The IAIM was established in 1986 and the UK chapter was founded in 1992.The infant massage routine developed by the IAIM's founder Vimala McClure draws on practices originating in India and also Swedish massage (About the UK Chapter (iaim.org.uk).

Peter Walker, whose organisation is called The Developmental Baby Massage Centre (http://www.thebabieswebsite.com/), also dates the spread of baby massage in the UK to the 1980s.

Since the 2000s and particularly since NICE recommendations include baby massage as an intervention (NICE 2012), there has been a widespread delivery of baby massage by Health Visitors and Specialist Health Visitors.

Although no collated data is available, baby massage groups are delivered in a variety of settings from a variety of providers including the IAIM, The Developmental Baby Massage Centre, and the National Childbirth Trust (NCT), which are part of the universal provision. Baby massage within specialist provision is offered through public sector organisations such as local council SureStart Centres or PIMHS within the NHS and by private sector specialist services such as the Oxford Parent-Infant Partnership (OXPIP).

Most group courses run for 5 or 6 weeks and have up to 10-12 mother and baby dyads with one or two instructors present depending on setting. As far as I can ascertain, there seems to be no blueprint as to how to run a baby massage group. The emphasis is often on the individual mother-baby couple rather than the group dimensions.

The very beginning of baby massage in this particular PIMHS was initiated by a Child Psychotherapist, who was the service lead at the time, after seeing a neonatal nurse who runs baby massage groups in a neonatal unit deliver a presentation at a PIMHS conference in 2004 (personal communication with the present service lead). The first wave of training was delivered by Peter Walker. However, since then the IAIM method has been followed.

By the time I got to observe a baby massage group delivered in the PIMHS in 2020, the service had been well-established for almost two decades with different treatment modalities available, including baby massage both for individual mother-baby dyads delivered in the home, and for groups. The service works closely with the county's health visitor teams who refer to the PIHMS, and sometimes GPs and social workers. There is a rolling programme of groups in response to demands and localities and the PIHMS service massage groups are delivered in local children's centres. On average, there are 6-8 mother and baby couples in attendance and the group is facilitated by two clinicians, one of whom is Specialist Health Visitor.

Referrals from the health visitors are screened and discussed by PIMHS team members and it is decided whether individual work or group work is indicated. There is also an option for some baby and mother dyads to access Parent-Infant Psychotherapy delivered by one of the PIMHS Child Psychotherapists. In this particular NHS Trust, PIHMS is part of CAMHS, and the ethos of PIMHS is strong amongst the Child Psychotherapists. Most qualified clinicians take PIMHS cases and devote some of their time to Parent-Infant work although, to my knowledge, infant massage is not part of their remit.

The intake for the groups is thus both driven by demand and availability. My sense was that there is a high demand and very regular offerings. There is also the crucial window of opportunity taken into account so as to deliver the intervention when the babies are between two and six months old. The reasoning behind this is that they are deemed to be too little before two months and at six months babies start to roll and it can be difficult to keep a baby still enough for the massage process. Developmentally, this is the age babies starts to push for some independence (that is when they normally start being put in an outside-facing baby carrier or pushchair), and that therefore what might need to be supported by the mother is more an outwards movement, rather than within the dyad. In terms of vulnerabilities and challenges, the focus seems to be on the baby's physical symptoms such as problems around sleeping, excessive crying, or feeding difficulties. The relationship between the mother and the baby is thus not explicitly addressed perhaps due to the group set up or the brevity of the intervention. The service uses Mother's Object Relations Scales (MORS) both as a screening measure and as an evaluation tool in determining the mental state of the mother and insight into the relationship.

The structure of the thesis

The report presented below is made up of two major parts: a literature review and the empirical research project. It is an account of my experience as a student-researcher of identifying a subject of study, submitting a research proposal, designing a project, attaining ethical approval, recruitment of

participants, data collection, literature review, data analysis, findings, discussion and conclusion.

In Chapter 2, I will be presenting a Literature Review in which the theoretical background and context of the project is collated along with relevant empirical research studies. The empirical study and literature review draw on psychoanalytic ideas around group processes, early object relations, defences, while also paying close attention to the process of the baby massage experience as observed and experienced by me. The evidence-base for baby massage as an intervention is explored.

In Chapter 3, Methodology: Dilemmas and Decisions in Project Design, I will be addressing the methodological, epistemological and ontological questions that arose throughout the setting up of the project. This included the research question, planning the method of data collection (observation) and data analysis (Grounded Theory), obtaining ethical approval, setting up the study and the process of data collection.

In Chapter 4, I will be presenting the Grounded Theory Analysis and Findings.

In Chapter 5, Discussion, the links between the Findings and Psychoanalytic Theory will be explored in the context of the Baby Massage Group.

In Chapter 6, Conclusion, insights from the project will be brought together that could be useful for clinicians, baby massage group facilitators and child psychotherapists interested in this intervention.

Chapter 2 Literature Review

The aim and purpose of this Literature Review

The purpose of this literature review is to ground the study and the observation of the baby massage group in the relevant literature. The study presented below is a piece of qualitative research that was carried out in the National Health Service (NHS). The empirical part of the project is a Psychoanalytic Observation of a 5-week Baby Massage Group in a Parent-Infant Mental Health Service, and data analysis was carried out using Grounded Theory methodology. In line with accepted and prudent academic practice a Literature Review is also included to contextualise and ground the project within the relevant theoretical, empirical, and research literature. To my knowledge, borne out by the preliminary literature searches, baby massage and child psychotherapy have not crossed paths in a way that this study has been striving to do. The literature review thus reflects this gap and aims to identify and link the literature from different fields to the project.

Search strategy

I conducted preliminary searches to ascertain if there have been similar studies that I could draw on as the most relevant context to my study. The preliminary searches showed that there has not been a psychoanalytical observational study of a baby massage group in the NHS. As a result, I decided to break the literature review into the following main areas:

- Baby massage – its origins and cultural context, baby massage groups and the implementation of baby massage in the NHS, baby massage research relating to emotional difficulties
- Psychoanalytic concepts relating to the infant body, groups, and early relationships – the body, the skin and touch in early mother-baby relationships

Both the study and the literature review are rooted in the psychoanalytic thinking and "learning from experience" in the Bionic (1962) tradition, one of the guiding principles of training as a child and adolescent psychoanalytic psychotherapist.

Inclusion and Exclusion Criteria

The only exclusion criterion was that articles, books, and chapters in languages other than English were excluded. I also set an inclusion criterion that only full texts were to be included as it results in being able to access literature that is available rather than abstracts or just titles. As this is a psychoanalytic study, I did not make exclusions in terms of the dates. I expected that the most pertinent results would be from the 21st century, apart from the psychoanalytic literature.

Databases used for the Literature Search

For the literature searches I first used the NICE electronic database, the Cochrane Library website and the Tavistock and Portman Library's electronic databases, the latter including CINAHL, as baby massage in the NHS is mostly delivered by Health Visitors and Midwives.

Baby or Infant Massage

According to the International Association of Infant Massage (IAIM):

> "infant massage is when a parent or primary carer lovingly strokes or holds their baby. Using a high quality non-fragranced vegetable oil, soothing holds and rhythmic strokes are given on each area of baby's body, following a sequence that has been developed over many years" (http://www.iaim.org.uk/about-baby-massage.htm).

As discussed in the introduction, there are many cultures where the use of massage from early infancy in everyday mother-baby interactions is seen as an old tradition, whereas within so-called Western cultures the importance of touch and massage seems to be a more recent discovery (Montagu, 1995, p. 1-3). In the UK, the two organisations that are the most influential are the previously quoted IAIM, founded by Vimala McClure, and Peter Walker's Developmental Baby Massage (The Developmental Baby Massage Centre - The Developmental Baby Massage Centre (thebabieswebsite.com) It is perhaps

helpful to note here that both organisations have been influential in the implementation of baby massage within the Parent-Infant Mental Health Service where the massage course I observed was held. There seem to be overlaps in the way baby massage is taught and delivered by either method, although neither seem to acknowledge these. Perhaps these parallel developments are not dissimilar to those within child analysis and child psychotherapy.

Amongst the claims of the benefits of massaging a baby are, for example:

- Helping your baby feel more securely attached
- Reduced crying and emotional distress
- Gaining deeper understanding of your baby's behaviour, crying and body language
- Increased confidence in your ability to care for and nurture your baby (About Baby Massage (iaim.org.uk)

The Developmental Baby Massage Centre specialises in working with developmental delay and disability. However, there is no timeline given to the evolution of this specialist focus and the books on baby massage by Peter Walker mostly focus on massaging healthy infants with a few specific conditions briefly mentioned such as cerebral palsy (e.g.: Walker, 2009, 2011). The subtitle of one of the books is also interesting to note. It is *Baby massage: proven techniques to aid your baby's development and strengthen the bond between you* (Walker, 2009). It is interesting to note that there is an emphasis on outcomes concerning emotional development within both schools of massage.

Baby massage groups are ubiquitous in community settings as a general offering within the area of mother-baby classes but there is little evidence of the history and development within the NHS. This may be due to the different service development needs although there seems to be a prevalence of health visitors amongst those offering the service (e.g. Underdown, 2009), often in conjunction with local authorities. There also seems to be a lack of joining up or rather perhaps in reality to starting up small and staying small which could be related to the subject in question: infant mental health. Daws (2009) encapsulates something of this when she quotes William Blake's *Jerusalem* in which there is reference to "Minute Particulars" in connection with doing good (Blake in Daws, 2009, xv). Daws makes a pertinent link to helping babies being linked to small endeavours. In my mind there is also a connection to how different services develop for mothers and their babies in such a local way. In the past 20 years, there has been more recognition of the importance of 'good-enough' early experiences in the foundation of later mental health or mental ill health (HM Government, 2021). Sadly, these important and high profile declarations of intent (e.g. Royal Foundation 2020, Five Questions) are difficult to put into practice in the current climate. Underdown (2009) wrote optimistically of generous grants to Sure Start centres enabling a focus on early intervention (2009, p. 19). She also quoted the Sure Start Practice Guidance of 2006:

> Baby massage is one way in which children's centres have sought to encourage infant-parent attachment and in turn promote good mental health in both parents and babies … Instructors … also include making the baby feel loved, facilitating body awareness, building both parent's and baby's

> self-esteem, relaxing parents and enabling them to learn about their baby's needs and desires.
>
> (DfES, DH, Sure Start 2006 cited in Underdown, 2009, pp.19-20).

The most recent Sure Start information on the HM Government website states that Local Authorities are running Sure Start locally (2021) which possibly results in what is commonly known as 'postcode lottery' due to the different priorities and service delivery. This is a phenomenon that is all too common in healthcare and social care delivery. Baby massage groups are often found in children's centres although there have been closures due to austerity in the past decade and SureStart centres have been decimated in many communities. Baby massage is a NICE recommended treatment and, for sleep disorders in infants by the *Handbook of Infant Mental Health* (Zeanah, 2019, p. 385), baby massage is also a recommended treatment modality in case of maternal postnatal depression (Zeanah, 2019, p. 181).

An often-quoted piece of infant massage research (see for example in Bond, 2001; Underdown, 2009; Zeanah 2019; Balakrishna, 2019) was carried out by Onozawa and colleagues in 2001. The study being a Randomized Controlled Trial (RCT) study adds to its value in the hierarchy of evidence-based research. In an article on the study titled 'Infant massage improves mother-infant interaction for mothers with postnatal depression' (Onozawa et al., 2001). The research was an RCT where 34 mothers and babies received one of two interventions. One was an infant massage group with a separate support group and the other one was a support group on its own. The mothers had been identified as depressed on the Edinburgh Postnatal Depression Scale which

were assessed again after the intervention. Videos of short mother-infant interaction were also analysed at the beginning and at the end of the study. The timeframe was five weekly sessions for each group. The researchers draw attention to the high drop-out rates and the small sample size but conclude that the study suggests that learning baby massage is an “effective treatment for facilitating mother-infant interaction in mothers with postnatal depression” (Onozawa et al., 2001, p.201). Furthermore, an interesting point is made in the conclusion about how combining infant massage and pharmacological intervention helped more effectively than just anti-depressants (p. 206). To my knowledge, there was no follow-up study. It would be interesting to find out if the intervention has continued to be delivered in this format.

There is substantial research on the physical benefits of baby massage, focusing on premature babies, weight gain, jaundice and other physical aspects of growth and development (see Field, 2019). Perhaps this relates to the quantifiable evidence that comes with, for example, weight gain. As Underdown, Barlow and Stewart-Brown write so succinctly, “touch is an intrinsic part of caring for an infant that establishes powerful physical and emotional connections between the caregiver and the baby and plays a pervasive role in communication and affect regulation” (Underdown, Barlow & Stewart-Brown, 2009, p.1).

It is of course incredibly important for babies to grow and develop physically, however there might also be a connection to the Cartesian mind/body split that has also been propagated by medicine and related fields but also by psychoanalysis itself (Bott Spillius et al., 2011, pp. 405-406). When it comes to emotional development, attachment and bonding are perhaps the most

common ideas that are researched in connection with baby massage (see Balakrishna et al., 2019). The aim of a systematic review conducted by Balakrishna and colleagues “was to establish the evidence of the effectiveness of baby massage interventions to support decision makers about funding these resources in perinatal services (ibid., no page number). The conclusion was that the evidence-base was not sufficient to offer long-term conclusion about the effectiveness of baby massage interventions. This was partly due to the methodological differences in the studies included in the review (ibid.).

There has also been research into the connection between improvement in maternal mental ill health and baby massage (see Onozawa et al., 2001; Field et al., 1996). Although the baby massage group delivered in the Parent Infant Mental Health Service is not explicitly addressing maternal mental ill health, as the ‘patient’ is the growing relationship and its apparent and underlying difficulties between the mother and the baby.

Baby Massage: NICE Database

I searched the NICE website and database with the words ‘baby massage’ only and had 14 results (See Appendix 1). NICE “provides national guidance and advice to improve health and social care” (nice.org.uk/about). NICE guidance relies on “evidence-based recommendations developed by independent committees, including professionals and lay members, and consulted on by stakeholders” (nice.org.uk/Guidance). I read through the headings of the results and some of the headings related to pregnancy care, for example *Antenatal*

Care for Uncomplicated Pregnancies a guideline that is not related to baby massage and after searching in the document I realised that it related to massage rather than baby massage.

The guideline entitled *Intrapartum Care for Healthy Women and Babies* refers to baby massage and links to the flowchart, which is also in the 14 results, *Social-emotional well-being in the early years*. Embedded in this flowchart is the *Postnatal Care Quality Standard* document which has specific recommendations to support the parents of vulnerable babies and children where additional parenting support is needed. The two main recommendations are for baby massage and video interactive guidance (nice.org.uk/postnatal care). This was the case for the mothers and babies who took part in the baby massage group that I observed. As the service wherein the intervention took place is the Parent-Infant Mental Health Service and the mothers had been referred by their health visitors, 'parenting support' was not overtly stated as a reason for the mothers and their babies taking part.

There is also a tab on the NICE website titled Evidence Search and I searched there for baby massage and systematic reviews. Here I found a systematic review from the Cochrane Collaboration website entitled *Massage for promoting mental and physical health in typically developing infants under the age of six months* (cochranelibrary.com). The findings of the report are not conclusive and, in the section titled 'Implications for Practice', the authors recommend that future research should focus on higher risk populations. Hence, it is cited as evidence for baby massage being recommended as an intervention for vulnerable mothers and caregivers and their babies. Through the Cochrane review and other linked research endeavours Barlow and

Underdown seem to have raised the profile of baby massage as an intervention with potential.

Barlow and Underdown conducted a comprehensive study that examined several baby massage groups delivered in Children's Centres around the north of England. The findings were published in two articles; *Interventions to support early relationships: mechanisms identified within infant massage programmes* (sic) (Underdown & Barlow, 2011); and *A realist evaluation of the process and outcomes of infant massage programs (sic)* (Underdown, Norwood & Barlow, 2013). The empirical study followed on from the Cochrane systematic review carried out by Barlow et al. (2007), referenced earlier in this literature review, due to its impact on service provision. The massage groups described seemed similar to the one I observed although they were not delivered under mental health services but within a social care framework.

The study's aim was to "examine what factors influence the uptake, delivery and outcomes of infant massage programmes delivered to mother-infant dyads living in socio-economically deprived areas" (Underdown & Barlow, 2011, p.21). The study used a mixed methods design. The qualitative part of the research consisted of analysing video recordings of the massage groups. These were made of the eight different infant massage programmes consisting of 39 mother-baby dyads and ten facilitators. In addition, "in-depth semi-structured interviews were conducted with all the facilitators and the participating mothers" (ibid., p.22). The quantitative part of the research was made up of several standardised measures such as the Edinburgh Post-Natal Depression Scale. The data analysis of the interviews was conducted with Nvivo and thematic analysis methods. The data analysis of the quantitative data was also carried

out. The results were studied together with theory, such as attachment theory and infant research. The findings focused on identifying “key mechanisms for effective support and/or bringing about change in the development of *sensitive reciprocal interactions*” (ibid., p.23, my italics). The mechanisms identified included different aspects of the role of the facilitators, for instance making sure that they personally invited the mothers or the effect that consistent facilitators can have on the mothers’ ability to engage, especially of more vulnerable mother and infant dyads. However, the study concluded that out of the fourteen mechanisms identified as key for effective support many were not provided in a large number of the programmes, thus not reaching the potential outcomes. A major difficulty identified was the importance of the facilitators being aware of the complexities of the mothers’ needs and risk levels. Consideration also needs to be given to the crucial role facilitators play in the way the mothers respond to the interventions. The relevance of this study to my own is that it draws attention to the potential impact that baby massage and the group intervention can have, if thought and consideration is given to the complexities of the relationships and the impact of the facilitators. This may also be linked to the way baby massage can be seen as a universally accessible ‘good’ intervention rather than a specialist intervention requiring in-depth thinking about how it is delivered.

Mother-Baby Groups

There is little literature specifically dedicated to baby massage groups in the NHS. However, there is a book dedicated to mother-baby groups entitled *Weaving the Cradle* edited by Monica Celebi (2016). The many groups described in the book include a variety of mother-baby groups most of which are specialist and aim to support parents who are struggling with the demands of becoming a parent and perhaps attend due to concerns raised by their health visitor or social worker. This is similar to the referrals in the group in the PIMHS. Two of the groups described in the book have massage as an element or main focus.

Groups for new mothers and their babies are common in community settings and seem to offer a significant window of opportunity when there are worries about the developing relationship. They are seen as especially beneficial when the families are isolated or when families are “overwhelmed by practical preoccupations, … find specialist services stigmatising or too intense” (James, 2016, p. 138). This was not explicitly discussed, although in the broad sense the institutional umbrella under which the massage group I observed took place was the Parent-Infant Mental Health Service, which is a specialist service. In addition, Paul and Thomson-Salo (2007) write about group work being indicated when the mother presents as cut-off and might be hard to reach in ‘individual’ work, or when mothers “have difficulties with their anger and may therefore be more supported in a group” (2007, pp.136-137).

Attention is paid to the group processes and, as Garland eloquently observes, “each kind of group and every individual group will have its own particular character since each method of creating and running a group for a specific purpose will be unique to the interactions between the organizer and those of the group members” (2010, xvii). This is particularly pertinent as the composition of the baby massage group I observed, although not a drop-in or open group, was different on each occasion and tracing the different group membership and its effects on the whole seems relevant in the narrative.

Furthermore, drawing on Foulkes, James observes that, group facilitators are required “to have the confidence in the group as a therapeutic tool in itself, where experiences can be offered to parents and babies *in* the group, *of* the group and *by* the group” (2016, p.138).

The Body, the Skin and Early Relationships

Babies cannot speak and use their own body and that of their mother’s to let others know how they feel. However, throughout the life cycle, communication, especially of distress, is often through the body. According to Paul and Thomson-Salo “when infants present with a psychosomatic symptom, they often improve without their mothers’ issues being addressed” (Paul&Thomson-Salo, 2007, p.136) which is pertinent to the ethos of the PIMH service and the baby massage group intervention.

The object-relations thinking of Klein and later of Bick is significant in the way the body and parts of the body symbolically get introjected from the earliest time

and in ordinary development aid growth and progress (e.g.: Bick, 1968; Klein, 1952). Rustin refers to this within the Kleinian paradigm as “the bodily roots of mental activity” (Rustin, M.E., online event, 13.02.21).

Klein, Bick, Winnicott and many others since have postulated that the infant experiences anxieties that can feel like attacks, or falling into pieces, disintegrating (see Klein 1935, 1940, 1948; Bick 1968, Winnicott, 1988). These primitive anxieties are experienced as bodily and can be alleviated to an extent on a bodily level. Winnicott also observed that in infancy the experience is that of “psyche indwelling in the soma” (Winnicott, 1960 cited in Coulter & Loughlin, 1999 and in Music, 2019). However, there is also the necessity of the maternal mind and body that can help or hinder the way primitive anxieties are managed for the baby.

Bick captures this when she observes:

> The need for a containing object would seem, in the infantile unintegrated state, to produce a frantic search for an object – a light, a voice, a smell, or another sensual object – which can hold the attention and thereby be experienced momentarily, as holding the parts of the personality together (Bick, 1968, p. 484).

She then asserts that when this experience goes on for too long or too often without the infant experiencing a mind/object that helps to contain the infant’s unintegrated state, a so-called second-skin formation becomes inevitable. Furthermore, early muscular development can replace dependence on the object (ibid.). What this means for later life and relationships can be pathological although nowadays there is an understanding that it happens for most people

to some extent. For example, the way people hold onto their mobile phones can be seen as a second-skin defence. Second-skin defences can also be understood in relation to failures of containment which will be addressed in more detail below.

From a contemporary neuroscientific point of view, it is now understood that “our sense of ourselves is anchored in a vital connection with our bodies” (Van Der Kolk, 2014, p.272). Music (2011) also draws attention to the importance of the embodied experiences of distressed babies who, if they “are picked up and soothed in their first year cry less than others after a year” (p.29). Elsewhere, Music (2017) explains the importance of the embodied experiences of observers and how to make use of this. There are also important links to infant developmental research and attachment research that, for lack of space, I am not addressing here.

Observing the massage group provided an interesting opportunity to think about both communication through the body in this way but also the difference that the massage itself introduced as a potential new ‘language’ perhaps between mother and baby and within the group and what Bond terms as a “dialogue of touch” (Bond, 2002, p.44).

Containment and Holding

As mentioned above, containment and its failures also inform the thinking about both the group and the participants. Bion (1962) extrapolated that in the ordinary course of development the mother is able to receive the infant’s

communications (amongst those “fears of death, nameless dread”) through the means of projective identification and through the process of reverie and alpha function she processes and gives back those unmanageable experiences to the infant in a manageable, digested form (Bion, 1962). He also refers to “container-contained” as a way of explaining the process (ibid.) If this process is established well enough then the infant can increasingly manage and will have introjected a good-enough container that develops throughout the lifecycle. At the same time, these processes are in operation to an extent within all relationships.

Winnicott named his conceptualisation of how the maternal mind works to make the baby feel understood ‘holding’ (1963; 1988). He describes this concept thus

> There is a valuable economy in the use, even exploitation, of the term *holding* (sic.) in description of the setting in which major communications take place at the beginning of the baby’s experience of living. … the mother holding the baby and the baby being held and rapidly going through a series of developmental phases which are of extreme importance of the establishment of the baby as a person (Winnicott, 1988, pp. 96-97).

He adds that “the mother’s capacity to meet the changing and developing needs of this one baby enable this one baby to have a line of life, relatively unbroken” (ibid., p.97).

Furthermore, also according to Winnicott, a version of this concept of holding was also essential for the therapeutic encounter between analyst and patient, and the term “facilitating environment” (ibid., p. 45) is now ubiquitously used to describe the conscious and unconscious dimensions of what the therapist

needs to bring to this. This is often one of the ways how therapeutic groups are viewed (e.g. Onions, 2016, p. 108).

More specifically, the levels of containment and holding within the observed group serve as another piece of the jigsaw or mosaic contributing to the understanding and meaning-making process of the research. Barlow writes that in mother-baby groups there is a *"parallel process* of containment [reaching] across the practitioner-parent-baby triad" (2016, p.15) which is seen as "an integral part of the effectiveness of early interventions" (ibid.). Drawing on this notion of containment, it could be argued that the observer might add yet another layer of containment to the 'triad'.

Gaps in the Literature Addressed by this Study

In conclusion to the literature review, a note on the present study's possible contribution to the way baby massage groups are delivered. The exploration throughout this project relates to the title and research question "What can be learnt from observing a five-week baby massage group in a Parent Infant Mental Health Service?"

In the literature review, a gap was identified in the lack of observational studies of baby massage groups. This is addressed by the present study through of the varied research and psychoanalytic literature gathered up above and by contributing to the discussion.

Chapter 3 Methodology: Dilemmas and Decisions in Project Design

The Research Paradigms

My background and continuing interest in infant observation, together with relevant research projects previously carried out influenced the evolution of my thinking about the research methodology. It also followed on organically from the topic and the subjects of the research. Namely, the evolving relationships and the unconscious processes in the baby massage group in a parent infant mental health service, which is the 'topic' studied, and the 'population' studied which consists of babies and their mothers taking part in this group.

To broaden and deepen the exploration, I chose Grounded Theory as the additional and complementary research method. My decision was also informed by the precedent of Grounded Theory analysis of infant observation material (e.g., Shallcross 2011 and 2019; Wakelyn, 2011), by research publications in the wider child psychotherapy field (e.g., Rustin & Rustin, 2019), and by guidance from my research supervisor. Connecting the psychoanalytic paradigm and Grounded Theory analysis, Shallcross (2019) observes that:

> Unconscious states are, by definition, not readily transparent and can only come to be "known" from the detailed observation of self and other in relation to their effects. Concisely examining such phenomena outside the confines of analysis [ie psychoanalysis in practice, in situ between a psychoanalyst and analysand, or group analytic context] is a methodological challenge. However, the conjunction of facts arising from

> psychoanalytic thought, line-by-line, in-vivo, and focused selective coding establishes the meaning and cause of such effects (p.33).

In the last sentence above, Shallcross refers to the method of grounded theory analysis that I also use for the analysis of the observational material. On the other hand, Rustin (2019) suggests that "because the procedures of grounded theory and those of clinical research in psychoanalysis are already so close to one another, questions can be asked about how much grounded-theory methods can add to the generation of knowledge in psychoanalysis" (p.175). He adds "in many influential papers in the psychoanalytic literature, there are close correspondences between clinical description and the new theoretical concepts and "kinds" which they are held to exemplify" (ibid.). Thus, the theory grounded in the data will be likely to have links to the researcher's own background. He gives the example of the original grounded theorists, Glazer and Strauss, whose own sociological sensitivity framed their "pioneering empirical studies" focusing on "patterns of interaction with terminally ill patients in hospitals" (Rustin, 2019, p. 174.).

Research Design

The project was designed to provide a learning opportunity, as a novice researcher, in setting up and carrying out a piece of qualitative research within a field related to my training in child psychotherapy and within the National Health Service. I chose the baby massage course because it is an early intervention within the Parent Infant Mental Health Service (itself within Child

and Adolescent Mental Health Service). It can also be argued that it is an early intervention from the point of view of the patient population, the particular babies and their mothers who are receiving this intervention. Geographically, the NHS Mental Health Trust is situated in one of the so-called Home Counties of the United Kingdom and the service covers the whole county. There are areas of rural affluence and rural poverty and the closeness to the capital impacts on the demographic which was reflected somewhat in the observations. This is another point where re-visiting the question of my subjectivity in the project is needed, as the socio-economic and psycho-geographical aspects of the experience have some bearing on my observations and analysis of the data.

The group: Its Set-up, Setting and Membership

The baby massage course I observed took place in the county seat, a small city with some socio-economic diversity. The mothers and babies came from surrounding smaller towns as well as from the city itself. The baby massage course is offered by different facilitators, in local authority children's centres in different locations, throughout the county. There are always two facilitators in a group.

The room used for the baby massage group was in a local authority children's centre. It appeared to be a recently built addition to the 1950s main building. The buildings were separated by a small courtyard and entry had to be gained by signing in at the reception of the main building. The room where the group took place was adjacent to another room. One was a baby room and the other

a toddler room, with the entrance to the baby room through the toddler room. The walls were light wood, and the room had a high ceiling. The furniture was sparse, functional and light coloured and there was a big space left in the middle of the room. There were a few armchairs one of which was a rocking chair which gained quite a significance in the group. There was a strong sense that this room was designed with babies and their mothers in mind. It was easy to create the space required on the floor to accommodate the circle in which the group sat and apart from towels, which were supplied by the facilitators, all equipment was there to make the space suitable, comfortable and welcoming.

This particular group was planned to go ahead within the regular offering of each locality every two to three months, when sufficient number of referrals had come in. The referral stream appears to be a well-oiled machine and there seems to be sufficient awareness of the group offering amongst local health visitors. The efficient nature of the intake process had its pros and cons which I will return to in the discussion about ethical considerations. By the time the recruitment for the massage group was going ahead the research project was two years in the planning.

The Group

The invitation to the baby massage course went out to twelve mothers, who had all been referred to the Parent Infant Mental Health Service by their health visitors. I had no knowledge of why exactly each mother and baby were referred. I had met the two facilitators, Maria and Sandra, on two occasions before the first meeting of the group. These two meetings were arranged so as

to alleviate some of their concerns and gain understanding, both the facilitators and me, about what the observation might look and feel like, and to think in depth about the process of recruitment to the project. We discussed the possible impact of my presence and what to do if mothers decline to take part as a result of being invited to take part in a research project. The mothers who declined the group because of the research would be offered a course within a month at another location. I did not find out directly whether anyone declined. The two facilitators seemed to feel reassured by meeting me in my own environment, at the CAMHS clinic where I was working at the time. They also helped with the letter that was to be sent out to the referred mothers which may have also made it more their project. However, the support and cooperation also brought its own difficulties. I believe that my gratitude for the facilitators' support had an impact on the group dynamic and my observations. Also, the mere fact of paying close attention to up to twelve individuals was going to be a challenge. However, the training and experience of two previous observations, and of writing up process notes throughout gave me some hope of being able to retain the salient points and emotional atmosphere of the group.

The two facilitators were 'old hands' at running groups whereas the mothers and babies and the observer-researcher were new to this experience, as was I. The facilitators were reassuring in the way they embraced my endeavour on a conscious level. My presence was presented as a 'given' which had its advantages. However, the lack of overt ambivalence could have impacted on the mothers and babies and influenced their experience.

With hindsight, I do wonder about what might have been projected into the mothers who were in a vulnerable state by virtue of being new mothers and

being picked up as being of ‘concern’ by their health visitors or because there were worries about their babies. The mixture of anxieties brought by us all, as individuals, was not acknowledged, which may have made a difference to the group coherence.

The group was made up of eight mothers and their babies, the two facilitators and me, the observer-researcher. There was a changing membership of the mothers and babies at each meeting and there was no exact repetition of the same group make-up throughout the five meetings. There was a break after the 3rd meeting as there was a PIMHS conference that the two facilitators and I were attending. I found the experience of the break and the PIMHS conference interesting and destabilising which may have been a counter-transference reaction picked up from the group, in addition to my own expectation of what a group framework might be like. I was reassured by the two facilitators that it is common that people drop out or simply get sick as it happened with some of the mother-baby couples, for the first time during the course. Drop-outs are common in baby massage groups (e.g.: Onozawa et al, 2001; Underdown et al, 2011). I shall return to this topic in Chapter 5, Discussion as I believe dropping out had particular significance in the group observed.

The time-limited nature of the intervention brought its own complexities, especially from the observational and therapeutic point of view. From an observational point of view, 5 weeks is not a usual length of time over which psychoanalytic observations take place. The most usual timeframe is a year, and the pre-clinical infant observation is two years. Thus, the five, weekly observations had inherent limitations, due to the brevity. Considering my previous two observations and the consequent write ups, the volume of material

was considerably less this time and in terms of the lives lived in the five weeks compared to birth to two, or 4 to 5 years old, which were the lifespan of the baby and mother in my infant observation and the little girl of my young child observation. Thus, the repetition and minutiae fundamental to the piecing together of experiences through these long observations was not available and posed a limitation due to the short timeframe of this observation. To my knowledge, the closest in terms of the observations' timeframe, were the observations described in *Observing Organisations* (Hinshelwood & Skogstad, 2000). The observations written up in that book lasted for 12-13 weeks (ibid., p.20). I shall return to this topic later in Chapter 3, Methods.

As referred to in earlier sections, the infant massage methodology applied by the facilitators was based on the International Association of Infant Massage (IAIM) model which is referred to as 'cue-based'. When offering the massage, the baby's cues are considered, while also having a choreography or process of massaging that is taught by the facilitators through role modelling on a lifelike doll.

The structure of Each Session

After about ten minutes of waiting for everyone who was coming turn up the massage was the first activity. The massage programme followed a progressive choreography and built further movements or strokes culminating in a full-body massage. The massage started with the mothers warming up oil by rubbing their hands together near the baby's face and this was part of asking for permission by the baby. Then, the instruction was to hold the baby's trunk by both hands in cradling motion. The legs are then massaged in a figure of eight

motion moving downwards and the knees are circled around. The feet are massaged with small figure of eight motion then toes are each elongated. The stomach then gets a gentle rub clockwise. The chest is gently tapped by fingers and the arms, following this, get a figure of eight rub down with the hands massaged in a circular motion. There is an option to stroke the face gently and rub the head before the baby is turned on his or her front. The back is stroked with a downward motion then the spine is traced with two fingers in downward motion gently. The cheeks of the bottom are instructed to be rubbed in a circular motion inwardly and the back of the legs are stroked downwards before the baby is turned back on the back and a trunk-hold similar to the one that began the massage ends the massage. There is emphasis on seeing if the baby is in agreement with whatever movement is being performed and the counterindications, for example immunisation within the last 24-hours, are mentioned throughout. At the first session, only the legs were massaged; the following week the whole front body and limbs, the face and head were added; the third week the babies were turned on their fronts and the back body was added. In the fourth and fifth sessions the whole-body massage was repeatedly taught as if to consolidate. After the massage a short relaxation-visualisation exercise was led by one of the facilitators before she encouraged the mothers to share about why they were referred then about the week's events for them and the baby. After this biscuits, fruit and water was offered to the mothers and the group then finished. I will return to the processes I observed and the group dynamics developed during the five sessions throughout the report as it forms a major part of my the thesis.

I shall now describe the members of the group. The information about the two facilitators comes from our meetings before the baby massage group and our unplanned, but nonetheless important, reflective discussions after the meetings which I did not record. With hindsight, these could have provided further, rich data. The information about the mothers and the babies comes from the observations themselves and the reflective discussions (the babies' ages are given as the mothers gave them, either in weeks or in months, an interesting distinction).

Maria is a Specialist Health Visitor in the Parent Infant Mental Health Service. She is in her late forties or early fifties and has been working in the service for a number of years. She had been running baby massage groups for several years too. Maria has a calm and quiet presence and seems confident in her role overall.

Sandra is a nursery nurse in the Perinatal Service and seems to be a similar age to Maria. Sandra had been running the baby massage groups alongside Maria for some years now and they come across as a familiar and comfortable double-act or couple and have become friends outside work. Sandra had a more dynamic, and perhaps anxious, presence although not while the mothers and babies were present.

Lorraine and baby Chris, who was three and a half months old at the first observation, were referred to the group because Lorraine's mother died when Chris was about a month old. They were also quite isolated. Lorraine also spoke about Chris' sleep difficulties and crying. Chris was the first child of his parents.

There were also anxieties around feeding. Chris and Lorraine were one of two mother-baby couples who attended all five sessions.

Tara and baby Christopher, who was nine weeks old at the first observation, came to the group because her father died about a month before the massage course, when Christopher was about a month old. Tara told the group that she asked to be induced so that her father would meet Christopher before he had died. Christopher was the second son of his parents. They attended the first session.

Cathy and baby Anna, who was three months old at the first observation, were referred to the group because Cathy had become so anxious about Anna dying after she was born that Cathy herself stopped sleeping. Cathy also spoke about her grandfather's death while she was pregnant with Anna which she described as traumatic. Anna was the first child of her parents. They were the other baby-mother dyad who attended all five occasions.

Diana and baby Marty, who was four months old at the first observation, were referred because of a traumatic birth experience. Diana also spoke about a history of anxiety and depression. Marty was his parents' first child. They came to four sessions, the first, second, fourth and fifth.

Pauline and baby Max, who was thirteen weeks old at the first observation, were referred to the baby massage group to help with bonding. Pauline had been a drug addict and her older son, who was two years old at the time of the observation, had been placed with her own mother. Pauline and Max had a social worker, and Pauline conveyed a sense of being under scrutiny. Max had a common chromosome condition which means he will have some degree of

learning disability. Max was the only baby in the group who had a visible and clear disability. This dyad was most clearly from a different social class from the other dyads too. They came to the group on two occasions, for the first and the third session.

Amy and baby Lily, who was sixteen weeks old at the second observation, were referred because of feeding difficulties and struggling with bonding. Lily was the second daughter of her parents. Amy also conveyed a sense of isolation from her own family who lived in another part of the country. Amy and Lily came once, for the second session only.

Maria and baby George, who was 5 months old at the second observation, were referred because George had been crying a lot in his first four months. Maria also spoke about a difficult birth experience following a struggle to conceive. She spoke about the experience of IVF impacting on the bonding between Maria and George. They attended four sessions, the second, third, fourth and fifth.

Rachel and baby Michael, who was four and a half months old at the second observation, were referred to the group because Rachel became very depressed after Michael's father left. She did not give a date but implied (or I inferred) that it was soon after baby Michael's birth. Rachel told the group that Michael was a much-wanted baby and was born after IVF treatment. They attended three sessions, the second, third and fifth.

From what I could ascertain, everyone was of White English or British background apart from myself who am White Eastern European. These features were not discussed but seem important to mention.

The Observer

I decided to introduce a section on the observer as I have come to regard myself as being part of the group, although my role as observer and researcher, as well as being a psychotherapist, set me apart and placed me as an outsider. An element which was clearly present in my mind, even if this was obviously not shared with the facilitators or the group, is that I was the only woman present who is not a mother.

I introduced myself to the group as someone with a lifelong interest in mothers and babies.Throughout the observations, I limited initiating contact with others in the group to the necessary but answered questions and there were a few occasions when I responded to baby-initiated communication. I will return to the group again in the following chapters.

The Wider Organisational Framework

The facilitators are Specialist Health visitors, perinatal therapists and specialist nursery nurses who trained to work in perinatal and parent infant mental health. Within the NHS Trust there is collaboration between the two services although there is quite a difference in the remit of the work offered by the two services. Whereas the perinatal service supports mothers with serious or complex mental health conditions, the parent infant mental health service can be characterised by its focus on the relationship between the parents and their baby. Often this is a first presentation to mental health services for the parent, most often the mother. There is an overt understanding that babies will communicate

emotional difficulties through excessive crying, sleep difficulties, feeding problems, making little eye contact or turning away. These are listed on the leaflet provided by the PIMHS both for professionals and parents (not included for reasons of confidentiality).

Different interventions are offered following assessment, discussion and triaging within the parent infant mental health service team. Considering the presenting difficulties and the needs of both the baby and the parents, the interventions include parent infant therapeutic sessions in the home or at CAMHS. These are delivered by perinatal therapists, specialist health visitors or child psychotherapists; baby massage is taught in the home individually, or through the baby massage groups. The baby massage groups are delivered in local children's centres.

From a pragmatic point of view, the five-week scope of the course seemed to provide a manageable and pre-existing timeframe to fit in with the training. It provided the frame of regularity that helps to generate observational material resembling the regular weekly appointments of infant and young child observation and psychotherapy. However, as mentioned above, the short timeframe added complications in that it was harder to see how the processes developed. The group provided an opportunity for me as the researcher to be party to the experience alongside the participants with as little intrusion as possible, and no intervention from me. This was a major feature of the design: the 'treatment', namely the baby massage group was to go ahead as unperturbed as it was possible. Thus, the referrals to the group went ahead within the regular framework, via health visitors. On the other hand, the awareness of an interesting 'power structure' became apparent early on and

has remained alive throughout the research process. The way, as the researcher, I needed the access to the group and the participants' experiences but made no contribution as an active psychotherapist and clinician. Stamenova and Hinshelwood draw attention to something along these lines when they write "the patient in analysis needs something from his or her analyst; in the research setting the researcher needs something from his or her subject. The relations of need and power are reversed" (2018, p.5). They then pose an important question to keep in mind "does this make a difference to what can be inferred from the data that the 'instrument' (the researcher's unconscious) is producing for analysis?" (ibid.) I would argue that not only is this true but that perhaps the data collection, whether via interview questions, or in my case the observation will be influenced. At the same time, being aware of this process adds to rather than deducts from the project's validity.

At the same time, the fact that I was a psychotherapist in training also had an impact on the way the relationships built up. My professional situation and status positioned me and my research interest was clear. I was and am interested in what happens in human relationships whether it is the relationship between the mother and her infant or those who happen to come together in a baby massage group.

The Research Question

The process of arriving at the research question started from thinking about the experiences of the mothers and the babies within the group, but as time went on the workings of the group itself became an additional focus and how to

capture it. Reading Bion's influential work on groups, *Experiences in Groups* (1962) in seminars, and thinking about "basic assumption" and "work" groups while also participating in groups was helpful in grappling with the group processes at a conceptual level. It was also helpful that my research supervisor has extensive experience in working with groups and helped to guide my initial theoretical forays into the topic. I also started to read about Parent-Infant Psychotherapy (individual and group), as well as other group interventions available for struggling parents and babies (e.g., Baradon et al., 2016; Celebi, 2017; Pozzi Monzo & Tydeman 2007). Interest in the unconscious processes and how to capture these is a continuing preoccupation for me as a psychoanalytic child psychotherapist and for others in related fields (e.g., Rustin, 2019; Stamenova &Hinshelwood, 2020; Holmes, 2020).

Arriving at a research question that encapsulated the line of enquiry and research and allowing for the thinking to develop was important. 'What happens in the baby massage group?' did not capture the fundamental aspect of the unconscious processes being present. Psychoanalytic thinking engages with the complexity of human existence and experience, thus trying to find a way to capture it in the research question was important too. This led to a refined question:

'*What unconscious group mechanisms support/hinder the workings of a five-week Baby Massage Group*?'

However, with time and further discussions with experienced parent-infant researchers, it became apparent that answering this question is not possible as it is too general on the one hand, and on the other hand, this question does not

allow for the “learning from experience” to be captured as well as a simpler question that seems to allow more space for exploration. The original question may also make the project less accessible and perhaps stifling for my own thinking. Thus, the final research question is:

What can be learnt from observing a 5-week baby massage group?

This question captures the project’s small scale and subjectivity. It also allows for further questions to emerge, the processes to be analysed and learning from experience being captured.

Hollway asserts that the infant observation method is able to “access what could not be verbally expressed by research participants; it could go beyond the intentional account and beyond narrative coherence” (2012, p.27). Whereas the mothers’ conscious experiences and intentional accounts could be gauged through questionnaires and interviews and would be of interest (Stamenova & Hinshelwood, 2019). Capturing the non-verbal, thus babies’ and dyadic experiences as well as possible was also important. Moreover, the group dynamics presented a new, interesting line of enquiry and a methodological challenge. This also means that I have strived to, and have been in some way forced to, challenge myself to prevent “overvalued ideas” (Britton & Steiner cited in Shallcross, 2019) from determining the enquiry.

Ethical Approval

Application and confirmation

The project proposal and design were submitted for ethical approval on 17 April 2019 to the Health Research Authority (HRA), the body overseeing all research activity in the National Health Service. After some adjustments requested by the ethical committee, the approval was granted on 17 July 2019 as IRAS No.: 249161. As the ethical approval is granted for specific places, in this case the service delivery site, three different Children's Centres in the same city were listed as possible research sites. Based on the ethical approval by HRA, a further, local ethical approval was granted by the Research Department of the NHS trust where the Parent Infant Mental Health Service is located. This was a quick process as the HRA ethical approval made extensive enquiries into patient well-being and protection, and the local ethical approval was granted on 25 July 2019.

Ethical approval

Participants and recruitment

Planning the recruitment and setting up the field component of the project was a process that took careful thinking which started at the time of the research proposal and continued throughout the ethical approval and beyond. It involved discussions with and guidance from my research supervisor while also negotiating with the PIMH service leads, the so-called gatekeepers (Hennink, Hutter & Bailey, p. 68), in the first instance; then through discussions with the two group facilitators in the latter stages of setting up. Although it is common in qualitative research to ask the help of the gatekeepers with participant recruitment for field research (ibid, pp. 92), there are other dimensions to the

importance of the gatekeepers for this project. The ethical dimension comes with the project being conducted in the National Health Service but also to manage the access to a potentially vulnerable group of people, as the mothers and the babies who took part in the baby massage group were struggling, to a smaller or greater degree. There is also “the benefit of the gatekeepers effectively becoming advocates for the research as they have a significant influence on the members of the community” (ibid., p.93). This was the case for the present project. Thinking and discussions around the research project with the service leaders and the facilitators was fundamental for the setting up of the project. It is also fortunate that infant observation is taught within the service and the service leads and the group facilitators all have some level of experience of observing.

The Steps in the Recruitment Process

I met one of the service leads and started planning for the observation almost two years before the actual observation of the baby massage group took place. Between these two timepoints I was in touch with both service leads, asking for their input with ethical considerations and I also asked for their thoughts about the Participant Information Sheet and Consent Form. With my supervisor, then with service leads, and with research seminar group, I thought about what would happen if someone was offered the baby massage course but declined to take part in the observation. The proposed and accepted solution was that mothers would be offered another course that was planned within six weeks which would fit geographically and the babies’ age (the babies who take part

are between two and six months old). When the ethical approval both at national and at local level was granted and it was time to start organising the observation there was an initial delay of two months as there were no courses running in the immediate future in the Children's Centres I specified in the ethical approval.

The facilitators themselves were recruited with the help of the two leads of the service. They were chosen because of their long-term experience of leading baby massage groups. As the proposed start of the course was approaching, I met the two facilitators twice, which was an important step in establishing a relationship and building up trust.

The facilitators and the wider PIMHS team approved a letter that I wrote to the mothers introducing the project and outlining the rationale. The letter was sent to the mothers along with the regular invitation to join the massage group. A detailed Participant Information Sheet and Consent Form was sent out to the participants together with the letter (see Appendices 2&3) in which the project was described in enough detail and all relevant ethical details were included. I also prepared copies of the Participant Information Sheet as it was not expected that the mothers should have to remember to bring the signed copy with them. At the same time, from an ethical point of view, it was an essential step to obtain informed consent and to offer the chance of withdrawing consent. Anonymity and confidentiality were addressed throughout the design cycle by using pseudonyms for all participants, storing all material securely, both electronically and manually, and removing all identifying information from the documentation. The number of participants could not be specified in advance as it was

dependent on the uptake of the massage course. Invitations were sent out to twelve mothers and four declined before the start of the massage course.

For ethical and methodological reasons, I did not have any access to the referrals or the histories of the participants. From an ethical point of view, the reasoning behind this was to be the least intrusive to the participants. From an experiential point of view, there was a parallel experience with the mothers and babies that I was going along to the baby massage course not knowing them and their background histories. In this way, perhaps, I did not have as many preconceived ideas about the participants as I would have if I had been party to the referrals. This mirrors the process of infant observation in its original form and my first experiences of observation. However, in this case there was an understanding that the mother and baby relationship was under some strain and there were some worries about it, otherwise the participants would not have been invited.

The dilemmas and challenges about the recruitment process continued throughout the process and remain a point of contention. Due to data protection and safeguarding issues, I did not have access to the files of the mothers and babies. This would incur another set of ethical approvals. Another reason why I refrained from gathering further information before the course was that it felt important to come into the observation with little or no information about the participants. On reflection, I wonder if this was also related to me identifying with the mothers and babies as they also did not know anything about me or the facilitators or, I imagine, even each other. Another way to recruit could have been to advertise and make the group self-selecting. As it was, the mothers having the participation in the project being added onto the baby massage

group perhaps made the mothers feel that they needed to take part. Although the consent form had a post-course opt-out option it may have felt difficult to exercise this option.

Retrospectively, this approach could have contributed to the high anxiety levels in the group. The level of intrusion that I felt in the countertransference was perhaps coming from the group feeling scrutinised and intruded upon. For example, although consciously I did not expect the mothers to read and sign the forms, perhaps unconsciously I was treating the project as one treats one's baby, in that it is so important to the mother (researcher) that it is hard to accept or imagine that others may not find the baby (project) as interesting. Perhaps, this is akin to the Winnicottian concept of primary maternal preoccupation (1956) which is essential for the mother-baby relationship but a bit of a hindrance to the researcher.

My presence as an observer inevitably reflected on the dynamic as I imagine everyone present was aware that there is no observer in most other groups, or to my knowledge in any other group (VIG is used in some instances but only with individual dyads). Different ways of preparing the mothers may have mitigated some of the difficulties that I observed, especially in the first two observations. It might have helped to hold a separate meeting for introducing the project and myself or organise a focus group with all potential participants. However, I also had experience of being an observer and some of the anxieties felt common with my previous experiences. For example, the sense that one is not behaving or participating in an ordinary way and the sense that persecutory anxieties are raised on initial contact and for some remain so. The tensions remained throughout as I held my position as an observer. With hindsight, a

debrief group may have been helpful to offer to the mothers and may have helped the writing up process.

The plan and the eventual process was that I would attend alongside the group on every occasion, observe as unobtrusively as possible and write detailed notes after each occasion. This constituted the data collection. I considered using video recordings as a way of data collection but decided against it as it would have diverged from the traditional method of writing up observations from memory. The data quality is inevitably different as it is my mind and its selection and capability to remember rather than the mechanical recording of the meetings that is producing the raw data.

In the Participant Information Sheet, I said that I planned to have the findings ready by December 2020 and that I would be in touch. Since the process of writing up was still on-going I wrote a letter to let the mothers know that they were welcome to get in touch in the future. I asked the facilitators to distribute (see Appendix 4).

After the analysis, writing up, Viva exam and amendments, the findings will be discussed with the Parent Infant Mental Health Service team and made available on request to the participants. There is an anticipation that some mothers might want to revisit the experience, and some might not. By the time the thesis is finalised it will have been about a year since the baby massage course took place and it is also a particular year, 2020. Shortly after the massage course, all our lives (and that of the whole world's population) were turned upside down by the Covid 19 pandemic.

Data Collection: Writing up the observations, the method and its difficulties

The method of data collection in the project can be considered as the classic way of gathering psychoanalytic observational data. Observers trained in this tradition will be paying attention to what is said as well as what is done by the observed (e.g.; Miller, 1989; Reed, 1997; Rustin 2019). The observer writes as detailed an account of what she has gathered up from memory. This is done retrospectively, as soon as possible after the observation has taken place. The reasoning behind this is so that the experience is as fresh as possible in the observer's mind. Recording in this way is based on the regularity and continuity of the observations. A narrative emerges over time based on the evolution and growth of the experiences and relationships as they happen. The observation notes can be seen as the 'prototype' of the process notes written on psychotherapy sessions. It is important to reiterate once again that the length of this observation could not yield as rich a set of longitudinal data as a year-long or two-year long observation might have.

The method of psychoanalytic observation was helpfully gathered up by Skogstad who, together with Hinshelwood, drawing on the original infant observation method of the Tavistock tradition, started to observe organisations (Hinshelwood & Skogstad, 2000; Skogstad, 2004 & 2020).

Skogstad then summarises the method is as follows:

> In order for the observation to be as rigorous as possible, whether for training or for research purposes, it is essential to separate three different stages within the observational process:

- the actual observation
- the recording of the observation
- the interpretation of the observed material.

In the *observation* itself the focus should be on the task of observing alone. The observer should be as open to the experience as possible; therefore no notes are taken, as this would interfere with the free-floating attention and the use of one's subjectivity. When observing, one's attention should be directed at three different areas at the same time:

- what one can see and hear outside, i.e. what people do, how they move, how they interact, little gestures, facial expressions, what is said, their tone of voice etc;
- what one can perceive empathically outside, i.e. the quality of the general atmosphere and how it might change during the observation, the emotional state of the people observed etc.
- what one can observe inside, in oneself, i.e. one's own feelings and impulses, associations, mental images, memories etc. (Skogstad, 2004).

Furthermore, elaborating on the potential of infant observation as a method, Shallcross (2019) asserts, “it could be argued that infant observation is a distinctive opportunity to research the border area between health and factors associated with anti-development” (p.34).

The set of five observations that form the data set for the project was done in this way with added field notes. The slight difference was that I drew a rough map of the room each time with the names and places of the mothers and

babies and facilitators at the beginning of each session. The field notes and the observations are continuous as the observations happened in the context of everyone arriving and gathering, the time when the whole group were together and the massage course was taking place, and finally the group dispersing and a short debrief with the facilitators. However, the observation itself offered its particular differences and methodological challenges. Firstly, there was the difference that arose from the fact that I was observing a group, rather than one mother and baby in their home environment as in my first observation and following one child in a busy pre-school environment. Here there was a focus on group life from the stance of both psychoanalytic infant observation and a child psychotherapist in training.

In preparation for the observation, a lot of thought and discussion was concerned with where and how to position myself in relation to the group, thus in the room. I was prepared, to an extent, for the feeling that I was going to disrupt the group as it would have ordinarily run. However, as the observations progressed, I did experience resistance and hostility. Remembering back to my infant observation, it is helpful to call to mind the early observations when the anxiety was at its highest.

The mothers and their babies and the facilitators are seated on small mats on the floor in a kind of circle with the two facilitators sitting in a line next to each other. An idea initiated by one of the service leaders, was that I should do the massage on a doll, like the ones the facilitators use to show the massage strokes to the mothers, alongside the group. On reflection, this would have positioned me as less intrusive in some ways. However, I decided not to take this up as I thought that it would take away from the observational experience

and would compromise my observational stance. It would have added another methodological challenge that I could not take on at this time. Perhaps this suggestion from one of the service leaders was intended to help me blend into the group. Another idea was that I might move around quietly in the room. However, as we reflected on this in supervision and after meeting and discussing it with the facilitators, it became clear that I would need to be in one place and find a vantage point that would hopefully allow me to see everyone. The position and status of the outsider was not possible to avoid no matter how much I wished for it. Me being stationary also influenced the group as it became clear that the same people would be sitting closer to me and far away from me. I shall return to how my role and influence was like in group.

In his book, *The Complete Observer?*, in a section titled 'Gamekeeper turned Poacher', Sanger makes some salient points about some external features that have repercussions for the experiences of all involved in an observation. He writes about a chameleon-like observer who blends in with those who are being observed by arriving at the same time, not earlier or later and also blending in with the activities of those observed but not positioning oneself so that it make associations with a role different from that of being an observer (1996, pp. 35-36). Whereas I did not strive to be chameleon-like, it was important that I took up as little attention as possible. The lay-out of the room also influenced my decision to sit on a small chair close to one of the two entrances. This placed me behind two of the mats where two mothers and babies took up their places. I was able to see everyone from this vantage point and because I was not moving around and did not speak there were some occasions when I did feel like a chameleon or a fly-on-the-wall presence. Since the group had the focused

activity of the massage course, it helped with having as little influence on or presence in the group as possible, although this was only at certain points not continuously (as I experienced it and remember). At those points it could be argued that there was a diluted sense of me being there for the group which perhaps allowed for a more naturalistic position. This was a major difference from my previous two observations where I did follow the baby and the young child around. Nevertheless, the intensity of the emotional experiences recorded seem comparable, which may be related to the amplification by the group.

Writing up the observations took place immediately after the observation itself. The process had similarities each time and the principles outlined above were followed. As my focus was the group, I tried to remain focused on the group rather than individual members, which was a challenge. I also had different experiences when writing up each observation. For example, the first observation seemed to flow out freely and the typing felt easy whereas typing up the second felt excruciating. I had to type up the third observation twice because it got lost after I wrote it up. The fourth observation was again difficult to write up and writing up the fifth observation felt sad, grief-charged and guilt-stricken.

The Advantages and Disadvantages of Flying 'Solo'

The traditional method of learning, teaching and researching infant observation, with few exceptions, involves a seminar group in which the observations are discussed. This method of teaching and learning continues throughout the child

psychotherapy training where it becomes small group supervision and there are also small supervision groups set up for research.

After my research proposal was accepted, I wrote a summary for the *Bulletin of the Association of Child Psychotherapists* and put out a call for others who are doing infant observation related research to form a peer research group. Unfortunately, this was not taken up. On reflection, the *International Journal of Infant Observation and Its Applications* might have been more fruitful for contacting and finding out if there was a possibility of attending an infant observation seminar in one of the institutions where these seminars are held.

I had the chance to present parts of observations within the small research supervision group that I attended concurrently with the observation process. During the analysis and writing up process I sought peer support with fellow child psychotherapists in training. I was also in psychoanalysis five times a week during the observations but not during the whole writing up process. The reflective opportunities reduced throughout the process which brought parallels in experiencing loss.

I shall now turn to the Grounded Theory analysis and Findings.

Chapter 4 Grounded Theory Analysis and Findings

Initial/ open coding of the 1st and 2nd Observations

The coding started with reading and getting familiarised with the data. Initial coding involves a “careful word-by-word, line-by-line, or incident-with-incident” (Charmaz, 2014, p.133) process in which “meaning units” (McLeod, Elliot &

Wheeler, 2010, p. 129) are identified. These meaning units form the initial codes. These codes are meant to serve as a tool for taking the researcher, in this case me, away from descriptions and toward concepts (Strauss and Corbin, 1998, p. 15). Charmaz poetically suggests thinking “of seeing a once familiar landscape with a fresh eye after a long absence” (Charmaz, ibid.).

I formatted the write-ups so that there was space both between the lines of the text and space left on the left-hand side for the codes. I coded by hand then typed up the codes. The initial coding resulted in 561 codes. Some of these codes were then refined. See Table 1 below for an example of initial coding.

Table 1

Example of initial coding

Observational material/Raw data	Line by line/incident by incident coding
Meanwhile, a new mother arrives with a baby carrier at the door of the room and carefully steps over the mats before placing herself in the corner diagonally opposite to me and away from the others already settled.	*Ambivalence about what might she bring in* *Anxiety about being new* *Ambivalence/Keeping a distance / being cautious about joining the group*
She tells Maria her name, Amy, and the baby's name Lily, and Maria makes a note that both names are with a 'y'. Amy spots that Lorraine looks like she is pulling up Chris with his arms and says with worry and dismay.	*Similarity between baby and mother's name - identification* *Interested vs vigilant* *Persecuted vs anxious about another baby*
"I was told you are not allowed to do that" and Maria interjects "Who told you that?" and Amy replies worriedly that other mums.	*Protective intervention from Maria* *Being unsure*
Lorraine says something about how she thought it helps the baby to learn and strengthen and helps with sitting.	*Individual belief about what's helpful to baby's development*
Lorraine and Chris continue this, and it looks like it's Chris pulling himself up and enjoying the game and his own strength.	*Our own way of playing and we like it* *Sandra has disappeared*
Amy settles down on the mat and takes baby Lily out of the baby carrier. Another new mother arrives with a baby carrier and introduces herself as Maria and her baby as George.	*There is space for baby L and A* *What an effort*

She almost collapses on the mat right next to the door. She has a big rucksack and looks overwhelmed. Baby George is alert, and he is looking around. He has a lot of blond hair and a face that looks quite mature.	*Heavy burden/overwhelming* *Looking outside/looking away* *Striking-looking baby*

Cutting up, in the physical sense, and starting the conceptual ordering (Strauss and Corbin, 1998, p.19) is the phase of the coding designed to help move another step further away from the original text and organise the initial codes around themes, properties, and emerging concepts. The cutting up also helps with the move away from the chronological order. In my case, this was important as in ordinary psychoanalytic observational analysis of material there is considerable importance given to the order in which events occur between mother and baby, therapist and patient. This difference in methodology brought out different vertices which provide a point of comparison that I will return to in Chapter 5, Discussion.

To further help researchers with both staying close to the data and to help with building theory analytic memo-writing is suggested. The purpose of this step is two-fold, one is to give existent or extant theories a separate place as I, the researcher, was interrogating the data, and the other is to support the constant comparative method (Charmaz, 2014, p.132) that underpins the analytic process in Grounded Theory.

Strauss and Corbin write about the challenge of maintaining objectivity and developing sensitivity (1998, p. 43). Bruck adds another important dimension to this when she says that the researcher must be careful not to find what they already know (Video lecture, 2019, last accessed 18 September 2020). This was proving a challenge throughout the analytic process as the data consisted of my own observations with emotionally stirring material. On the other hand, the foundational paradigm of the child psychotherapy training is individual, object-relations psychoanalysis. The challenge of observing the group in itself, and consequently analysing the material while thinking about the group as well the individual and dyadic relationships helped to pull me away from pre-existing knowledge to a considerable extent. The memo-writing and research supervision also helped to keep the focus. Several clinician-researchers helpfully point out and almost encourage preparing for an initial chaotic experience which is best embraced (e.g.: Bruck, 2019; Charmaz, 2014; Wakelyn, 2011; Wren, 2019). To my mind, an association to the concept of cognitive dissonance (Wittebols, 2020) could be related to the conflict between the intense emotional experience of observing the group and recording those experiences; and the objectivity I was expecting of myself to engage with the 'data'. This added to a stop-start and anxiety-filled experience which I think had a lot to do with the nature of the undertaking, the observational material, as well as the time and place of the analysis. By the nature of the undertaking, I am referring to the new learning of grounded theory and the tension I feel between the paradigms. Engaging with the observational material in this way also added a layer of tension. The time and place of the analysis relates to the inevitable contrast that came into sharp relief through the added isolation brought on by

the coronavirus pandemic. Nevertheless, the efforts to remain grounded in the data have continued throughout the process.

Categorising and focused coding of the 1st and 2nd Observations

The cut-up codes from the first two observations were organised and grouped together in terms of their prevalence and importance. Charmaz defines that "one goal of the focused coding is to determine the adequacy and conceptual strength of your initial codes" (Charmaz, 2014, p. 140) and to distinguish "those codes that have greater analytic power" (ibid.). During focused coding, I concentrated on the most frequent or significant among the initial codes and tested these against large batches of data (Charmaz, 2014, p. 343).

Different levels of movement and the importance of embodiment were becoming the apparent organising concepts in those codes, but I wanted to keep an open mind as there were three more observations that needed coding.

It became apparent early on that repetition was a key feature of the data. Charmaz posits that "[t]he more unproblematic – that is routine, familiar, and ordinary – observed events seem…, the more problematic creating an original conceptual analysis of them will be" (2014, p.132). Although, on the whole, the experience of the 5 meetings was neither routine nor unproblematic, I made the decision to use selective coding for the next phase of analysis.

Coding the 3rd, 4th and 5th Observations, Axial Coding and Further Categorising

The next step in coding involved both looking for new themes and concepts while also constantly comparing and at the same time noting the further occurrences of the focused codes.

Strauss and Corbin (1998) describe and 'prescribe' axial coding while Charmaz (2014, p. 147) points out that it has been a controversial topic amongst the more recent proponents of Grounded Theory. According to Strauss and Corbin "axial coding is the act of relating categories to their subcategories along the line of their properties and dimensions" (1998, p. 124) and this relating takes place at a conceptual level (ibid., p. 125). Axial coding involves looking "for answers to questions such as why or how come, where, when, how … and in doing so they uncover relationships among the categories" (ibid., p. 127). The originators of grounded theory and some earlier studies propose that the conceptual categories 'emerge' from the data (e.g. Anderson, 2005; Glaser cited in Charmaz, 2014; Strauss and Corbin, 1998). Others, which is my position as well, will argue that the conceptual categories are constructed by the researcher through paying close attention to the data, the constant comparative method and memoing.

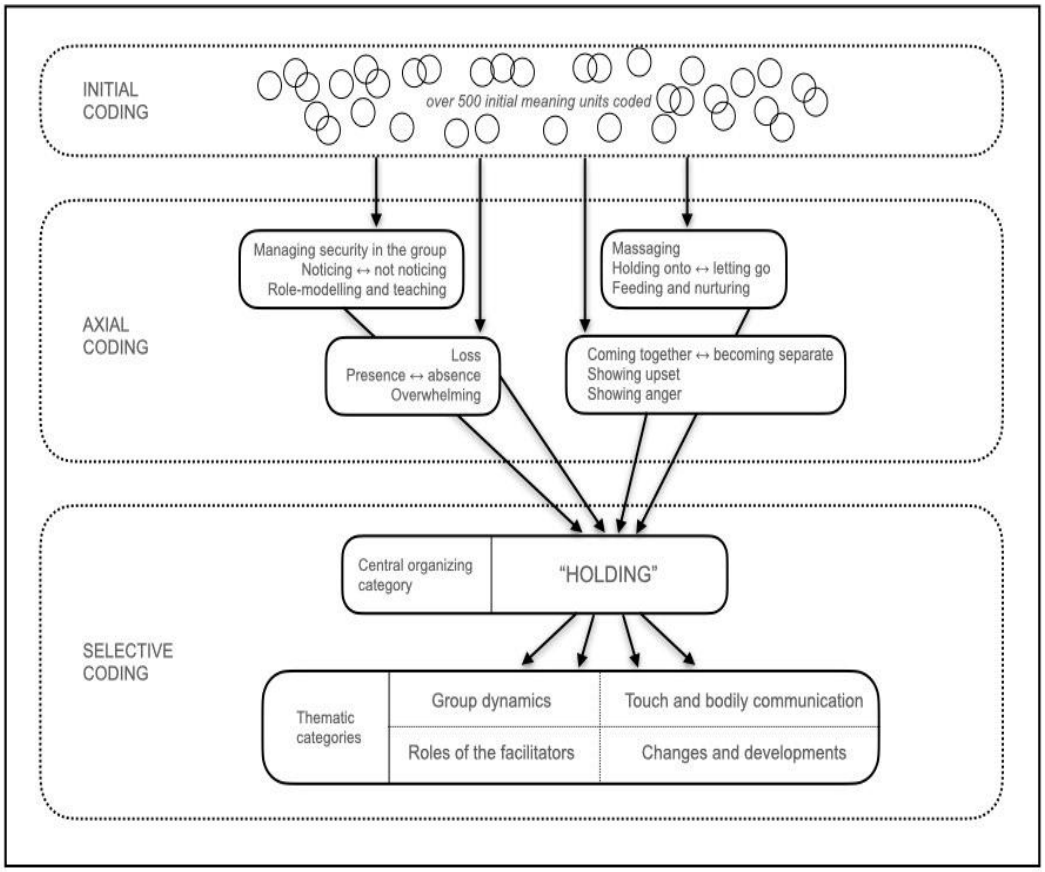
Below is the List of the Focused Codes:

- Moving in and out of the group
- Giving each other space
- Coming together
- Being in the body
- Grieving
- Needing feeding / giving nurture
- Preoccupation with digesting/evacuating
- Bringing the baby close
- Loss

- Comings and goings
- Attracting/giving individual attention
- Role-modelling
- Moving forward/taking steps
- Noticing and doing something about it
- Forcing vs persevering
- Presence/absence
- Massaging
- Feeling unsure/feeling certain
- Being enough/being too much
- Anxiety relating to the baby
- A baby becomes visible in the group
- Different bodies/similar needs
- Risk taking
- Being on the periphery
- Ambivalence about joining in
- Moving together
- The group allows for individual preference
- Choreographing the massage
- Managing security in the group
- Developing through the massage
- Dismantling the group
- Creating a physical space/creating group
- Structuring the group
- Taking up space
- Obstacles to being together
- Expressing disturbing thoughts
- Outside the group
- Holding onto/letting go
- Anxiety about the group
- What is said/what is shown
- The group allows for loss being thought about
- Worrying about inexperience
- Feeling different
- Showing upset
- There is hope in motherhood
- Anxiety/ambivalence about being a mother
- We have what we need for the group
- Ambivalence about the baby
- Gauging the distance
- Chain reaction
- Showing anger
- Comparing/contrasting
- Overwhelming
- Competing needs
- Teaching/learning

Before I turn to the detailed findings, below is the Grounded Theory Diagram to illustrate the way the codes, the subthemes, the central organising category and the four thematic categories are connected.

Grounded Theory Diagram



Chapter 4 Findings

Main themes, subcategories and the central organising category: holding

The findings are centred around themes that relate to what I observed in the group and the process of carrying out the observations. In this section I will be illustrating the themes and subcategories that I constructed from the data. The themes and categories are in interaction with each other as it is illustrated by the Grounded Theory Diagram above. The coding helped with this to an extent, albeit the subjective and interpretative nature of the data analysis remain a strong feature for me.

Roles of the facilitators

The different roles two facilitators fulfilled were categorised in the following three subcategories in within this major theme are *Managing security in the Group, Noticing/Not noticing, Role-modelling/Teaching*. Maria and Sandra, and the centrality of their contribution to the functioning of the group was one of the major themes that has been observed. The different functions of the facilitators both overtly and in more subtle ways came through the process of coding, memoing and further categorising. A major feature of this theme is related to containment or the lack thereof it which will be explored further in the next chapter.

Managing Security in the Group is a subcategory that has both explicit and more hidden ways of coming into force and it was interesting to see how these manifested throughout each session and also from one meeting to another. This was also connected to keeping the group going fundamentally. It was Maria who carried most of this function, but Sandra also contributed. Here follow some examples from the observations of how the two facilitators were bringing this subcategory alive in the group.

In the excerpt below, Maria, one of the facilitators, thinks about consent in its concrete form but also implies that those forms are the to protect everyone, including the observer.

Maria asks me about the consent forms and says that she doesn't expect the mothers to remember. From Obs 1

Another instance when the role of the facilitator, here Sandra, is about managing security is again a concrete expression of making sure that the members of the group are safely positioned while also containing this particular mother's anxiety about her own place in the group. Interestingly, this depressed mother positioned herself between Sandra and me throughout the course.

Upon arrival, Rachel looks around and wonders aloud where to sit and Sandra comments that people often sit where they first found their place. Obs 3

The following quote from the fourth observation exemplifies an aspect of *Managing Security in the Group* that happened a few times when a mother, and most seemed to have expressed similar difficulties, became highly anxious and seemed to spiral further into anxiety thus upholding the group and the facilitators worked hard to bring back the focus in the group.

The massage is about to start when Cathy arrives with Anna in her arms. Cathy apologises and explains about the reason for being so late; their washing machine just broke mid-wash. Not only that but it was Anna's dirty nappies she was washing. Maria (facilitator) reassures Cathy and gives her a couple of towels. Cathy continues to talk about the incident, getting more and more agitated. She is undressing Anna in the meantime and the facilitators gently suggest that the massage can start. Obs 4

It was a difficult balance for the facilitators to both allow the mothers to express their worries and anxieties as there were some mothers who had a tendency to dominate in the group due to their individual difficulties.

Noticing/Not noticing is a subtheme within the *Role of the Facilitators* main theme, which was difficult to allow to come into existence as it captures difference and perhaps conflicts between the facilitators, and the observer. It relates to an aspect of the facilitators role that captured whether vulnerability can become something to think about, and also brings into the picture the complexity of the observing stance.

Noticing/Not noticing also relates to how the facilitators defended against the pain of seeing and understanding perhaps. They may have felt that noticing and trying to understand was out of their remit both professionally and personally. This subcategory also links with the time-limited aspect of the baby massage course in that there may have been a feeling for the facilitators that only so much can be thought about within the five sessions and perhaps it contributed to the *not noticing* aspect of this subtheme.

At the very beginning of the first session, there is an acknowledgment, that something fundamental, the right kind of temperature, for the babies' might be missing from the setting and it could be argued that it then gets ignored as the facilitators may not feel able to find another way of managing this concern in themselves.

Sandra frets about the temperature in the room. She feels cold and the two facilitators look at the radiators and try to work out how to raise the temperature in the room. It does not feel warm enough to me either for very young babies to be undressed. Maria reassures Sandra that when everyone is here the room will naturally warm up. From Obs 1

Another aspect of this subcategory was related to a specific part of the sessions, the short relaxation exercise, that seemed to feel quite forced into the middle of each session. There was a sense that it was to go ahead no matter what even if it did not seem to have the desired effect on the mothers and babies. It was as though the idea of 'relaxation' was noticed but the feeling of it not materialising was not noticed.

Maria suggests a short relaxation and reads out the same script as last week. It's quiet in the room but doesn't feel relaxed, it's more a cut-off feeling or going through the motion for the sake of pleasing the facilitators. Some of the mothers feed their babies, some hold them close in a cuddle and a couple look absently while their baby lies on the mat. Obs 2

This sense of not noticing the absence of relaxation remained strong throughout which is further exemplified in the excerpt from the fourth session below.

Maria suggests a relaxation exercise and Sandra remembers that she forgot to show the acupressure moves on the soles of the babies' feet. There is a sense of feeling rushed and the relaxation exercise also feels like that…While the relaxation is going

on, Marty's staccato crying gets louder and Diana stands up with him and jiggles him up and down. Obs 4

Role-modelling/Teaching is a subcategory that captures how on one level, by virtue of the group's explicit purpose, the facilitators are there to teach the baby massage. However, the baby massage choreography facilitated other, more subtle role-modelling and teaching, for example by allowing the mothers to notice and see their babies in a different light. The explicit teaching was mostly related to the baby massage techniques and the benefits of baby massage. These were repeated at every session in some form or another and inevitably structured the experience. What was also important about the way the facilitators were role-modelling something about the importance of a routine. Although the baby massage differs from ordinary routine experiences such as feeding, changing, cleaning up, the method of teaching through repeating and the regularity with which the group ran and the framework was adhered to modelled the importance of routine and repetition without being forceful or preaching. There was a sense that whatever the mothers could take in, the facilitators would accept.

Sandra talks about how important it is to listen to the baby's cues and if the baby doesn't want to be massaged not forcing it. Obs 1

Maria asks if anyone has managed to practice the massage and the mothers who were here look at her sheepishly and Maria tells them not to worry, we will recap every week and the mums will hopefully find the opportunity to practice. Obs 2

An interesting, innovative and challenging way of connecting with the mothers was observed when the facilitators showed the mums how easy it is to get depleted and how important it is to find ways of looking after oneself as a mother.

Sandra leaves the room and returns with a jug full of water and several cups. She talks about how the mothers are there for the baby, she pours water into a cup; they are here for their partner, she pours water into another cup; they are there for their parents, she pours water into another cup; they are there for their friends and the jug is now emptied. Sandra holds up the jug and says that there is nothing left for the mums and adds how important it is to keep something little for oneself and suggests that everyone should do one thing for themselves in the next couple of weeks, something small like having a bath by the time we next meet in a fortnight's time. Obs 3

The mothers who were present in the third session and came back for the fourth reported some activity that related to this exercise although with mixed results and mixed feelings, however from the perspective of the role of the facilitators, they seemed able to hold onto a way of teaching and role modelling that facilitated the group's work on many levels.

Group dynamics

Another major theme that developed from the observations is that of the group itself within the setting, its membership and the complex dynamics that permeated the experience as I observed and participated in. The group's membership was fixed in that only the invited mothers and babies could join however it was an evolving group as the make-up of membership changed from week to week thus the combination of different members coming together inevitably impacted on the group.

Presence/absence, the subcategory relates to both to concrete experiences of comings and goings in the group to which I was particularly sensitised but also the extent to which the members of the group, including me, the observer, were able to be present to the experience of the given moment, sequence or session. This subcategory also relates to spatial dimensions of how the group was brought into existence for the first time and on each occasion.

Maria finds eight mats and lays them out in the shape that reminds me of sunrays and puts a soft square blanket in the middle. She frets about the ninth place and puts down a towel. She also explains that she will sit facing into the room with Sandra next to her. I place my chair slightly behind and a few feet from where Sandra will be sitting and outside the circle of mats but close to two mats. Obs 1

This arrangement of the room remained although the highest number of mother-baby couples present was five, but the eight mats were there throughout as a reminder of those who were meant to be there. Related to this experience was the way that those who did not come to the second session after the first session were not mentioned.

Maria makes no mention of the two mother-baby couples missing but acknowledges the three new mothers and their babies and suggests that everyone says their names and the babies ages and then we can start the massage. Obs 2

Another way *Presence/Absence* could be illustrated is how there were moments observed when a member of the group actively and noticeably distances themselves from the others as described in the vignette below. There were several other occasions like this with other mothers and babies. What is particularly noteworthy is that others completely disappeared, like Tara and Christopher who did not come back after the first session, whereas Cathy and her baby, Anna came back every week. A level of ambivalence is also connected to this subcategory.

Tara goes to the corner furthest from me and the facilitators and places the baby carrier so that the baby faces out of the room. Obs 1

Cathy arrives in a hurry and goes to the mat they had used the past two weeks. She looks harried and anxious and sits for a while staring in the room. She also feels very far away from everyone else who are on the side of the room where I am sitting, the facilitators are seated, and the other three mothers and babies are. Obs 3

Towards the end of the same session there is another strong and memorable moment when the group communicates about absence and presence and the complexities of how difficult it is to remain a group outside this setting. Maria reminds the mothers of the break in the course because the facilitators and me were attending a conference on perinatal loss although the mothers were informed of this only as a training event. The excerpt below illustrates deep feelings for the whole group that remained active throughout.

Maria (facilitator) reminds the mothers that we are not meeting next week and asks if they are able to meet and go to the cinema as they discussed previously. Cathy asks for people's numbers. Maria and Rachel apologise and say they have other plans. Obs 3

The short-term nature of the intervention can also be linked to this subtheme and the intensity of the group experience as it is demonstrated by the way I describe the babies in the vignette below from the last meeting of the group.

I'm also aware as I'm writing up that the two babies who I can remember during the last conversation and sharing is Anna who fell asleep gradually and Michael who was being breastfed in front of me and the other babies seem to have fallen out of my memory. Obs 5

Overwhelming, this subtheme was formed from an 'in-vivo' code during the data analysis. One of the mothers who was only able to come once, summarised her experience of motherhood with this statement.

Amy says that she was hoping that the second time around it would be easier but it's not. She pauses and says, "there is one word for it: overwhelming". She adds that Lilly has had tummy problems and turns to her and says, "because you take your bottle down too quickly" Obs 2

What is also important to note here again is that Amy and Lily only came this once and it is easy to imagine that this particular group experience was also overwhelming for Amy. Yet, as I was proceeding with the analysis, refining the codes and categorising it came to mean more than the intended meaning relating to this particular mother's experience of motherhood. Expressions of being and feeling overwhelmed were connected to the group experience too which can be illustrated by the experience of the observer becoming tearful in the first two sessions.

Rachel says that Michael was also an IVF baby and very much wanted. His eyes are fixed on her as she talks. I can only see Rachel's back but able to see Michael who is lying on his back, still. Rachel is stroking his front while she is talking. She tries to talk about the experience of having Michael and all I can make out is "and he left us". Her head hangs and her hand stops. My eyes fill with tears. Obs 2

Another salient moment from the observations that exemplifies the subtheme of Overwhelming is illustrated by the powerful experiences conveyed in the excerpt below where both mother and baby bring into the fore deep levels of feeling overwhelmed in the moment.

Pauline starts to undress Max who starts to cry immediately. Pauline tells him in a soothing voice "You don't like undressing" and tells Maria and Sandra that he always cries when she undresses him for a bath. She perseveres for a couple of minutes before putting Max's clothes back on… She rocks him energetically until he falls

asleep… gazing longingly at Michael who is being massaged by his mother. After a while Pauline's eyes close and she seems to keep awake then gives into sleeping. They sleep through the massage. Obs 3

Loss is subcategory that characterised the group on a deep level as even before the first mothers arrived there were a few who had declined the group. There were also two mothers who lost a parent or a grandparent recently an experience that inevitably contributed to the experience of the group. Loss of identity also was another aspect of loss that featured strongly and came to the fore in interesting ways, as seen below in the second quote. There were also expressions of lost pregnancies due to failed IVF and miscarriage. Worries about loss of one's sanity were not far from the surface either. The loss of the group both in the sense of the membership changes and in the fourth and fifth sessions the grief around it finishing were also around in this important subtheme.

We talk about the group numbers. Maria says three mothers weren't coming for different reasons and there is a baby who is only 7 weeks old and the mother thought they were too small. Obs 1

The loss of identity also was present in connection with the observer as one of the mothers, who consequently was lost to the group, seemed to express the feeling of difference in our status and a loss of her professional identity.

Tara asks where I'm studying, and I say that at the Tavistock which is a training institution for psychotherapy mainly. She asks if I commute from London and then comments on it being the other way from hers. Obs 1

An interesting and significant moment that captures the loss of the group itself was also about a level of denial of its loss as the group collectively turned their attention to the different birth experiences and another service in the last session. Perhaps acknowledging that this intervention was not enough and there was more needed could only happen in this indirect way.

When Chris was born there was a knot on the umbilical cord which no one has known about and although everything was fine in the end, it was difficult. Apparently, this is so rare that the midwife asked whether she could show the knot around. Cathy adds that she had this when she had a molar pregnancy before Anna. Maria (mother)

encourages the other mothers to call the 'Listening Service' which is set up in the local hospital to help mothers process their birth experiences. Obs 5

Changes and developments

The subcategories that capture this theme are *Coming together/Becoming Separate, Showing Anger, Showing Upset*. Throughout the five meetings of the baby massage course changes took place that seemed to indicate both development in relationships but also development in the process of how vulnerability, anger and upset and even breakdown could enter the group.

Coming Together/Becoming Separate was a subtheme that seemed to develop both on a dyadic and group level. As each dyad brought their own relationship patterns and showed them, these changes seemed specific to the dyads where they could be observed or took place. A moment of coming together that took place for the mother and baby dyad below occurred in the very first session at the end of the very first massage.

Sandra wraps up the massage with the same trunk holding movement, both hands placed on the doll's trunk, as she started it. Lorraine places her two hands on Chris' trunk and he gazes up at her with what looks like awe. I'm reminded of him being described as a terror at the very beginning of the session. Obs 1

On a group level, there was a coming together that can be exemplified by the way three of the babies in the third session seem to be in a similar state of mind as they wait for the massage to start.

Maria (facilitator) suggests that they get started and reminds everyone that it's a good idea to start with the same gesture of rubbing hands together with oil to signal to baby that it's time for their massage. The three baby boys closest to me are all undressed and seem to be waiting for their mothers. I look at Michael then Chris and George and none of the three are moving but lying almost motionless with eyes fixed on their own mother's face. Obs 3

There were important moments of separation and development that occurred in the way some of the babies connected with each other and the group which was vividly expressed by baby Clara while her mother is talking about a night apart so that Cathy could get adequate sleep.

While Cathy is talking Anna rolls over from her back to her front and Cathy exclaims with pride "Clever girl!". There is an air of admiration in the room. Anna looks a bit stunned but looks into the room with an interested look on her face and Cathy brings a toy closer for Anna to look at. Obs 4

Showing Upset is a subcategory that is captured by the way Rachel makes a moving plea in the last session when there is discussion about the changes that the mothers have noticed and the developments for themselves and their families throughout the baby massage course.

Rachel is barely able to say anything apart from a very quiet and painful "It's still very difficult". Maria (facilitator) says to Rachel that she will get in touch with the health visitor and offers to call Rachel after the session today. Rachel goes quiet for the rest of the session. Obs 5

Another interesting and almost shocking moment of upset seems to be expressed by the way Maria (mother) arrives with George for the fourth session after the break. In this excerpt Maria seems to express something about how she might have felt left by the facilitators and me although it is George who is in peril.

Maria brings George in and places him in the breastfeeding chair so that he is at the back of the seat leaning against the backrest and instructs him to stay like that and she quickly goes outside to bring her rucksack. George looks startled and seems to lean forward. Sandra says that she can see George might fall headfirst while standing up and standing in front of George hovering her hand in front of him. Obs 4

Showing anger was also related to the break and was expressed by Cathy, perhaps on behalf of the group.

Cathy notes that there are only four mothers and their babies today and Maria lets her know about Pauline's text that they can't make it but adds that she hasn't heard from Rachel and Cathy says something about it being a free course and you would expect that people at least let Maria know whether they can make it. Obs 4

Touch and Bodily Communications

The last but just as significant theme is that of *Touch and Bodily Communications.* The three subthemes of this theme are *Massaging, Feeding and Nurturing, and Holding onto/Letting go*.

Massaging is a significant subtheme as the process of the massage routine evolving as every week something new was being added on seemed to have an effect on what was then brought out in the group both in the time of sharing and also the following week when the group was reconvened. What is also noticeable that although the routine of the massage stayed vividly in my mind, capturing the way individual mother and baby couples progressed was not possible. In each session, there was a mother and baby who could not join in. There were moments that I was able to observe that stood out which were moments when there was a unity of movement in the group.

There is a collective feel of relaxation and I find it hard to concentrate and recall a picture of several naked babies on their mats being rubbed on their stomachs in the way Sandra is instructing the mothers, clockwise and each baby's gaze almost transfixed onto their mother's face. Obs 2

The massage also posed challenges and although there was progress from week to week, the differences and difficulties also became more apparent in accessing the massage as the following excerpt illustrates so vividly.

When the massage of the front of the babies' bodies is finished, Sandra suggests that the mothers turn the babies over to their tummies. I look around the room to see how the babies respond to this. Marty looks startled and flops down. Anna also flops down. The mothers are instructed to put a towel under the babies' arms lengthways and Anna looks startled by this and starts to cry. George has turned back onto his back. Chris and Michael are quietly holding themselves up and the mothers are following the massage strokes that Sandra is demonstrating along spine and the back. Obs 5

Feeding and Nurturing, a subtheme that relates to difference these to concepts. Naturally there were many opportunities to observe these somewhat opposing ways of feeding and nurturing. There was individual, dyadic and group levels to this subtheme as the excerpts below demonstrate.

On an individual level Sandra communicated her need to be nurtured at the beginning of each session in the same way but perhaps most vividly in the first session.

Sandra bursts through the door, greets Maria and I, and announces that she is ravenous and must have her lunch then asks Maria and I if we have eaten. … She eats a salad and talks about the ingredients and relishes the taste. Obs 1

On the other hand, Maria has a different way of preparing for the group. As she lets Sandra and I know at the end of the second session.

Maria says that she might have her lunch and adds that she gets a funny tummy before the massage groups. Obs 2

Whereas one of the facilitators needs to be almost fortified on a bodily but perhaps mental level as well before the group, the other facilitator seems to only feel able to nurture herself once she has given to the group.

On a dyadic level, there were an array of feeding and nurturing experiences but perhaps the most salient example is the way the rocking chair in the room was utilised for feeding by three different mothers. However, the difference is perhaps best captured in the way Cathy breastfed Anna when not in the chair and also when they were using the chair.

Anna is now lying in Cathy's lap while Cathy is sitting cross-legged on the floor. I'm struck by the way her legs form a basket shape. She is eating her sandwich and comments that Anna always seems interested when they sit down to eat. Cathy puts her sandwich down and unclips her dungaree and lifts her shirt to breastfeed Clara. Cathy's breast is quite large and she is able to feed Anna without lifting her up to it and Anna latches on easily. Obs 1

It was interesting to see how this mother and baby couple managed the feed and the baby seemed used to this arrangement.

Holding onto/Letting go, in amongst the many examples of how touch and bodily communications were such a fundamental theme in expressing the more unconscious dimensions of relating there were two interactions between Maria and George that stand out in showing the difficulties in relationships through touch. There was something almost unbearable about these moments although they also felt important to bear witness to.

Maria says that George is an IVF baby and she focused so much on getting pregnant that there wasn't any thought given to what it will be like when the baby is here… he cried solidly for 4 months and didn't sleep. Her hand is on George's leg but there is a sense that they can't be closer at the moment. Obs 2

Later on, in the same session another moment when the touch seems almost too much for both mother and baby and looking at each other is impossible.

I catch a fragment of a conversation between Maria and Lorraine. Maria asks Lorraine about the reason why she and Chris are here, and Lorraine says that her mum died before Christmas. She had a brain tumour, and they were in the hospice with her for Chris' earliest life. What is striking is that George is sucking his right thumb and his head is turned away from Maria and Maria's head is turned away from George and held so rigidly so that she is not looking at him. Maria's hand rests on George's tummy. This seems to go on for what seems like too long. Obs 2

The following week Lorraine and Chris seemed to be put into a difficult position and Chris seemed quite stirred up by it and managed to show how much he was not ready to be let go.

Maria asks Lorraine to hold George while she unpacks and gives him to her with some force. Lorraine holds George on her lap while Chris is lying on the mat looking up at his mother and the other baby. He is holding on with both of his hands to the front of his Babygro. Obs 3

A level of bodily communication that relates to this subtheme is the way Diana and Marty seemed to hold onto experiences and each other which Marty showed how hard it was to let go, which Diana, and I imagine the whole group found hard to make sense of. They were not the only dyad where digestive issues were in the forefront of their

everyday experiences and also in the group. However, they seemed to express something for the group as well.

Diana picks him up and takes a muslin to cover his face which I find quite difficult to watch. She takes a bottle of milk from the side pocket of her rucksack and offers it to Marty who eagerly starts to suck on the teat but stops after a few gulps and yelps with pain. This is repeated a few times and it is as if Marty's stomach is inflating with every attempt. Diana's face looks tense, and her lips are tightly held together. I'm struck by how she is isn't saying anything to Marty. Obs 4

Another interesting way of holding on was expressed by the way the two mothers who sat in front of me showed with a very much bodily communication how much they needed to be close and being held and perhaps appreciated the physical closeness of the observer.

I am suddenly aware of Chris' head very close to my leg and feel the warmth of him, Lorraine back on my left leg and the warmth of Rachel's back to my left leg. Rachel also glances towards me as they talk as if to include me in the conversation. Obs 3

The Central Organising Category: Holding

Holding is the central organising category that I constructed from the data. In this instance the concept of holding is present on many different levels of the experiences in the group from concrete to abstract, from bodily experiences to psychological ones, and also the way the observational experience is held together in my mind. Holding in this context also denotes something unhelpful and anti-developmental, a way of holding onto types of functioning that are counterproductive and where flexibility might be required.

Now I will turn to the Discussion where the Grounded Theory themes will be linked to the psychoanalytic concepts explored in the Literature Review within the contextual information about the baby massage course.

Chapter 5 Discussion

“What can be learnt from observing a five-week baby massage group in a Parent Infant Mental Health Service?” is the research question and the discussion below will focus on bringing together the findings, the psychoanalytic ideas, and the contextual information about baby massage groups.

In this chapter, I will be linking the Grounded Theory findings to the relevant psychoanalytic literature, contextual information about baby massage groups, while also placing it within the context of the baby massage course and the group I observed. The intensity of the experience of observing the five-week baby massage course followed by the grounded theory analysis and writing up brought with it further links, questions and dilemmas. The impact of the group setting, and the impact of the observer will be considered, as they seemed both considerable and inevitable. Possible dilemmas for the facilitators will also be addressed along with reflections on approaches taken in the massage group. Possible links and implementation of psychoanalytic concepts and framework for clinicians delivering baby massage groups are also will be explored, for example the impact of breaks and the attention to beginnings and endings of each session, especially in the context of the Winnicottian concept of *holding*, Bion’s thinking about *containment* and Bick’s concept of *second skin*.

A note here about the intensity of the experience as an observer, I was there to take in as much as possible about what was happening on a feeling level. The mother-infant dyads all brought their own intense, very new, and evolving relational dynamic to the group. We were all learning something new together while the dyads were still very young. There were many raw and primitive emotional experiences present.

Roles of the Facilitators

Roles of the facilitators is one of the main themes arrived at through the Grounded Theory analysis. Within this main theme, the subthemes are *Managing Security in the Group, Noticing/not noticing and Role-modelling and teaching*. It is not surprising that the facilitators and the different roles they fulfil is one of the main themes as the facilitators are the foundation for the group. Underdown and Barlow (2011) in their findings also bring attention to the roles of the facilitators when they write about the important mechanisms contributing to the 'success' of baby massage groups. These link to my findings, in that out of the 14 mechanisms they identified most related to the role of the facilitators, thus underpinning just how fundamental it is for the facilitators to be invested in the group and in the baby massage.

When thinking about the psychoanalytic concepts that are linked to this main theme, containment and holding are the most relevant. When thinking about the three subthemes, the facilitators are providing the presence of mind that is necessary for the group to come into existence at the beginning of each session, throughout the session and at the end of the session. From the examples in the findings above, the time when Rachel arrives and thinks about moving to a different place within the room comes to mind. In that moment, Sandra helped Rachel and the group by containing Rachel's anxiety about her place in the group. This showed that Sandra was keeping everyone's needs in mind. Another level of containment here could have been the way Rachel was thus physically placed next to Sandra and next to me and another mother who had a much less anxious presentation to Rachel. From the Winnicottian holding perspective, Winnicott's observation about how "holding … often takes the form of

conveying in words at the appropriate moment something that shows that the analyst knows and understands the deepest anxiety that is being experienced, or that is waiting to be experienced" (Winnicott, 1963, p.240). It could be argued that Sandra was performing this function in the way she helped Rachel and baby Michael to remain in their original spots within the room.

The subtheme of *Noticing/Not Noticing* is one that can be linked to the relevance of defences, out of which Bick's theory of second-skin defences has been mentioned and will be elaborated on further in the chapter. Within the Grounded Theory findings, I linked this subtheme to the facilitators being defended against the pain of seeing and understanding. However, further exploration is needed as there could be more complexity to this than thematic grouping. There could also be a link to containment made here as often containing also means more of an unconscious process. By not noticing for example that the relaxation exercise seems quite hard for the mothers to achieve can also be seen as containing. I have wondered about the way the baby massage choreography and the inclusion of the relaxation exercise might limit the opportunities to really notice and make sense of what is happening in the group when they focus on the task of the massage. It could be argued that the work of the facilitators is to keep the group to task which is the learning of baby massage and sharing of difficulties. The massage choreography perhaps has an element of taking the focus away from the emotional pain and difficulties and thus has a potential of enabling the mothers to see their babies in a new light and the babies to experience the mother's gaze and touch in a new and hopefully beneficial way. Perhaps a risk for these two facilitators could have been that they did not feel skilled enough to make interpretations or even observations consistently throughout the baby massage course. Thus, the things that they notice or not notice may be also linked to a feeling

of inadequacy shared by every member of the group perhaps. An example that comes to mind from the findings is the complicated predicament of baby Marty and Diana. The facilitators seemed not to take note of his crying during relaxation exercises. Were they trying to show that a baby crying is something ordinary and accepted here. Or were they feeling inadequate in helping Diana and Marty to feel more contained which could have been tried by wondering about Marty's state of discomfort perhaps? Diana seemed to be filled with feelings of inadequacy in these times which may have made it hard for the facilitators to make direct interventions. There seemed to be a constant to and fro between paying close attention and focusing on the baby massage. The focus on the baby massage may be increased by the difficulties experienced by the mothers and the babies. At the same, this is a point where it seems important to reflect on the role of the observer in relation to it being very different in overt activity. Whilst the facilitators were interacting with the group, the mother-baby dyads and sometimes individuals while also trying to keep to task and help others trying to keep to task, the observer was observing. By virtue of being available and trained to watch and take in, this is probably reflected in what I saw and noticed and what I did not.

Role Modelling and Teaching is another subtheme which seems self-explanatory in the way it links to a fundamental role fulfilled by the facilitators. Yet there are links to be drawn both to the contextual information about baby massage groups and to psychoanalytic theory. In the findings above I noted the way the facilitators were showing the baby massage routine that is outside the realm of ordinary routines although one hopes that there is tender touch available for most mother and baby couples. I also commented on the sense that whatever the mothers and babies could take in seemed to be accepted as sufficient by the facilitators.

An interesting connection to containment was the example that Sandra gives with jug of water and cups. Very small children often play in a similar way in child psychotherapy sessions and in regular play, and the psychotherapist often link it to the child's experience of a containing mind or lack thereof. There may be a link to primitive anxieties about not having enough or falling to pieces in the way Sandra demonstrates and attempts to teach the mothers how to look after themselves.

In the contextual information provided by Underdown and Barlow's 2011 paper on the mechanisms that support change in the parent-infant relationship within baby massage groups, there are four mechanisms that explicitly refer to teaching and modelling. For example, mechanisms relating to role modelling and teaching that Underdown and Barlow identified were "teaching about infant states and cues, and facilitator models sensitive interaction with doll (Underdown and Barlow, 2011. p.24).

Group dynamics

The second major thematic category in the Grounded Theory findings also links to psychoanalytic theory and to the contextual information explored in the literature review. The three subthemes are interlinked. On the whole the group functioned well, but these subcategories link to feelings of deep unease and difficulty which had some space to be explored although perhaps not quite enough.

The subtheme of *Presence/Absence* is, in my mind, related to the important point Onozawa et al. (2001) make about the relatively high level of drop-outs in the baby massage groups that took part in their study. This was my experience too. Two out of the eight mothers and babies left after one session and one left after two. The reason

for the drop-outs in the other study “appeared to be the time of the class” (Onozawa et al., 2001, p.205). However, this is not further elaborated on although as the study was conducted with depressed mothers perhaps this was related to the high levels of drop-outs. It is likely that depressed mothers will struggle to hold onto more positive experiences, can feel easily persecuted and probably react more acutely to sleep deprivation than mothers who are dealing with ordinary challenges of early motherhood. It is important to note that dropping out was something the facilitators of the group I observed expected. There is a follow up with each mother or their health visitor afterwards whether they take part or drop out. There is also a link here to the role of the facilitators and how much they can do to engage or re-engage the mothers, both from a service delivery point of view and from a therapeutic point of view.

Another important aspect of the group dynamics is related to the membership. There seems to be a prevalence of mothers and babies who presented as quite isolated, which relates to the subtheme of *Overwhelming* in the findings. James (2016) suggests that mothers and babies who are isolated can benefit from group work and there is a similar policy within the Parent Infant Mental Health Service. Within this particular group, the sense of isolation and overwhelming experiences seemed quite strong and could have made it difficult for some of the mothers to stay within the group. Especially for those who did not come back after just one session. James (ibid.) also notes that some parents find groups more accessible when specialist services are felt to be stigmatising. In this group it was not explicitly stated that the facilitators were working in a PIMHS although the referring health visitor hopefully discussed it with the mothers. The physical setting was a generic, well-equipped baby room in a regular children’s centre, but perhaps those mothers felt stigmatised or persecuted by the fact they ‘had’ to come to this baby massage group because something was going wrong

for them and their babies and it had been noticed. By virtue of taking part it was shared and was brought into the open.

There is also a link, in my interpretation, to mothers who present as angry or cut off benefiting from being in a group, according to Paul and Thomson-Salo (2007). I imagine if this is the dominant presentation amongst the mothers in a group, it can become too difficult to manage for everyone and the benefits are outweighed by difficulties. There are ways in which anger can be helpful in a group, as I think it was for this group which I will elaborate on below. I also believe that there is a link to difference which I felt acutely in the group. Class differences were not addresses, and could not be expected to be addressed, but were nonetheless painfully present. Pauline and Max were there on the recommendation of their social workers and Max was the only baby with a visible profound learning disability. Although they managed to come to two sessions, they clearly struggled with the experience which on occasion meant that they slept through the massage. Pauline seemed to struggle with the experience of seeing the babies who did not have visible signs of disability like Max. The contrast seemed unbearable, and the sleeping may be linked to this.

The third subcategory of this theme, *Loss*, is something that is relevant from a psychoanalytic point of view. Grief, mourning and loss are fundamental parts of psychoanalytic practice and theory, starting with Freud's *Mourning and Melancholia* (1918) and continuing to parent-infant psychotherapy. Often the work is around the mourning for the baby whom the mother or parents imagined needs to take place before the baby who is there in reality can be truly embraced (e.g. Broughton 2016, Raphael-Leff, 2000). There were moments when this could have been opened up but there was also a sense that the group could not manage to be stirred up more. It is interesting to note here that in the fourth session, after a week's break, Maria the

facilitator ‘lost’ her phone. She left her phone in her car which meant that the mothers and babies who could not make it were also lost to the group. This was felt by the ones who were there and was difficult to contain for the facilitators. It is also relevant to the third main theme, *Changes and Developments*.

Changes and Developments

There were noticeable changes and developments that took place throughout the time of the baby massage group.

Coming Together/Becoming Separate is the first subcategory of this theme. In the findings above the example that was first given concerns a coming together that seemed significant, as Lorraine and Chris started the first session with Lorraine describing Chris as a terror. It could be argued that Lorraine’s persecutory anxieties were contained by the group which freed her up to engage with her baby. Lorraine seemed to be able to use the group for development which was not possible for every mother and baby in the group for internal and external reasons. It is important to note is that Lorraine and Chris’ relationship seemed to change most visibly in the course of the baby massage group. They were one of two mother baby couples who attended all five sessions. There were problems with feeding and sleeping at the beginning of the course which seemed to lessen to quite a large degree by the end of the course. However, the most remarkable change was in the interactions between this mother and baby which by the last two sessions was full of enjoyment for them both. This mother and baby couple had the internal capacity to use the baby massage course in a therapeutic way and also to take in what was available in the group. Interestingly,

this seemed to have been done in a way that did not evoke intense emotions in other mothers and babies as much as it could have. Towards the end of the course, Chris was also engaging with the babies closest to him which seemed significant in that he was developing separateness. It seemed to indicate a deepening level of security for him and his mother where he was able to become more separate while also more dependent, both of which his mother could tolerate. Although expressed in a more fraught way, something similar was also noticeable for Cathy and Anna who were the other mother and baby couple who attended the whole course. The example in the findings is Anna rolling over while her mother tells the group about their first night apart. This happened in the fourth session and in the last session Cathy and Anna came from another mother-baby activity, signing for babies. The link in my mind between these two experiences is that Cathy seemed to replace the baby massage group with something else even before it ended, and I wondered how this could reflect on her and Anna's relationship when Anna might strive for more separateness from her mother. Cathy may have found the loss of the group to difficult and had to immediately replace it with something else so as the loss would not be so painful.

The subcategories *Showing Upset* and *Showing Anger* can be considered together. They seemed to link to the break in the sessions and the ending of the course. In the findings above one of the examples relates to Rachel and Michael's deep struggles and her way of letting the facilitators know that they need more help. As Rachel seemed to struggle so much to be present, Michael was looking at Sandra for long periods of time. At first, Maria, the facilitator, responded by offering to call Rachel and Michael's health visitor, but a bit later offered to call Rachel. This offer of a direct intervention seemed to contain Rachel's anxieties enough to be able to return to Michael.

On the other hand, Maria's way of leaving baby George precariously sitting in a chair expressed how distressed she was by the break and how upset and perhaps angry she was for having to endure being left alone again with her baby. Once again, Sandra responded with her holding function when she addressed how George might fall headfirst, while she stands up and guards him in case he topples over. This action can also relate to group functioning which is summarised by Garland as "desire for special status, and the wish to control are universal and ubiquitous" (2010). This is what Maria seems to achieve by getting Sandra's attention. It seems to make her, and her baby gain special status by virtue of her putting him on a chair when she had made the group aware that he could not yet sit, even with props. This resulted in George being in danger and needing a direct intervention from the facilitator.

Touch and Bodily Communications

Touch and Bodily Communications is the last thematic category in the findings. According to Bond (2002), baby massage can become a "dialogue of touch" (p. 44) between mother and baby as it can become an additional way for communication between them. What seemed notable throughout the observation was that the dialogue of touch and massage could only be accessed if there were other factors available to them. The babies needed to be comfortable with undressing for example and it seemed that there was also an optimum state in terms of being hungry but not too full. I also can imagine that these physical attributes also had corresponding emotional and relational equivalents which made some of the mother-infant dyads

more or less receptive to take in the massage. In the findings, *Feeding and Nurturing* is a subcategory that relates to the way the facilitators helped to create a facilitating environment for the mothers and babies.

Holding onto/Letting go is a notable subtheme as the examples relate in my interpretation to the development of second skin defences, which according to Bick develop when the infant is experiencing an unintegrated state where the object is not available to them. In this state the infant searches for something to help manage the anxiety and often stares at something or holds onto something if they are able to grip or there is precocious development movement. It seemed to be present for baby George and his mother Maria, who clearly struggled with to hold onto each other and found different ways of managing. For example, George was sucking his toes throughout the course. In the findings above an interesting example is when Maria asks Lorraine about what brought them to the baby massage course and Lorraine tells her about her mother's death which seems to overwhelm Maria. Maria seems to react instinctively by looking away from George and George seems to be looking away to find something else to fix his gaze on to hold himself together. With this mother and baby dyad there was a fixed quality to this way of relating. For Lorraine and Chris, a moment where Chris had to be left to his own devices seemed to be a result of Maria's projections and Chris' response is one that seemed quite despairing while also helpful for him. Maria asked Lorraine to hold George while she laid the towel on the mat and Lorraine engaged with George and Chris held onto his baby gro with both hands. This was the only time I observed Chris doing anything like this, but it seemed to be a response coming from deep within him. It was easy to imagine him feeling like he is falling apart when his mother was holding another baby in her arms.

“Sensitive reciprocal interactions” (Underdown & Barlow, 2011, p. 23) are key to healthy emotional development and a key to the outcomes of the baby massage group. They identified how important it was that the maternal difficulties are kept in mind. Furthermore, Paul and Thomson-Salo (2007) comment on how the psychosomatic problems of babies can be addressed without the problems of their mothers being addressed. I think this was something that was present for Diana and Marty in him being constipated and his mother not being able to talk to him when he was showing distress. This was also repeated by the group. I wonder if Marty’s difficulties could have been spoken about in the moment, and whether Diana might have felt more held and in turn could have felt able to address Marty’s needs.

Dilemmas for the Facilitators

The group membership and facilitation seemed to pose some difficulties which can also be linked to the presence of the observer. Although the explicit aim of the group is the teaching of baby massage, the facilitators may have felt that they needed to give more. The inclusion of the mindfulness/relaxation exercise may have been a result of this and perhaps there was a sense that it would contribute positively to the experience of the mothers and the babies. This could be related to difficulties in tolerating excessive anxieties and resorting to ‘doing’ rather than ‘being’.

Another dilemma for the facilitators is when and how to intervene, whether verbally or physically. The holding function of the group could be enhanced by bringing the babies more to the fore whether addressing the psychosomatic experiences or noticing and

verbalising for them. This could in turn enable the mothers' interactions with their babies.

On reflection, it was incredibly difficult to think about the dilemmas above which could be related to the feeling of indebtedness for the opportunity to conduct the study and not wanting to criticise. This feeling is still present. However an awareness of these complexities can also inform further projects both for myself and for others.

The psychoanalytic concepts of holding and containment are hard work when practised and impact on those who are experiencing them: the mothers, the facilitators and the observer alike. However, awareness and exploration within the context of supervision, a reflective space or one's own psychotherapy can add to the depth of experience and thus enhance the practice of facilitation and observation.

Chapter 6: Conclusion

‘What can be learnt from observing a five-week baby massage group in a Parent Infant Mental Health Service?’ is both the research question and the title of this thesis. In the paper presented above I have tried to convey the learning experience as a novice researcher and child psychotherapist about a treatment modality that I was not familiar with, namely baby massage. In the sections below I will be exploring the insights gained from the project that could be useful for clinicians, for facilitators and services.

Through the process of setting up the project to carrying out the observation and the writing up I have learnt about the historical and cultural context of baby massage while also experiencing it alongside the facilitators, mothers and babies of a particular massage group.

Upon reflection on my learning from the experience, if I were to take on the project again, I would include an introductory session and a de-brief session for the mothers before and after the massage course. I would also include a space for reflection for the two facilitators after each session. I think the study could be enhanced by including outcome measures to compare with the observations. This would give the mothers a stronger voice. I would also have supervision during the observation, and join a group of observers in the traditional Tavistock seminar model.

The learning most useful for practice pertains to the importance of the short timeframe and the potential accessibility of baby massage as a gateway intervention, where perhaps more serious maternal mental health difficulties are not possible to address. The baby massage group offered in PIMHS is an early intervention in its truest sense. Baby massage, in its universal appeal, can be accessible to mothers and babies who

may not engage in other interventions but need help. Furthermore, the experience shows, that actively engaging mothers and babies is important. Despite the short timeframe, the mothers, and in turn the babies, could benefit from having more preparation prior to the massage course. This could be an extra phone call. I imagine this would make the mothers feel that their participation is valued, and the baby massage group is not something that is offered to them without careful thinking. Babies can still benefit from the group experience and mothers can be directed to other modalities, such as parent-infant psychotherapy, which without attending the massage group and difficulties coming more into the open may not have been possible.

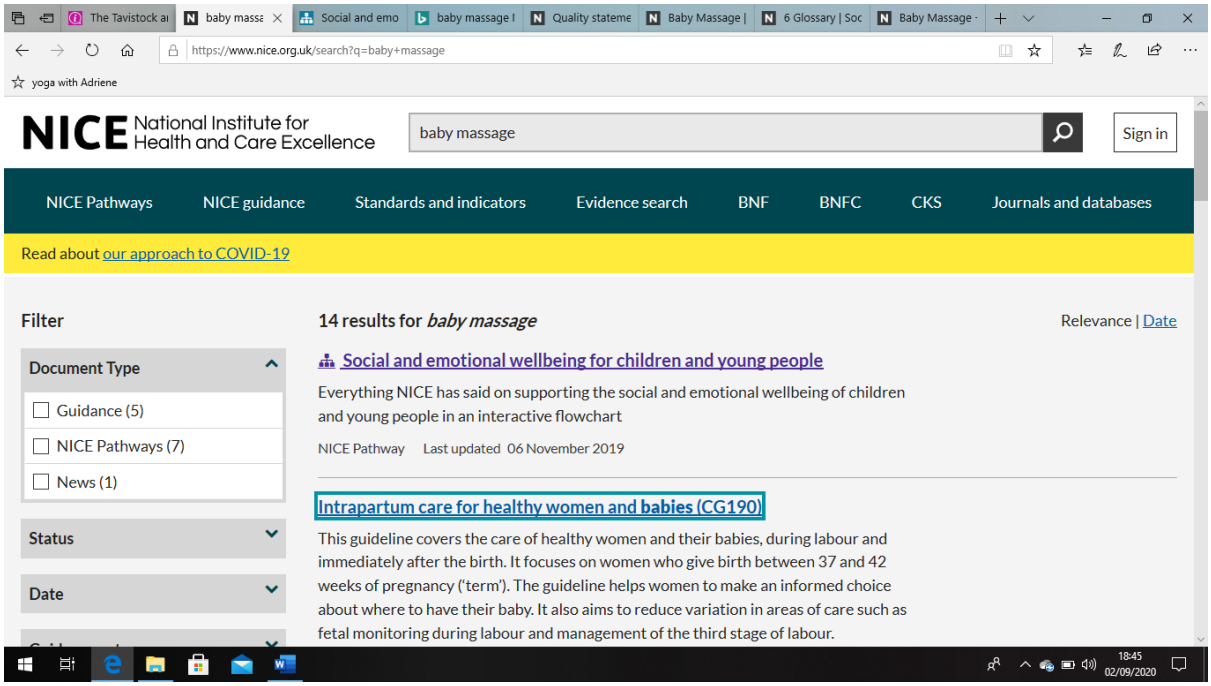
Thus, the five-week baby massage group in the Parent Infant Mental Health Service is an early intervention that can function either as an exploratory space or a therapeutic space for the mothers and babies who take part. For some mothers and babies, this intervention is a first contact with mental health support, and they might discover that the baby massage group is not the right type of support for them. They are nonetheless in touch with an institution that can support them further. For other mothers and their infants, the timely delivery of the baby massage course may right developmental trajectories which could become unhelpful without this intervention.

One of the outcomes of the present research is that the inclusion of the mindfulness/relaxation exercise is something that may need further thought. My impression is that this exercise seemed to take away space from the mothers sharing. There was a sense that it shut something down that needed to come out rather than helping to regulate, which I imagine was the well-intentioned reason for including it in the sessions. I wonder if it was at the very beginning of the session or at the very end of the session, it might work better. From a service point of view, the follow up of drop-

outs from the massage course seems to be an important recommendation which I imagine happens, but nonetheless want to note here. This is perhaps something that was reflected in my not following up with questions to the facilitators or with the service lead. The follow up could be done by someone other than the facilitators as it may feel quite persecutory, for example for the mothers who leave after one session if the baby massage course facilitator calls them up. At the same time, it can be of significance for the particular mother and baby dyad accessing support at such a crucial time when the group may not have felt right for them.

As it often seems to be the case with baby massage research, this project is a small study where it is difficult to conclude with generally applicable recommendations. However, perhaps its value amongst the many other small-scale studies is just that: to try to think about the individuals who make up the particular group and who need unique attention but may not be able to access it due to internal and external obstacles. To generalise and manualise baby massage groups further would not be beneficial to the babies and mothers who take part in them as it would not take into account the make-up of the particular group of mothers, babies and facilitators. There may be universal experiences present in most baby massage groups but that may not be helpful to the individual mother-baby couples or the facilitators in the here and now of a particular group.

Appendix 1


https://www.nice.org.uk/search?q=baby+massage
yoga with Adriene
NICE National Institute for Health and Care Excellence
baby massage
Sign in
NICE Pathways
NICE guidance
Standards and indicators
Evidence search
BNF
BNFC
CKS
Journals and databases
Read about our approach to COVID-19
Filter
Document Type
Guidance (5)
NICE Pathways (7)
News (1)
Status
Date
14 results for baby massage
Relevance | Date
Social and emotional wellbeing for children and young people
Everything NICE has said on supporting the social and emotional wellbeing of children and young people in an interactive flowchart
NICE Pathway Last updated 06 November 2019
Intrapartum care for healthy women and babies (CG190)
This guideline covers the care of healthy women and their babies, during labour and immediately after the birth. It focuses on women who give birth between 37 and 42 weeks of pregnancy ('term'). The guideline helps women to make an informed choice about where to have their baby. It also aims to reduce variation in areas of care such as fetal monitoring during labour and management of the third stage of labour.
18:45
02/09/2020

Appendix 2

The Tavistock and Portman
NHS Foundation Trust

A Psychoanalytic Observational Study of a 5-week Baby Massage Group in a Parent-Infant Mental Health Service

Participant Information Sheet

Thank you in advance for taking the time to read this information sheet. I would like to invite you to participate in my research project which takes place alongside the 5-week Baby Massage Group you have been invited to take part in city name. My research involves observing the group throughout the whole course. I am a Child and Adolescent Psychotherapist in Doctoral Training.

What is my project about?

The Baby Massage Group is a successful intervention for new parents and their young babies who are struggling and have been referred to the programme by their health visitors or GPs. I am interested to find out how the interactions on every level of the group contribute to its success and the intricate non-verbal and verbal aspects of what takes place and unfolds over each session and over the 5 weeks. The Group is an early intervention in its truest sense which is a particularly interesting aspect of the process for me.

By taking time to look closely at what happens in the group I hope to gain further in-depth understanding of the workings of this particular way of helping parents and their babies to develop their relationship.

What will my study involve?

Your group will be running as normal and I will take great care not to get in the way of the important work that takes place. I will be sitting quietly with you in the circle and may move around a bit so that I can see everyone. I will remain in the background as much as it's possible so that you, your babies and the facilitators can get on with the work in a 'business as usual' kind of way.

I will have the consent form ready for you to sign before the first massage group meeting and would like to ask you to sign the consent form that day. I will be at the venue half an hour earlier and happy to answer questions either before or after the first meeting. When you speak to the organiser from the PIMHS in advance of joining the group, it would be really helpful if you could give verbal consent.

What are the potential benefits of taking part in this study?

I hope that by watching the group closely I can develop ideas and understanding about *how* it works. In this sense the potential benefits are not direct but hopefully will be seen in the future. I will be paying very close attention to the interactions between the babies, the mothers and the facilitators both verbally and non-verbally. By taking time to look closely at what happens in the group then thinking about it and understanding it I am hoping to gain insight that could

be useful for clinicians who help parents and their babies at such an important and often challenging time of their lives.

How will I make sure that what happens in the group is private?

In order for you to feel safe I will think carefully about how I will write about your private and personal experience that I will be allowed to look into. All information you give will be anonymised and all identifying information will be removed or changed to protect your confidentiality. Anonymity will be achieved by using pseudonyms as early as the initial note taking to keep your identity protected. I do not expect to have many paper notes but the ones I will have will be kept in a locked filing cabinet in my place of work. All electronic notes will be kept in passworded documents on a computer only I have access to. Confidentiality will be achieved by also removing all identifiable data including place names, the name of the NHS Trust and the names of the professionals and providing pseudonyms for all identifiable information. The information will only be used for the purposes of the Doctoral Project and any professional publication or presentation pertaining to it. Your name and contact details and the signed consent form will be kept separately in a locked filing cabinet at my place of work and it will be disposed of securely 6 months after completing my doctorate. I have completed two similar observations as an element of my Post-Graduate studies and have extensive experience in looking after the sensitive information gained through observation.

How will my information be kept safe?

The Tavistock and Portman NHS Foundation Trust is the sponsor for this study based in the United Kingdom. I will be using information from you in order to undertake this study and will act as the data controller for this study. This means that I am responsible for looking after your information and using it properly. I will keep identifiable information about you from this study for 6 months after the study has finished.

Your rights to access, change or move your information are limited, as I need to manage your information in specific ways in order for the research to be reliable and accurate. To safeguard your rights, I will use the minimum personally identifiable information possible. I will use your name and the contact details you provide only to contact you about the research study. I am the only person who will have access to information that identifies you. I may be assisted in the analysis of this information by senior colleagues, but they will not be able to identify you and will not be able to find out your name or contact details.

You can find out more about the legal framework within which your information will be processed by contacting the sponsoring Trust's Clinical Governance and Quality Manager, Irene Henderson: IHenderson@tavi-port.nhs.uk

What if there is a problem?

If you have any questions or concerns about the study, please feel free to ask me. If you would prefer to speak to a senior staff member about your concerns, you can speak to X Lead for PIMH or Specialist Health Visitor PIMH, Group Facilitator at NHS Trust and/or Simon Carrington at the Tavistock and Portman NHS Foundation Trust on 020 7435 7111.

Where will the findings of the study be published?

The project will be written up as part of a Doctoral Thesis. I am going to prepare a feedback report for the service and a research summary for the participants by December 2020. I may also publish the findings in relevant scholarly journals or present it at relevant conferences.

Who has reviewed the study?

As this is my Doctoral Research Project, it is reviewed at the Tavistock in the first instance. All research in the NHS is looked at by an independent authority called Research Ethics Committee, to protect your safety and rights, well-being and dignity. This study has been authorised by Trust and NREC (reference no: 249161)

I shall give you a copy of this information sheet with the copy of the signed consent form.

Thank you for taking the time to read this information sheet,

Julianna Katona

Contact details

Appendix 3

The Tavistock and Portman
NHS Foundation Trust

A Psychoanalytic Observational Study of a 5-week Baby Massage Group in a Parent-Infant Mental Health Service

Consent Form

Please initial box

- I confirm that I have read and understood the information sheet dated 17/04/19 (V-2) provided for this study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
- I understand that my participation with my baby in this study is voluntary. Although I understand that it is unlikely that something distressing happens in the group, in case there is an event that I would not want you to include I will let you know within two weeks after we finish the course. (Please refer to the Participant Information Sheet Page 2 for further information.) ☐
- I understand that the findings of this observational study may be used by the researcher in future publications, reports or presentations. ☐
- I understand that any personal data that could be used to identify me will not be included in any written document and that I will not be identified in any publications, reports or presentations. ☐
- I agree to take part in the study. ☐

Participant's Name (Printed): _____

Participant's signature: _____ Date: _____

Appendix 4

The Tavistock and Portman
NHS Foundation Trust

A Psychoanalytic Observational Study of a 5-week Baby Massage Group in a Parent-Infant Mental Health Service

Dear

I hope you are both keeping well in these strange times. Once again, thank you so much for allowing me to observe you during the massage course at the early part of this year. I hope the year has gone well for you both and your families under the circumstances.

I am writing to update you on the study and to let you know that I am writing up my analysis of the deep and rich experience that I have been allowed to observe.

As we have previously agreed, all your personal data has been anonymised and all identifying information will be removed or disguised in the final report.

It was a privilege to conduct this observation and I am grateful for having this opportunity to see and think about the particular Baby Massage Group at that particular time in your lives.

Should you like to read a copy of the DProf report, please feel free to get in touch around June on julianna.katona@xxxxx.uk

Your participation in the project is much appreciated and I wish you and your family all the best.

Julianna Katona

Appendix 5

List of initial codes & list of focused codes

1.Arriving in good time

2.Uncertainty about the location

3.Is it a little oasis or is it a place where families go where something has gone wrong?

4.Barrier or protection of the space

5.Is it the right time?

6.Do I have to be different?

7.Being certain vs feeling unsure

8.Does the observer help out?

9.Anticipation

10.Containing anxiety about what's to come

11.Discovering the place for the observation

12.This is a good place where children are really thought about

13.We have bodies that need feeding

14.This is a good place for babies

and the mothers

15.Making the environment suitable for the baby massage

16.There are some mothers and babies who aren't coming after all

17.Something necessary for the baby massage is missing from the room

18.We have what we need for the group

19.Getting used to a new person

20.This is the way the space is organised for the group

21.Not enough equipment vs ingenuity

22.This is the way we do things here

23.Finding one's own place

24. Trying to find a good vantage point

25. Important admin task to facilitate the observation

26.Getting ready for the massage/for the mothers and their babies

27.Tight schedule for Sandra

28.There are other responsibilities than the massage group

29.Getting fortified before the work and making sure everyone else is

30. Getting to know the facilitators and their lives outside of work/ the two women are friends outside work

31.Is it going to be comfortable for everyone?

32.How does this place work?

33.Worries about the babies being cold

34.The first arrivals

35.Whose need: to feed vs to be fed?

36.Anxiety about the feed

37.Appearing young

38.Hard to read the mother's face

39.This baby has a father around and this woman has a husband around

40.Claiming the space right for breastfeeding

41.The baby makes a proper entrance

42.Maria names and keeps the group in mind

43.How will we differentiate between the similar names?

44.Let's try the feed

45.Feeling rejected

46.Is there a worry about being judged?

47.Maria notices the worry and has done something about it, she's addressed the issue

48.Is the baby interested or is he turning away?

49.Mother responds

50.Posture of baby signalling rigidity

51.There is official approval of the observer to join and observe

52.The baby might be confused

53.Who is looking and observing who?

54.This is important: earliest arrivals and coming from the farthest

55.Taking part in this group matters to this mother and baby couple

56.There is little professional support where they live

57.What happened to this mother to make her seem so lonely?

58.Keeping track of the group

59.The second arrivals

60.The second baby is here but not here

61.Are the two babies similar or is it only their names?

62.Giving space vs taking up space

63.What's underneath the confident looks?

64.Ambivalence about being here

65.Ambivalence about being too close/ protecting the baby

66.Mother guarding the baby

67.Worry about going beyond the names

68.Mother can't settle down yet

69.Permission to look granted

70.Maria and Sandra don't expect the mothers to remember

71.Mother's worry about having space for the new baby in her mind

72.Maria keeps the time

73.Are the needs of this group kept in mind outside of the group?

74.Third arrivals

75.Two new mothers arriving together, seem already familiar with each other

76.Taking up positions in the room

77.The place has been stirred up

78.Maria makes sure everyone is accounted for

79.A mother makes a strong impression and shares a lot /Anxiety about being welcome

80.Deep sense of wanting to be known vs intense neediness

81.Feeling rushed and needing looking after

82.Maria's permission to eat seems necessary

83.Another mother and baby haven't got much space

84.Maria takes the lead and joins up everyone who is here into the official group

85.Bold message via clothing/ playfulness

86.Closeness/distance to the facilitators

87.Closeness/distance to the other mothers and babies

88.Closeness/ distance to the observer

89.Maria is the central figure/ Sandra is absent in the write up

90.Maria starts introductions with first arrivals

91.Getting to know first mother and baby

92. “He’s a terror” What makes the mother feel terrorised by the baby?

93.The baby’s rigid posture: the cause of or response to the terror

94.Getting to know the second baby and mother

95. Mother 2 allows baby to be seen for the first time

96.Awake and safe in mother’s arms while joining the group vs worry about the new faces/people

97.Strong ambivalence about being here

98.Getting to know 3rd mother and baby

99.Age of baby, important information

100. Striking posture of mother: holding baby in cross-legged ‘basket’

101.Ambivalence about baby intruding on parental couple’s mealtime/pre-emptive information sharing

102.Baby’s need is perceived to be priority

103.A distinctive way of breastfeeding

104.Ambivalence about being here

105.Baby’s age is added, important information

106.Striking posture of mother holding her baby

107.A distinctive way to breastfeed

108.A new introduction

109. Who needs holding onto?

110.The group seems complete

111. Why there is an observer here

112. Maria notes that the babies are ready for the massage

123.Magic moment of calm and togetherness

124.Gradual exposure of babies’ bodies is very important/thought about

125.4th new arrivals

126.Joining in and introduction

127.Unsettling the group vs being welcome

128.Mother takes the most marginal space in the room available

129.The baby is protected from the gaze of others

130.Anxiety or physical impairment

131.Nervous twitchy facial movements

132.Where is the older child?

133.Maria refocuses the group on the massage

134.Baby's discomfort or hunger

135.Is mother feeling rejected?

136.Is mother feeling judged?

137.How do you know what your baby needs?

138.Mother looks uncomfortable and anxious

139. What exactly happens physiologically during baby massage?

140.Who benefits from the massage?

141.There are times when it's best not to massage for the baby's sake

142.The babies need time and a gradual introduction to the massage

143.Sunflower oil – anomaly

144.There is good reason for the use of sunflower oil- Maria knows what she is doing

145.A baby becomes unsettled

146.Mother's visceral/bodily reaction

147.This baby is completely different/ Down's baby

148.Another baby becomes unsettled

149.A unique vocal way of reacting to baby being unsettled

150.Soothing sound vs drowning out baby's cries

151.Maria's ability to bring the anxiety down in the group/Keeping to task

152.Where is Sandra?

153.Let's get the massage going

154.The importance of communicating what's going to happen to the baby

155.There is specific move to get started

156.Baby massage vs recent vaccination

157.Mother’s confusion and worry about putting the baby into danger

158.Sandra comes to the fore

159.Sandra alleviates mother’s anxiety

160.Mother’s confusion about time/baby time

161.Does the baby make it hard to leave the house vs is it mother’s choice?

162.Let’s get going again

163.Nearly all the babies are undressed and readied for the massage

164.Who gets exposed and unprotected without the nappy: baby or mother?

165.There is a risk that the babies will urinate

166.A moment of intimate connection between a mother and baby

167.The change of leader/facilitator is spelled out

168.Clear role distinction between Maria and Sandra

169.Are the facilitators like the mums with their dolls?

170.Reassuring physical hold of babies

171.A unifying moment: deep connection when holding babies’ trunks at the same time

172.Joining in the massage/joining up together

173.The intimacy between mother and baby vs being on display

174.Close shared pleasure of touch

175.The next important step in the massage

176.The importance of following the moves

177.A mother and baby joining in late

178.Mother starts with the right moves

179.What’s the connection between mother rubbing her hands together and baby beaming at her?

180.Contrast between baby as terror and deep connection through the eyes

181.Anxiety about the massage breaking down

182.Anxiety about the relationship

183.Can anyone be left behind?

184.Moving on with the massage

185.Specific way of massaging the feet

186.Baby expresses: Don’t touch my foot!

187.Baby’s communication always needs to be taken into account

188.The connection between feet and the digestive system explained

189.The anxiety about baby’s taking in/digesting/excretion

190.There are points on the baby’s feet that can alleviate pain and anxiety for both mother and baby

191.The noisiness of digestion

192.A baby burps as a reaction to the massage

193.The group reacts together with a laugh

194.Anxiety about baby’s constipation

195.Anger about baby being difficult – link to defecation

196.Baby is seen as hard to soothe

197.Deep-seated anxiety surfaces about baby’s inside functioning

198.Sandra notices the mother’s difficulty and makes a helpful suggestion linked to the massage

199.Top trumps of defecation from another mother vs sympathy

200.Is the topic making the others close up?

201.Sandra notices that there is an uncomfortable feeling around and moves the massage on

202.Mother loses confidence when baby protests vs baby protests, mother receives communication

203.Has the baby had enough of the massage?

204.Anxiety about the baby needing an object to soothe him

205.Anxiety about not being able to soothe the baby

206.Baby’s crying vs mother’s anxiety

207.Maria notices the ping pong of anxiety and soothes both mother and baby together

208.There are different times that suit different babies

209.Not all babies react to the massage by being relaxed

210.Is the baby cutting off or has he had enough?

211.A fresh start when the massage is finished

212.Maria offers gentle calming with words and breathing for the mothers

213.Sandra is best advert for meditation

214.Maria focuses the mothers on the most fundamental function: breathing

215.Looking inward/ connection with the baby

216.A mother takes up a lot of space in the group

217.Calming intention vs holding oneself together

218.Is the meditation short because of the mothers or because of the babies

219.If I can calm down does it calm down my baby? Vs If I'm anxious, does it make my baby anxious

220.Mother and baby are visibly separate after the meditation

221.Welcome back mum

222.Was it the massage and the breathing/meditation that helped to bring the mother and baby together and allow the feed to commence finally?

223.Finally! Successful feed can happen!

224.What happens when mother's needs are not met

225.It's hard to leave the baby even for a short time

226.Mother's need to evacuate vs the worry about leaving the baby

227.Is the baby frightened or is she contained by the group

228.The baby's needs being met is dependent on mother's need being met

229.Worry about baby left alone spread around amongst the mothers

230.Maria reminds the group about the other important reason we are here for

231.Being the first can become stuck

232.Recent loss of mother's own mother

233.The baby makes things even harder

234.Grieving vs struggling to settle and feed

235.Is this exposing or is there relief in sharing difficulties?

236.Leaving space between the stories is important

237.A different story

238.Being separated permanently from first baby

239.Something went wrong with the mother

240.New baby, new beginnings

241.Not wanting to make the same mistakes

242.Helpful attention vs intrusion

243.There is hope in motherhood

244.What damaged the baby?

245.I don’t feel completely alone with this

246.Withdrawal/feeling overwhelmed by sharing

247.I can’t relate to everyone but I’m able to relate to someone

248.Parent loss and having a new baby

249.Hoping against hope

250.The pressure to be coping vs feeling fragile and grief-stricken

251. Remembering/being confronted with the loss

252. There is comfort here vs feeling exposed

253.Abrupt withdrawal follows sharing

254.A special way of rocking the baby to sleep

255.Baby closing his eyes doesn’t seem enough

256.Is it a case of like mother, like son?

257.A new, different story

258.The main problem is the awful worry

259.The birth of the baby vs the extreme worry about the baby dying

260.We’ve had a lot to deal with as a couple

261.Not having enough time vs not feeling confident vs feeling rejected/ left out

262.This little baby is under a lot of pressure already to look after the parents

263.Mothers who share something awful in their history

264.How can one have good bond with a drug addict parent?

265.Lack of confidence in one’s ability as a mother vs manic busyness to fill a void

266.Feeling like an outsider

267.Will this place make me feel different as well?

268.Always feeling judged

269.Worry about inexperience

270.Feeling upset vs needing comfort from cuddling baby

271.Loss of mother's grandparent vs worry about baby dying

272.Socialising with other mothers and babies vs being a good mother

273.Bereavement, a new baby and loss of job, perfect storm!

274.Professional help can be useful

275.Being here feels different

276.The pregnancy that caused so much worry that mother's mental health suffered

277.Maria creates a space for another mother to tell her story

278.Depression can come back at the most joyful times

279.There is something wrong in this relationship

280.Feeling maddened by one's worry

281.Revealing one's most disturbing thoughts

282.Who does the baby need protecting from?

283.The baby has changed a relationship between two women in the family

284.Reverie-like space where worries and sadness can be aired

285.The group has achieved its purpose

286.Maria brings the group together with acknowledgement and validation

287.Maria and Sandra fading into the background helps the mothers to share

288.Nourishment is offered to the mothers / group

290.This group allows for individual preference

291.There is still a shared experience here

292.The baby has finally managed to fall asleep

293.Maria brings the group to a timely close gently

295.There is preparation for a gap after the first three meetings because of the professionals are going to be away

296.The group could come together without the massage, would make sense

297.In the world outside this group can the mothers come together in a similar way or the differences are to big

298.Babies in transit seem to disappear

299.The leader of the mothers have come forth!

300.The mother who wants to be accepted or the mother who needs to be control

301.Lovely chatter – are the mothers talking about their babies?

302.Anxiety about the group being viable after today's one

303.A mother who asks for/needs a fair amount of looking after

304.The ethical and bureaucratic side of the observation interferes but it's important

305.Taking part but being apart and committing to come back – observer

306.Mother who feels easily judged/in the wrong

307.Granting permission to be watched/seen/looked at/observed

308.If I give you permission, will you help me with my baby right now?

309.Muddled boundaries vs I trust you more than mother-in-law

310.Why this baby needs to be held while mother leaves the room for a couple of minutes?

311. There are moments that are difficult for us all

312.Anxiety about being judged as too mad

313.The institution behind me vs the person I am who is here to observe

314.Ambivalence and loss of work identity vs observer as a work identity vs rivalrous feelings

315.A reunion after a few minutes apart

316.Not wanting/being able to leave alone with the baby

317.Ambivalence about giving official permission to observe vs is there a choice not to sign?

318.Finding it hard to leave

319.There is a limit and a time frame vs the neediness

320.The space is transformed back to its original setting

321.Conflict between being an observer vs wanting to be useful/helpful

322. The group may not be enough for some mothers vs projected feelings of inadequacy

323.Being ready, being early, being prepared

324.Are we a team now?

325.Maria has made sure that every mother is contacted who had been originally invited

326.Maria is preparing for a different group membership

327.Maria keeps the observation in mind

328.The observer's place and duties are kept in mind

329.Maria has experience in keeping a group going with a slightly different membership

330.Does the group change with different individuals joining or leaving?

331.Does it matter if the group membership changes?

332.Experience vs being open to the unique and unknown

333.The contrast between the massage and the mothers' stories

334.Maria does other important work that goes on outside this group

335.VIG: another type of observation

336.VIG is Maria's expertise vs can one be an expert at observation

337.There is no instant feedback here just continued attention

338.Are there big differences between Maria and the observer?

339.Maria can help these mothers

340.There was something important going on last week that also helped the babies

341.Sandra: here I am!

342.Sandra gets depleted by the time she gets here

343.Sandra also does important work outside this group

344.This group matters a lot to Sandra

345.Making the space ready for the massage vs need to eat

346.It's good to be prepared for a different group today

347.Anxiety about changing the way Sandra and Maria work

348.It seems important to keep to the setting

349.Will the change in the group membership affect everyone in the same way?

350.First arrivals – all attention on the mother and baby couple

351.Does the mother need to find a new place for herself and her baby?

352.Eyes on the prize

353.This is place/space where this mother can relax

354.Taking the throne

355.Now mother and baby can both settle down

356.Once mother is settled baby appears fully

357.Does this feel familiar to the baby or is it completely new again?

358.There is a baby who gets individual attention

359.Who is in charge of the space now?

360.Getting rid of the observer's chair vs not knowing whether the chair has a use

361.There is a lot to carry when one has a new baby

362.Reunion between mother and baby after the separation of settling in

363. Ambivalence about what might she bring in

364.Ambivalence/keeping a distance/being cautious about the joining the group

365.Similarity between baby and mother's name

366. Interested vs vigilant

367.Persecuted and anxious about another baby

368.Protective intervention from Maria

369.Being unsure

370.Individual belief about what's helpful to baby's development

371.Our own way of playing and we like it

372.Sandra disappeared again

373.There is space here for A and baby L

374.Third arrivals, another new baby and mother

375.What an effort

376.Heavy burden/overwhelming

377. Looking outside/looking away

378.Striking-looking baby

379.Being prepared

380.Anxiety about contamination

381. Feeling unsure

382.Acknowledging the make-up of the new group vs where were you last week

383.Sandra reappears

384.Other business than the massage ie research

385.Making consent matter of course

386. Being here is not quite supported by husband

387. We know each other already vs anxiety about arriving alone with one's baby

388.Is the baby too heavy or the mother too worn out?

389.Baby not sleeping and mother lacking sleep

390.Deep anxiety about baby making a noise and crying

391.Babies cry: ordinary disruption and disturbance

392.Maria picks up the level of anxiety about crying baby

393.Making an entrance without being noticed vs being overshadowed

394.Another new arrivals

395.Joining the group but staying very close to the facilitators and far from most other mothers and babies

396.Posture: anxiety about missing out vs wanting to be seen

397.Maria makes sure that everyone is accounted for

398.It's time to get on with our work!

399.Let's start again with gathering everyone together

400.Acknowledgement of the different membership make up of this second group

401.Starting with the latest arrivals, newest addition to the group

402.One mother signifies the baby's age in a different way

403.The group allows for difference in expressing baby's age

404.Did the mothers keep the group in mind in between?

405.The massage was left here last week and will commence again today

406.Supporting relationships between mothers and their babies in this special way

407.Maria and Sandra have different roles but are a team

408.The surprising benefits of massage for both mother and baby

409.Sandra makes sure that everything needed for the massage is given out

410.It's good to start together, in the same way – choreography

411.What happens when baby communicates: this isn't comfortable!

412.Anxiety about baby's protest/vocalisation

413.An intimate/specific way of comforting each other

414.There is space for the mother to express herself in whatever way

415.Mother’s vocalisation vs baby’s vocalisation

416.Who needs to be held: baby or mother?

417.The babies’ bodies are exposed at the same time

418.Determined physical prowess vs accidental discovery to self-soothe

419.A baby who is able to do something sensational with his body

420.The baby’s newly learnt skill appreciated or degraded

421.Maria makes notices that there might be comparing and helps to straighten it out

422.There is no need to show or feel put down

423.In this group resources can be shared

424.Something has broken up the group’s focus

425.Some mothers carry on with the massage while others are left behind

426.Sandra notices the wavering of focus and brings back the massage into focus

427.The importance of beginning at beginning: choreography

428.This is the way to start and it works, believe you me

429.Individual babies can respond to the predictable start in a satisfying way

430.The second step in the massage is also important

432.Is previous experience helpful or does it get in the way?

433.The baby’s will and individuality vs joining in the massage

434.Sandra is steady and constant in bringing the focus back onto the massage

435.A moment of intense coming together and focus bw m&b

436.A mother and baby try to join in again but to no avail

437.There is a different need dominating

438.Taking the throne

439.The massage takes mother away vs merging the mother and baby together

440.The development that takes place through the massage strokes

441.A new area of the baby’s body vs a new emotional connection

442.If one pays attention the baby’s preferred touch can be seen

443.Reverie-like space while moving in unison to the same choreography

444.The moment when the doing and being massaged becomes elevated/transcendence

445.Do we stay where we are in the learning or do we push forward with new strokes?

446.The opportunity for exploring face and head massage vs it might not work for every baby or mother

447.A baby for whom head massage is not feasible right now

448.Opting in and opting out of this part is allowed

449.The choreography in the here and now vs adapting it to your own baby's needs

450.The steps for finishing are prescribed and important

451.A mother and baby who have not been able to take part in the massage today

452.What's ordinary mess vs mess that happens because of the massage

453.A moment when some mothers seem to feel forced to be close to their babies

454.A mother who isn't yet ready to cuddle vs a baby who isn't yet ready for a cuddle

455.Nurturing vs feeding

456.The group magic has been broken

457.Something difficult bubbles up to the surface

458.Feeding and absence

459.Feeding and presence

460.We've hit the jackpot

461.The rocking chair as the symbol of maternal and material comfort

462.A strong sense of deprivation, the throne has been taken away

463.Maria re-focuses the attention onto the simplest way to bring everyone together: breathing exercise

464.How to set up for an exposing/difficult discussion?

465.Spelling out the group's other/main function

466.The importance of acknowledging the change in the group membership

467.In this group there is space to share but there is also space to not to share

468.Maria and Sandra create the right atmosphere for sharing

469.Air of anticipation before the opportunity to speak is taken up

470.Problems conceiving overtook the mother's life

471.The pregnancy didn't prepare me for early motherhood

472.While mother is talking about difficult early experiences, baby finds a way to manage

473.There are witnesses here to the pain that's spoken about

474.Baby's hunger or mother's need to regulate and manage difficult emotions

475.There have been unbearable feelings about being a mother to this baby

476.Ambivalence about fleeing or the feeling that this is the right group for this mother and baby couple

477.Palatable experience or too difficult to hear

478.The mother and baby who have found a way to manage disappointment, anger, sadness in this moment, thanks to this group

479.Another mother who has had fertility problems

480.The baby who has to hold his mother together with his eyes

481.What can be shown and shared in this space?

482.Mother needs soothing

483.The unspeakable experience of being left by father/partner

484.Almost breaking down, it's unbearable pain

485.Sandra can comfort the mother both emotionally and physically

486.The mother who always has tissues ready and seems prepared for tears

487.Having my second baby has made me feel left on my own

488.There is no mothering for this mother

489.Being a geographical outsider is something in common with one other mother

490.Being the mother of this baby is also a struggle

491.Standing up and rocking the baby vs being able to talk about the struggle

492. "A face like a slapped arse"

493.The support from family that's dwindled into nothing

494.The hope of an easier experience second time around dashed

495."Overwhelming"

496. What could be an ordinary issue has become too much

497.Frustrating experience of having a needy/greedy baby

498.What happens when the feed is to quick?

499.The three 'new' mothers followed by the three 'old' mothers

500.What leads to summing up briefly

501.There is space for silent withdrawal from the group

502.Who needs to be rocked and soothed: mother or baby?

503.Listening to each mother's story while also holding the group together

504.Is Maria also having a similar experience to new motherhood?

505.We all are affected and that's okay

506.Paying attention to every body not just the babies'

507.What is the catalyst for smaller groups?

508.Staying static and close to the neighbours

509.Simultaneous breaking up of large group and formation of smaller groups

510.What might we have in common?

511.Could the baby be cutting off from the feed when mother is upset and complains about father?

512.The baby who feeds to fast and the baby who doesn't eat enough

513.No one seems to be able to get it right: mother, father, baby

514.Low self-esteem and attacks on newly post-partum body

515.Are we offloading or are we comparing miseries?

516. The mother who withdraws/recoils when others share

517.Is it sometimes easier to talk in pairs?

518.Sitting next to one's baby yet being far apart

519.Recent loss of a mother

520.Talking about nursing a dying mother while being a brand-new mother

521.Physical reaction for mother and baby while listening to another's experience of grief and loss

522.The only way to manage is turn away from each other and look elsewhere

523.This is too much, makes one want to leave

524.The pressure to grow up, to move onto 'solids' vs the loss of a new-born experience

525.When the large group isn't together, something dangerous/toxic might emerge

526.What happens when fathers and partners are spoken about?

527.The fathers are absent from this group but not from the mothers' minds

528.The mothers who find their partners unhelpful and the mother who does not have a partner

529.The comfort in breastfeeding when mother feels left out or overwhelmed

530.How does one find out if the baby is hungry?

531.A particular way of checking if the baby is hungry

532.Settling down for a feed vs taking the throne

533.A big change in the feeding relationship

534.Positive changes happened in the past week for this mother and baby

535.Sustenance vs junk/convenience

536.Keeping babies alive entails sleep deprivation

537.The mother who has too much on her plate vs manic filling up with experiences

538.Maria keeps the temporal boundaries

539.Preparing the group for a break, what might the mothers do with the time

540.A full baby or an exhausted baby

541.The baby carrier has taken the baby in and away

542.Anxiety and ambivalence about the observer

543.Deep ambivalence about giving permission to be observed

544.There are other things more important than being here vs wanting to stay

545.The pressure to sign vs pressure to run away

546.Being backed into a corner by the observer

547.The mother who needs a lot of space and attention and finds it hard to leave

548.Maria creates a space for gentle separation

549.Simultaneous feeding and excretion on display

550.Soaking mother with urine

551.Does the mother have to put up with excrement

552.Anxiety about baby's excretion/defecation

553.Anxiety about baby's constipation

554.Anxiety about a new experience as a family vs baby's constipation

555.Claustrophobic spectacle of explosive excrement

556.Who needs looking after and clearing up: mother or baby?

557.Bad experience of excrement vs funny memory

558.Are we all in the same pooey experience together?

559.Who makes sure that Maria's anxiety is contained?

560. The anxiety and anticipation of running the group makes it hard to take in food for Maria

561. The old anxiety of mother's fertility being destroyed by cancer treatment vs the reality of the baby in the here and now

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Reflections on the Clinical Research Portfolio

This paper is a final reflection and recollection of the diverse experiences that contributed to the handing in of the accompanying thesis which represents the culmination of my research journey so far. The professional, academic and personal converge and are reflected on below as I collate and address the different components of the learning experience. The Clinical Research Portfolio is comprised of both the Qualifying Paper and the DProf thesis, and there are links between the two pieces of study, along with important differences.

The origins of both the clinical case study and doctoral research project can be traced back to the first term of the first year of the clinical training. I first met the young girl whose psychotherapy was the subject of the clinical case study in the first term. The concerns at that time were about starting and maintaining psychotherapy. The idea about doing research in the Parent-Infant Mental Health Service arose through a chance conversation with the Lead Child Psychotherapist in the trust where I was starting my four-year clinical training post.

According to the online Collins dictionary, research "is work that involves studying something and trying to discover facts about it" or "systematic investigation to establish facts or principles or collect information on a subject" (Research definition and meaning | Collins English Dictionary (collinsdictionary.com) last accessed 16.12.2020). These definitions serve as a starting point for my reflections on the processes and journey throughout the integrated professional doctoral programme and Child and Adolescent Psychoanalytic psychotherapy training. Each word in the two definitions above evokes strong feelings and tensions that have run through the

last four years for me. The definition also helps to focus on the main subject of this piece of writing: research and what it has meant to me in the context of my training.

This piece is also reflective of the work it has taken to get here and a feeling of certainty that it is not quite finished, nor can it ever be. By studying 'something'; something can be broken up into many different parts while also having a unified subject: the human mind and living experiences of one person, dyad, family or group at a time, through psychoanalysis, its practice and its theories[1]; the discovery of facts and constantly reflecting on and questioning what is a 'fact', a "clinical fact" (e.g.: O'Shaughnessy 1994; Quinodoz, 1994; Tuckett, 1994 cited in Rustin 2019) or a research fact within psychoanalysis as a research paradigm. Edwards, drawing on Hinshelwood, adds that "in talking about the evidence base for the validity of psychoanalytic knowledge (thus the theory…). Hinshelwood spells out how "research confidence in clinical material has always been the basis of evidence in psychoanalysis". … The generation of psychoanalytic knowledge is thus ongoingly recorded and amplified in the theory that we use, backed always by researchers from the consulting room" (Edwards, 2015). The confidence, authority and experience that it takes to put these notions into practice has been a constant challenge for me.

Both final studies, or as final as any piece of psychoanalytically informed writing can be, compromising of the clinical case study and the qualitative research project that is written up in the thesis accompanying this piece, have their origins in the very first term of my training. They were built slowly into the empirical research projects that make up the Portfolio.

[1] The tension between the particular and universal and the tension between conception and language comes through here which is again something I have grappled with throughout the training; and I imagine I shall continue to do so.

A particular reflection that perhaps belongs here is on the experience of being part of the second cohort on the new clinical integrated doctoral programme between the Tavistock and Portman and Essex University. The hope and possibility about the doctoral programme and the clinical training running closely together also mixed together with conflicting demands. Being part of something so new and pioneering within the institution of the Tavistock Child Psychotherapy training often felt burdensome and disloyal to the long-standing tradition and established ways of working. Here, I turn to Bion, who saw far ahead when he wrote about psychoanalysis being like a stripe on the tiger's coat when considering how we understand the human endeavour (Bion, 1990). Thus, looking to other paradigms can be useful even if sometimes it also makes one come back wanting to learn more about psychoanalysis.

Research Methods – step by step

Being a novice researcher and I have found it hard to cultivate what I think of as the researcher side of me. In the first two years of the training, the different units that make up the Research Methods teaching, and learning were structured to give a flavour of the different components that make for good research practice. While learning about the ontology, phenomenology and methodology of qualitative and quantitative research methods, we were required to submit pieces of work that built up towards a research project proposal. Although these pieces were academic, they also had empirical aspects to them that informed the later projects. The critique of an empirical study, annotated bibliography, and the analysis of process notes using a qualitative research method all were new endeavours and opened up the level of enquiry and possibilities of generating knowledge within the field of Child Psychotherapy Research.

Child Psychotherapy Research is also critical in building up the evidence base for the treatment modalities offered by Child and Adolescent Psychoanalytic Psychotherapists. This a relatively new area and there are tensions between old and new while there is a strong recognition that the possibilities research can create are exciting, important and valuable. I have in mind the IMPACT study which has offered many new avenues for knowledge generation and evidence base building (see Rustin & Rustin, 2019; Isaac, 2020), which is still on-going.

As mentioned above, the empirical and clinical come together in a particular way in the clinical case study which is an established way of learning and teaching in psychoanalysis, stemming from Sigmund Freud and used ever since. However, the tension has also existed ever since Freud to prove these theories that have originated from the consulting room. The twenty-first century has brought on technological advances that can make measuring feelings and human relationship patterns possible and there has been interesting developments in Neuropsychoanalysis (e.g. Singletary, 2015; Solms, 2021) that support the dialogue between those who are steeped in different scientific paradigms.

Although these new developments are beneficial for the child psychotherapy field from afar, my individual learning has been concentrated within the consulting room on an on-going basis with the expectation that one of the three intensive training cases seen throughout the training would be the focus of the clinical case study (CC4) which is the requirement for qualification as a Child and Adolescent Psychoanalytic Psychotherapist.

I chose to write about my adolescent training case for the qualifying paper because with my latency and pre-latency cases the children and the mothers were often seen

together, and I wanted to write about a case where there was solely individual work. Another aspect of the case that motivated the choice was the abrupt and painful ending that I wanted to understand further. The young adolescent I started working with in my first term of training who was mid-adolescent stopped her treatment after two years. This illustrated to me close-up the far-reaching consequences of her particular early relational trauma, internal landscape and a reality of double deprivation (Williams, 1997).

The methodology of my clinical case study followed convention in that I saw the young person for intensive, in this case three-times weekly, psychotherapy for a period of nine months. Previous to this we met once-weekly for over a year. During the intensive treatment I wrote up extensive process notes and had weekly supervision. Throughout this time themes emerged in the work, however it was the retrospective process of re-reading the process notes that guided the thinking and writing about of the clinical case study. The study did not present findings. However, in terms of generalisability, the study itself is part of line of similar case studies and presents work that can be characterised as “normal science” (Kuhn cited in Rustin, 2019).

I will now return to the research methods and the doctoral research project proposal.

Changes in Research Design – Embracing What is Possible

At the end of the second year, I wrote my research proposal. This followed discussions with the (PIMHS) service leads and what might work within the patient population of new mothers and babies who are vulnerable and struggling with crying, establishing feeding, sleeping, the relationship. Baby massage groups are offered as an early

intervention to mothers and babies who are referred by their health visitors or GPs. In the context of Child Psychotherapy, my interest in intervention at the earliest opportunity and what it might look like comes from the experience that often early relationship difficulties and birth trauma are part of the presentation in children and adolescents who are seen in Child and Adolescent Mental Health Services (CAMHS).

The research proposal was a mixed method design. Initially, I was going to use a quantitative, comparative analysis of the Mother's Object Relational Scales (MORS) before and after attending the baby massage groups, along with interviews with a number of mothers after the baby massage group. Reflecting on this ambitious, and still interesting, proposal now it seems that it was motivated by wanting to show concrete results and perhaps contribute to service evaluation. The reality of carrying out the project was not feasible which was helpfully noted at the Supervisory Panel Meeting soon after the research proposal was academically approved. The Supervisory Panel included my Research Supervisor, Dr Brinley Yare and the chair was Dr Jenifer Wakelyn. They helpfully suggested that I scale down the study to something more manageable within the timeframe of the remaining two years of the clinical and doctoral training. With their support, I settled on the meaningful and worthwhile possibility of observing a baby massage group. I felt relieved by this decision and hopeful for the next steps. I discussed this with the two service leads of PIMHS who were supportive of this change and then re-wrote my research project proposal with infant observation as my data collection method and grounded theory as my method of data analysis.

The evidence base for infant observation research is relatively small as infant research often relies on video recordings, questionnaires and interview data rather than the naturalistic observation. This seems especially driven by service provision and funding

for services. A research study conducted by de Rementeria (2018) made use of infant observation while analysing short video sequences of different mother and baby dyads in psychiatric mother-baby unit. I have not yet had a chance to read the full report, however it seems like an innovative way of using the method of infant observation that is also more widely acceptable.

Parallel Workings – Ethical Approval, Planning, and Further Decisions

The third year of the training involved intensified parallel workings and decisions about the two final projects. It took almost the whole academic year to secure ethical approval. This was another new process that I found challenging and anxiety-provoking. It was also partially due to the patient population who were the subject of the study, mothers and babies who can be classified as vulnerable. Stringent ethical interrogation of data protection and informed consent was followed. Interestingly, the sense that despite all these measures I often felt that I was taking something from the participants. On reflection, as many aspects of the experience, this is linked to the strong infantile feelings that were stirred up throughout the project.

While grappling with the ethical approval (and the many other demands and duties the process entailed along with undertaking the clinical training), my adolescent intensive case broke down. I felt this to be a painful experience but powerful learning. Although the treatment finished prematurely the space afforded between the ending and writing of the qualifying paper helped with the processing of the experience.

The striking parallel in the data collection methods is that I used my own notes both for the clinical case study and for the observation. The data analysis was different as

the themes for my clinical case study were developed through the weekly supervision and the close reading of the process notes but not as rigorously as the line-by-line coding of the grounded theory approach. It would be interesting to see whether the themes would be different if I used line-by-line coding on the process notes. There is now evidence that the themes that emerge can complement with rich understanding the psychoanalytic theories (e.g. Creaser, 2019; Shallcross, 2011; Wakelyn, 2010). In the case of my study the line-by-line coding simultaneously helped me to immerse myself in the data while also provided a triangular space where projective identification did not dominate so much.

The range of learning and the connections between the two studies feel manyfold and far reaching for me as a qualified clinician and researcher. Whereas the “hypothetical infant” (Spillius cited in Briggs, 1997) is present in all psychoanalytic treatment as reconstructed through the build-up of clinical material, transference, countertransference and acting-out, the observation of the group of mothers and their infants in the baby massage course context helped me get closer again to the actual infant. It could be argued that the pre-clinical observations sensitised me to the clinical work and the clinical work further sensitised me to observing infants and their mothers.

Obstacles – internal and external

The research process has been helpful in finding an authoritative voice and ownership of the project. What has been interesting is that I have found it almost impossible to transfer the growing clinical confidence of the second part of the training to the research project. This could be related to the personal meaning of the DProf and to the infantile feelings stirred by starting something new so many times during the period of training.

The challenges of fitting together all the different parts of the training and DProf and feeling up against time has been a constant feature of this experience for me. The observations, i.e., data collection and grounded theory analysis coincided with the last year of my training and the preparation for professional qualification which had practical implications on the time and mental space available for the other parts (i.e. the literature review and the writing-up). The impact of this was that coming into the literature review there is a certainly a sense that there is a lot to learn and understand while also appreciating that the experience of observing the baby massage group had belief in the process but also a certain naiveté to it (both myself and the participants). The difficulty in holding onto the research supervision experience along with the concurrent mourning and different levels of loss I experienced were perhaps related to the level of psychic pain and primitive anxieties I encountered as an observer. A question I ask myself about the study is: Why the baby massage group? The parallels between the importance of the intervention and its potential and the difficulty in getting into the 'depth'. Along with the process of writing up a constant oscillation between the project and the baby massage group as being very important and not being significant.

The Covid 19 pandemic has had unexpected effects on my research experience. I wrote the qualifying paper during the first national lockdown. It was during the very last term of the training leading up to qualification. Although there were uncertainties and anxieties, the structures of the training and the placement were still there. However, the main bulk of the analysis and writing up of my observational study happened post-qualification. As time went on, the thesis grew into a source of deep anxiety. I started a new full-time qualified post. The person who I am in a bubble with was hospitalised twice which added to the worries. In the meantime, there was a second national

lockdown and increasing worries and social isolation. With the support of my research supervisor and the research course co-lead I applied for a four-week extension during which time I have managed to finish the thesis. I shall be learning from this experience for a long time to come while also wanting to leave it behind.

Difference and Working Through

Reflecting on the process, there is a glaring whiteness that I find myself noticing again. All participants, teachers and supervisors I have referred to are white. Whereas I am a foreigner, albeit I am white. By virtue of my profession I am part of an elite group that in some ways that makes me feel uncomfortable. I am also a woman which is important to note as Child Psychotherapy is a female heavy profession. In contrast, it is also interesting to note that both my intensive case supervisor for the clinical case study, and my research supervisor were men. This certainly enriched my experience. Although one hopes that the third position and triangular space is something that we keep in mind regardless of our gender, I believe that my thinking capacity has been enhanced by the difference afforded by virtue of our genders. The observational aspect of the supervisory role is not lost on me and the containment provided by having a compassionate witness to one's struggles makes a real difference.

Another aspect of difference that I would like to mention here is the difficulty of holding onto the shared experience of research within the peer group. This, of course, has links to my individual make up but contrasts with the clinical groups. It may be connected to the newness of the integrated research doctorate which accentuates our collegial differences. For example, from a research experience point of view. The last

six months of the writing up have been particularly lonely as we all were looking for jobs or starting new jobs. Differences in the group came to the fore once again.

The experience of conducting an observation just as I was nearing the end of the clinical training afforded new insight into the practice of infant observation. I made a strong link to the basis of the training and M7, while I was also ending four years full of rich clinical experiences that can only be part of M80. I see myself graduating to parent-infant psychotherapy, group work and therapeutic observation as a result and would like to share my experiences in a mentoring or teaching capacity while also continuing to learn and build on the experience.

Final Reflections

Learning from experience is humbling, challenging, painful and enriching. Thinking ahead, I can see that the silt of all that has been upturned in the processes of the past year will settle. I am looking forward to the VIVA where I can further discuss the empirical research project and next steps. My clinical practice will continue to benefit from the rich and evolving landscape of the Child Psychotherapy and Infant Observation Research. I hope my contribution will find its place within the field.