

A Decade of Parent and Infant Relationship Support Group Therapy Programs

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ABSTRACT

A 10-year experience with a unique, short-term community group therapy program, Parent and Infant Relationship Support (PAIRS) for high risk infants and their parents is discussed. The program offers ten, 2-hour closed weekly group therapy sessions for mothers and their babies, following a parallel conjoint model of group work. The aims of the PAIRS group program are three-fold: to increase positive parent-infant interaction and secure attachment, to decrease maternal postnatal depression, and to foster optimal infant development. Evaluation of the program has shown promising results in comparison with a control group. Clinical case material is used to illustrate therapeutic processes underlying the positive outcomes.

PARENT AND INFANT RELATIONSHIP SUPPORT (PAIRS)

The idea of holding groups for parents and infants arose as an extension of working for several years with a parallel conjoint

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model of group work for preschool children and their parents. The original model of time-limited group work is described by Parmenter, Smith, and Cecic (1987) and had been adapted for work with preschoolers in the 1990s. Feedback from psychologists working with a referred population of preschool children with special needs (developmental, social, and behavioral problems) in the specialist services section of the state Welfare Department in Victoria, Australia, identified a common history. Mothers of referred children aged from 3 to 5 years frequently reported that their children had been unsettled babies, crying a lot and showing poor sleeping and feeding patterns. In this way the idea of an infants' and toddlers' group was conceived as a lower age application of the model already in use by the service for troubled preschool children and their parents.

Three agencies (Child Psychiatry, Early Intervention, and Maternal Child Health Nursing [MCHN]) collaborated to undertake a needs survey based on notification of all live births to the region and a clinical community-based research project was designed. A profile of those in high risk categories, such as premature birth, teenage mother, substance abuse, domestic violence, single parent, difficult birth, multiple births, and infants of parentst with a disability or mental illness, was examined. It was agreed to begin with a pilot group for premature infants from birth to approximately 2 years of age. Practical and administrative decisions were made relating to suitable community venues, staffing, clinical responsibilities, and research measures. The program had three aims: to increase positive mother-infant interaction and secure attachment, to decrease maternal postnatal depression, and to enhance infant development.

Evaluation of the pilot program was based on repeated measures at pregroup and post-group for the three major areas. A contrast group of mothers and infants with similar difficulties, who were receiving universal or specialist care but not the PAIRS program, for a similar period of time, was randomly selected and assessed.¹

Following the promising outcome of the pilot study, the client base was broadened, a training package and manual was devel-

1. The PAIRS program was funded by an Innovative Project grant from the Victorian Health Department in 1997.

oped, and the program was presented at local and international conferences.² By the end of the decade in excess of 50 PAIRS programs involving over three hundred families and their infants had been established in several regions in Australia, with an average of six families per program. A representative sample of the participants completed outcome measures and these findings are presented.

RATIONALE FOR THE MODEL

In the early 1990s there was an emerging literature on the efficacy of brief interventions targeting mother-infant interaction in reducing maternal postnatal depression (Barnard, Morisset, & Spieker, 1993; Cramer, 1993). This, in turn, was shown by others such as Murray (1992) to enhance infant development. Dyadic work with the parent, usually the mother, and infant continued to grow during this decade until the focus shifted to triadic observation, monitoring, and intervention in the new millennium (Fivaz-Depeursinge, 2006). Work on the early effects of trauma on young brains became a study in itself, with authors such as Perry, Blakley, Baker, Pollard, and Vigilante (1995); Moore (1997); Pynoos (1993); and van der Kolk and Greenberg (1987) linking early trauma with organic changes and later maladaptive behaviors. Attachment theorists from Bowlby (1999) and Ainsworth, Blehar, Waters, and Wall (1978) onwards stressed the protective value of secure attachments between mothers and infants, and the detrimental effects of poor attachments (Carlson, Cicchetti, Barnett, & Braunwald, 1989). Given the plasticity of the infant brain during the first two years of life (Fox, Calkins, & Bell, 1994), it was hypothesized that in addition to reducing risk by enhancing attachment during early intervention, some reversibility of preexisting trauma effects may be possible (Fonagy, 2001; Fonagy et al., 1996). By the end of the decade, authors such as Schore (1999) were foreshadowing and linking the effects of a secure attachment on brain development, affect regulation, and infant mental health (Schore, 2001). More recently, Gallese (2006) illustrated the existence of “mirror neurons” in the infant brain.

2. Visit the PAIRS Web site at www.PAIRS.net.au.

These are triggered during mother–infant interaction, allowing anticipation by the infant and the formation of a neuronal template for interpersonal attunement and intimacy.

Group therapy has a well documented history of providing social and emotional support for members as well as allowing ventilation and exploration of feelings in a contained setting. Insight may develop with observation and reflection on one's own and others' behaviors and experiences over time. Social learning is possible by imitation and modelling and social comparison may lend an altered perspective to one's own difficult life situation. The group dynamic is a powerful agent for change, as described by Bion (1974) and Yalom (1985). Group phenomena such as "identification with the group" allow for social referencing and comparison. The group can act as a container for primitive emotions and a safe place to explore negative thoughts and experiences, which may lead to new perspectives (Minde, 1993). Time-limited therapy is known to be motivating as it carries with it the belief that improvement and recovery are possible (Fisher, 1980). Limitations of short-term interventions include the potential loss of support at the conclusion of the program. Comparatively little has been written about working with groups of mother–infant dyads, although during the mid-1970s mothers' and parents' groups had emerged as a way of working in child guidance clinics (Pasnau, Meyer, Davis, Lloyd, & Kline, 1976).

The parallel conjoint PAIRS model utilizes elements of the Ainsworth Strange situation (Ainsworth et al., 1978). In the Ainsworth context, separation and subsequent reunion between mother and infant makes it possible to assess attachment status. The parallel, combined group structure within PAIRS allows for observation of the attachment and for therapeutic work with the mother–child relationship at the points of separation and reunion each week, promoting the mother as a more secure base. Reservations about the possible harmful effects of separating parents and young babies were addressed by building in adequate preparation for separation and reunion. In the original model, school-aged children and their parents spent half the time together, and half apart (Smith, 1985; Parmenter et al., 1987). In the preschool adaptation used for PAIRS, the 2-hour session begins with infants, mothers, and staff together for 45 minutes, then,

after due preparation, mothers and babies separate to form parallel groups for 45 minutes. Both groups then reunite for a final 30-minute combined session.

GROUP STRUCTURE, PROCESS AND ORIENTATION

The initial combined group is formed by mothers, babies, and staff sitting in a circle on a carpeted floor. Mothers are encouraged to hold their infants, and take turns to be welcomed with a greeting song. At the first session each mother gives a brief introduction of herself and her baby's story, and her hopes for the program. At subsequent sessions mothers take turns in reporting back on events, progress, and problems through the previous week. They are encouraged to "wait, watch and wonder" at their infants' experience (Muir, 1992). The approach is predominantly psychodynamic in orientation with some use of modelling and interactive coaching. The group then engages in interactive games such as peek-a-boo, singing, and enacting nursery rhymes, and on occasion practicing infant massage, before preparing the mothers and infants for separation. The mothers are advised that in their absence, the infant-therapists will make attempts to soothe and settle a crying baby for 5 minutes, but if this is unsuccessful, the therapist will call the mother back to the baby (or the mother may leave the mothers' group and return to her infant). The mothers are encouraged to tell the infants they are leaving and give their baby comforters to the staff. The mothers then leave the room with two dedicated therapists to form their parallel mothers' group in an adjacent room, while the babies remain, forming a babies' group with a high ratio of staff.

The mothers' group is intended to provide a safe and nurturing space for the mothers (on rare occasions, including a father) to explore the complexities and traumas associated with their experience of motherhood, free from primary responsibility for baby. The approach is informal, with coffee and cookies provided. In the first weeks, women are encouraged to talk about their reasons for attending the group, and to share their experiences of pregnancy, labor, early parenting, and support. Therapists may make links between past and present experiences raised by participants, explore feelings of ambivalence and loss, and articu-

late common themes. Turn taking is encouraged, group discussion and joint problem solving facilitated, and the feeling content of the mothers' experience explored. The time limit is flagged before the mothers' group ends so that powerful emotions expressed can be contained and a sense of closure reached. The mothers are reminded that their infants will be cued to expect them back and are encouraged to greet them on reunion.

In the separate parallel infants' group, the task for the infant-therapists is to build up an understanding of the internal world of each infant and the pattern of their relatedness with others. This composite picture is informed by observations of baby in mother's presence, at separation, and on reunion, and by the direct interpersonal experience of the therapist being with baby (Beebe, 1998). At times, significant infant distress manifests. While this provides useful information about a baby and his or her relationships, it poses a challenge to staff and to the therapeutic goals of the program. Babies whose crying is extreme or prolonged are reunited with their mother after attempts to comfort, settle, or distract them have failed. Staff try to soothe infants by talking to them gently about mother's absence, perhaps showing a photo of mother and infant. Comfort and understanding are offered before picking the infant up. Therapists aim to express an empathic understanding of distressed infants' feelings by looking at their faces and gently talking to them about how they feel in their mother's absence. The intention is to help the infants to regulate their emotions. Younger infants may be given a soft cuddle rug or firmly swaddled and laid to rest with rocking or back rubbing. Older infants may be distracted by stimulating toys, nursery rhymes, or by engaging in play with other infants. Babies and toddlers may have a bottle, or morning tea. A small duck (the logo of the PAIRS program) may be stuck to a clock and the baby's gaze directed to this marker to signify when the mothers are due to return, with sayings such as "quack, quack, mummies come back." Most infants settle in the first few weeks of the program, others are passive initially but protest later, and then settle.

Before re-entering the babies' room, mothers are reminded to knock to announce their imminent return. Staff face the babies toward the door where the mothers will enter, voicing this expectation. When the mothers and leaders return to the room,

mothers and infants greet and resettle into a circle, to form the final conjoint group. The leaders from the babies' group then give feedback to each mother in turn on how her infant managed the separation and what play activities he or she engaged in. The whole group also receives feedback about themes from the mothers' group. The session concludes with a ritual farewell. This may take the form of 5 minutes quiet time together before singing a goodbye song using a puppet to name each mother and infant in turn, before all members leave.

Before the program ends, fathers, partners, and support persons are included with mothers and therapists in one or two evening groups to explore and endorse their role in the family.

METHOD

Risk Population

Demographic risk indicators were considered from three domains: parent, infant, and family. Parental mental and physical illness was deemed relevant, in particular maternal postnatal depression (PND). Domestic violence, substance abuse, and sexual abuse histories were also considered as risk factors, as were poor relationships between mother and infant. Single parenthood and teenage parenthood were considered as stressors as were family isolation, lack of social support, and immigration. In relation to the infant and perinatal period, premature, unplanned, and multiple births; difficult births; birth deformity; developmental delay; failure to thrive, settle, or sleep; and excessive crying were encompassed. Following the pilot groups with premature babies, the referral base was broadened to include clients from these categories. Mothers with acute psychosis and heroin use were excluded. Participants for each PAIRS group were selected to include a heterogeneous mix of families.

Sample Characteristics

Referrals were predominantly for maternal PND and bonding difficulties. The treatment group infants comprised 33 girls and 41 boys ranging in age from 2 weeks to 27 months, with an aver-

age age of 9 months. The control group infants included 12 girls and 20 boys aged from 2 to 36 months, with an average age of 9.9 months. Approximately 30% of both groups were premature infants, the remainder being unsettled or interacting poorly.

Research Design and Assessment Tools

Three quantitative assessment measures were selected to assess the three major aims of the group program, using a pre- and post-group repeated measures design to evaluate the effectiveness of the program. A selection of qualitative tools was also included.

Mother-child interaction was assessed using the Dyadic Mutuality Code (DMC; Censullo, 1991). This is a behavioral rating scale assessing responsiveness in interactions between mother and infant. Strengths and weaknesses on six dimensions are measured: mutual attention, positive affect, turn taking, maternal pauses, clarity of infant cues, and a global rating of maternal sensitive responsiveness. While the Ainsworth Strange Situation was not used to assess attachment status, the DMC gives a measure of the mother-infant attachment. The DMC was given in a standardized way, with mother and infant sitting facing each other, having been asked to play and talk as they normally would for five minutes. The interaction was videotaped in community clinics (not labs), before and after the program, and at follow-up at home. Staff and research assistants were trained to use this instrument and to follow the scoring procedure.

Maternal postnatal depression was rated before and after the group program and at follow-up by mothers' self-reports on the Edinburgh Postnatal Depression Scale (EPDS; Cox, Holden, & Sagovsky, 1987). Scores above 12–13 indicate a depressive illness, while scores of 9–10 alert primary care workers to the possibility of postnatal depression.

Infant Development. The Bayley Scales of Infant Development (Bayley, 1993) was selected to assess infant development. This test covers three domains of development during infancy from birth to 36 months using mental, motor, and behavioral scales. The Bayley was administered by psychologists pregroup, post-group, and at follow-up.

Sample size. Data was obtained from several regional sites. Full data sets were obtained for 74 mother-infant pairs completing PAIRS group programs from 1996 through 2006.

Control group. The same set of measures was administered to a control group on two occasions over 10 to 12 weeks. These were referred mothers and infants with comparable difficulties who were receiving routine postnatal care (and specialist care, such as physiotherapy) but not relationship group therapy. Full data sets were collected for 32 mother-infant pairs.

Follow-up. A subsample of the treatment group (14 mother-baby pairs) was followed up and reassessed using the same measures several months after the end of the group. On average, follow-up assessment took place about 12 months after the post-group assessment, with a range of 6 to 28 months. The control group was not followed up due to lack of resources.

Qualitative measures. In addition to the information gathered from the measures described above, parents were given 5-point (Likert) scales to complete on an evaluation sheet at the conclusion of each program. These included open questions as to what was helpful and not helpful about the program and suggestions for change.

RESULTS

Quantitative

Mother-Child Interaction. Positive mother-infant attachment, as measured by the DMC, was initially at a lower level for the treatment group than the control group, but showed a statistically significant increase for the 74 mother-infant pairs who completed PAIRS group programs ($p < 0.001$). The slight improvement in the control group was not significant (Figure 1). The progress in the treatment group was maintained and increased for the smaller number of mothers and babies available for longer term follow-up.³

3. Further psychometric details are available from the corresponding author.

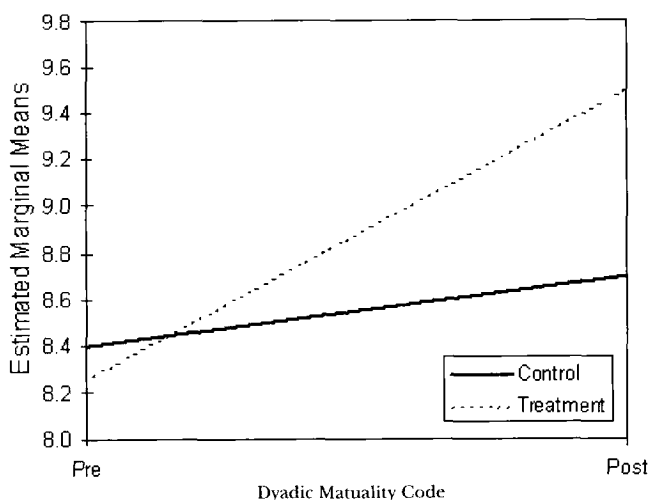


Figure 1. Pre- and post-DMC scores for the treatment ($n = 74$) and control ($n = 32$) groups

Maternal Postnatal Depression. For the group of mothers attending PAIRS programs, self-reported depression (EPDS) decreased to below the primary care cut-off score, despite being in the clinical range at outset ($p = 0.006$). For the control counterparts receiving routine care but not targeted mother-infant therapy, the decrease did not reach a level of statistical significance (Figure 2). The follow-up research showed that this improvement was maintained.

Infant Development. After correcting for differences in averages where the control group was less well developed than the PAIRS intervention group at outset, the outcomes for the three scales of development—mental, motor, and behavioral—were compared. For the mental scale, the PAIRS infants showed greater gains in cognitive development than control infants, but the difference was not statistically significant. Similarly, a nonsignificant difference in motor development was found between the two groups,

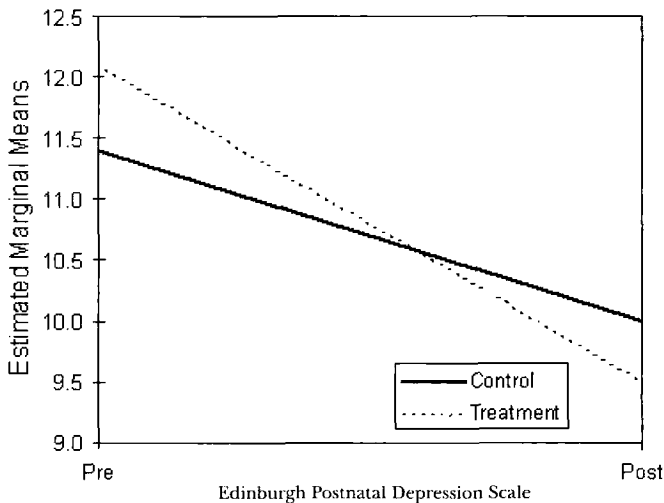


Figure 2. Pre- and post-EPDS scores for the treatment ($n = 74$) and control ($n = 32$) groups

with the PAIRS intervention group showing greater improvement. On the behavioral scale, which assesses the infant's ability to self regulate, to focus on the task presented, and to cooperate in responding to changing test items, notable gains were made by the infants attending PAIRS programs, but not for the control group. Significant gains in behavioral regulation were also found for those PAIRS infants followed up.

Data from the follow-up sub-sample were analyzed using an analysis of variance (ANOVA). This procedure compares the relative contribution of the three variables to the significant differences in the PAIRS groups from pre to post and at follow-up. The findings were that improvements in mother-infant interaction contributed most, followed by decreases in maternal postnatal depression, with gains in infant development (behavioral regulation) contributing third ($p = 0.001, 0.007$ and 0.008 , respectively).

Qualitative

Ratings. Mothers in the PAIRS groups rated their satisfaction with the program on four dimensions, namely: bonding with the infant, support for the mother, parent confidence, and decrease in postnatal depression. On the first three measures, mothers' responses indicated that they were mostly to fully satisfied with their relationship with their infant, the support they received, and their confidence as parents. They were slightly less satisfied with their perceived decrease in PND. Parents also rated their satisfaction with how the program in general had attained its goals, the vast majority rating that they were highly satisfied. Negative feedback related to the time of day the group was held (clash with infant sleep time), disappointment at group drop-outs, hearing the baby cry during separate group time, open ended discussion without solutions being given, and a wish for more cups of tea!

Parents' Feedback

Social Support. Parents said that they valued the support from the other group members. For some, the transition from a work culture and identity to home-based motherhood constituted a crisis. Meeting other mothers and babies decreased their sense of geographical and emotional isolation. Some families had missed out on a tradition of song and nursery rhymes and here cultural diversity and the sharing of English, Scottish, European, Middle Eastern, and Asian lullabies, nursery rhymes, and TV jingles enriched the group. Books of songs were collected over the years. After participating in interactive games, dance, infant massage, and hearing feedback on the babies' choices of toys, games, and playmates, some mothers said that they realized for the first time that their baby was "a person." Feelings relating to separation from their babies were mixed. Some parents appreciated time away from the baby during the parallel sessions and the feedback on the baby's adjustment. Others felt guilty when the babies cried, or realized for the first time how much their babies needed them. Some felt it was a good preparation for returning to work. Several mothers who were collected and transported to the pro-

gram each week acknowledged that they would otherwise have lacked the motivation or resources to attend.

Information Sharing. Mothers living in new growth areas that lacked infrastructure made friendships with other group members and went to visit each other, joined play groups, or formed support networks at the end of the program. They shared knowledge of local resources such as swimming classes, gyms, child care, and library facilities, as well as professional speech therapy and counselling services. Where relevant, at the conclusion of the program, participants were informed of domestic violence and sexual assault agencies, or referred on to adult psychiatric services and home visiting maternal and child health nurses.

Role of the Father. One or two evening sessions were held for mothers to bring their partners or support person. Many mothers wanted their partner, usually the baby's father, involved and engaged, but a small subgroup saw the father as part of the problem and wished to leave them out of their "secret women's business." Several mothers gathered courage from the group to leave an abusive partner altogether. Some sought to test the waters and reconcile with the fathers of unplanned babies, or to seek a new partner. Of the fathers who attended with the mothers, many had a highly emotional response to fatherhood. One told of how he carried the sight and sound of his wife's distress and his son's cry to work after he left them each morning. Another father related how he had asked for a transfer from the infant burial section of the cemetery where he worked after it was discovered that his own newborn son had a heart defect. Many poignant stories were told, and mothers were at times surprised to hear how emotionally connected their partners were to the infant's and their own distress. It was not uncommon to hear that a couple had continued to talk for many hours into the night after an evening meeting.

Case Studies

Embedded in the research findings are many stories of change, some greater than others. The following three case studies have been selected to present families where mother-infant interaction improved markedly, maternal postnatal depression lifted and infant development blossomed.

Case Study 1: Mother Sally and Baby Pip: A Case of Impaired Mother-Infant Interaction⁴

Mother Sally and her baby daughter, Pip, were referred for help with mother's depression and infant distress. From the outset they demonstrated extreme difficulty in relating face-to-face, both actively avoiding looking at each other's faces. Pip presented at the first week of the PAIRS group as a delicate, thin, pale child of 10 months, with a runny nose, who looked anxiously about as Sally carried her into the room. She was placed on the floor, crawled toward some toys and then turned looking in distress for her mother, dissolving into an inconsolable whine of despair. Though able to crawl, Pip appeared immobilized and did not approach her mother. Sally in turn did not go to Pip, but instead stated with resigned frustration, "this is what she is always like . . . always whining!" Pip's distress escalated, confirming Sally's sense of inadequacy and defeat. Eventually Pip crawled across the space to where Sally was seated on a low chair and snuggled at Sally's feet, with her face tenderly placed on Sally's shoe. Pip did not try to look at Sally's face or to seek any other comfort. Sally was at that point unable to acknowledge Pip or to reach down and comfort her. The baby's moving away from mother, feeling lost and despairing, then approaching mother's feet and settling on mother's shoes was repeated several times, as if she could neither be away from nor close to her mother.

Sally was desperate to express her feelings of despair to the group. Thoughts and statements around the birth included "she wasn't my baby," "I didn't recognize her," and "she wasn't what I expected." Her stated aim in attending the group was "to not feel so distant to Pip." Sally already had some intellectual understanding that her feelings of difficulty with Pip were connected to her feelings about her own mother, who left when Sally was 13 years of age. It was decided at this first group session that rather than separate to another room, the mothers would move to one end of the shared room for a relaxation exercise on the floor, while the babies and infant-therapists stayed at their end. Pip cried despair-

4. From the files of Anne Cumming, Siobhan Hannigan, Christine Steentjes, and Dr. Sophia Xeros-Constantinides, Melbourne, Australia.

ingly as her mother moved away and could not be comforted by her infant-therapist. When taken to her mother lying on the floor at the other end of the room, Pip lay on her mother's stomach and continued to cry inconsolably. The mother tried to comfort her but the baby wriggled, pushed away, and averted her face. The therapist put into words the baby's need for her mother and how her mother felt unable to satisfy her no matter what she did. At the end of that session, the therapists were left with the striking image of Pip having laid her head at the mother's shoes and of the mother's emotional detachment from her.

At week two, Pip was a little less agitated and distressed and more able to return to Sally's shoes for comfort, as if these were her secure base. She did not cry inconsolably as she had the previous week. Pip continued to show marked gaze avoidance in relation to her mother, but was able to sustain eye contact with the therapists in the joint group. Again Sally appeared unaware of Pip's communication; however, Sally did respond, by picking Pip up, when Pip banged her head during the conjoint group. At the separation Pip cried as Sally left, but was able to accept being held in a therapist's arms. However, Pip remained tense and anxious. The therapist walked and rocked her, made reassuring noises, and talked to her about her distress. Despite this the therapist struggled to contain Pip's distress until a second therapist, responding to Pip's continued crying, came alongside and held Pip's gaze and spoke quietly to her. Pip eventually relaxed. This threesome of Pip and two therapists remained engaged in this way for several minutes. Pip appeared soothed and soon fell asleep in the therapist's arms, where she remained until she was woken just before the mothers returned from the parallel mothers' group. Having contained Pip's distress, the therapists were hoping to promote a different experience of encounter between mother and baby at reunion. It was important to have the baby awake and aware of her mother's approach, while at the same time being held by the therapist. The hope was that Pip would be able to carry into her reunion with her mother the experience of containment which she had received with the two therapists. This seemed to occur. On reunion Pip uttered a brief cry and then was held by her mother and given a cookie. She then settled

in a relaxed way on Sally's lap, gazing outward. In hindsight the therapists identified this as the first critical shift in the therapy.

At week three, Pip was still returning to Sally's feet but less often, and seemed reassured by visually checking back to her mother from across the room. She and Sally made brief eye contact. Pip was not whining on this occasion and perhaps this made it possible for Sally to look at her without feeling overwhelming helplessness and anger. At the separation Pip protested, became sad and clung to the therapist, but did not sleep. After a time she was able to be placed on the floor next to the therapist, where she started to play with the toys and looked at the other babies. At the same time in the mothers' group, Sally was developing a stronger sense of her separateness from her husband and locating some of the difficulties in the marital relationship rather than blaming herself.

At week four Sally began by stating that things were now much better between herself and Pip. Pip was trying to communicate more and was now showing pleasure when seeing her mother. Sally reported that they were playing together more at home and also that she had felt able to begin writing at home, which she enjoyed. During the joint group Pip made more active attempts to interact with her mother. She tried experimenting with a noisy toy and then looked toward her mother for affirmation. At first Sally did not respond. The therapist put the baby's communication into words: "look mum . . . I made a noise." Sally then said to Pip, "give me a special kiss." Pip came up to Sally's face for the first time and kissed her. During the separation Pip was more settled and snuggled into a therapist's shoulder while she was rocked to music. She then fell asleep. It was during the separation that a second critical shift in the therapy occurred. The mothers were encouraged by the therapists to express themselves in writing or drawing. Sally titled her first piece of personal writing *Prebaby*. "Before baby I was probably a little girl myself . . . I can't remember because that person dissolved like an aspirin years ago." She began to find a way to acknowledge and verbalize her distress through her writing. Over these first weeks Pip mirrored Sally's emotions, both being highly anxious and disconnected initially, and then gradually feeling more confident to explore and communicate.

It was necessary to cancel the fifth session because of a national holiday. In the sixth week, Sally entered the group carrying Pip, who was holding a bag containing a teddy, her mother's old mobile phone, and a hairbrush. While Sally was speaking Pip relaxed in her mother's lap holding the teddy, which Sally reported she had recently become attached to. Pip seemed now able to use a transitional object. Sally was tired, as Pip had been waking frequently at night. Sally also expressed some self-blame in relation to two group members who had left the group after the week's break. In the mothers' group, there was a sense of "this is a safe place to express the unspoken." Into this space Sally made a request that highlighted her growing trust in the group. She asked that she be allowed to continue to write her thoughts for five minutes each week as she felt she could not write freely at home. She also chose to share her writing weekly with the group as a whole. For the first time it seemed she felt she could ask the group to listen and act as a container for her negative feelings, bleakness, and sadness. Her second piece of writing was entitled *Anger* and related to her experience of arriving home at 13 years to discover that her mother had vanished: "I am angry because I think everyone will desert me and I don't know how I will stop them!" It seems that the group had unwittingly provided a repetition for Sally of the feeling of being abandoned by others—by those who left the group and by the one-week break. On this occasion she was able to use the group to express and have affirmed her feelings about this. This allowed for a different emotional experience, that of having her distress understood. The therapists saw this as the third critical shift in the therapy. This time at the separation there had been a brief protest by Pip, but she was quickly able to contain herself in the therapist's arms, clutching her teddy and her mother's mobile phone. She sought to lock her gaze with the therapist and stayed held in her arms for about 15 minutes. Pip then allowed the therapist to put her down but remained close while she looked at other babies. On reunion Sally and Pip cuddled. Pip breast fed calmly in her mother's lap, was stroked adoringly on the forehead, and then fell asleep.

The pair missed a week from illness and returned in week eight. They seemed more connected. Pip was content to snuggle into Sally's shoulder. Sally spoke of her decision to leave the past

behind. Although there was a sense of idealizing the future there was also a healthy sense of moving on from the past. Once again, in the mothers' group, Sally expressed her feelings about her past in a powerful piece of writing entitled *Family*: "I thought that by changing the colours in the walls, I could get rid of it. But it didn't work. The house is contaminated. My family, over years, succeeded in poisoning the walls, the floors. . . . I'm hiding in my room now but can still hear the plates smashing against the wall. . . . Ghosts live here. They're everywhere in the walls and under the new paint." This vivid description of Sally's early life allowed the group to understand a little of her experience prior to her mother's departure from the home.

Week nine. In this second to last week there was a regression. Once again Pip seemed fragile and easily distressed. Sally spoke for the first time of her current relationship with her own mother, of the repeated disappointments in that relationship, and her feeling that her mother made no effort to be part of her life. She was again rather detached from Pip. In the separation Pip protested loudly, but accepted comfort from the therapist. She was then able to play beside the therapist but became distressed if the therapist moved, as if fearing the therapist was going to leave her. On reunion Pip snuggled into Sally's neck and shoulder, still anxious. In the mothers' group Sally had written a piece entitled *Baby Crying*: "She sits on the floor and cries. She thinks I'm going to leave her, walk out the door and never come back . . . she's sobbing . . . not yet . . . I don't go to her just yet." In the context of the impending end of the program, Sally explored her incipient loss and her past loss, across the generations, in relation to her baby Pip.

At week ten, the group began with Sally carrying Pip into the room. Considerable change was manifest in their behavior and interaction compared with the first week of the therapy. Pip, held in her mother's arms, was clutching her teddy and there was more face-to-face contact with Sally, who reported feeling closer to Pip. Talking of Pip's first birthday, she stated, "I have no recollection of her first year. It's as if she has just been born at one year." Sally expressed her worry about the group ending. However, there was a greater sense that she had integrated some difficult feelings and was less blaming of herself and others. During the separate

groups, Pip was more wide-ranging in her exploration and play with the toys, but remained somber in mood. The therapists considered how this mother and baby might best be supported once the group ended, as their new relationship was fragile. One of the therapists was in a position to offer some individual support in the home and Sally readily accepted this. Positive progress was reported at follow-up.

Case Study 2 - Mother Maria and Infant Toma: A Depressed Pair

Toma, 11 months, his mother Maria, and father Tan were from Timor. They were referred to the PAIRS program by their Maternal Child Health Nurse after the mother had had pernicious anaemia and vitamin B deficiency, and Toma developed megaloblastic anaemia. At 7 months Toma had been left with a friend and mother reported that he had “turned blue.” He then stopped developing and difficulties with separation followed for both mother and child.

At the pregroup assessment Maria expressed her distress at these events. She was visibly depressed and Toma reflected the same flat affect and passive inert state. Maria sat with Toma clutched tightly to her chest as she spoke with staff, and was reluctant to put him down on the floor. She said that he was fully breast fed, and took solids. Toma looked well nourished, healthy, and well dressed, but he was unable to sit unassisted, and unable to roll, creep, crawl, or say any words. Maria was gently encouraged to lay Toma on his stomach on the carpeted floor next to her. Toma looked surprised to find himself in this position and quickly began to move his body, twisting from side to side. He was visually alert and looked with interest at the toys around him on the floor, flexing his fingers but not reaching out. The therapists told Maria that they felt that Toma would benefit from the stimulation of the group.

Each week Maria and Toma were transported to the program venue by a support worker. In the combined group Maria sat holding Toma firmly on her lap as before, joining the circle on the floor, but preventing him from moving or touching anything as they watched the interactive games and songs. Both mother and Toma looked sad and distant and made no move to join in.

Toma watched the other babies, at times struggling to get off her lap or reaching for a toy. Each time, Maria would pull him back, fearfully. A therapist gently suggested to her that Toma seemed interested in exploring and that perhaps this would help him.

Over the 10 week course of the group, Maria expressed her extreme worry about her son's lack of progress and various illnesses. She feared that he would catch germs from the floor or toys and become ill (and die). When staff understood this fear, Maria was reassured that the toys were washed each week and that she could lay Toma on his own baby rug on the floor. Maria found the separation from Toma almost unbearable and wondered if she should leave the program. When she heard Toma begin to rage in protest at finding her gone after the mothers had separated, she would leave the mothers' group immediately to return to him in the infants' group next door. Group leaders tried to understand what the separation and Toma's crying meant to Maria. Maria spoke five languages. One of the therapists was able to converse with her in *hakka*, her native East Timorese tongue. Maria explained that in her culture only bad mothers leave their babies to cry. On hearing this, the therapists made an exception to the separation procedure for Maria and Toma. They allowed her to stay on in the infants' group and take longer to settle Toma or return whenever she wished if she heard him cry, rather than wait a few minutes for staff to try to settle him as other mothers were advised to do. Paradoxically, this permission led to a greater tolerance on Maria's part for letting Toma cry, and an increase in her trust and participation in the mothers' group. To facilitate Maria remaining longer in the mother's group, Toma's therapist learned to say his name in *hakka* and carried him outside if she could not settle him in the group of babies.

Mid program, one mother in the mothers' group commented on how well she thought Maria was doing, and how well she spoke English. From that moment on Maria became more a part of the group. Where at first she had spoken very softly and then only to a group leader, she now spoke to the other mothers, engaging with the whole group. She also responded to the acceptance shown to her by offering generous gifts of food at group sessions. She described with great anguish how her own mother had

died when she was seven months of age (the age at which Toma 'turned blue'), and how she was reared by relatives in another part of the country. Once she was able to speak of her mother's death and the terrifying fear that something like this would happen to Toma, she was able to move beyond her fear of separation from him and explore her own experiences. She described how she felt alienated from her country of birth and from her country of upbringing. She felt ambivalent toward her husband's Asian family in Australia. She said that she had no social supports and mostly stayed in the house with Toma.

On the day that she spoke of her grief for the loss of her own mother, Maria still had tears streaming down her face when she was reunited with Toma for the combined group. Toma was not crying at that time and as the therapist passed him from her arms to Maria's he looked in surprise at his mother's face. As if registering her as a separate person with separate tears, he began to gently wipe the tears from her cheeks with his hand. The therapist commented "Mummy is sad today because she lost *her* mummy."

In the conjoint group, despite her fears, Maria was willing to lift Toma up in the air during the PAIRS good morning song, and both enjoyed this game immensely. Toma would giggle at his mother as she held him aloft, and Maria's sad, drawn face would break into a beautiful smile. This was a game they also enjoyed at home. When Maria allowed Toma to lie on his stomach on his own rug he began to 'commando' creep, hitching himself forward with his arms beneath him. Then, in the mothers' group, instead of describing his crying and illness, Maria began to tell of Toma's crawling up and over cushions she laid on the floor for him at home. Her mood lifted and she seemed to take heart from the fact that Toma was now, once again, making progress. The pairs' development was moving in parallel, and both mother and baby were less depressed.

In the infants' group, Toma for his part went through stages of terror, frustration, and rage—at his mother for leaving him and his physical incapacity to move in any direction. When Toma could not be consoled, he was carried on brief outings to the park outside. He stopped crying when the therapist held him facing out

(to minimize the impact of him seeing how different her fair hair and complexion were from his Asian culture) and stopped speaking English to him. The therapist noted his interest in watching cars moving along a nearby road and helped him track them by moving him in an arc as the cars travelled. In this way she tried to attune to Toma's interest and give him a sense of agency by silently responding to his body language. Later, he was held up to look through a wire mesh fence to enjoy watching children play in an adjoining kindergarten. After this he began to approach infants in the group, but only in his mother's presence. Another time he stood for the first time, grasping the back of a bench, silently supported by the therapist. When tired of standing he sat and watched clouds in the sky and leaves moving in trees, exploring some leaves with his eyes, hands, and mouth. The next week, as he sat relaxed on the bench next to the therapist, Toma picked up his woollen cap and began to babble, as if 'talking' to the small teddy bear motif on it. The therapist fed back to Maria in the combined group that this was the first time that Toma had vocalized, apart from crying or screaming.

The parents' and partners' evening group brought the father, Tan, Toma in his pajamas, and Maria with a feast of Timorese food. Where Maria had protectively blocked Toma's efforts to move away lest he fall and hurt himself, his father sat back and allowed his son to attempt to stand. Toma reached up and succeeded in grasping the edge of a low central coffee table with his hands, pulling himself up and standing balanced for some minutes. The group of parents and therapists applauded Toma's new achievement.

By the conclusion of the group program, Toma had made significant progress in his development and his mother was less depressed and spoke of wanting a second baby. Maria was now more confident to take Toma outside to nearby parks and to join a toy library. Her local MCHN organized transport to a community play group for Maria and Toma. At follow-up two and a half years later, Toma was seen at home. He was walking and talking, naming letters and numbers in English as he completed inset jigsaw puzzles with his mother sitting close to him.

Case Study 3: Mother Tess and Baby Gem: Delayed Infant Development and Maternal Mental Illness

Gem's mother Tess had recently been an inpatient in a mother-baby unit⁵ where she was diagnosed with bipolar disorder. On discharge in a stable condition she was referred to the program by a psychiatry registrar who had taken part in a previous PAIRS program. The referral noted delays in Gem's development, poor attachment to her mother, and parenting difficulties.

In the preprougroup assessment Gem, 11 months, was noted to be hypotonic and appeared to have a disproportionately large head. She moved her legs from front to back in a sitting position, but gained no ground. When placed in a prone position, her attempts to reach toys were frustrated by the fact that she could only inch backwards. Her mother said that she gave Gem little 'tummy time' as it made her frustrated and she soon cried. Tess was encouraged to place her baby in this position with an interesting toy in front of her, and sit beside her, for a few minutes each day.

At the start of the group program Gem was able to tolerate being placed in a prone position and was beginning to try to gather her hands and knees under her, instead of remaining spread-eagled on the floor. Tess had facilitated this development by acting on the previous week's suggestions. This pattern was to continue, with Tess quickly picking up on the cues and clues offered by the therapists and practicing at home between sessions. Initially, a coolness was noticeable in the relationship, with physical and emotional distance maintained between mother and infant. This gradually changed as Tess became more attuned to Gem's needs, and took in feedback about her attachment behavior.

In the mothers' group Tess was initially quiet and tended to listen to the other mothers. She joined in from time to time when experiences such as sexual child abuse were shared. She spoke about how helpful it had been for her that ideas were offered to help with Gem when co-residing in the mother-baby unit. Tess also voiced fears and concerns about her lack of bonding with Gem and her delayed physical development. Tess told of the diffi-

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culties of having a partner who had become so seriously mentally ill himself that the couple had to separate. She described her own escalating depression, her need for support for herself and Gem, and the difficulty of getting admitted to hospital. Tess described how lonely it can be as a sole parent with a young baby. Later in the program she was able to speak of her problems trying to wean Gem onto solid foods—of being caught in a cycle of trying to force feed solids, then giving in and allowing Gem to feed herself a bottle of milk. She sought ideas to assist her from the other mothers. Later she said how pleased she was that Gem's physical development had progressed and described Gem beginning to crawl and follow her around the house. Next, she told of enjoying Gem's emerging personality, their play times together and said that the bonding had improved during the group. Toward the end of the program Tess articulated the wish to return to tertiary studies that she had undertaken before Gem's birth. By the conclusion of the program she had arranged distance education to enable her to study at home and still spend time with Gem.

In the babies' group Gem was initially detached, isolated, and silent. She sat where she was placed on the floor, seemingly oblivious to the fact that her mother had left the room. She was also indifferent to the distress of other babies and to the presence of therapists in the babies' group. However, after some weeks, she began to scan the room as if searching, and then seemed to realize that her mother had left. After a delay of some minutes, she reacted to this event and began to cry. Gem then needed to be held and talked to by her "chosen" therapist. When that was not enough, she was picked up and carried outside for a short while. The therapist then brought her in to sit with the group. Gem sat on her lap watching the other babies and children, and was comforted. As the weeks progressed, once Gem realized her mother had left, she would become upset more quickly. On one occasion she became inconsolable toward the end of the parallel group time. Her dummy could not be located, and soft blankets, toys, or any therapist could soothe or distract her. In the next room her mother was distressed because she had forgotten to tell the staff the whereabouts of Gem's pacifier and that Gem had recently been unwell. As it was near finishing time, Tess remained in the mothers' group unable to act or speak, as if paralyzed, perhaps

in a similar way to when she had been mentally ill in hospital. On this occasion the infant-therapists also experienced a profound sense of helplessness, perhaps a mirror of Gem's reaction to the time when her mother had been deeply depressed, unaware, and unavailable. These experiences were shared during feedback in the combined group which followed.

Gem's motor development proceeded and once she was able to creep and crawl she began to engage in games with her therapist. She particularly enjoyed playing with toy telephones and her own "dolly." Dolly had appeared from home, as a transitional object, in the middle of the group. Gem was intrigued with a role play of Dolly being naughty when on the toy telephone to the "mummies' group." This enactment of naughtiness appeared to be therapeutic for Gem. The next development was when Gem began actively greeting her mother on her return, rather than turning her head away. Gem refused to take her bottle from staff, and waited for her mother to return. She then had a special "milk time" with Tess, holding her bottle while gently touching her mother's leg. With the passage of time, Gem became less dependent on her particular therapist and other workers were able to comfort her. Next she was able to anticipate and say goodbye to her mother before Tess left the room. Shortly after this she was able to play imaginative games such as tea parties, engage in ball play, and share toys with other infants within the circle of babies, toddlers and therapists. Toward the end of the babies' group time, Gem would watch the wall clock with its baby duck marker waiting for the mothers' return. When the mothers entered, she would greet Tess with a delighted smile. By the conclusion of the PAIRS program, Gem had begun to talk and use symbolic play. At the post group assessment session, she was also able to stand, holding onto her mother, and her motor skills had returned to normal.

Timely referral to the PAIRS program allowed strategies for motor development (tummy time) to be suggested to Gem's mother, who in turn showed a readiness to respond. Tess also understood Gem's progression from indifference (detachment), through a period of distress (insecure attachment), to a more secure attachment to herself, through the repeated partings and reunions inherent in the program format. The separate space enabled Gem to have her own therapist and Tess to explore her

trauma in the safe holding environment of the mothers group. These developments were reflected in gains in mother-child warmth rated on the DMC, a decrease in postnatal depression scored by Tess on the EPDS, and an advance to normal development on the Bayley Scales of Infant Development for Gem. These gains were maintained at follow-up.

Discussion of Case Material

There are many ways of thinking about developments that occur for the mother and baby over the course of the therapy program. Selma Fraiberg writes that "In every nursery there are ghosts . . . when . . . therapy has brought the parent to remember and re-experience his childhood anxiety and suffering, the ghosts depart and the afflicted parents become the protectors of their children against the repetition of their own conflicted past." (Fraiberg, Adelson, & Shapiro, 1975, p. 422). In the first case study, the ghosts of the mother's childhood kept baby at a distance, both physically and emotionally. It would appear that the PAIRS therapy program allowed the mother to address her own childhood ghosts, helping to make space in her consciousness for the evolving recognition of baby Pip as a person in her own right. Mother Sally's comment, following Pip's first birthday—"I have no recollection of her first year. It's as if she has just been born at one year"—represents this moment of psychological birth for the baby in the mother's mind (Mahler, Pine, & Bergman, 1975). Baby Pip, too, has been enabled within the PAIRS groups to experience connection with others and to have her distress contained, allowing mother and baby to interact in a more mutually satisfying manner. Within the PAIRS group structure, the power of mother's childhood ghosts had been attenuated, and mother and baby found each other anew. Similarly, for Case 2, the group structure allowed a historical search to take place in mother Maria's mind. In the safe, holding environment of the mothers' group she located her own very early trauma, which threatened to repeat in her infant Toma's stalled development. For mother Tess, in Case 3, the trauma was from past abuse and also more recent crises.

For all three infants, infant therapists were available to tend the infants and provide a more sensitive template of interaction

while their mothers' needs were being addressed in parallel. Commonly, as in these case studies, the baby mirrors the mother's emotional state. For infants Toma and Gem, the mother's emotional state of deep depression also appears to have impeded the infant's developmental imperative.

The three case studies illustrate how the parallel group structure fosters the emergence of parallel themes and developments. While progress may occur in parallel, as in Case 3, sometimes the recovery is mother-led as in Case 1, or infant-led as in Case 2. The experience of being sensitively separated, supported in their respective peer group, and then re-united, appears to help secure the attachment between mother and infant. A shift from an insecure attachment (inhibited for Pip and Toma, disinhibited to selective for Gem) to a more secure attachment with each mother was observed.

DISCUSSION

Childbirth and infancy are times of risk and rapid change, which may precipitate crises. Mothers are in a state of psychic and hormonal fluidity before and after giving birth, and so are readily accessible to intervention. The rapid improvement shown during the PAIRS program is characteristic of early parent-infant interventions in general. It is increasingly recognized that the interface between mother and baby is critical to maternal functioning and mental health as well as to infant development. Clinically, it has been found that the PAIRS group therapy model addresses this important interface by creating spaces to work with the multiple and diverse needs of the mother herself, of the infant, and of the mother-infant relationship.

Yalom (1985) and Bion (1974) have written extensively on the power of the group process on the human psyche. Inclusion in a group for mothers and infants makes some mothers feel less alienated and marginalized from the outset. The decision to join is a major one for socially anxious women. Group members affect each other forcefully and the most common if not universal experience is for the mothers to identify with the group and feel that they are not the only one with problems with motherhood. Through social referencing group members compare themselves

with others in the group and position themselves as being not the same but better or worse off than others. They may then feel relief that there are those worse off than themselves; for example, “that could have been me,” or “I thought that I had big problems until I heard about so and so.” In some groups there is competition for group attention by more deprived mothers implying “my problems are worse and deserve more of the group’s attention than yours.” Group leaders need to be skillfully trained in managing group dynamics, encouraging sharing and protecting the group from being overwhelmed by excesses of emotion. Leaders require the capacity to work from a theoretical model, to contain powerful emotions by maintaining emotional equilibrium themselves, to adhere to predictable time structures, and to observe protocols on turn taking as well as keeping all group members in mind. A third therapeutic process is the disclosure of deeply wounding personal experiences such as childhood physical and sexual abuse. This is not uncommon in the mothers’ group and usually occurs in the ‘forming’ or middle stage of the 10 week group program, once trust in the group and group leaders has been established. Such disclosures are managed by the therapists ensuring that these women know of relevant community services, before redirecting the focus of the group to the impact of the past trauma on current parenting. In this way, the “hurt baby-within-the-mother” is kept in mind, as well as the present baby in the infant group in the adjacent room. Descriptions of infanticidal fantasies, and suicidal or homicidal thoughts, by more articulate women allow silent agreement by head nodding for quieter members. This process appears to be less threatening among peers. Disclosures are often accompanied by ventilation of feelings, such as crying in the presence of other women. Acknowledgment of such feelings may be shown by passing the tissue box to weeping members. The therapeutic benefits of the PAIRS program encompass traditional group therapeutic gains, but the structure offers more than this. In the context of the holding group environment, the repeated separation and reunion format assists the development of a secure base. It also provides a reality check for the mother after she has explored her negative thoughts and feelings in the mothers’ group and then returns to the baby group room and sees her *real* baby thriving. This enables her to unhook

toxic projections. The baby's fears of abandonment are met with attempts at reassurance by the infant therapists in the mother's absence, then hopefully by genuine reassurance and joy on her actual return.

The quantitative and qualitative research findings show that for the sample of families assessed after completing PAIRS programs, the most significant improvement occurred in mother-infant interaction, followed by decreases in maternal postnatal depression and then gains in infant self-regulation. Parents reported that being part of a group was the most helpful experience, and that taking part in the program had raised their confidence as parents and led to a closer relationship with their infants. In this way the program aims were met for most families.

CONCLUSIONS

Ten years of practice and research with high risk populations have shown that the PAIRS model of maternal-infant group work is robust and highly effective. Although needing multiple resources to establish, once begun existing programs have continued to operate and expand. Consistently positive outcomes have been demonstrated when using the model in different contexts with different subgroups. Therapists and participants alike have experienced the benefits to mothers, infants, and their families, whose futures were seriously compromised. The research findings confirm what parents and referrers report and staff repeatedly observe – that the PAIRS program promotes maternal mental health, secure attachment, and enhanced infant development.

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