An 'anthropological' exploration of individuals' perceptions on Infant Mental Health in South Africa

by

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Abstract

Infant Mental Health (IMH) is a concept developed by psychologists, psychiatrists, child development specialists, to describe preverbal children's emotional well-being. In everyday life, however, people may not be familiar with this idea, use these terms or think about infant well-being in the same way. The research therefore posed the general question 'do infants have mental health?' to a range of participants, including parents, grandparents, and those who haven't had children. A decolonial feminist-queer approach was used. The research revealed that although people did not think of their children's well-being using the language of IMH, they had their ways of ensuring the 'mental health' of their infants. Secondly, mental health is often understood in terms of illness and not as wellness. Lastly, although infants were not thought to have 'mental health', the participants agreed on the presence of mental health in infants and used a variety of terms to describe this concept in their own words as opposed to the formal descriptions according to IMH paradigm.

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Chapter 1: INTRODUCTION

Exploring the psychological concept of Infant Mental Health anthropologically

"Wasn't there an easier topic?" Mashudu asked me this question after I told her what my research topic is about. I had already informed Mashudu that I was working on my master's research and would appreciate her participation, I had not given her any information about my topic prior to our conversation. It was a hot weekday, and we were sitting outside the porch to cool off the scorching Venda sun in December. So, when I finally explained my topic, her response was mixed with laughter, wonder and confusion. She proceeded to ask me questions like *"what is this infant mental health? Is it a baby who is always crying? I mean how will you even see that? When a baby is still small you can't see that, it could just be udzindela"*. I told her that I want to hear what she thinks, then our interview began.

On the 27th of December 2021, my ex-colleague, Naledi, asked for advice on a 'clogged milk duct' on her WhatsApp status. We had a lengthy conversation over text, and I even asked my grandmother what methods Naledi could use to 'unblock her duct' and ways to boost her milk production. After we spoke, I casually invited her to participate in my research She proceeded to ask me what it is about, I simply said "my topic is infant mental health. Her reply was how can she help to which I replied *"can we schedule a time to chat soon? I'm still conducting my interviews in Venda"*. Her reply was one I had received before, telling me that she does not know much about it. In her words she sent me this text as a reply: "*Ohk cool. Will hear from you then. First time I hear of the concept. When hearing your topic my husband asked if infants can string enough thoughts together to know if they depressed... I giggled but that goes to show how dense our own adult understanding of mental health is...*"

What became clear from my research is that 'mental health', a term in popular use among many of my generation, is not necessarily associated with infants or babies. Many people, as we have seen in examples above, seemed surprised or confused by the concept of 'infant mental health'. However, what did emerge was that people thought about the wellbeing of their infants in ways that, once analysed, reflected some of key characteristics of the Infant Mental Health paradigm as described in the Handbook for Infant Mental Health (Zeanah and Zeanah Jr 2009). These multiple ways in which people understand and care for wellbeing of their infants will be explored in this thesis. I aim to shed light on various ways people understand the concept of infant mental health.

The inspiration for this research and question 'do infants have mental health? arises from two sources. The first is the concern with ‘mental health’ in public health and growing concern about how to secure adult mental health through interventions in childhood. The second comes from Alma Gottlieb’s (1998) seminal study ‘Do Infants Have Religion? The Spiritual Lives of Being Babies’. Gottlieb (1998) argues that Anthropology has explored religion by focusing on the lives, experiences and viewpoints of adults not sufficiently exploring the relation between religion and children’s lives (Gottleib, 1998: 122; see also Gottlieb 2000). Similarly, I would argue that literature on mental health, more specifically IMH as a concept is few and far between.

More recently, Ross & Pentecost (2021) reviewed the scope of childhood studies in Southern Africa stating childhood studies are overlooked, which is premised on the quote "not known because not looked for" from T.S Eliot’s Four Quartets, published in 1941 which was later addressed by Pamela Reynolds in 1995 (Ross & Pentecost, 2021: 1); the article maps current configuration of childhood studies and notes a critical gap in studies of infancy. It is thus imperative to me as a young black female researcher to contribute to the body of work of infancy in anthropology and as Ross & Pentecost (2021: 16) state in their conclusion, "an on-going interrogation of what and how we see, and with what eyes, remains an important task, particularly as this relates to infants". Local studies on childhood are important, and even more important is who does this work.

Conceptual Approaches

Mental health has become a widespread topic of discussion and concern in the public imagination and discourse, especially among Millennials and lower generations. It is thus unsurprising that international bodies such as the WHO and UNICEF are developing and pushing for interventions and policies that focus on infancy as the site for the development of life-long health via emphasis on the first 1000 days of life and early childhood.

Nurturing Care Framework

In 2018, the World Health Organisation (WHO) published the Nurturing Care Framework (NCF), based on *The Global Strategy for Women’s, Children’s and Adolescents’ Health* (2016-2030). The vision is “a world in which every woman, child and adolescent realizes their rights to health and well-being; both physical and mental” (WHO, 2018:2). The foreword of NCF

passionately lays out why this framework matters. Taglined: "a framework for helping children survive and thrive to transform health and human potential" (WHO, 2018:1), it argues that investing in early childhood development is “the right thing to do, helping every child realize the right to survive and thrive” (ibid). The responsibility to ensure this thriving is allocated to multiple stakeholders; “parents and caregivers, national governments, civil society groups, academics, the United Nations, the private sector, educational institutions and service providers” (ibid).

These organisations are concerned about nurturing care because they firmly state that early childhood investment is 'good for everyone' as childhood and infancy is the foundation of life. The axiom that children are the future as famously stated by the former president, Nelson Mandela, has become a motto which every intervention and policy concerned with children iterates. Nurturing care "means giving young children opportunities for early learning, through interactions that are responsive and emotionally supportive" (WHO, 2018: 2). The aim is to ensure every child not only survives but thrives, because the world is increasingly affecting children.

It is critical to mention the limitations that have been highlighted on these kinds of parenting interventions. Global interventions such as the Nurturing Care Framework and others claim to rely on "robust, state-of-the-art evidence”, however, this is disputed by some who argue that "its knowledge base is highly selective and strongly biased" (Scheidecker, et al. 2022: 3). For example, the Nurturing Care Framework is premised on responsive caregiving and attachment theory. This is arguably a limited look at child rearing as it is essentially a parenting style that is "valued in Western middle classes, it is not based on scientific findings about its benefits in the global South", thus globalising this 'parenting style' needs to be examined (Scheidecker, et al. 2022: 15). Anthropological research has shown that other parents in other places other than the West "purposefully" choose to parent in opposition to responsive caregiving, thus disrupting the assumption that this style of care is the only appropriate way to raise and interact children, everywhere. Lastly, an additional critique against global interventions is that they ironically tend to treat parents like children while telling them how to raise and treat their children and ignore the validity of the child rearing styles and preferences in the South to perpetuate and drive interventions. The result is a narrow, biased and limited blueprint that is implemented globally even when it may not serve local contexts while excluding research in targeted communities.

Infant Mental Health (IMH)

IMH is described as "a multidisciplinary professional field of inquiry, practice, and policy, concerned with alleviating suffering and enhancing the social and emotional competence of young children" (Zeanah Jr & Zeanah, 2009: 6; see also Berg & Lachman, 2021). While the concept of 'infant mental health' is widely accepted in psychological sciences and has traction in the global north, it has less traction in the south (Lachman et al 2021). Stellenbosch University in South Africa hosts the only professional training in IMH on the continent. Mental health is a psychological concept that is predominantly considerate of WEIRD[1] individuals. South Africa is a multiracial and multilingual country with a majority of Black people. Many concepts and practices that are typically western in origin may not be well accepted or practiced, and if they are, they may be spoken about in a completely different way. Attachment, relationship and care differ universally, and their expression is diverse (Lachman, Berg, Ross & Pentecost, 2021:1). IMH models were developed in the Global North based on research in middle-class households characterised by nuclear families, and there is concern that some of its precepts may need tailoring to "meet caregivers and infants in ways that are meaningful to them and still retain general applicability" (Lachman, Berg, Ross & Pentecost, 2021; 1). Despite the burgeoning of psychological theory in everyday life and medical practice, there is little known about how people think about the mental well-being of infants in southern Africa. Understanding local contexts is important to ensure that interventions and therapeutic models make meaningful change. My study therefore offers a qualitative account of how lay people conceptualise and actualise infant mental health.

While the language of psychology has become almost naturalised in everyday conversations about wellbeing in some sectors of society, 'mental health' has become reified as something one 'has' or does not, at the same time, the idea that infants might 'have' 'mental health' is often greeted with surprise or scepticism, even among practitioners who work with babies and children, and more so among lay people, as we have seen in the vignettes that open this chapter. The focus of this study is to pose the question of whether people think that infants can and do have 'mental health', thus problematising both the idea of 'mental health' and its relation to the life cycle and asking how people envisage the everyday work of raising children.

I explored this by asking a small snowball sample that began with my own family questions such as 'Do infants have mental health?' and, what do you think it is? What factors influence

[1] Acronym for 'Western Educated Industrialised Rich & Democratic Societies'.

an infant's 'mental health'? What terms would individuals use to describe 'infant mental health?'

Why does this research matter?

This work matters because in contemporary times, research conducted becomes policies and interventions in the real world and affects real people. Ross & Pentecost (2021) in their review of infancy in South Africa state that critical evaluation of globalised models of childhood, development and well-being are necessary. Thus, the role of anthropological studies of early childhood and infancy and of the interventions made in their name are crucial. At the same time, "anthropologists are well-placed to offer careful evaluation of how powerful contemporary global discourses around child well-being shape interventions at the individual and population level" (Ross & Pentecost, 2021:16), and with what effects. What I hope my research will do is allow imagined audiences of policies and programs such as infant mental health to tell their stories so that their experiences can potentially inform the process of knowledge production and any subsequent output to be holistically people-centred.

Anthropology has been closely linked to psychology from its early beginnings by factors such as "the characteristics of alleged "primitive mentality" versus the universality of mental processes; the effects of child-rearing and social experience on personality; or the role and variability of perception, memory, learning, etc. in culture" (Eller, 2019: 1). Traditional western biomedical systems predominantly posited that the mind and the body are separate, as contended by the Cartesian duality[2]. According to Forstman, Burgmer & Mussweller (2012) phenomenologically, people perceive their minds to be different from their bodies. In contrast, in medical anthropology, Scheper Hughes & Lock (1987; 30) say that "most clinical practitioners admit that the mind and the body are inseparable in the experience of sickness, suffering and healing."

Scheper-Hughes & Lock (1987; 6) state that the Cartesian dualism that separates the mind from the body or the spirit from matter, is part of a historical epistemological tradition that stems from Western thinking and biomedicine. Furthermore, they posit that this cultural and historical

[2] Mind and body are therefore, two kinds of substance, which are distinctly different, and can exist independent of each other. With Descartes' establishment of his soul or mind as existing independent and distinct from his body, the seed of Cartesian dualism was thus sowed. Descartes did however admit that they interact with each other (Mohammed, 2012; 100).

construction is not universal and yet that is it now widely accepted that the mind and the body are inseparable but that they influence each other. Similarly, Doctors such as Gabor Mate[3]' a Canadian physician, has made parallels and connections to the mind and the body being coeval, and noting how of the environment plays a role too. This paradigm calls for holism, treating the mind, body and environment as not separate but interconnected.

At the same time, there is growing awareness of the significance of 'mental health' in contemporary times. It is a common topic of discussion among many people in society; more than in any point in time, individuals discuss their mental health and talk about 'taking care' of their mental health and how much they are struggling, naming their 'illnesses' as anxiety, depression and so on. That is, the concept of 'mental health' has become naturalised and reified in everyday parlance. Even so, however, it is not often associated with infants, and the people who I have talked to in this research - friends and family – many of whom use the term 'mental health' in their own self-descriptions, do not tend to talk about infants and mental health in the same breath. It is important to note also that only some sections of society have naturalised the term 'mental health' in English. In addition, this framing is not applied across languages, as linguistic repertoires tend to influence how things are talked about. For example, as I will explore in more detail, the word 'mental' was translated to 'crazy' in TshiVenda. The translation carries the traces of the history of biomedical and missionary intervention in southern Africa. It then becomes evident that language offers translations which can add complexity to meaning and showcase that English offers only one way of understanding concepts.

I did not solely be look at people who were parents and caregivers only, I looked at how a broad spectrum of individuals with whom I am associated think about this concept. This is because children are influenced and shaped by more than just their caregivers; their family members who frequent their environment have an influence on them too (Bowlby, 1969). Indeed, this is explicitly recognised in the southern African proverb, "It takes a village to raise a child". In other words, I will seek to explore how the concept materialises in reality and everyday life, and, if it is not already part of people's everyday conceptualisation of infant life, what happens when the concept is introduced to them. My project therefore explored the idea of 'infant mental health' itself; it doesn't presume that infants HAVE mental health or ill-health

[3] See https://humanwindow.com/dr-gabor-mate-interview-childhood-trauma-anxiety-culture/ and https://www.youtube.com/watch?v=vhBRcG-FxC4&list=WL&index=4&t=3468s

but asks people about their understanding of the concept itself and its relation to their idea of infant personhood and qualities of care.

Thesis argument

My argument is that infant mental health is a concept that is not readily associated with infants in people's imaginations and perspectives. Due to the perception that ‘mental health’ refers to mental illness, and stereotypes about who suffers and what suffering looks like, the concept is not immediately associated with infants. Although a clearly articulatable concept of mental health was present, associating it with infants was foreign for majority of my participants. Furthermore, although the concept of mental health was naturalised in certain environments, especially in popular discourse in some generations, it was expressed differently, using a broad spectrum of language. The mobilisation of language was different, not always invoking psychological terms to describe taking care of and raising infants and children.

My intention is to illuminate and explore the various and diverse perspectives that my participants provided about when we talked about the concept of mental health. I deliberately did not seek an ethnicised account of mental health infancy and childhood. Instead, I was interested in the complexities that arise as people navigate different knowledges and practices in a multilingual and non-homogenous society.

Thesis Outline

Chapter Two outlines the decolonial feminist queer methodology and conceptual frameworks that I used for my research. I introduce my participants and describe my positionality and ethical conundrums I faced.

Chapter Three offers a literature review, with a particular focus on attachment theory in the field of psychology and psychiatry. This seeks to understand ‘attachment’ as a conceptual apparatus; an artefact of a way of thinking about significant relationships. I also explore anthropological inquiry into attachment, infants and infant mental health in South Africa.

Chapter Four explores participants’ ideas about infant mental health, with a particular focus on crying. My participants distinguished between ordinary crying and ‘too much crying’, associating the latter as an issue with an infant's wellbeing and mental health. This chapter also looks at the question 'what is infant mental health' and details the perspectives that my

participants had. This chapter argues that excessive crying was understood as indicating a problem with an infant MH.

Chapter Five reflects on factors which my participants listed as being important for an infant's mental health. Quinn (2005) highlights cross-cultural variability of raising children to become adults in their given societies. Likewise, this chapter examines the ways my participants the different things people deem important for child rearing.

Chapter Six I end with looking at parents as they are considered important in relation of a children. I look at the stereotypical assertion of the centrality of the mother. I also explore the perceptions of fatherhood in South Africa which have a long history.

Chapter Seven concludes the whole research paper. The arguments I presented show what people imagine children need to be well. It explores the different ways language is used to talk about IMH. It also highlights the centrality of parents in relation to child rearing and explores the role they in contribution to the 'mental health' of an infant. I show that IMH as a concept needs more local exploration to be influential in the public imagination

Chapter2: LITERATURE REVIEW

In this chapter, I explore an overview of the literature available on infants, mental health, attachment theory and infant mental health as field. I also highlight anthropological engagement with the abovementioned terms, looking at how these concepts are understood in this field. Lastly, I also examine some literature in the South African context.

Anthropology and Infants:

Infants have been studied in different forms in anthropology, the contexts they have been studied includes co-sleeping practices and kinship (Haviland, Prins, Walrath & McBride, 2007: 6), child rearing (Quinn, 2005), infant sleep (Ball et al., 2019) and feeding practices (Mattern, 2020) as well as the ethnography of childhood, pioneered by Margaret Mead (e.g. "Samoan Children at Work and Play" (1928) and Balinese Character with Gregory Bateson (1942) where they describe how childhood plays out in Bali, to name a few. In the 1920s field studies by travellers, missionaries, colonial missionaries and even anthropologists included reports that denoted how children in varying countries and conditions were raised. (LeVine & New, 2008: 1). Research on infants and mental health is almost non-existent in the field of anthropology as Ross & Pentecost (2021) highlight. There are, however, a few books and research on attachment theory as a cultural ideology, child rearing and care in African cultures and infancy in a cultural lens (LeVine et al., 1994; Keller & Bard, Smorholm, 2021) in anthropology, as well as child development (LeVine & New, 2008). These authors argue for a more holistic look at infancy, child rearing as well as the models that govern them and dismantle the universalising notion which is often perpetuated. The research also highlights the fact that in Africa, attachment styles in childhood are understudied and that cultural diversity in the continent has a role to play in attachment behaviours since Mary Ainsworth first published her observations from Uganda over 50 years ago (Voges, Berg & Niehaus, 2019).

Gottlieb (2000) states that there are a number of reasons why infants have been excluded in anthropological discussions. These include but are not limited to "the problematic question of agency in infants and their presumed dependence on others" as well as their seeming inability to communicate (Gottlieb, 2000; 121). The result is that any data that can be harnessed from infants is from either their caregivers, or by the researcher who observes and thus interprets on behalf of the infant from their respective perspectives. In 2000, when Gottlieb wrote her article, she stated that anthropology of infants was still in its infancy. This was 21 years ago, and as Ross and Pentecost (2021) have recently shown, to date there is still very little work on infants

in anthropology. This is particularly surprising considering wealth of work done on reproduction. I have been unable to find consolidated studies relating to the 'mental health' of infants. By contrast, psychology has a wealth of knowledge and journals dedicated for infants, and infant mental health, although the concept itself is still somewhat new.

What is an infant?

Definitions of infancy tend to differ by discipline. Gottlieb (2000: 122) uses a developmental psychology definition which states that infancy is strictly the period that encompasses birth to the onset of toddlerhood- which begins when the child learns to walk. On the other hand, Zeanah Jr & Zeanah (2009: 6) use a definition from paediatrics, which states that "infant usually refers to the first year of life". In mental health interventions, there is a tradition that infant refers more broadly to the period from birth to 3 years (ibid). However, Zeanah Jr and Zeanah (2009: 7) additionally state that infant stage stretches to age 5 because much research and many clinical programs extend beyond the first 3 years. According to Gottlieb (2000) many non-western people take a contextual approach when it comes to infants and their growth. For example, when a specific developmental skill, such as walking or talking is reached, is considered important, regardless of the age that the child masters it. Thus, she notes that the end of infancy is cross-culturally dependent and argues the same could be said for the beginning of infancy, which is also widely debated. For the purposes of this study, the definition of an infant that is being adopted is Zeanah Jr & Zeanah (2009:6).

Although the working definition is the above. In defining infancy, it is important to note that much of what is known about child development is guided and premised by Euro-American ways of knowing which are presented as being applicable to all human diversity. This is a limited and flawed approach. Thus, acknowledging the differences the values and practices that guide the rearing of children worldwide is important (Nsemanang, 2008). Furthermore, Nsemanang (2006) presents a noteworthy definition of human development. He stated that African development in children is premised on assigning stage appropriate developmental tasks. He uses a theory of ontogeny which sees children as "co-participants of social and cultural life" (Nsemang, 2006:293), which strays from the biological definition of the stages that children are assigned with is in fact, Eurocentric in origin.

Gottlieb (2000; 123) argues that the effort to 'round up' ages that constitute infancy is not based in biological certainties but is merely a cultural convention of Western culture and its stipulated calendars of childhood and so-called milestones. Multiple factors influence infancy, and

‘culture’ shapes a lot of aspects of infancy. Anthropologically, culture is “a society’s shared and socially transmitted ideas, values and perceptions. These in turn are used to make sense of experiences which generate behaviour and are reflected in that behaviour” (Haviland, Prins, Walrath & McBride, 2007: 9). Although psychology has tended to presume that context makes little difference to development (although see Voges et al 2019), there is growing awareness that the social and cultural context that an infant develops in is essential, a claim anthropologists have long made. According to Mead (1954: 398) "whenever children have been observed, they have been found to display, within the limits of their biological development, the types of learning characteristic of their culture". For example: The first ten words of French children are French, not Siamese. Children habituated to a diet of chili pepper will be able to eat hotter food than those who are not; children who have been accustomed to being carried passively will relax in the arms, and children who have been taught to hang on will hang on; children who have slept in cribs or been fed from bottles will respond to the sight of the crib or the bottle differently from those who have not (Mead, 1954) . Infant mental health will hence differ cross-culturally, as different societies have their own definitions of the natural progression of childhood and childcare. People’s lives need to be understood contextually and thus any solution to any conceived ‘mental health risks’ that an infant could face, also need to be cross-culturally sensitive (which is why anthropology as a discipline and way of thinking is invaluable to studies of infant mental health).

Infant Mental Health is currently assessed in terms of the psychological theory of ‘attachment’. Ideas about infant mental health may vary cross-culturally and yet the field is mostly governed by Western models of attachment. For example, interventions such as the 'Parenting for Lifelong Health Programme for Infants uses Western theories in South Africa to teach mothers how to take care of their children, how to bond, breastfeed and rear their children (World Health Organisation, 2019). Local context as well lived experiences of the people who will have to apply the programs is not often considered or evident. This is problematic because the context of people's lives in South Africa is currently characterized by one of the highest and most persistent inequality rates in the world where many parents will thus be preoccupied with socioeconomic issues.

The idea of culture influencing the development of infants is discussed by Jared Diamond (2013). He states that we should be interested in the way that indigenous societies such as hunter-gatherer, farmer and herder communities raise their infants. An academic reason is that

children account for up to half of a society's population. Despite those good reasons for us to be interested in child-rearing in non-Western societies, it has received much less study than it deserves. It is also useful to know different societies rear their infants to dismantle universalised and Western exclusive standards as the norm, which is the role and importance of cross-cultural studies in childhood. In addition, there is already an immense amount of data on child rearing practices in Western societies (Diamond, 2013: 154). Quinn (2005: 507) states that it is important to note that cultural universals and cultural variations are the two sides to the same coin. Furthermore childrearing, although variable is "equally designed to make the child's experience of those important lessons constant…" (Quinn, 2005:477) and that the lesson is the same for all children, to raise them to be well-functioning adults. Cross-cultural studies matter so that generalisations can be avoided because context matters. Infant mental health programs or interventions need to be considerate of this cultural context to make sure that the work they do is effective, to actualise their mandate which will be discussed.

What is Infant Mental Health?

According to Zeanah Jr & Zeanah (2009: 6), a widely accepted definition that was a result of a committee on Infant Mental Health that was convened by Zero to Three (2001) states that:

Infant mental health is "*the young child's capacity to experience, regulate, and express emotions, form close and secure relationships, and explore the environment and learn. All of these capacities will be best accomplished within the context of the caregiving environment that includes family, community, and cultural expectations for young children. Developing these capacities is synonymous with healthy social and emotional development".*

Infant mental health is also "a multidisciplinary professional field of inquiry, practice, and policy, concerned with alleviating suffering and enhancing the social and emotional competence of young children" (Zeanah Jr & Zeanah 2009: 6). The holistic approach of anthropology mixes well with infant mental health, as naturally anthropology is also interdisciplinary, and it allows due scrutiny on presuppositions and practices in other disciplines, with an added benefit of internal reflexivity within its very own discipline. In addition, an added benefit that anthropologists offer is to highlight the presuppositions or theoretical framings 'settle' in any given context, and where they fit and identify frictions, tensions, or outright harm. Zeanah Jr & Zeanah (2009: 6) shares similar sentiments, as they state that infant mental health is complex "interrelated nature of human development and its

deviations require expertise and conceptualizations" that transcend any one discipline. As such, the field of infant mental health is pluralistic, a subspecialty within a number of different disciplines, rather than an integrated and distinct discipline itself.

Does the way that we were raised affect who we become? Some of my participants believed this to be true and literature from the field of IMH also emphasises the importance of early experiences (Zeanah Jr & Zeanah, 2009). The attachment theory is a psychological theory which was pioneered by psychoanalyst John Bowlby (1969) and then studied by Mary Ainsworth (1967). According to Bowlby (1969: 195) attachment behaviour has been defined as seeking and maintaining proximity to another individual. In contemporary times, Zeanah, Berlin & Boris (2011) provide a similar definition, the only difference being the inference of emotional connection with an adult caregiver. Whereas the early definition focused on proximity with a 'principal figure' and focused on a biological function (Bowlby, 1969: 179). These behaviours which were deemed biological included "differential smiling at mother, movement to mother and clinging to her when the child is alarmed, and finally ways in which an attached child behaves in the presence of his mother and in her absence" (Bowlby, 1983; 208).

What is attachment theory?

Attachment is considered important for the "social and emotional development" of an infant (Zeanah & Zeanah Jr, 2009: 421). Ainsworth et al, 1879 (in Zeanah & Zeanah Jr, 2009:) described four different attachment styles, which are "how infants (and parents) negotiate attachment behaviour". There are three core attachment styles, secure attachment is seen by the ability of an infant to "openly and genuinely display their emotions and use their parents to help regulate their distress". Furthermore, infants with secure attachment "appeared to "trust" the parent to provide care and protection" (ibid: 93). The second pattern is anxious avoidant, where the infant "behaves as if they did not need comfort from their parent at all" (ibid: 93). The third pattern is anxious-ambivalent attachment, "infants generally appear desperate to have contact with their parents but appeared unable to be soothed by the parent once reunited" (ibid: 94). The fourth pattern is disorganised which is characterized by an infant who "often with histories of maltreatment, abuse, and neglect, seemed to lack a coherent, organized strategy for gaining proximity to their parents when distressed, but instead displayed bizarre or uncoordinated behaviours in response to the stressful paradigm" (ibid: 94). Infant mental health interventions are based on attachment theory.

Attachment theory is posited to provide ‘evidence’ of how ‘important’ it is for infants, to have “a positive and joyful relationship between babies and their parents” (Levine & Heller, 2010: 3). Secure attachment is a so-called goal that all parents must impart onto their children, despite the fact that not all parents, everywhere, are created equally and that all parents everywhere, parent in different circumstances. So, it is questionable why a standardised attainment of ‘secure attachment’ is the goal, while the other ‘attachment styles’ are labelled dysfunctional. Attachment styles are not determined, they can be changed. Research, such as that of Scheidecker et al., (2021) has been exemplary in further dismantling the universal notion of positing and favouring one sided institutionalised views of what is best when it comes to child rearing and so called 'optimal growth for infants' following one or a few rigid WEIRD 'researched methods' and including only a few poorly and subjective and non-holistic studies in the global South.

An important aspect of both attachment theory and infant mental health paradigm is the growing emphasis on the first 1000 days of life as a critical period for interventions that have lifelong and population-level effects on health and well-being (Tomlinson, 2015; Pentecost and Ross 2019; Suchman et al. 2020; & Lachman et al., 2021a). According to Tomlinson (2015: 538) the first 1000 days of life, which constitutes of the antenatal period as well as the first 2 years of life, are characterised by rapid formation of brain development and neural connections which are central to later social, emotional and cognitive development. This precariousness of brain development has been additionally highlighted by Zeanah Jr & Zeanah (2009).

Infant mental health paradigm & anthropological literature

Anthropology uses the term child rearing and socialisation to refer to the practice of caring for infants. Although this research sought to investigate people’s ideas about IMH, what came out was different perspectives of how people rear their children, and how they employ a multitude of concepts which come from multiple sources such as orally transmitted information from mothers, grandmothers and aunts, and knowledge gleaned from popular sources, educational interventions, biomedical settings etc. That is, people are navigating the field of early childhood by using many tools and understandings, some of which may be different to those of an earlier generation.

LeVine (2016) states that parents in America who have been heavily influenced by psychology and psychiatry are blinded. They fail to see any other story, conceptualisation, or the

acknowledgement of 'normal' being a spectrum. This matters because it affects childrearing, leaving it to the professionals as well as institutions to set the rules and outcomes.

IMH, along with psychology and psychiatry, and child development, have created specific narratives of how parents look at and understand their children and how they influence their children. Some of these have become embedded in how parents think about, and practically raise their children. However, it is important to note that these 'modes of parenting' are exactly that, there are various ways in which people all around the world parent, and care for their children which has been widely studied in anthropology such as the books "A World of Babies" (Gottlieb & DeLoache, 2016), "*Do Parents Matter*" (LeVine & LeVine, 2016) which is a cross cultural comparative look at how children from a variety of societies and cultures tend to turn out to be the same well-adjusted adults all around the world no matter the parenting style, whilst similarly "*Different Faces of Attachment*" edited by (Otto & Keller, 2014) explores facts which were gathered through rich ethnographic knowledge about how people in other societies view and raise their babies to name a few. These works pose a challenge to existing attachment models by revealing different ways of raising children and socialising them into adulthood.

Anthropological engagement of attachment theory

Are mothers essential for attachment?

The attachment theory is based on the dyadic relationship between a child and one or a few significant individuals. However, Keller & Chaudhary (2017:109) call into question the construct of attachment, stating that there are diverse childcare arrangements that exist in all cultures that differ from western norms and show how these are equally normative in their respective cultural contexts. This is similar to the argument made by Gotlieb (2000) when she states that Western cultural norms are not the standard just one kind of cultural convention, which is not the standard for all societies everywhere. Additionally, LeVine (2014: i) also states that it is necessary "to break the mould of attachment theory and reconsider the relationships of infant, mother, and others with a renewed and expanded search for universals as well as variations across a fuller range of the world's cultures". More importantly he critiques the advocacy from medical experts in the 1900s which placed a heavy burden as well responsibility towards parents not only for their children's conduct but also for their mental ills.

A mother is undoubtedly pivotal in the lives of their children; however, a child needs one or more people who have an emotional relationship with the child and are 'crazy[4] about the child' (Keller & Chaudhary 2017: 111). The centrality of the mother does not mean that investments by other caregivers are not as important to a child and their positive development. For example, Diamond (2013: 166) talks about the role of "alloparenting" which is defined as; "individuals who are not the biological parents but who do some caregiving". The role of alloparents has been decreasing in recent decades, as families move more often and over longer distances, and children no longer have the former constant availability of grandparents and aunts and uncles living nearby. This is of course not to deny that babysitters, schoolteachers, grandparents, and older siblings may also be significant caregivers and influences. However, alloparenting is much more important, and parents play a less dominant role, in traditional societies (Diamond, 2013: 166).

According to Keller & Chaudhary (2017: 111) the mother fulfils a biological necessity, however, 'mothering or caring for a child' is an attitude and activity that is not necessarily bound to biological function. Any other nonbiological roles can be fulfilled and distributed, supplemented by one or more individuals, such as fathers, older siblings and grandparents. Additionally, Keller & Chaudhary (2017: 112) states that in the attachment theory a mother must invest exclusive, intimate relationships to emerge between a single adult and a single child, she must be assured of her own safety and survival, the child's survival, a stable environment free of imminent dangers, food secure and moderate temperature. However, this dyadic exclusivity in the main reflects WEIRD environments. This would not be applicable in other parts of the world.

Furthermore, Keller & Otto (2014: 307) assert that there is no doubt that attachment is a basic human need, a cross-cultural motivation that babies carry in their genes when entering this world. However, this world is not a uniform environment with one adaptive ideology of parenting, with one conception of good parenting, and one view on valued developmental achievements. Anthropology's lens allows for this to be valuable alongside psychological or psychiatric research, that benefits both the mother and the infants, to both thrive, in their respective environment. A one size fits all approach cannot be further applied.

[4] This phrasing in the context of my research is ironic as my interviews revealed that people associate 'mental health' with mental illness'. At the same time the term for mental health in TshiVenda translated is crazy.

Anthropologically, cultural context of caregiving varies considerably and may play a part in the goals expected by parents for their children and the methods used to attain these goals (Gladstone et al., 2018:2). Culture plays an important role in an infant's life, as well as the way a parent takes care of their child. The ideas and actions of parents everywhere are strongly influenced by culture, specific norms, and practices at every phase of the reproductive process, from the formation of conjugal unions, through pregnancy and childbirth, to infant care and child rearing. Moreover, Bema Nsemang (in Serpell, 2019) purports that human development in Africa, for example, is deeply rooted in and affected by the cultural heritage and imbedded in the social circumstances in which children are raised. This illustrates that a theory like attachment needs to consider seriously the varied social landscapes, histories, cultural and traditional realities in which certain 'attachment' can take place, and this be more flexible in the norms and standardised and limited styles of attachment. Norms of parenting reflect and help sustain the moral standard of a community (LeVine & New, 2008: 1). The field of infant mental health constitutes of a variety of factors that sum up to create conditions, which are not necessarily deterministic in their nature, but which can be positive or negative for an infant, which will vary cross-culturally.

Culture is an integral component for child development, it is an essential ingredient in the plans of parents, on the kinds of care they provide and the developmental pathways they establish for their infants (LeVine, 2007: ix). Cross-cultural research is important for parenting and infancy and how cultural differences are influenced by cultural agendas that structure parental behaviour and activate different potentials for behavioural development beginning in infancy. Thus, attachment theory and infant mental health and related interventions or programs can benefit greatly be considering the above, so that solutions are targeted, holistic and provide parents with solutions that are on par with their lived experiences in reality.

An additional critique of attachment theory is given by Robert Levine (2014: 51). He questioned the historical perspective on the psychology of attachment that Mary Ainsworth and her student used based on Bowlby's model of attachment. It claims that it is an objective perspective that was based on empirical evidence concerning infancy and childhood in the human species. LeVine (2014) argues that attachment should be seen as part of the 20th century moral campaign to change childcare in Britain and America after the second World War. This is based on the premise of sentimentality which views children as innocent and lovable creatures needing both protection from harsh conditions and loving care from their mothers.

Conversely, attachment research often pathologizes mothers when they do not meet all the requirements of their psychiatric model that boxes attachment on a set of behaviours.

The relationship between an infant and its caregiver is nuanced and complicated, it can be seen culturally, psychologically and/or psychiatrically. The relationship between attachment and IMH is the axiom that attachment exists in three defined categories of secure, anxious and avoidant. These attachment styles are said to be predictors of future behaviour of wellbeing. Secure attachment is thus prized as it signals resilience whereas the other attachment styles do not. Anthropology can offer a grounded view of what conditions of care children are born and raised in are affected by social and cultural factors and these can shape their worlds.

Infant mental health and attachment theory are lenses that allow the relationship between an infant and their caregiver to be analysed, studied and for solutions to be uncovered, solutions that help to optimise the outcome of both parties as they affect each other. Although variations occur of these relationships, it is important presently, to consider the multiple ways, that are holistic and interdisciplinary to curate an epistemology and practice that will be beneficial in the field of infant mental health.

IMH & South Africa

Given that ten percent of the South African population is under four years of age (Statistics South Africa, 2016), it is urgent that this receptive stage of development receives the attention of the academic community (Berg & Lachman, 2019). Therefore, prioritising IMH in a South African context is recognised as relevant and valuable intervention. Importantly, studies of child development and infant mental health as well as attachment research, are largely confined to North America, Europe and other Western countries which comprise less than ten percent of all children in the world (LeVine & New, 2008: 1). The majority of children are born in Asia, Africa, Latin America and the Pacific. More urgently is the need to acknowledge the importance of valuing the involvement of the local community as experts (Oppong & Strader, 2022) who provide local knowledge of child rearing practices to ensure that ay interventions that are implemented actually serve the targeted community.

South Africa is a developing country and has high levels of inequality, additionally, according to Tomlinson et al. (2005: 1044) developing countries, specifically African countries, are characterised by higher proportions of young children than in developed countries. The apartheid past of South Africa created conditions of adversity that still affects the Black

population disproportionally. The apartheid legacies and conditions are evident across all aspects of child development, high infant mortality rate, stunted growth, high rates of early drop out from high school and general low levels of educational attainment, as well as homelessness and criminality. According to Tomlinson et al. (2005) & Richter (2003) these hardships go hand-in-hand with high rates of psychological disturbance. Zeanah (2009) states that larger complex systems affect the way that parents can show up for their children and the quality of their relationship in turn.

Without glorifying poverty and glamourising resilience this signifies the importance of context and the need for cross-cultural consideration in infant mental health studies, not all poverty and crime ridden communities will display avoidant attachment in the same way (Tomlinson, Cooper and Murray, 2005). Studies may routinely report that poverty has negative consequences for the infant-caregiver relationship as well the positive outcome of infant mental health, however, one thing cannot be true in all places in all times, this complication is why anthropology can bring forth a nuanced and useful perspective in the field of infant mental health. Although poverty has devastating effects on wellbeing, this does not equate that children in poor environments are not securely attached or cared for. The problem is that there is not enough support for the practices that lessen difficulties. Anthropologically, cultural context of caregiving varies considerably and may play a part in the goals expected by parents for their children and the methods used to attain these goals (Gladstone et al., 2018:2).

Given that globally, majority of infants and toddlers live in settings which are different from the ones described in globalised models of research, more localised research, including language reform to ensure that research output is effective, is necessary (Berg, 2016). Given that studies of childhood, specifically infants, are few and far in-between in the field of contemporary anthropology in South Africa as Ross and Pentecost (2021) highlighted, this work is valuable and relevant. 'Attachment' is read as a marker of infant well-being and of infant future well-being - i.e., as setting the adaptive ground for long term emotional and psychosocial development. IMH being a theory grounded in psychology and psychiatry is significant, it is not inherently problematic. However, looking at it through the lens and perspective of anthropology and even in a multidisciplinary manner can only have benefits. The main critique that anthropology poses to theories such as IMH and attachment theory is the lack of acknowledgement of cross-cultural variances which are not only relevant but important.

Chapter3: METHODOLOGY

Adopting a decolonial feminist queer methodology

This research is a step away from culturalist ways of thinking about concepts and how they resonate with people presumed to share the same cultural frameworks or ethnic identities. I approached my research using a decolonial feminist methodology which was conceptually undertaken deliberately as an intervention which applied 'queer methodology'. According to Ndlovu-Gatsheni (2017), "the process of its decolonisation is an ethical, ontological and political exercise rather than simply one of approach and ways of producing knowledge". With this in mind, my ethnography is a purposive dismantling of traditional modes of 'doing' anthropology and most importantly 'doing' ethnography by attempting to undo what Ndlovu-Gatsheni (2017) terms as "forcing students to adhere religiously to existing ways of knowing and understanding the world". For instance, my fieldwork was not in one designated space or place as traditional ethnography does, instead, my field was rather everywhere I happened to be during the period I designated myself 'to be in the field and do fieldwork'. In part, this research also has parts which are autoethnographical in nature. The choice to do so is part personal and part necessary since the majority of my participants were my family members. This chapter will outline why I have chosen to take the decolonial route with my research as well as queering of traditional methods of anthropological research which I adopted from Boelstorff's (2016) concept of queering methodology. I will also reflect on my positionality and choice to be part of this research project. Lastly, I will also elaborate on the ethical considerations pertaining to my research.

Decolonising feminist ethnography and queering re-search methodology

I chose my methodology for several reasons. Due to the long history of "research of men studying women, whites studying Blacks and Westerners studying third world countries" (Harding, 2014: 8) my intention was to undo this by purposefully using my politics and positionality in my process of knowledge production. I attempted to achieved this by favouring and validating the perspectives and opinions of my participants as knowledge, as a contribution to existing knowledge and even a contribution to knowledge production. Decoloniality largely calls scholars to "free themselves from the shackles of coloniality that exists still in the domains of power, knowledge and being" (Ndlovu-Gatsheni, 2015), thus it is my hope that my research would be a step towards this endeavour. Furthermore, although my research is based on a topic

that is largely WEIRD which led to the necessity of engaging with mainstream research which has been criticised for its bias and lack of localisation and robustness in engaging with literature and research from the global south. Thus, engaging in feminist theory and decoloniality was necessary to allow for nuance and critical engagement with various epistemologies.

In Chapter 1 of "*Surfacing: On being black and feminist in South Africa*" by Desiree Lewis and Gabeba Baderoon (2021:2) they emphasise that their book is an intervention into "What kind of knowledge matters" and most importantly, "Whose knowledge matters?" I highlight this point because my research was exploring a topic that is typically left to 'professionals' such as psychologists and academics as knowledge into the concept. These works allowed me to first conduct my ethnography by being mindful not to fall into the trap of depicting the "re-searched" as "specimens rather than people" Ndlovu-Gatsheni (2017) as far as I could. Working with my family and friends was challenging, this is because I had to add a formal element to our relationship, asking them to sit with me and conduct a formal interview and proceed to ask them questions. At the same time, the benefit was that I had established rapport with them due to the nature of our prior relations.

To avoid the 'specimen' approach, I was open about the whole process and allowing them to ask me questions at any time, providing them with any and all information they needed, during and after our interviews. I also made it clear that they are helping me, instead of me using them to source information, it was evident that my intention was academic pursuit. Furthermore, due to the nature of having a prior relationship with all of my participants, with me as the researcher leading this aspect of this new element of our relationship, the process was enjoyable with me listening. I would say that working with my family allowed me to understand their perspectives about children in relation to my topic, and also allowed them to learn new things from me about formalised ways of raising children. None of these exchanges were done with the intention of changing anyone's way of life, but as a generative way of information exchange, or at least I hope this was the case for all involved. This research is not ethnicised or culturalist, I was looking at the different ways that people mobilise knowledge, and the setting was ideal as working with family and friends, the assumption would be that we share similar knowledge due to our backgrounds.

Furthermore, I employed feminist methodology (Davis and Craven, 2016) by creating knowledge that engages with feminist theoretical and ethical perspectives, I also deliberately cited work by feminist, and women as far as I could. Boellstorf (2016: 215) talks about adopting

queer methodology as "an open conceptual space for interpreting queer studies as a modality of inquiry which can be potentially applied to any topic". I applied this queering in the choice of participants, working with family and friends, with my field site not being in a designated place. I also made sure to design my methodology by adopting multiple methods such as face-to-face interviews and online interviews. I did not stay in one location speaking to people of a particular culture. Therefore, I employed 'queer' as a verb, applying methods that are not necessarily 'traditional' in ethnography nor anthropological inquiry (ibid).

As a scholar, I abide by feminist praxis of making the personal political such as ethics of care (Hyder, 2021). While I was in the field collecting my data, I made sure to include my participants in the process because "an ethics of care ensures everyone's voice is recognised and given the respect it deserves" (Hyder, 2021) which I did by listening to all my participants and what they had to say, even if I disagreed in my personal capacity. After I was finished asking all the questions I felt were relevant, I would ask my participants how they felt about the conversations and if they had any questions for me. At times this led to a lengthy and very enjoyable and sometimes tough and vulnerable conversation about the questions I was asking during the interviews. Important to me was that my participants voiced that they had learned something new or heard a new/different perspective that they had not thought about before after these conversations. Ndlovu- Gatsheni (2017) states that it is imperative "to re-position those who have been objects of research into questioners, critics, theorists, knowers, and communicators" and I did this as far as I could. This was important to me because I did not want to be extractive in the process of my research, and to ensure that the people who agreed to participate in this research knew their participation was valuable.

The decolonial approach included conducting research on a topic which is predominantly dominated by Northern perspectives. Thus, this is a contribution by a black woman, providing a local South African perspective. I also conducted some of my participant observations in my home language of TshiVenda which allowed my family to be at ease with me asking them such complex questions which sounded serious. Furthermore, to get away from an overly ethnicised account of knowledge which is colonial in nature, my participants were diverse in identity and culture as well as their relationship to me. Lastly, Ndlovu-Gatsheni (2017) reminds us that we should not pursue "the native view of "research" as an innocent pursuit of knowledge", because it is not, I had reasons which will be outlined in my reflection about my positionality.

Data collection: Participant observation, ethnographic interviews, and video card

The actual methods I used to conduct and collect data included participant observation, ethnographic interviews as well as showing my participants a video card and eliciting discussion about it in my interviews. I started talking to people about my research from early 2021 until about July 2022. In 2021 while preparing my research proposal, my supervisor encouraged me to start early with having conversations with a range of people about my topic to see 'how this concepts lands'. This was very uncomfortable at first, I wanted to start with my family as I was home during the 2021 working and studying from home period due to the Covid-19 pandemic. However, it felt too uncomfortable for me, so I went ahead and asked friends, colleagues and acquaintances on WhatsApp. From this moment forth, my field site became wherever I was posing questions about the idea of IMH. In doing so, I present a snapshot of diverse opinions and ideas that people in my network share. The aim in so-doing is to reflect on how a concept is taking form in everyday life without imposing a preconceived idea of meaning-making. This research project was done during an awkward transitional and liminal time, at the height of the second and third waves of covid-outbreaks in South Africa. It is important to note that although the topic of my research is 'Infant Mental Health' I did not focus solely on 'infants' by definition. In different conversations with participants, they could either be talking about the experience with their child when they were an infant, a young child or an experience with someone else's childhood a different age. So even though the times when the participants were speaking about child, children, baby, it was always different pertaining to the question or the experiences. Below is a list of the individuals who participated in this research:

Participant List

Name	**Age**	**Age of children (if any at the time of the data collection)**	**Education**	**Parent/non parent**	**Source of knowledge about childcare**
Jenna	36	3 years old	Master's degree	Parent of 1 Aged 3	Published articles, books, social media (Instagram

					parenting accounts & WhatsApp mom groups)
Itani	52	Children: #1: 28 #2: 26 #3:21 #4:15	Undergraduate	Parent of 4 Grandparent to 2	From parents and university (profession is a teacher)
Mashudu	47	Children: #1: 28 #2: 26 #3:21 #4:15	Honours degree	Parent of 3 Grandparent of 2	From parents and university (profession is a teacher)
Lutendo	38	Children: #1: 16 #2: 12	Matriculation	Parent of 3 Number 3 born after data collection (7 months in June 2023)	From mom, grandmother, mother-in-law, clinic visits
Tshegofatso	35		Military education	Parent of 1 (Child born after data collection, 7 months old in June 2023)	From grandmother, personal experiences
Grandma 1	70	Children: #1: 46 #2: 44 #3: 36 #4: 34	Grade 7	Parent of 4	From mother and grandmother
Grandma 2	65	Children: #1: 24 #2: 21	Primary school	Parent of 3	From mother and grandmother

		#3: 19			
Nontando	37	#1: 15 #2: 17	Two years in university	Parent of 2	Personal experience, just goes with the flow, uses her guy and sometimes advise from elders.
Alex (born and raised in Germany)	22		Undergraduate university student	Nonparent	Own experiences and opinions
Zanele	28		Undergraduate degree	Nonparent	Personal experiences, therapist, psychiatrist, online videos, books on children and parents and Google.
Mariam	43		Honours degree	Parent of 4	Books, parenting workshops, therapy, social media, her own lived experiences and talking to other moms about their experiences, and her children.
Naledi	29	Children: 4 months old	Honours degree	Parent (first time)	Research and books (articles and journals). Mom and aunts
Thabang	35	Children #1: 13	Undergraduate diploma	Parent of 3	Mom, personal experiences

		#2: 4 #3: 1			
Moon	22		Honours degree, undergraduate degree in first year	Non parent	Sociology studies from university and the internet
Lufuno	35		High school	Parent of 3 boys and 1 girl	Mom, sister, social media
Mbali	N/A		PhD degree	Parent of 2	Research, mom, mother in law, social media
Adorance	24		University degree 3rd year	Non-parent	Personal experiences and observations from siblings and cousins.
Raja	22		Undergraduate degree	Non parent	Material from her studies (studying to be a psychologist), Google, Tik Tok
Grandma 3		Children: #1: 45 #2: 45 #3: 37	Primary school	Parent of 3	Mom, practical and personal experiences
Mpho			High school	Nonparent	Personal experiences and baby sitting nieces and nephews

Tshifhiwa	25		Honours degree + PGCE	Nonparent	Personal experiences, teaching

My observations mostly took part in Venda where I also took fieldnotes and participated in many activities which led to conversations about my research. The languages I used to conduct my interviews include TshiVenda, English, IsiZulu, and Sesotho. I would converse with my participants in their own language as far as I could and encouraged them to express themselves and answer in the language they felt most comfortable with. Fieldwork began at the beginning of the festive season. [5] In December 2021, I was set to spend my festive season in Hoedspruit and then Venda, both located in the province of Limpopo. My research primarily began in Hoedspruit in my aunt's house. My participants also included an extensive network of friends, peers and colleagues. A table outlining my participants is attached as an addendum. I conducted 4 'formal interviews' (these were planned beforehand) for this research, two of which took place online on Teams, Skype and Zoom. This is another way my research was decolonial, in that geographically I did not subscribe the to the traditional way of one location for a period of time, as anthropology fieldwork originally does. I had one informal conversation with my cousin and the rest of my interviews were a mix of discussions and informal interviews either during cooking Christmas lunch, on the porch with family, or sitting outside under mango trees with aunts and grandmothers. I showed 7 of my participants the video card which I explain below.

The last method I used for my research included using a video card, "*Together from the Beginning"*. The card, created by child and adolescent psychiatrist, Professor Astrid Berg in conjunction with the Department of Health, and the Red Cross War Memorial Children's Hospital, is designed to be shared in waiting rooms at antenatal clinics (Marais, 2017: 4). It emphasises the value of early childhood development and maternal and child health during the first thousand days period, as supported by the latest research in neuroscience. It also highlights a variety of childcare practices for parents, but specifically mothers. The aim of the video is "to increase awareness in parents regarding their infants' development and needs and thereby

[5] "Festive" season is a very busy time in the South African context. A lot of social events such as parties, braais and so on are happening. Family members usually gather around in one family home in anticipation and preparation for Christmas, Boxing Day and then New Years together. However, the 16th of December is also celebrated. December 16th is the Day of Reconciliation is a public holiday which was an attempt to strike a balance between a divided past and the promotion of national unity and reconciliation in a new political dispensation.

enabling them to adapt their handling of their young children" (Berg, 2006 in Marais, 2017: 4). The video displays childcare scenarios in various socioeconomic backgrounds, representing racially diverse families and caregiving in the Western Cape and South Africa at large, and offering advice on optimal conditions for child development. I showed this video to seven of my participants after initial conversations. I used the video to elicit commentary and to see whether participants' opinions would change after they have watched the contents of the video. This was an intentional choice on my part to elicit conversation and insight, to see, how and if the opinions about infant mental health would shift or change, and most importantly to hear their opinions and feedback about the video in relation to the topic and all that we had discussed beforehand. All the participants who watched it told me that IMH and infant wellness is something they had not thought about in the way that the video described. They also said the video allowed them to see the ways in which they can ensure the wellbeing of an infant.

Before I went to my aunts, I alerted all my family members that I would be doing research during the holidays. I asked them if they would be interested in being part of my research, and initially, they sounded curious and excited to be able to help me. For Christmas at my aunt's house were a total number of 26 people; 13 were my cousins, 2 being my children, and 10 included my grandparents, my uncles, aunts and their partners, not forgetting myself. It was very challenging to work with my family and finding the time during a busy time such as the festive season, made things even harder. All the while all I could do was observe, mainly because there were many children. I did not observe the children per se, as that was out of the scope of my research, and I did not have ethical clearance to work with children. I rather, looked at the interactions between the adults and the children, and noted how all the adults behaved in relation to the children, myself included as I became primarily the caretaker as the oldest cousin, and a mother to two children. Although my topic is on infants, seven of the children at the house were under the age of six. In addition, I felt it would be useful to start my conversations with my family members based on the things I had observed, to have an entry point into a difficult conversation. A snippet from my fieldnotes details my state of mind at the time:

"It has also been a little challenging to find time to chat about my research with my family. Fiona says the field is anywhere you are, but I'm in quite a chaotic environment and I get overwhelmed quickly, coupled with my imposter syndrome that leads me to procrastinating making progress with my research. It's been challenging though with having so many children around to take care of and clean up after. I'm trying to find ways to improvise, and I really

need to start talking more about my research. That's the only way it will start to become easier, to ask questions that flow and lead to conversation". [14 December 2021]

To paint a vivid picture of just how chaotic it was during this time: 22 December 2021

"*All in all, the number of children here is 10 children which is a lot to deal with on a daily basis. In between is breaking up fights, comforting someone because they were hit, or someone won't share, or they want to eat something that's off limits (sweets in the morning, or a third serving of ice cream). Needless to say, finding relaxed time to sit and start talking about my research is quiet challenging.*
Secondly, my aunts had been busy working, one of my aunts works then comes back home and sews (she is a seamstress and designer). She is off this week (from the 16th of December) but since then she's had orders to make dresses and I felt like I'd be disturbing her as she was working. My grandmothers just came today (22 Dec), and I am hoping to interview them tomorrow. The process has been slow, but I am making progress and trying to improvise where I can."
From here onwards, my research seemed to go smoother, I felt more confident to bring it up while things were happening, such as sitting outside with my cousin or when I was getting my hair done by my aunt, cooking Christmas dinner, sitting outside mango trees to get away from the sheer heat of December in Venda, and visiting family to say hi and so on.

Before going into the field, I had read work on decolonising methodologies, such as that by Linda Tuhiwai-Smith (2021) and I was quite captured by storytelling and listening to the stories from our elders and grandmothers, and that is exactly what I did. I was challenged to leave my preconceptions, 'knowledge' and beliefs behind; to sit and listen, question respectfully, which is challenging when conversing with elder Venda women. In the TshiVenda culture, it is disobedient to talk back to an elder, or to question them, so naturally this was a tough exercise when it came to conversations with my grandmothers. When it came to questioning, I tried to focus on the content in relation to the topic of my research to make sure it does not seem as if I am questioning an elder, or disproving what they are saying, but to make them know and feel that the information they are giving me is valuable and important to me, which is an important and powerful part of listening to stories in decolonial methods of research and knowledge production (Tuhiwai-Smith, 2021).

During my fieldwork I was very fortunate to have an opportunity to have two of my grandmothers, my two aunts, my uncle's wife and my stepmother sitting in a circle. We had a

lengthy conversation about my research, but it was a beautiful experience where conversation flowed and I only stepped in to ask more, to probe and facilitate the impromptu 'focus group'. My subsequent conversations happened as life went on in different settings with different people. For example, with my housemate and her girlfriend who came to visit from Germany, with my neighbour-friend who connected with me as a 'fellow mother' which gave me an opportunity to find common ground to talk about my research as a bonding experience of talking about our children.

Data Analysis

Gobo (2008) in "Doing Ethnography" introduces an analysis process by Strauss and Corbin (1990) which is divided into three stages, namely deconstruction, construction and confirmation (Gobo, 2008: 224). Although my research did not follow thee stages as strictly as detailed in the book, I loosely followed these stages to produce my thesis.

During the process of data collection, I observed various recurring themes and interesting topics that emerged from my conversations. This phase can be referred to as the deconstruction phase (Gobo, 2008: 228), as I examined the field to identify concepts that could elaborate on the observed phenomena. I would share these findings with my supervisor, who would challenge me to further explore and probe the participants. Additionally, I took the initiative to ask participants about intriguing topics, themes, or perspectives that had been brought up in previous conversations in order to expand upon them. Although some of these discussions did not make it into the final thesis, they provided valuable insights and were engaging for the participants.

To analyse my data, I initially listened to all my recordings and took notes throughout this process. Subsequently, I reviewed and analysed the collected notes, which allowed me to identify underlying themes. This stage can be characterized as the construction phase (Gobo, 2008: 234), as I aimed to construct a coherent framework based on the identified themes. Following this, I embarked on a literature search to explore relevant sources that could inform my understanding of the collected data. It is important to note that my analysis was driven by the data itself, rather than being guided by existing literature, as advised by my supervisor. The approach I employed was not as formal and scientific, as I relied on a notebook for notetaking and began writing based on the themes that provided the most comprehensive information and conveyed a coherent narrative. This marks the final stage of the coding process, during which

I initiated the writing process by connecting the identified themes to relevant theories and existing literature.

Positionality: A moment to reflect, and why I chose to be part of this project

In continuance of the methods of feminist praxis, queer methodology and decoloniality, being cognisant of my position as the researcher and the impact of [my] particular attributes and social positions on [my] research was important for a number of reasons (Davis & Craven, 2016:77) I will reflect on how my positionality potentially influenced this research. Firstly, I am a mother, and Alma Gottlieb (2012) has emphasized how being a mother and working on research that is about infants and or children impacts and influences how one undertakes this kind of research. Gottlieb (2012) states that once she was pregnant, mothering became an intrinsic part of who she was as a person and subsequently as an anthropologist. This is especially because her feminist inclination to make the personal political was a huge part of her work. Furthermore, she iterates that " who we are shapes the fieldworker we become" (Gottlieb, 2012: 2). She points out that all her professional decisions around her fieldwork are governed and influenced by her mothering. Importantly, she also talks about how our "so-called private lives" conspire to shape our scholarly decisions and agendas, "including the topics we choose to pursue, the field sites in which we come to feel at home, even the theoretical orientations we embrace" (Gottlieb, 2012:3). Based on my own personal experience, I agree with what Gottlieb is saying as my positionality influenced why I took part in this research project. Lastly, Gottlieb (2012) boldly states that she offers no apology in discussing her personal side to her anthropological work in childhood, I too use anthropology unapologetically to inform my choices in academic and personal spaces, which are intertwined, deliberately.

Secondly, in my personal capacity as a human being, I am deeply passionate about mental health as well as children and the inheritances we are born into generationally, hence why I was happy to join this project with so much eagerness. I had read a lot on topics such as attachment theory, child rearing, parental paradigms such as gentle parenting, conscious parenting and psychological information on being human before I began this work, as part of my own parenting practice. This informed my interest in the topic in the first place, but at many times during my fieldwork, during my writing up and thinking process it became a challenge, namely because this is an anthropological inquiry and it became quite clear just how embedded

the above-mentioned was in my ways of knowing, understanding and being in the world and thinking. It had become tacit knowledge to me, and this proved challenging at times.

Due to my feminist beliefs, the personal is political for me, and I have come to accept that who we are will be in our work. It became easier to see some of my own prejudices and inclinations towards how I shape, present, present information and most importantly to tell a story ethnographically or rather to be anthropological. Yewande Omotoso (2021) in her chapter titled ' *What We Make to Unmake: The Imagination in Feminist Struggles*" in *"Surfacing: On Being Black and Feminist in South Africa",* talks about how she has certain personal interests which are connected to the kinds of stories she tells. This is the case for me too, I see subjectivity as a helpful ally, which allows me to work on things I deem valuable to me, which are current human concepts which are relevant and current.

Part of this research can be considered autoethnographic. Ellis, Adams & Bocher (2011: 274) define this as "an approach to research and writing that seeks to describe and systematically analyse (graphy) personal experience (auto) in order to understand cultural experience (ethno). Anthropology and feminism have helped me understand and contextualise my life greatly. According to Davis & Craven (2016: 81) feminists have a long history of valuing personal experiences and how it informs and often becomes part of scholarship. Feminist studies have also emphasised how 'the personal is political', which I have outlined in my reflection. This method of ethnography was useful in my conversations with not only my family members, but to the participants who were parents; my experiences gave me a way into hard and emotional conversations. With my family, it allowed our personal connection and relationships to assist in asking bold, personal and confronting questions surrounding the concept of infant mental health, so autoethnography was a crucial tool to approach my research.

Lastly, my participants were chosen due to their proximity and accessibility to me. In anthropology, participants are usually strangers you build relationships with during the ethnography process. However, I had pre-existing established relationships with all my participants. This is unlike any traditional anthropological study in that way, and my methods and methodology allowed this to work in my favour. I was told research can take place anywhere where you are, by asking anthropological questions, as an anthropologist and I took full advantage of this.

Ethical considerations

Due to the nature of my research question being about ‘mental health’, I anticipated that I would be asking my participants questions that may lead to vulnerability and information that may be emotionally charged. My responsibility as a researcher towards my interlocutors dictates that I should anticipate potential harm, act to protect respondents and to secure their dignity. To that end, my research was conducted in accordance with the *Anthropology Southern Africa* ethical guidelines. As per the stipulated guidelines that all anthropologists must follow, it is my duty to treat participants as subjects not as the objects of research or as a means to an end.

Importantly, although ethically anonymity is important with certain projects, I worked with people I know, my family members, friends and colleagues, therefore ensuring anonymity was challenging. However, with regards to conducting research that is decolonial in nature, or rather dismantling the façade of a distant 'objective' researcher who goes off to do research with strangers in a strange land, I was in a familiar place, with people I had established relationships with, having unfamiliar conversations for the pursuit of knowledge. Although it is disclosed that I worked with people I know, I did use pseudonyms, nonetheless. I asked my participants if they would prefer a pseudonym or if I could use their names. Two of my participants agreed for me to use their real names, whilst the rest either gave me their preferred pseudonym or said I could choose the names. Informed consent was established from all interlocutors (ASnA guidelines) whereby I outlined the purpose of my research and all other necessary information. Furthermore, I informed my interlocutors that they can withdraw their participation from my study at any time without any harm.

Lastly, Tuhiwai Smith (1999) urges researchers to disrupt the rules of the research game and move toward practices that are more respectful, ethical, sympathetic and useful, rather than racist practices and attitudes, ethnocentric assumptions and exploitative research. As a young emerging anthropology researcher, I sought to do exactly this by doing work that is heavily premised on ethics of care, where I respected my participants during fieldwork and subsequently in the writing up process.

Chapter 4: Why is my baby crying and what is infant mental health anyways?

"*Infant is a baby, right? So, it means it is a baby who is always crying"*- Mashudu (participant)

My topic is one that most people do not necessarily consider or think about in everyday ordinary conversations. This was apparent in the way one of my participants asked me "*why you would even choose to research about this? Were there no other, easier topics*?". There was always a visible shock in the faces of my participants when I told them what my topic was about. The reactions ranged from laughing, frowning, and even asking me what it is. Although the reactions varied, the common themes were that infants were synonymised as with crying, and the concept of infant mental health itself was understood in its negative form, as problematic - 'something is wrong' - a pathology as well. Additionally, extending from the commonplace understanding and use of the term 'mental' to indicate pathology, a quite notable thing that emerged with my field work and conversations was that 'mental health' as a concept was understood in terms of illnesses, for example, depression, something to fix. This was especially the case when crying came in. Specifically, during my fieldwork which started in Venda, two interesting perspectives about crying and the word 'mental' arose surrounding the infant.

Crying and infants were talked about in terms of a child who cries excessively, or unreasonably who would be labelled as 'u(ya)dzindela' or 'olemiwa'. The word, 'mental' in TshiVenda is 'upenga' which translates to 'crazy', this understanding is what led to noting the relationship between mental health and illness. These ideas will be explored throughout this chapter. I will look at how the concept of infant mental health was understood in varying contexts, by different people with different knowledge bases and backgrounds. Despite their differences, all emphasised crying as a key dimension in how they understood infant mental health. I therefore examine their ideas about crying and distress before further exploring what my participants had to say about the concept "Infant Mental Health". In examining the ideas about IMH I will also talk about how I used the "*Together from the Beginning"* video card which depicts early childhood development and the importance of the first 1000 days of life. As I show, despite differences in sociocultural aspects and education, all my participants associated the term 'infant mental health' with 'illness', suggesting that the term settles on grounds already shaped by prior discourses about illness. Crying and IMH were linked by connecting excessive crying

as indicative of something being wrong with a baby; this problem could then indicate an issue with an infant's mental health.

Jenna, Jude and the Judo Game; Infants, crying and IMH

Jenna is a 36-year-old married woman who has a master's degree in Media Studies, she is a first-time mom who has a son named Jude. Like most mothers, Jenna talked about how she was sleep deprived and how she needed time to acclimate and build a relationship with her son. Jenna and her husband then decided to create a game called "*Judo, what does this cry say*?", to figure out why their son was crying. Judo consisted of a checklist of things such as "*feed, sleep, dirty nappy and so on*". Sometimes the game would need to be repeated before Jude's need was met, or rather before Jude stopped crying. Over time, thanks to the Judo game, Jenna started to understand what each cry meant, and she was much calmer when Jude cried. Jenna emphasised how responsive she is to her son, describing herself as attentive to his emotional needs at all times. She often unselfconsciously used the words 'secure attachment,' an indication that the psychological framing of wellbeing was part of her 'everyday practice'. It's worth noting that the Judo game appears to have been about physical needs, yet she has been able to translate her attention to his physical needs into an awareness of his emotional needs. Jenna told me that as a mother she prepared herself and still does read journal articles, books, and is part of WhatsApp groups about parenting, which is how she gets her information about attachment.

Of considerable interest was that for all my participants, infants and crying were almost synonymous. By this I mean that infants are expected to cry, because they are unable to talk, hence their crying is widely and accepted and understood as 'a way to communicate'. Additionally, crying was something that makes people uncomfortable. Most of my participants said that as new parents, crying was hard to deal with at first, but as time went on, they would get 'used' to it and know how to 'deal with it'. Others, however, regarded it as a 'problem that must be solved', proposing that when it is too constant it could signal that something is wrong. In other words, if a child starts crying, it is problematic, and a solution is necessary to get the crying to stop. Basically, crying is perceived and experienced (mostly by the adults) as uncomfortable and problematic.

Yet, the life of an infant almost always starts with crying (Maldonaldo-Duran & Lecannelier, 2019). Interestingly, this "first act" is celebrated as a sign of life when it first happens as it

represents that a baby has ‘survived’ “the difficult process of being born” (Maldonaldo-Duran & Lecannelier, 2019: 195). It is considered a gift, a sign of life. I remember this well: after birth, my children broke the silence in the delivery room with very loud cries, one after another, and when I first bought my babies home, they also cried a lot, throughout the day. When I would start to show signs of frustration and exhaustion, my grandmother would tell me that it is OK, I should be happy because my sons are “growing their lungs”, an idea that Maldonaldo-Duran & Lecannelier (2019: 195) also mention. My feelings about my grandmother’s explanation, was two-fold. On the one hand, I understood metaphorically what she was saying and found it comforting in some ways. However, on the other hand I found it to be cynical as it did not make sense that a child needed to cry to expand their lungs and how the two were related.

However, during my very first interview with a Thabang, a father, my initial question - ‘when I said infant mental health, what was the first thing that came to your mind? – caused him to pause. He said: *“Shuu yoh I don’t know…”*. His reaction was hard to decipher as we were communicating over Teams, and his camera was off. However, his audible sigh indicated the abstractness of my question, he then told me “*Uh. I think first, it's probably something I have never really thought about*”. As we went further into the interview, I then asked him if he thinks infants even have mental health, and to that he said that he thinks of mental health in terms of “*them [his children] being like normal, I hope… So, what I would do is, uh, we just checking that, you know, that when he cries, he cries for a reason, right? That he doesn't have like chronic crying, or I don't know what the term is for that. But it does happen that you find kids would just cry forever*”. From his iterations crying exists for a reason, and without reason. The latter would indicate to a parent that something is amiss with their child.

In the field of paediatrics, "crying has physiological and neurophysiological usefulness in the early days of neonatal adjustment. Babies survive with the help of their first cry" (Brazelton, 1962:579). Which means, infants need to cry, in order to receive attention and care, and to get their needs met by their caregivers. Furthermore, according to Armbrüster et al (2021:402), crying is considered a natural alarm, it is an "emergency expression of a motorically helpless infant", which is recognised by both parents and scientists. Interestingly, Armbrüster et al (2021) goes on to state that the information that is available about crying is mostly dedicated to giving advise on how to stop the crying, reinforcing the idea that some of my participants shared, that crying is problematic. Armbrüster et al (2021) states that although most of these reports and guidebooks mention that crying is a normal expressive behaviour of all infants,

there is a general focus on its unpleasant and disturbing character, particularly so-called excessive crying, something that, as we have seen above, Thabang directly noted. At the same time, crying is also viewed as a way that infants and children use to "provoke a response from a caregiver" (F Ross 2023 personal communication, 24 January), because as mentioned it is distressing and cannot be ignored.

From this part of the conversation, it almost sounds like when a parent has provided a child with their basic needs, such as the ones that Jenna mentioned in her checklist for Judo, crying outside that is deemed irrational and not normal, and is read as signalling something wrong. There was a correlation between 'reason for' crying, which could be why crying outside reason was considered problematic, and in the extreme, could signal an issue with an infant's mental health. The notion of 'crying for a reason', was not thought of in terms of communication used by a pre-lingual child in these cases- this only seemed to be acceptable at certain ages and only for certain needs. For example: is the reason why a child is crying reasonable, important or worthy? These understandings are that of the adults, the child may think or feel that crying to drink their water in the yellow cup instead of the red cup is "*reasonable*" as Mariam told me when we were talking, however the parent may think this is an unreasonable reason to cry. My participants all voiced how their understanding of crying is dependent on whether they find it rational, and thus any action that follows crying is judged on how reasonable or unreasonable it is for them.

Crying, u'lemiwa and udzindela

As I have discussed above, at some point, as the infant starts to grow, their crying stops being received as a 'gift', but most certainly a difficulty which parents and other caregivers must solve. Another contrast that I noted in participant responses was that although crying was considered 'normal' and 'healthy' and "*a way of communication, because children cannot speak, so children use crying as a way to speak for themselves*" as Zanele put it; Simultaneously it was a challenge for adults to know *'why'* a child is crying and then to find a way to stop it. The first solution that some of my participants admitted to using, as a way to 'understand why' the child was crying, or to get the crying to 'stop' if it had been going on for a while; would be to either say '*don't cry*' or '*why are you crying*' and '*stop crying*' which would follow with a bribe (if the child is old enough to understand the practice).

When I spoke with family and friends in Venda, people had similar understandings of crying but used two specific terms that are used to describe crying. All my TshiVenda speaking

participants mentioned these two terms or concepts: “u’lemiwa”, and “u’dzindela”. The first time this came up was during my observations, before I started interviews. The adults would often use the term when one of my cousins was crying for ‘unreasonable’ things. It also came up during my very first interview with my cousin Adorance. We were sitting outside on a typically hot summer day in Limpopo, while our younger cousins, brothers and sisters were playing outside, and some were in the house watching television. We randomly started talking about discipline, because the house was filled with many children who all had different needs, personalities, and temperaments. As adults, we found it challenging to keep the peace as there were many episodes that ended in tears, or even long tantrums which led to someone isolating themselves in the bedroom.

While we continued our conversation, Adorance told me that he had been a ‘mild child’, he always listened and did as he was told so there was never a need to hit him. Whereas other children do not listen, you tell them the same thing over and over, and the only way to ‘get them to listen’ is to smack them. And the thing about some children is that they are left to do what they want from a very young age and then as they older they become hard to deal with because their parents or caregivers “vho vha lema” - ‘spoilt them,’ or rather ‘did not discipline them’. Corporal punishment is often used as a way to silence children and is often used as a way to instil 'discipline'. I asked him what it is to “*lema nwana*” – which can be translated to “spoil a child”. He replied, “*When a child cries, you give them what they want, even if that thing is not available, a plan is made to acquire/buy that thing for the child*”. He went on to say that “a child “*o’lemiwaho hana vhumatshelo*” which translated can mean “the child won’t have a good future, because they are used to getting what they want and in the real world this doesn’t happen”. Subsequently, with all the interviews I had while I was in Venda, the phenomena of “u’lemiwa and u’dzindela’ came up usually in conjunction to ideas about crying and ‘discipline’ or rather the lack thereof, it is with regards to a child and sometimes with infants too. One of my participants, Lutendo, who at the time had an infant, told me that although the baby at the time was under one year (s) of age, that she could tell when he was crying for ‘valid’ reasons or not. She could discern "*tshililo*" translated to ‘*the kind of cry*’ that her son was ‘making’. Lutendo says she knew when her baby was crying if; "*zwia'pfala*" translated to ‘in a way that makes sense’ and categorized under: “*he is hurt because he fell*”, “*he is hungry*” or “*he needs a nap*”. Anything outside of ‘*urgent*’[6], she categorized as ‘just a

[6] This was to her own subjective discernment as a parent, to determine the seriousness or lack thereof, of her son’s meaning behind crying.

child's usual 'u'dzindela'. My aunt Lufuno defined "ulemiwa" as a word that describes a child who is disobedient and spoiled, such as a child who cries for things (especially after they've been told no) and a child who doesn't do as they are told. This definition is similar to the one Adorance gave me when I asked him to define it too, which shows how the ideas we have are passed down to us. Furthermore, if you give your child whatever they want, when they ask for it, every time, and whatever the child says goes, that child "*ha'kaidziwi*" in turn "*o'lemiwa*" and his behaviour is "*udzindela*". In essence, any level of crying before finding out the reason for it, can be seen as 'udzindela'. If a child proceeds to cry it is deemed irrational, then a child who cries and gets what they 'want' o'lemiwa.

The Tshivenda language tends to give lessons using idioms. A popular idiom or belief with regards to discipline is "*thanda i khothololwa i tshe nnu ngauri ya oma i a vundea – you must straighten the rod whilst it is still wet because if it gets dry, it can easily break.* This suggests that an early start in teaching and modelling the correct behaviour to the child is strongly encouraged, something noted by other scholars (Murovhi, Matshidze & Netshandama, 2018: 29). I believe these are the ideas that Adorance was alluding to, by suggesting that if you 'spoil' your infant they will not be susceptible to discipline later on.

A TshiVenda dictionary reveals the following: *-lema*[7] is defined as: "spoil, pamper, be lenient with someone when ought to be severe". Furthermore, *lemala* is defined as "be spoiled, pampered, and therefore sensitive, disobedient, unruly e.g … a child which has been allowed to do as it likes and is not amenable to discipline…" (Van Warmelo, 1989: 134). *Dzindela* means to "mewl, whimper persistently & irritatingly, be fretful, cry for things not really wanted (child feeling out of sorts); pester". Lastly, *kaidza* is defined as "chide, reprove, reprimand" (Van Warmelo: 92).

In the TshiVenda culture, respect, obedience and 'good morals' are deemed important qualities. According to Murovhi, Matshidze & Netshandama (2018: 23), *Vhavenda* children are expected to be silent in the presence of adults, and they are also expected to show respect to elders by kneeling when greeting, receiving with two hands and saying, 'thank you'. Thus, a child is raised to be respectful by virtue of instilling discipline through *Nyaluso ya vhana* which means *'the raising of children'* or (childrearing). Damon (1977: 167) affirms that "… authority is the central social relation between children and adults". This statement rings true to the relationship

[7] These words are in verb form are: u'lemiwa, u'dzindela and u'kaidza. However, when in adverb/action verb from it is "o'lemiwa and u'yadzindela".

that Adorance is expressing about his upbringing and how he imagines raising children. This is evident in his own admission of total obedience as a child, and his iteration that children who are not obedient are "u'lemiwa". Ultimately, what is being described is a complex set of relationships between respect and obedience, and between instilling discipline and spoiling' a set of ideas that are instilled early, including in response to tears.

The only person who had a different opinion and some nuance about *"u'lemiwa*" was Moon. She stated that the way she understands it from how people talk about it, as "*a child who does what they want, when they want*". However, Moon went on, and said that considering the topic mental health that I was bringing up to her; then isn't it the case that we should listen more to children and find a way to cooperate with them, and in a way find a way to give them what they want at times? She suggested that the problem is that we [adults and caregivers] see this as a negative thing. Moon continued that "*u'kaidza nwana*" (to reprimand a child) is done in a way that affects 'the mental health' of child negatively by shouting and smacking because it is harsh and in a controlling manner, suggesting that if you are reprimanded in a harsh way, it can affect you negatively mentally, by causing possibly lasting emotional distress.

When I asked her to explain in her own words, what "*u'dzindela"* is, she said that is it *"a child who is, like, nagging*" she went on to say, "*crying and u'dzindela is different because the child is tiring because they always want something*". Importantly, she said she feels a contradiction between how she was raised and got used to/socialised into parenting, because she is familiar with the adult's authoritative statement, such as, *"because I am your mother and I said so. You won't understand because you are a child*". At the same time, she revealed that seeing the way I parent and talking about my research topic 'infant mental health,' it may just be that adults are resistant to allowing children some freedoms and then in turn, they label them with terms such as "u'dzindela and u'lemiwa" and consider these children as spoilt, because they cannot control them and do not want to be uncomfortable.

I asked participants if they thought that crying and mental health were related, or whether they thought crying could signal something about the mental health of an infant. Alex, who struggles with what my generation has come to call 'mental health issues', told me that she believes that crying and an infant's wellbeing are connected. She went on to say that when she was little, she cried a lot about *"everything",* she described herself as a "*very sensitive kid*", adding that what she has noticed about children, specifically her younger brothers were that they cry for things that they want, even things that are "*not good for them*". In her own words she stated

that "*I wouldn't say that crying is the most purest form of showing emotions, but it is the most alarming to the next person.*" Crying is important. She also stated that "*there must be some form of biological release with crying… there must be something that happens*". She mentioned this biological explanation as she has disclosed that in therapy her childhood was discussed, and this explanation was offered by her therapist, which she then mobilised as knowledge. Interestingly, the participants who connected crying to mental health, stated that they as parents could not diagnose a problem, but would need to take the child to a doctor who would then tell them if there were 'something wrong with the mental health' of their infant.

People to whom I spoke seemed to equate excessive or inconsolable crying with reason or unreasonability. When crying could not be explained and seemed to endure longer than expected, it was read as signalling a state of distress. Some related this to mental health, although most of my participants seemed unsure of the term or how a child's 'mental health' was secured. I quickly learned that the question of why babies cry was an easier way to delve into the complex terrain of 'mental' health and its relation to infancy.

Do infants have mental health?

One hot December Monday afternoon, two days after Christmas, two of my grandmothers, my aunt, my uncle's wife and my stepmother were sitting outside congregating together. I thought it would be the perfect opportunity to go and talk to them about my research. I told them that my research was about IMH and immediately one of my grandma's asked me to translate it for her in TshiVenda, so I told her "*ngwana*" means 'infant/baby' and when she asked me to define mental health, I translated that to *"zwithu zwa muhumbulo"* which precisely translated means 'things of the mind' loosely translated is 'things to do with the mind'.

Among the Vhavenda, older women are respected in society due to their personal experience. Their expertise is usually recognised during rituals such as initiation schools. Their position as elders in society puts them in a good position to be transmitters of knowledge in an indigenous knowledge context concerning pregnancy, sexually transmitted infections, childbirth and infancy (Mulaudzi, 2007: 8). So, while I was present as an anthropologist doing an ethnography, in that moment I was listening to my grandmother, telling me what she thinks infant mental health encompasses. I asked her if she had heard people talk about the term 'mental health', and when she agreed, I asked her if she thinks a baby has 'mental health' and if so, what that looks like. but asked if it is the same as when "*muthu ono penga nyana so?"*.

Which means "is it a person who is crazy[8]? I said in regard to a baby, but more about their mental wellbeing, I asked her if she thinks a baby has ‘mental health’ and what that looks like. She started to talk about how the ‘mental health’ or, perhaps more accurately, ‘wellbeing’ if I translate it in the ways they spoke about it; is affected by the demeanour of the mother while breastfeeding. She told me that according to her beliefs, if a mother breastfeeds their child while they are unhappy, crying, angry or unwell, then these feelings will be transferred to the child. She particularly used the word ‘infect’: *"mme udo shelela nwana"* which translated means ‘the mother will pass it on the child, saying that the mother; through her milk, would infect her child which could result in the child being a slow learner, for example or not 'well' in the mind. However, after asking for clarification she seemed to be speaking about a mother who has ‘mental illnesses’ which may sometimes be familial or genetic, suggesting that the act of breastfeeding leads to the ‘illness infecting’ the child. When I asked, “what if the mother is mentally well?”, they (my grandmother, aunt and uncle's wife) told me that, either way, when you breastfeed a child, you have to be in good spirits, talk to the child, play with them and be in good spirits.

Furthermore, they said that even while you are pregnant, you need to care for yourself and make sure you don’t get too angry for prolonged amounts of time, that you don’t cry for too long because it affects your baby and their wellbeing. There is a two-fold understanding here which plays on conceptions of mothers. One is that if a mother is well and healthy, the child will be too, thus a child’s wellbeing is dependent and incumbent on the mother. The second conception is if a child is not well, it is directly linked to the mother, this is an old blame-filled trope which sees mother as sole caregivers removed from any support.

Concepts land in interesting and varying ways in people's minds. For example, it is not impossible that some of my grandmothers’ ideas were shaped by South Africa’s response to the HIV pandemic. There is extensive research on breastfeeding being the cause of ‘infection’, referring to Mother-To-Child-Transmission (MTCT) of Human Immunodeficiency Virus (HIV) (Aishat, David & Olufunmilayo, 2015). In the early 2000s there was a huge push of HIV/AIDS education in South Africa. It existed in the form of billboards, pamphlets from Soul City and LoveLife, which would be handed out in local neighbourhoods and clinics. South Africa has had numerous campaigns, programmes and policies which have been created to combat, prevent and create awareness surrounding HIV/AIDS.

[8] 'Mental' in TshiVenda is understood as upenga which translates to crazy in the English language.

For example, Soul City Institute was born out of the need to "address the legacy of apartheid on mother and child health". Their published book "HIV Free Babies" could be found in local clinics and was widely distributed in low-income and rural communities. Soul City also curated a television show which ran from 1994 until 2014. This is one of a long list of educational television campaigns which have been used in South Africa to create awareness of societal and health issues. I can vividly remember sitting at home while we lived in Naturena, South of Johannesburg in the evening watching Soul City, and I also remember going to clinics and there would almost always be talks given to mothers in the baby wellness clinics about HIV/AIDS education. This pamphlet specifically, was handed to all mothers who came into clinics, whether or not you had HIV. In other contexts, people are concerned about "bad air" (personal communication, April 2023 Dlamini).

My grandparents and my aunts lived through these campaigns, and in some way, this information may now be knowledge they use, due to how widespread and constant this information was. My argument here is that all this information from the HIV/AIDS campaigns, including the information repertoire that my grandmothers have shared as common sense or embodied knowledge which they were sharing with me. An added element here is that in the TshiVenda culture, when you have a child, your mother and grandmother, serve as an encyclopaedia of sorts after a woman gives birth. They become the primary source of information guiding you, and telling you what to do, what not to do. This information is then spread across generations. This was definitely the case with me, after I gave birth, my mother and grandmother spent time with me and my children, and my grandmother slept with me every single day for months. During this time, I was an apprentice of sorts, although I was not a gracious one as I fought back majority of the time.

Mental health perceptions

As mentioned in the introduction, mental health seemed to be conceptualised around 'mental' which was understood or perceived in a derogatory (pejorative) meaning in general in Tshivenda because it is referred to as "*u'penga*". A Tshivenda dictionary defined "*penga*" as to "be mad and inclined to violence or mischief (not harmless, imbecility); degenerate…" (Venda dictionary, 1977: 295). If someone has any kind of mental illness or they are 'eccentric' or an outcast, they are described by that word. This word is derogatory, and the tone used when saying it is demeaning and used as a word that stigmatises people who suffer from mental illnesses. So, it makes sense that my grandparents immediately thought of traits such as slow

learning and being mentally unwell being passed on to a child, by a mother. Thus, here we see how different levels of knowledge culminate to influence how people perceive different concepts. Even though my grandmothers are not as informed about mental health, much less IMH, they were able to mix different ways of knowing to tell me what they think IMH is.

The question of 'what is infant mental health?' was answered variously according to the way that people understood 'mental health' generally and even in relation to themselves and others, and especially towards 'infants and their behaviour' and whether the two terms made sense together or side by side. Mbali is an anthropologist lecturer, she is interested in issues of motherhood and politics of reproduction. She stated that when she hears the concept 'infant mental health' what first comes to her mind, is feelings and emotions, particularly those of her daughter. Thabang and Naledi, both said that they had never thought about the concept before, until I asked about it. However, Thabang's conceptualisation was interesting. He told me that "*it is essential for one to be cognizant of their mental health*" while at the same time having difficulty with how one could "*determine if an infant is fine… because at a young age… it's almost like a new computer and you are trying to install software in it, you know, and you cannot tell yet how well it's going to process or function*" thus it is difficult to knowingly assess the 'mental health' of an infant in that regard.

Naledi, on the other hand, a first-time mom whose baby was just a few months old at the time, admitted that she is of the understanding that mental health is something "*people of an older age, are diagnosed with, whether its anxiety disorder or depression or something. I wouldn't imagine that an infant or a child has something of that nature*". Naledi goes on to say that the concept is foreign to her because in her understanding, *"a baby is born pure, innocent, with no concept of the world, and as parents we just love and grow [raise], change diapers, feed them and sleep until such a point something traumatic happens and it shapes the trajectory of their mental health for example…".* Naledi's model of mental health was that it was jeopardised by trauma.

Interestingly, all participants agreed that there is nothing a parent can do to prevent a child from having 'mental issues'. For example, Itani and Mashudu said " "*that one I cannot control, there is nothing I can do, it's beyond me, it is in God's hands. All I have to do is take care of that kid, other than that you cannot control mentality of a child… there is really nothing you can do, because every parent loves their child and all you can do is take care of that kid… you can't control the mental*". The reasons that a parent cannot prevent mental illness

or emotional difficulties is because there are additional factors which are beyond a parent's control. However, Jenna also stated that there are things a parent can do, she said "parents should make sure that they are in a good place, it is very important, they should try to recognise what their child's needs are, for the development, they can educate themselves with books or courses".

There are three core themes that these participants have said about infant mental health. First, some appear to believe that infants are blank slates who need adults to programme them. Second, the term 'mental health' is associated with adults who have mental illness, rather than indicative of child well-being. Lastly, people had not thought of a relationship between infants and mental health, some even saying it was the first time they had heard of the concept. Naledi for example, told me after watching the video card on infant mental health that although in the beginning she had not thought about an infant having mental health, none of the concepts she learned were new, but that the video showed her that if she is not a good space, then her child will be affected by that.

In contrast, Alex, who is not a parent herself said: "*The first thing that comes to mind is, I think that it is something that is very real, but that, not that it is not talked about enough, but people neglect it fully…".* She also shared a similar understanding to Naledi, noting that *"you need to be a proper person and have a life"* to be able to have mental health. She went on to say that *"I think that everybody is born with somewhat of a mental health… especially since infants are so vulnerable, obviously it's not in their hands, they can't care for their mental health, so it's all dependant on how they are treated and what's being done to them" ,* adding, "*and I can imagine that it is something that, especially since the first year of development seems to be important, that the mental health in that stage is something that can affect them for their whole life, but other than that I don't really have an image of what infant mental health may be, I never read about it…".*

When I asked Mariam, who is a mother of four girls, what she thinks 'infant mental health' is, she said "*I think about all of our stories of hearing about motherhood. I think about how we were raised in my family, where when you are a child, you were not really a person, you are just an extension of someone, but how that has changed now with today's parenting because kids are now seen as their own little human beings, understanding that they need to process information and feelings and all of that, whereas I feel like when we were probably small that*

was not a factor at all and that has to do with the mental health of a child, that's why we have so many messed up adults [laughs] in my opinion". Personhood alongside child rearing seems to be a factor in how my participants are understanding the concept of IMH.

Personhood came up during my interviews with my participants measuring a child's abilities by whether they are fully persons or not. In other words, for example when Naledi said that "*you need to be a full person*" [which she said in English] means 'older' and thus able to consider to 'have or experience' mental health issues. One definition by Apparell-Warren (2014: n.p.) states that personhood is an analytical term to which can be used to indicate whether any individual "within any given culture" [or society] can be seen as a "fully functioning member". Personhood is determined by examining "the attainment of physiological and social competences" which are cross culturally dependent. Moreover, McIntosh (2018: 1) states that ethnographic work has revealed that not every society has a term for "personhood", they do however have "beliefs and ideologies" about the things that are necessary for an individual to be classified or treated as a full person in the world. Thus, the invocation of implying that it is hard to discern whether a child may or may not have mental health, and how one can determine this, as my participants contemplated is in consideration to their own beliefs about personhood.

Although some of my participants stated that the concept of mental health was not something they associated with infants and children, they did agree that infants can have mental illness. Jenna and Naledi told me that the idea of infant mental health is something that the privileged understand and have time to cater to. By this, they mean that people who have to worry about putting food on the table, and live in violent environments daily, will not focus on the same things as Jenna, who has time to read articles about child rearing and attachment would for example. People have different affordances and energies to dedicate to certain things, especially where childrearing is concerned. In my interview with a fellow colleague, Mbali, she told me that her mother did her best for her, but that she just did not have the time to give, to listen to her feelings all the time. Furthermore, Jenna told me that she knew she was privileged to be able to for example take an antenatal class which is where she gained skills. She says the skills were essential as a new mom, and she knows that mothers in low-income spaces do not have that opportunity and hence a concept like mental health is not one that would be considered or put first in many realities, especially in a country like South Africa. In essence what these women were telling me is that being aware of and consciously applying methods outlined in interventions such as Infant Mental Health is beneficial. However, most people either don't think about it in those terms, and most importantly, many people just do

not have the affordances, energy and time to be able to be attentive to and responsive to their children in the same ways. This is due to economic, social as well as spatial realities which surround them, as claimed by Mbali, Naledi, Alex and Mariam. Their claim was that parents do their best with what they have, whether in material, emotional and otherwise, and that lack of these resources influence raising a child.

Looking at the discourse that adults have about crying allowed me to create a larger discussion about the perceived emotional lives of babies. Adults' general response to crying with anxiety or concern allowed me to explore people's ideas about children's' 'mental health'. I showed how crying was delineated due to reasonability and or rationality; I furthermore showed how excessive crying indicates a problem with 'mental health'. My participants drew from a range of different ideas in thinking about infant mental health, some (including my own) informed by western psychology and modern parenting guides. Others were based on experience and networks of elders and peers, and, often, particularly for a younger generation for whom the idea of 'mental health' is normalised in everyday conversations. This showed that people source information from a variety of sources such as from people in their lives, expert's such as doctors, unsolicited information and the internet (Majimbozi, 2021). Psychological literature makes it obvious that it is impossible to "spoil" a child. However, my participants' responses are influenced by societal and cultural norms and theories about how to create future members of society (Quinn, 2005). This in turn shows that views on mental health are linked to broader concerns about societal wellbeing rather than only to a person's own cognitive and emotional growth. Furthermore, the term 'infant mental health' finds itself carrying the stereotypical and pejorative connotations of mental health as illness and pathology or in the same category as 'crazy' or 'upenga' in Tshivenda. Questioning the concept of 'infant mental health' and asking the question 'do infants have mental health?' sparked new questions with my participants. The chapter thus demonstrates the subtle ways that concepts land and take form in social life.

Chapter 5: What contributes to an infant's mental health? Infant Mental Health practices

If we change the beginning of the story, we change the whole story- Dimitri Christakis

What do children need to develop to their full potential? This chapter will explore the practices that my participants carried out to ensure the 'mental health' of their infants or children. I will explore care as well as love in relation to the concept of Infant Mental Health. I ground this discussion in the World Health Organisation's (2018) Nurturing Care Framework (NCF). The Framework understands Nurturing Care as consisting of five components (p.2): "the conditions that promote good health, adequate nutrition, security and safety, responsive caregiving and opportunities for early learning". Furthermore, the Framework is centred around children, their families and other caregivers and the places they interact. Most importantly, the NCF aims to invest in early childhood development because the period from pregnancy to age 3 is considered the most crucial in laying the foundation for health, wellbeing, learning and productivity throughout a person's life. Moreover, this period is said to impact the health and wellbeing of the next generation. The interventions and campaigns such as Side by Side: Road to Health and documents such as Child Gauge emphasise using the methods outlined by powerful organisations such as the World Health Organization, the United Nations Children's Fund and other public stakeholders which cite a similar motto which states that "children receive the care they need to survive and thrive" (Side-By-Side). This is indicative of the external stakeholders that are invested in childhood.

Among my participants, the conceptualisations of what an infant needs varied, but the common thread was that care is most important. They also understood care differently although all saw infant wellbeing (including mental health) as linked to care. For example, participants consistently listed food, shelter, a safe environment and people who love and care for the child as critical for infants. What is most interesting here is that the things listed here strike a very close resemblance to the components of the NCF. My argument is that the way that people conceptualise taking care of a baby vary, but at the same time there are basic premises held in common that resonate with these larger stakeholders who purport to be the facilitators of children's wellbeing. This is because the larger systems, norms and ways of taking care of babies become embedded in our own ways of knowing as if it is innate knowledge that we have, or knowledge passed down. The things we know are based on things that already exist in society, which is something Zanele kept saying during our conversation. Almost every time I

asked her a question, she would say, "at a societal level" which she said there are two ways of knowing: what you believe after making your own decision based on different perspectives; and what society wants you to say, believe and do, which are norms.

How do we come to know? How do we know what we know? How is knowledge produced and then embedded and then shared? In this chapter I aim to show that, while all the participants to whom I spoke had a similar sense of desiring, surviving and thriving for children, however, the ways they envisaged how this care looked varied. In addition to this, this chapter will also explore the idea that 'care' is being mobilised as a project of making live, that is, that 'care' is mobilised as biopolitical care. I draw on Lisa Stevenson's (2014) discussion of care to ground this. Lastly, I will also talk about the concept of love, which came up when I asked some participants what an infant needs.

A core pillar in the Nurturing Care Framework has to do with parenting. Indeed, interest in parenting has grown considerably in the last five or six decades. Whereas Winnicott, one of the founders of attention to infant life, was concerned with 'the good enough mother' who, in his ordinary attention to the infant, provides the stable grounds for infant emotional security and development. More recently a diverse range of 'parenting practices' has come into the popular realm, shaping knowledge and behaviour (Ross, 2022 personal communication, 22 December). Parents are different, and parent undertake the task of parenting differently. Today, there are multiple ways and paradigms of parenting, for example 'authoritarian', 'gentle' and 'conscious' parenting, 'strict' parenting and so on.

Conscious parenting "focuses more on the parent and how mindfulness can drive parenting choices"(Gill, 2020a). Whereas authoritarian parenting is "the strictest style of parenting. It takes on a more "traditional" approach in which children are expected to be seen and not heard" (Gill, 2017b). These two styles are just two in a pool of many parenting styles, I am noting them due to their polarities and how they are usually put up against each other in popular discourse and social media parenting pages. When my participants started answering the question of 'what things contribute to an infant's mental health", they would often start with the 'basics'. For example, Jenna said: "*Obviously, you would think of Maslow's hierarchy of needs… before anything else they need a clean safe home environment, with no violence, access to food is very important, you know nutrition, at least one parent who is connected to them who they can trust and rely on*". Furthermore, Mariam listed these first "*access to food, resources… what they eat is also important because if a child is not fed, it will affect how they interact with*

the world, then the people around them also have influence because that affects how they think of themselves, so all those things together influence how babies are basically". Their answers are strikingly similar to the Nurturing Care Framework component of good health in that they both cite basic needs such as food, resources, and most notably, a caregiver(s) who will be aware of not just only the needs mentioned previously but the emotional too.

One of the points listed under good health component of the Nurturing Care Framework (2018:13) is "monitoring children's physical and emotional conditions" as well as "giving affectionate and appropriate responses to children's daily needs". The remaining points relate to ensuring physical health of a child. I have noted these two specifically because they are identified as crucial in securing infant mental health, and the majority of my participants expressed that paying attention to a child's emotions is important, even equating caring for emotions as equivalent to Infant Mental Health. For example, when I asked Mbali what comes to mind when I say the words Infant Mental Health, she immediately thinks about feelings and emotions of her daughter, being aware of them and catering to them because she feels her emotions were not catered to or considered as a child. She would do this by looking for cues in her behaviour. The 2017 Child Gauge (p:20) states that "love, nurturing care and a sense of belonging are arguably the most essential elements for children's emotional and mental well-being" which reinforces the importance that is placed on emotions by policy and interventions aimed at children's wellbeing.

One morning while having coffee in our porch, I decided it was the perfect time to talk to my housemate Alex, a good friend, about my research. She had been very interested in my research since 2021 and had offered to gladly be interviewed and share her stories with me. What is interesting about Alex is that she is from Germany and was adopted, and she is passionate about issues like mental health as it has been something she has had to be aware of and focus on due to her early life. When I asked Alex what she thinks contributes to an infant's mental health, she said: "*I think the surroundings are extremely important, I can imagine that since they react to the mother's voice even when they are in the womb, even the way they are spoken to and the way people around them speak to each other… the things they see, unpleasant things happening around them and to them can cause stress*". This point is echoed in the *Together from the Beginning* video card when Somi (a baby in the video) is aware of both his internal and external environments while in his mother's womb, hearing her voice (Marais, 2017:5). Raia, Alex's girlfriend, who is training to be a psychologist, was visiting from Germany at the time. She had this to say: "*The mental health of their parents, stress level and because babies are also*

sensitive to emotions of their mother or father, also maybe how they are treated with respect, how their boundaries are respected". Raia draws on very specific set of ideas, which may be influenced by her studies to be a psychologist. Moreover, these set of terminologies themselves are linked to ideas about proper personhood and how to create the appropriate social distance between people. Lastly, Thabang during our online Microsoft Teams interview said: "*relations, how you relate to other people… circumstances, some circumstances probably drive, or they fuel mental health upwards or downwards. Finances, definitely, money doesn't buy happiness and so forth, but finances can play a big role, they can bring certain pressures or alleviate pressures …but most importantly I think it is relations, how we relate to others* [being the infant in this case]".

The above shows diversity among participants and also their different perceptions; namely that Raia and Alex are both Germans raised by white parents, whereas Thabang is a black man who values supporting children financially as a man- which is expected for a black man, to be a provider; about what an infant needs in order to have 'good' mental health. The diversity is mainly around the things people cite as most important, which varied from financial needs being important to raise a child, to the environment affecting the child, and the emotions of a child being important. Although the expectation to provide is not a racial one, it is one linked to modernity, colonialism and capitalism. In the South African context, colonialism which led to women to not be considered workers and men to be providers through the migrant labour system has created a society where racial significance and the economy are significant.

I noticed that my participants tended to cite factors which could be considered northern in origin. This is unsurprising considering the flow of information in society. In *"Do Parents Matter"*, Robert LeVine (2016) talks about how Americans parents rely on information that they get from media, internet and 'experts' such as paediatricians. Most importantly, LeVine (2016: 9) states that that what passes for general knowledge in psychology is based largely on studies of individuals from "weird" societies. This is information that becomes embedded in our language due to the flow of information, which becomes normalised, shared and reshared. This leads me to ask, just how much of what we think we know comes from this kind of 'knowledge'? Ziyanda Majombozi (2021:86) states that mothers get information from multiple sources; namely knowledge and information from friends, colleagues, health professionals, grandmothers, mothers in law, books, social media, apps, and often this information is unsolicited. Furthermore, these mothers have their own ways of 'tinkering' and sifting through this information to make their own decisions. In this chapter we will see just how westernised

child rearing is in South Africa. Western ideals embedded in South Africa are due to colonial and the subsequent apartheid inheritance, coupled with the rapid spread and sharing of ideas due to living in a globalised world which shares information far and wide.

Many concepts and theories are created in the global north and brought into the global south and expected to work and operate the same. Although many of these concepts and practices are typically western in language, for example referring to parenting as 'gentle parenting or conscious parenting' alludes to the idea that knowledge production is valid when it has that particular language. However, as this research showed, the participants who worked with me did take the wellbeing of their infants into consideration, they just did not use the same kind of language. The findings are revealing of how these ideas materialise in the real world, the reproduction of inherited knowledge.

According to DeLoache & Gottlieb (2016: 5) "every group thinks that its way of caring for infants is the obvious, correct, natural way - a simple matter of common sense". What they are saying is that there are different norms and practices, and, in each place, people think that their way of doing things is the right/natural way. It is only when you see other people's things differently that you might question the norms of your own group. In other cases, when you encounter information that offer alternatives. And, where this happens in an unequal society with a dominant group (even if that group is a minority), there is real potential for colonisation of thought, as Majombozi (2021) notes. Thus, it is evident that multiple kinds of information culminate to form what individuals call their knowledge, this becomes their worldview. Hence, my participants evidently reached for multiple pieces of information in our interviews.

You cannot control the mentality of a child!

After asking my participants what factors they felt influenced an infant's mental health, I would also ask what they felt they could do to ensure that their infant 'had good mental health'. All my participants except one vehemently asserted that a parent cannot prevent a child from having mental issues or illnesses, there are many things that can affect or influence that which are beyond the parents' control. Raia stated that although this cannot be prevented, in retrospect; "*Parents should make sure that they are in a good place, it is very important, they should try to recognise what their child's needs are for their development, they can educate themselves with books or courses*". My mother, Mashudu, had this to say: "*that one I cannot control, there is nothing I can do, it's beyond me, it is in God's hands. All I have to do is take care of that kid, other than that you cannot control the mentality of a child… there is really*

nothing you can do, because every parent loves their child and all you can do is take care of that kid…" This sentiment was also iterated by Grace who stated that you cannot stop your child from growing up and having some sort of 'issues' because 'people just have issues anyways'. The Infant Mental Health paradigm suggests that you can support healthy development with particular kinds of behaviour and actions. Ultimately, according to my participants, you cannot prevent kids from having mental health illness in the future; all you can do is 'take care of them' which many of my participants said. The participants seem to have understood the idea of Infant Mental Health as being some kind of mechanism or means to offset mental illness rather than as a way to ensure emotional wellbeing. i.e., they seem to be conflating illness and emotions. This may be because many people associate the idea of 'mental' with 'illness' (i.e. upenga).

How to care for infants

The chapter began by outlining Nurturing Care, which is a concept that speaks to the things children need. However, in this part of the chapter, I will highlight what parents said their children need, and how the care they provide looks like; it will also highlight how they cater to their children in relation to the concept of IMH. For the purpose of this chapter, the context of the kind of care I am describing is an interpersonal and an intimate kind of care between a parent and a child that is communicated in the actions and relations of the caregiver towards their child(ren). The foreword of the NCF places moral and ethical responsibility on multiple stakeholders so that care for children is achieved. Complexities arise when we are looking at the multiple cultural contexts in which this framework will be implemented, as the historical legacies and people's present affordances may shape care in contradictory ways. Although the NCF (WHO, 2018) states that 'no child should be left behind', contextually and in a situated sense, care, is not provided and available in equal or universal ways.

For example, Jenna says this about what a child needs: "*obviously, you would think of Maslow's hierarchy of needs… before anything else they need a clean safe home environment, with no violence, access to food is very important, you know nutrition, at least one parent who is connected to them who they can trust and rely on*". Care for her is physical and emotional. Whereas for Mia, it is largely emotional, even before a child is born*: "I think the surroundings are extremely important, I can imagine that since they react to the mothers voice even when they are in the womb, even the way they are spoken to and the way people around them speak*

to each other… the things they see, unpleasant things happening around them and to them can cause stress". Lastly, Mariam said "*access to food, resources … giving the child the opportunity to explore, it gives them self-confidence and helps them figure shit out, what they eat is also important because if a child is not fed, it will affect how they interact with the world, then the people around them also influences because that affects how they think of themselves, so all those things together influences how babies are basically*". Thus, we see how care is a mixture of tangible and intangible factors which must be provided to children. I will point out here that these quotes are from two millennials and a Gen Z, whereas the participants who were boomers for instance did not instinctively mention emotions, citing care as shelter& food as my grandmothers stated. I want to be clear that variations in the inclination between physical and emotional is not as straight forward and opinions may vary with a Gen Z valuing physical factors over emotional, the story I am telling is a generalisation amongst the people I conversed with about my research, not a whole population.

My participants stated that taking care of their child(ren) was important. According to Black (2018: 80), "care is "a shifting and unstable concept" that may variously describe medical practice, health, familial caregiving, biopolitics, discursive formations, or even affective states. Care is almost always described in terms something to be given, however, it also has biopolitical implications. Lisa Stevenson (2014: 3) argues that care is "the way that someone comes to matter and the corresponding ethics of attending to the other [person] who matters". Furthermore, she goes on to say that it is [important] to "shift our understanding of care away from its frequent associations with either good intentions, positive outcomes, or sentimental responses to suffering..." (ibid). Importantly, Stevenson (2014: 3) talks about biopolitical forms of care which is care and governance that is primarily concerned with the maintenance of itself and is directed at populations rather than individuals. I argue that interventions such as the NCF proposes a form of biopolitical care. At the same time, the Infant Mental Health paradigm is part of the kind of care that Stevenson described as care that is associated with an ethics of attention that may also be associated with good intentions and positive outcomes.

To provide context to the limitations of the NCF, the Children's Institute published the South African Gauge in 2018. It revealed that in 2017, over half of children (65%) lived below the upper bound poverty line (with a per capita income of below R1,138 per month), and 30% lived in households where no adults were employed. How then should these adults provide all the components of Nurturing Care to the children? This is not to insinuate that poor people cannot care for their children, as research done by Tomlinson (2005) states that they do care for their

children and are emotionally present. Furthermore, a fifth (20%) of children travel far to reach their primary health care facilities and 12% of children live in a household which reported child hunger (Child Gauge 2018). The Covid-19 pandmic has considerably worsened these statistics as it affected society in very adverse ways (The World Bank, 2020). Thus, care is compounded by many external factors that may hinder a parent or caregiver from providing care as they personally define it, and the way that it looks biopolitcally according to the NCF.

When I asked Zanele what she thought infant mental health is, she said that it is important to take care of children so that they develop properly. All my participants cited 'taking care of' a child in reflecting on adult contributions to an "infants' mental health". These components are similar to the ones that the NCF (2018) cite in their document. My participants also stated that parents and caregivers' responsibility is to ensure the wellbeing of their child by taking care of them (which included proving a roof over their head, food, clothes) and loving them (feelings and emotions). This ideology is one that was iterated many times, especially among the older generation of my participants. Parents believe if they just love and care for their child, their job is done.

What's love got to do with it?

Thabang, who is a father of three, was nervous for our online interview on Microsoft Teams. He had been my boss when I worked for a research company and when we worked together, he had been the one who asked people questions. During our interview I asked him about love and an infant's mental health. He said: "*I watched this series or an episode of a series that had to do with being in the minds of a serial killer or something. It was a US-based series and one of the things they said there was that their lack of parental love is one of the main contributors that lead people into violent and criminals... So, on that basis alone, I think it's that important. To have that kind of love*". Other participants shared similar ideas, for example Jenna said: "*I mean if you look at the world, a lot of kids are being raised without love, but now the question is what will the effect be down the line? So, yes you can raise a child without love, but it will impact on them. If they don't feel like they are someone's whole world, especially in the beginning when their ego is so big and it is all about them… if they don't feel like it's all about them in the beginning then it will be very hard to recoup that feeling and to have a healthy sense of self down the line*". Alex, however, had a completely different opinion on the importance of love in raising a child. She said that it is completely irrelevant and not important,

that children rather need other things more than they need to be loved. She mentioned dedication, patience and something to give the child such as shelter, a support system, and basic knowledge of how to raise a child, saying "*you need to be ready, something in you must tell you 'I can do it*'". It is interesting how her explanation of what a child needs are leaning towards basic human needs provisions. In contrast Jenna stated that there is no way you can spoil a child by loving them or being attentive to them because it is important for their development.

According to Liao (2012: 347), "being loved as children is a primary essential condition for a good life". That is, children need to be loved in order to be adequate functioning individuals. Philosophical literature has explored the question of whether children have the right to be loved (Ferracioli, 2014), stating that children's basic needs can be met without being loved, and the interest of a child has in being loved, is not sufficient to ground a right to be loved. All my participants said children need love, but Ferracioli mentions that love is not necessarily a duty, and notes that seeing love as a right forces parents to love a child, which is morally wrong. Interestingly, the NCF (2018: 3) states that it is working to realize every child's right to survive and thrive. The document states that "we know that millions of young children are not reaching their full potential [due to] … a lack of love and early stimulation…".

None of my participants said that love is a right, but they noted its importance for a child. They did however allude to the reasoning that if a child is loved, their mental health would be good. For example, Jacqueline stated that *"children just need to be loved, supported"* so that your emotions are validated at a young age because it affects your future relationships.

bell hook's (2001) chapter titled 'Justice: Childhood Love Lessons' in *All About Love: New Visions* starts with a powerful quote from Judith Viorst:

> *Severe separations in early life leave emotional scars on the brain because they assault the essential human connection: the [parent-child] bond which teaches us that we are lovable. The [parent-child] bond which teaches us how to love. We cannot be whole human beings- indeed, we may find it hard to be human without the sustenance of this first attachment* (Viorst cited in hooks, 2001: 15).

Early experiences are again highlighted as vulnerable and important. The first 1000 days is crucial in a variety of ways, and although a child may have material needs met, many believe that love is also important and essential. My participants spoke about love in different terms, as "meeting the emotional needs of my child", "taking care of your child", even things such as "feeding them and giving them a roof over their head" were envisaged explained as expressions

of love. This is reminiscent of the gendered dimensions of care, for an older generation (and it's still widespread today), paternal love was demonstrated through provision (especially where men had histories of migrant work) and maternal love in other ways. For example, David, as one of the three men I interviewed for my research named finances as important first, and only mentioned love after I asked him if it is important, whilst all but one female, in my research named love as essential. So, in this way, people learn that love is and can be a multitude of things or can be expressed in a variety of ways.

According to hooks (2001) love is learned about in childhood. hooks (2001) argues that children tend to learn that love is primarily about feelings that are good, even in the context of dysfunction or function, no matter how troubled or happy, childhood is the school of love. Furthermore, children then end up learning that love encompasses "acts of attention, affection and caring" and crucially, the things provided to them by their parents or caregivers. By contrast with hooks' argument that care, and affirmation are the foundations of love (hooks, 2001:22), most of my participants remember being told by their parents that because their basic needs have been provided, they are loved. I did not initially explicitly ask about love, until a participant stated that love is important, when I went back to my older interviews, I tried to see the different ways love may have been spoken about without using the word 'love' per se. Arguably, for the purpose of analytical discourse I put it forth that my participants used words like 'being gentle to my kids', 'being attentive to my child', 'listening to my child', 'caring for my child' and so on. These are actions, which are carried out in the spirit of love, the 'good feeling' hooks (2001) describes.

It is not my intent to prove or disprove whether love is necessary for a child to have 'good' mental health, but rather to discuss the perceptions that my participants hold about the purpose and importance of it in raising their children. Although, all but one agreed to its importance, its appearance and definition, in service and in reality, differ. Crucially, hooks (2001) talks about how the lack of love, the presence of injustice to children and lack of care in childhood leads to adults who are likely to be either dysfunctional or predisposed to abuse others violently. Thabang echoed this in his understanding of the consequences of a lack of love for a child. This is a core concern in the infant mental health paradigm, where a lack of love and healthy attachment is considered a risk factors likely to manifest in poor health and social outcomes in adulthood from children who do not experience healthy attachment in infancy (Zeanah Jr & Zeanah, 2009).

In conclusion this chapter looked at the different ways that people imagine a child needs care. The way this care was described can be synonymised with IMH, even if they are not the same thing. What a children need was dichotomised between physical and emotional factors. My conversations with my participants also revealed that although parents will do their best to care for and love their children and provide what they can, in the end they cannot stop a child from having any mental health issues in future. This chapter also showed how different sources come together to culminate the knowledge that people use to undertake the talk of raising children.

We also saw that the origin of knowledge and information from the West may erase other ways of raising children when the language is different. We also saw how different knowledge systems come together, and how larger organisations and government seeks to influence only childhood and child rearing outcomes. In turn, this knowledge becomes reproduced by people, as it settles into social life and becomes tacit knowledge; and how children are raised is thus beyond the parent and is influenced by larger organisations and stakeholders.

Chapter 6: Do Parents Matter?

This Be The Verse (Philip Larkin)

They fuck you up, your mum and dad.

They may not mean to, but they do.

They fill you with the faults they had.

And add some extra, just for you.

But they were fucked up in their turn.

By fools in old-style hats and coats,

Who half the time were soppy-stern.

And half at one another's throats.

Man hands on misery to man.

It deepens like a coastal shelf.

Get out as early as you can,

And don't have any kids yourself.

Parents are central to a child life, whether they are present or absent, they play a big role as my participants stated. Philip Larkin's poem, as confronting as it is, is a representation of the general sentiments that majority (mostly the millennial and Gen Z cohort) of my participants had to say about parents, parenting, being parents and being parented. It is no question that parents have influence over their children. The question is, just how much influence do they have or exert over an 'infant' and moreover, over an infant's mental health? Most importantly what is a parent? According to Strathern (2011) "parent" is a relative kinship term; it is defined

with respect to another. Parenting is defined as "the process or the state of being a parent" (Brooks, 1987 in Chan, 2004: 182). The process of parenting starts when you have a child. Chan (2004:182) also states that parenting is "the process of developing and utilising the knowledge and skills appropriate to planning for, creating, giving birth to, rearing and/or providing care for offspring". Furthermore, Devaraj (2019: 2) states that parenting also refers to "the aspects of raising a child other than the biological relationship". This distinction is important to note as a child can be parented by caregivers who are not biological parents. My participants indicated that a parent or a caregiver is responsible for taking care of a child. LeVine (1974) states that parenting is both universal and variable. Furthermore, the Nurturing Care Framework, has questions of parenting that have come more and more to the fore, with new programmes teaching people how to parent being rolled out across the world. e.g., WHO Parenting for Lifelong Health, more locally an example is the Road to Health book with additional resources such as "How to Raise a Healthy and Happy Child".

Although not every participant in my research was a parent, they all referred to their parents for reference on thinking about their memory of their mental health and how they perceive they will think about or cater to their potential children in the future. Strathern (2011) says that parenting is a social and cultural relation not a biological one. While only two of participants shared the belief that a biological parent is important, Alex, who was adopted stated that a parent is not a biological being, but the people who raise you. Even though my participants agreed that both parents are responsible for the wellbeing on a child. They generally allocated stereotypical responsibilities separated by gender. Mothers were the nurtures, whereas fathers were the providers. This chapter will focus on illuminating the ideas and perspectives around parenting that my participants expressed. I will look at mothers (motherhood, maternal instincts) and lastly fatherhood in terms of their roles and their absence in parenting and ultimately their role in an infant's mental health.

Children are socialised by a variety of people, however, primarily parents or a parental figures such as a caregivers are the first and closest sources for most. Children here is used broadly to include infants from birth, and incudes contextually the age a participant may have been referring to according to the question posed and the experience they may have been drawing from. This chapter will explore how my participants, parents and non-parents (in future); decided to parent, whether they went against the grain and chose not to ‘fuck up’ their children as the poem says or decided to just not become parents as the author of the poem suggests. In either case, a parent and their influence are important in an infant’s mental health and

upbringing, and my participants agreed. Parents (and caregivers) and parenting as the first attachment in a child's life thus become the facilitators of an 'infants mental health', they are the ones who provide care, ensure wellbeing and that a child will grow up and not only 'survive but thrive' (WHO, 2018), as children are dependent on a caretaker.

LeVine (2016) states that parents in America who have been heavily influenced by psychology and psychiatry are blinded, similarly to Nyamjoh's (2012) argument of being blinded by sight, due to public discourse on children and raising children which they are expected to follow. For example, today there is a multitude of information on how to raise children properly, which is provided by parenting books, research by organisations such as the WHO and UNICEF, the local government (Road to Health) and non-governmental institutions such as Mothers to Mothers, and even social media. These sources present nurturing care as something all children need "to develop to the best of their ability" (Side-by-Side). As nurturing care is their core component, a parent must provide 5 things to ensure the optimal care of their children and to ensure not only survival but thriving. These 5 pillars are adopted from the NCF of 2018 by the WHO. They are nutrition, love, protection, health care and extra care. The only difference is that the NCF (WHO, 2018) has "opportunities for early learning" as its fifth pillar. A proper parent is thus one who is able to provide these to their children, with the assistance of other stakeholders such as policy makers, local government, and civil society.

Many parents rely on these multiple resources and sources of information to guide their parenting journey. Parenting is influenced by a multiplicity of factors, systems, histories, ideologies, social norms and information which comes from diverse sources, especially today with social media, the sharing of knowledge from 'experts' as well as trends on Tik Tok and Instagram.

Parents, parenting and IMH

Although I did not explicitly ask my participants if they thought parents influence an infant's mental health, they unanimously argued that an infant's parents and/or caregiver's own mental health will affect that of the infant. A theme that emerged was that the participants who were parents were very much affected by how they were parented, and some used their experiences to actively consider their own parenting strategies and practices. Some parented completely differently or in opposition to how they had been parented, while others referred to how they were parented or raised in their own consideration of being a parent. For example, Thabang,

who grew up without his father and wishes to find his father or at least his father's family, had this to say about parenting "*However I learn or try to raise my kids, that's how my mother raised me. I do have times when I think 'Shucks, I wonder what my dad would have done in a situation like this? But I don't have a reference to that so… what I do try as best as possible to instil the same disciplines in them as I learned from my mother*". Here, Thabang describes his mother's parenting as a template for how to be a parent.

One afternoon, Mashudu, Itani and I sat outside on the porch to avoid the scorching Venda heat. During our conversation, they continuously mentioned how the mental health of a child - what they referred to as 'mental' - is influenced by the parents. At the same time, they asserted that there is nothing a parent can do to prevent future mental illness or 'issues'. They stated that it is the responsibility of the mother and father to "discipline" a child and make sure that they are respectful, behave well especially with other people. Mashudu stated that Infant Mental Health *"is not just behaviour and feelings, but how a child is raised, how they are treated, how their parents communicate"* and most notably that *"ziwthu zwine zwaiteya utshe nwana zwiya u'affecta utshihula"*; "*the things which happen when you are still a child affect you when you are an adult*". The most important being the presence of parents in a child's life. Furthermore, Mashudu and Itani were adamant that a child needs their biological parents because their absence would affect their mental health as they get older. They told me that, even if a child is raised by a good family who loves them, when they get older, and they do know that the people raising them are not their 'biological' family, they tend to seek out their birth parents. Mashudu emphasised that this was because biological parents are important because for example, their ancestors would be calling out to them. Traditionally, different tribes have their own ways of conducting rituals, this can vary from one tribe to the next. Andile Mayekiso (2017) in his master's thesis talks about how and why children are introduced to ancestors. This practice is deemed important for many people who still practice these traditions. The reasons that a child needs to be introduced to their ancestors include "for protection against evil spirits" (ibid: 20), offers protection for new-borns (ibid: 22) and to "give the child an identity in terms of the clan name" and lastly " to incorporate the child into his lineage" (ibid: 67).

So, I started to ask my participants this: "is it important for a child MH to have both parents or rather a mother and father figure and if that could possibly affect or impact that child's mental health?". Mbali who is an academic and has done work around mothers specifically, said: "*No, so I don't think that, whether you are a raised by a mom and a dad or without, you will have*

mental issues either way… I do not think any parent, whether a mom, whether a dad collectively, is 100% equipped to ensure that their child never has emotional issues….and sometimes for some children, having both parents can be the worst thing that can happen to them, if the parents cannot work together as a team to parent. Sometimes for some kids the best thing that can happen for them is to have one single mother or father…". As previously mentioned, the biological aspect of parenting and caregiving was described as unimportant for all but two of my participants. In my research, only 4 of my participants grew up with their fathers present in their homes and their lives. Whereas the rest of the 19 had fathers who were migrant labourers, who came home a few times a year. Some had absent fathers, and some had fathers who did not want to be in their lives. Of my participants who were parents, five were mothers who had their children's fathers active physically and emotionally, playing all the roles, not just as a provider, and Thabang as the only father is a present father raising his children with their mother. Only four of the twenty-two participants in my work either grew up in a nuclear family or are in a nuclear family now. This shows the diversity in family compositions, dismantling the perceived importance of a mother and a father and that parenting is more.

It is also important to wonder why mothers were emphasized, even if fathers were thought of as important. It would seem that people's conceptualisation of the importance of mothers are a reproduction of societal norms and expectations which become embedded as natural. These ideas, according to Cheryl Walker (1995), are very strongly embedded in society and have become a blind spot for them.

Motherhood, maternal instincts and IMH

Motherhood as a concept is accompanied by social standards and ideologies. Mkhwanazi and Manderson (2020:48) state that it is important to understand the way that ideologies influence the practice of mothering. Especially when 'good mother feeding practices contradict those advised by health workers' (ibid). Motherhood is a part of life where advise is ever-present in every direction, especially unsolicited advice (Majimbozi 2021). In my research, during the conversation with my grandmothers and aunts, the ability of a mother to provide breastmilk was contested. Two women from one generation had opposing views, Lutendo who at the time had a baby who was a few months old stated that "breast is best", whereas Nontando said this is not true. Nontando told me that when her son was born, he could not breastfeed, it made him sick, and they never found out why this was happening. She said they went to all the doctors they could, and tried as many formulas as they could but it didn't help. The solution she was

advised by her elders, which she defended, was to feed him loose porridge. She says in the end he ended up "just fine", and that doctors are not always right. Lutendo is part of the generation which were given the new clinic cards 'Road to Health' book by Side-by-Side which emphasizes breastmilk. Nontando had her son over 13 years ago, and although she may have come across breastmilk information, she did not have that choice, and her experience has influenced her decision, because as she put it in her own words, her son turned out just fine, and he does not get sick.

Zanele is a 28-year-old who is a mental health advocate for personal reasons. When I asked if a mother's presence is important for an infant/child, to grow up and be well mentally, she said: "*I think it is important… I think the expectations from society is the one that makes this question difficult, because the expectation is that the mother is the nurturer … the importance is placed on her because she gave birth, so all the components of giving birth and carrying you for nine months and whatever, are attached to her…So yes, we do need mothers… children need their mothers, they need that nurturing, that emotional side, that softer side you know, the connotations that they give to women you know, the gentle side. I think that it is important for a child to see because in most cases it is the mother that gives them the validation that they need emotionally that they need*". Here we see the mothering ideologies, which she notes as societal norms and expectations. Interestingly, even as she notes this, she still labels mothers as such. This narrative is one Thabang also shared when he was talking about how and why mothers are important, citing words such as "*natural, soft and comfort*".

The 'good mother' ideology needs a mother who sacrifices herself, one that should know what is best for her baby, knows the best way to raise and teach her child, and most importantly has so-called 'maternal instincts' (Borovski, 2015: 104). In my research, perspectives often shifted, although it was acknowledged that both mothers and fathers are important and should play their roles, physically and otherwise, the same ideologies were repeated. For example, Mariam told me that parents and other caregivers are important in a child's live, "*but at the end of the day, maybe the mom is important because they are the person that will say, I need my child to have this… and maybe you know your kid better than someone else, so maybe in that way moms are important in determining what the child needs…*". This shows just how deeply these ideologies influence our ways of knowing.

Maternal instincts?

Many of my participants were aware of the influence 'society' as an institution has on conditioning normative ideas about certain things. For example, motherhood, what a good mother is, and so-called maternal instincts. While talking about motherhood, I noticed the chatter towards an understanding of motherhood as natural, instinctive. So, I asked my participants what they thought maternal instincts are, and furthermore if they mattered in raising a child, in being a mother; and or if they could influence an infant's 'mental health'. Jenna, stated that "*I don't think it is automatic, some people are born with maternal instincts, others don't, some women never feel they can be mothers or even want to be mothers but then they fall pregnant accidentally then with the shift of hormones, they suddenly feel maternal, and some moms never have that 'maternal feeling', so it is definitely not something that you just have as a woman*". When I asked her if it was necessary to have maternal instincts to raise a child, she said "*I think you don't necessarily need to be maternal, as long as you still care about the child...".* Whereas Mariam, a mom of four said *"this is something we have been trained to think we have by society. I think that men can also have instinct about their children, but we don't give them a chance to do that, because there is this idea that the kid must only spend time with the mother, and you need to bond with your child".* Importantly, she disrupts the social norm surrounding 'maternal instincts' when she talks about how her husband was the primary caregiver to her daughter when she was working*; "so he had what they call mother instinct, but it was because he was allowed that space to be with his child, he was the caregiver during the day. So, I don't think that that [maternal instincts] is a thing. I wouldn't call it mother instinct; I would call it parents' instinct".*

None of my participants thought 'maternal' instincts were natural or instinct even. Most of them were aware that it is merely an ideology created by society to bind mothers to a certain standard or that derive from the particular ways that society is organised at a given moment, or from powerful norms instantiated by hegemonic power structures. According to Borovka (2015:105) instinct is an innate tendency of behaving in a certain way without having received any training, thus maternal instincts are the "innate skills of raising a child". This definition supposes some sort of biological disposition, which then indicates an unnatural-ness or abnormality for mothers who do not display these skills. Hrdy (2001) states that motherhood is not natural or instinctive, rather it depends on various factors such as the environment and individual conditions. Maternal sentiments are socially constructed in comparison to innate biological reactions. The biology of motherhood leads to the difficulty in recognising the

ideologies that become associated with it. Motherhood can be seen as instinctive due to the normalisation of certain values which become widespread and popularised. These then devalue or negate any behaviour of ways of mothering which are outside of these ideological models.

Fathers, fatherhood and IMH

Fathers are a contentious topic in South Africa. Fatherlessness, absence of fathers, whether physically, financially or emotionally is problematic (Hall et al., 2018). The level of fatherlessness and in South Africa are significant and have a long history. Black African fathers have historically been separated from their children by the need to work (as the financial providers) in distant places due to the migrant labour system, where they were only permitted annual visits home. This led to experiences of men with limited fatherhood and in some cases, they frequently abandoned and neglected their children as a result (Morell & Richter, 2006). This is the history that fatherhood has in South Africa.

There is a television show on Mzanzi Magic called U'tatako; which means 'your father'. The guests who go to show to seek out their fathers cite that things in their lives aren't going well because they have been removed from their roots, disconnected from their ancestors. This idea was mentioned by Mashudu earlier when she said that a child will always want to know their biological parents. She gave an example that if a child is raised by a single mother, eventually they want to seek their biological father. This show can be considered a manifestation of the state of fatherhood in South Africa, their absence in their children's lives, this affects their well-being, and essentially on their mental health as adults. The consequences include having what millennials call "*daddy issues*", which leads to having difficult relationships with men as Zanele expressed to me, which stemmed from their absence from infancy. The people who go on this show believe that the lack of a father, or in some cases a father figure but not their biological father; is the cause of their issues. Finding their fathers will allow light back into their lives and their lives will 'get better' going forward because their ancestors now know them and they know their father, their origin. This was explored above in connection to being reconnected with their ancestors (Mayekiso, 2017), which brings back light into their lives and allows for things to be better in their lives.

Furthermore, Richter (2010: viii) states that she found very little literature on fatherhood as a core identity of men, "or as a repertoire of socialised emotionality and behaviour" rather what is abundantly available are the failures of men, and their neglect of their children for example.

This is exemplary of the narrative that fathers have in South Africa. Historically, due to colonial rule in South Africa and the migrant labour system, stable heterosexual relationships were rendered impossible (Manderson & Mkhwanazi, 2017). This meant that the nuclear family of mother, father and children was not the norm- what was and still is the norm is a family structure that looks like; "women and children or women, children and patrilines (Manderson and Mkhwanazi, 2017: 81). Although children often spend the early years of their lives with both biological parents, this is not the case as they grow up and most grow up without a co-resident father (Hall & Mokomane, 2018). This does not mean there are no father figures; it is, rather, the ways that biological reckoning is given significance. I have already stated that South Africa is characterised largely by extended family structures and according to the Child Gauge (Hall & Mokomane, 2018:34) "less than one fifth of households in South Africa take the form of a nuclear family". It is important to note that, while fathers may not always be present, father figures or male presence was available.

Contextually, South Africa is characterised by the "absence of biological fathers. This is problematic for children of both sexes but more so for boy-children according to Ratele, Shefer & Clowes (2012:553). Furthermore, Ratele, Shefer & Clowes (2012: 554) make a pivotal counter note that many studies have been done on how the absence of a biological father, or the absence of a traditional western nuclear family is used by policy makers and the public to perpetuate notions of an idealized heteronormative, nuclear family thus demonizing and devaluing non-normative ways of 'doing' family while reproducing a binaristic gendered notion that both a male and female parent is essential in this unit and therefore casting a punitive lens on those families and those men and women that do not 'fit' this normative framework.

Mbali had maintained that both parents are necessary in a child's life, and when I asked her about whether fathers are important, she told me that fathers have a role to play in a child's life, but due to her own loss and absence of her father in her life, that has influenced how she thinks and feels about fatherhood. She had this to say about the relationship between her daughter with her father: *"Watching my daughter with her dad, … I think he [father] is her favourite, sometimes I think what he says matters more than what I say, which then means for her, what he does and what he says might have more of an impact than what I have to say… because he is her favourite, and she is her favourite. And so, they have a different kind of relationship. And there is no way that relationship won't impact the kind of woman she grows up to be*". Here Mbali alludes to the belief that fathers influence their child wellbeing.

According to my participants, absent or not, fathers play a role in the mental health of an infant, and subsequently as you become and adult, this affects you and your life in numerous and sometimes monumental ways. These will of course differ in manifestation from one person to the next. But for example, Thabang states that the lack of his father affected him, he felt he did not have an example on how to be a father, but he claims that he turned out alright because he had his mom, even though he would have liked to experience being fathered. While I was in Venda talking to my aunts and grandmothers, they all agreed that the lack of a biological father is inconsequential to a child, to their wellbeing because there are other figures in a child's life which include aunts, uncles, and grandparents. Lutendo, who just had a baby told me that her son and her other two children are very lucky to be growing up with their father, who is present and actually takes part in the raising of their children. She further acknowledged that this is not the norm, but also stated that as long as a child has a mother, or caregivers who love them, and take care of them, they will be fine, and their mental health will too.

However, Zanele did not share the same sentiments stating that the lack of her father's presence as a young child affected her negatively, especially her mental health. She said: "*On a societal level… a father would be the one who goes to work and brings money home… The whole archaic thing that has been passed down. Society wise or the way that I have experienced it is that I never how to treat a man because I did not have a male father figure in my life… I didn't know how a man was supposed to treat me… it is also generational, you know how people say that men learn from this from their fathers, so in my societal understanding, I had to be afraid of a man*…". This is exemplary of how the absence of a father can affect an individual's life and perceptions of men.

My participants reflected on their childhoods as lessons, to either do parenting differently, or to reflect on the things they would like to include in their parenting. Those who had the language of mental health started thinking about it in relation to children whereas they had not before. All the millennial parents considered the emotional wellbeing of their children, but only three out of twelve actually used psychology language in their discourse about parenting their children alongside mental health. The rest of the participants said that after having the conversations with me, this will be something they actively consider. The older generations had their own understanding of the concept, citing cultural and traditional elements such as ancestors and how breastfeeding may be a factor that affects an infant's mental health, the common thread here is that parents were the conduits to an infant's mental health.

The argument of this chapter is that parents are central to an infant's life. Moreover, parents are arguably the facilitators of an infant's mental health, although this does not necessarily mean they are the only contributors but merely that they are primary. In this chapter I showed how the gendered expectations which become norm in society over-emphasise the role of the mother. Thus, a mother becomes the biggest contributor to a child wellbeing, or their 'mental health'. At the same time, the trope of absent fathers is another factor which negatively affects the mental health of a child, according to my participants.

Most participants were aware of the mistakes they felt their parents made, and they consciously thought about how to make sure they do not repeat those, in other words, they did not want to 'f***k up their children', not on purpose anyway. My participants who were millennials were cognisant of emotions and feelings, and many conflated the two terms. They equated them with the concept of infant mental health saying that because they cater to their children's emotional wellbeing, since their parents did not; then they are catering to their children's 'mental health'. Thus, in this way, parents and IMH are related because a child is dependent on a parent, and in turn a parent is in some part responsible for and influences the mental health of an infant. Parents and caregivers are thus considered central in the conceptions of the mental health of a child, the presence or absence matters and has effects.

Chapter 7: CONCLUSION

The state of IMH in South Africa

My research question was "do infants have mental health?". The question was deliberately left bold to gauge people's perceptions about this concept. I did not seek to prove whether infants have or do not have mental health but to see how the concepts resonates with people and explore the multiple ways that people claim to know about children. It was revealed that ALL my participants agreed that infants HAVE mental health, and this looked different as opposed to the way it is described in the IMH paradigm in psychology and related fields; especially because this research followed the perspective of adults, about children. I would say my participants saw infant mental health as the care a parent and caregiver provide to a child. The physical things and emotional attention towards a child. Most importantly, most of them thought of mental health as something that adults had, not children nor infants, but could see how they could after our conversation. The opinions shared about mental health were shaped by beliefs, stories and viewed from the perspective of adults and what they imagine the inner world of a child is, how to care for them, what they need to be well and to have 'good mental health'. These ideas were shaped by various historical and generational factors, by the campaigns in the early 2000s to the recent explosion of mental health discourse on social media coupled with the therapy and psychology talk.

The most poignant thing that came out of the research was that majority of my participants did not associate 'mental health' to infants and babies, even when they have pre-existing knowledge on 'mental health'. This is because the mobilisation of the ideas behind the word 'mental health' has become associated with illness in adults, not children and definitely not in infants. The language itself and terminology of 'infant mental health' seemed to be a barrier due to the preconceived and varied associations that people have about 'mental health'. One could argue that the language is alienating since it is so closely associated with illness and pathology and not with wellness (Skuban-Eiseler, 2021). This research thus showed that the language of IMH is not useful due to associations that people have about the word 'mental', and mental health with the word infant. Thus, a more approachable term to replace ‘infant mental health’ will be useful to make it more accepted by people.

IMH was characterized by various factors, it was also thought of as many things, such as excessive crying. This could be linked to the pathologizing of mental health itself. The stereotypes and anxieties associated with crying is thus likened to potentially signalling an

issue with 'mental health'. This line of thinking surrounding 'mental health' was also present with 'upenga', ulemiwa and udzindela which fell into the category of negative behaviours which incline one to think of 'mental' as illness and as a problem.

Parenting priorities differed across generations in my research. Millennials like to think of themselves as 'generational curse breakers', and this is echoed on social media by public discourse on different platforms such as TikTok, Twitter and Instagram (Haslam, Tee & Baker, 2017 & Duggan & Lanhart, 2015). People increasingly engage in and use 'therapy talk' in everyday conversations (Palus, 2019), talk openly about their mental health struggles and share tips on how to be mentally well and how to be a generational curse breakers. This was evident in some of the language used by participants such as 'healthy attachment', 'emotional wellbeing', 'mental health awareness', 'boundaries' etc. It seems then almost inevitable that this talk will trickle down to parenting "being a better parent because you know better" and have access to resources are ideas that are used widely in public discourse. It is by no accident that this is happening in this period of time where the sharing of information is immense due to technological advancements. In addition, my research showed that participants think that parents are central to an infant's care and wellbeing and ultimately the infant's mental health. Parents and caregivers were considered the people who primarily care for infants, as children grow up in multiple environments and family structures. Parents and caregivers were considered central to a child's life, an infant literally needs a caregiver and or parent to survive.

An interesting theme which crossed all the themes in my research was that participants wanted to do things differently from old societal norms, such as parenting roles, redefining how to care for infants, how to respond to crying, what to offer infants to ensure their well-being and so on. This trend is one that is prevalent today, which could be seen as an influence of social media and popular discourse around parenting offering up different lifestyles, information and choices which penetrate people's lives and ultimately what they do in their own lives. This is a step away from generational knowledge, which is not to say this kind of knowledge is gone, but the manner in which it was transferred has changed drastically.

While my research showed that people rely on information and advice from family, friends and the internet. Looking at these things in tandem with literature showed how raising children is heavily influenced by information and expectations of external stakeholders and larger organizations. It is thus important to question the reach these organisations possess in society. Part of looking at different stakeholder's offerings to child rearing such as the NCF and the

IMH, as well as local interventions such as Side-by-Side showed that child rearing is institutionalised. This shows that children and child rearing is influenced by these stakeholders, by social media and so on.

Furthermore, IMH itself, as more than a concept, as intervention and policy were described as inaccessible for the masses by three of my participants, namely, Jenna, Zanele and Mbali. Mariam, Alex, Mbali and Zanele pointed to the fact that this generation and lower, being Millennials and Gen Zs, are lucky enough to be born into an era where talk about mental health is accessible, where shame and misinformation, although still present, is much less. This means that people have space to care for their mental wellbeing, to care for their mental health and in turn become parents who have or can learn skills that can allow them to attune to their children and to nurture their emotional wellbeing.

There is no shortage of mental health talk, and yet the concept of IMH is still absent in imagination of many people. Thus, it is imperative to ensure what becomes public discourse is shaped in a balanced way, unlike popularized discourse of mental health, attachment and so on. Lastly, as stated in the introduction, with reference to Ross and Pentecost (2021), it is imperative and relevant to localize these global models to make sure that the context of South Africa and how care is imagined, is necessary to ensure that any application is useful to the people it seeks to help. This research is a contribution to childhood studies in South Africa, and the quest to localize global models of care.

Chapter 8: REFERENCES

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