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Local South African understandings of persistent crying in infants: Perceptions of health care workers and traditional healers

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Supervisor Prof Katherine Bain

DECLARATION

This work has not been previously submitted in whole, or in part, for the award of any degree. It is my own work. Each significant contribution to, and quotation in, this dissertation from the work, or works, of other people has been attributed, and has been cited and referenced.

Signature  Date…30 October 2021….

ABSTRACT

More often than not challenges that are experienced in early infancy may be precursors of the development of mental health problems for both the infant and the mother. One commonly under-researched challenge of parenting is sitting with an inconsolable, excessively crying infant. This research aims to explore the encounters with and reflections of local health care practitioners' with excessively crying babies in South Africa, and their understandings of this phenomenon. Including participants from both Western-medical and traditional healing orientations, the study explores culturally and contextually situated conceptualisations and understandings of excessively crying infants and highlights convergences and divergences between traditional cultural understandings and Western medical approaches. The study employed a qualitative research approach, and utilised a social constructionist paradigm, allowing for exploration of the understandings related to the management of persistent infant crying within black South African culture. Data collection was in a form of eight semi-structured in-depth online interviews with health care practitioners who have experience working with mothers and persistently crying infants. An interpretive thematic analysis was used to analyse the interviews. Key findings that emerged indicated that cultural frameworks ascribe persistent crying in infants to the influence of supernatural powers. However, significant overlaps with Western medical and psychological worldviews were also evident. The main conclusion reached was that mothers often straddle both local, culturally sanctioned care and Western medical approaches in their navigations of health care for their infants, and require respectful support from health care professionals.

Key words: *Persistent crying, newborn infants, traditional beliefs, evil spirits, traditional medicine, rituals , ibala /hlokaona, inyoni, imbeleko, maternal support.*

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1. Introduction to the study

1.1. Introduction

In South Africa, most black Africans have been found to use both culturally-sanctioned, traditional forms of healthcare alongside Western-based public sector health care systems (Campbell-Hall et al, 2010), adhering to their own belief systems in determining causality of illness. The need to orient "Western practitioners towards a culture-centred approach to mental health care" has been identified (Campbell-Hall et al, 2010, p. 610). Very few studies related to persistent or excessive infant crying have been conducted in non-Western cultures. Thus, this dissertation aimed to contribute to this gap in the literature on traditional parenting and child development within South African cultures, giving voice to local knowledge about persistent infant crying. The study also explores tensions in the dichotomised positioning of dominant Western approaches and those considered traditional and indigenous.

In particular, this research study aimed to explore traditional local South African understandings of excessive crying in babies through the perspectives of health care practitioners working from both western and non-western orientations. Interviews were conducted and an interpretive thematic analysis was used to analyse the interviews. A social constructionist framework, that regards knowledge as socially, culturally and contextually constructed (Jankowski, Clark & Ivey, 2000) was used. The interviews explored the participants' traditional, culturally- and contextually-situated conceptualisations of excessive crying in infants, their understandings of the causes, manifestations, and management of an excessively crying infant. Additionally, the study aimed to gather the participants' perceptions of the mothers' understandings of infants' persistent crying. The study provides deeper insights into local South African understandings of excessive crying and how these experiences are managed in mother-baby relationships, through the lens of the health care professionals who are in continuous contact with these mothers.

1.2. Aim

There is much variation between cultural groups with regards to their disease theory systems and conceptualizations. However, there are also often common overlaps in held beliefs, customs, and practices around childbirth and care. The purpose of this study is to explore healthcare practitioners' (drawn from both western medical and traditional healing orientations) understandings of the cultural constructions of persistent crying in infants and

their perceptions of the understandings of the South African mothers with whom they work. The intention is to capture culturally-embedded understandings of excessive crying in babies through the perspective of health care practitioners from western and non-western orientations.

1.3. Rationale

The challenge of sitting with an inconsolable, excessively crying infant is under-researched internationally (Helseth & Begnum 2002). This phenomenon appears to occur across cultures and is framed, interpreted and understood differently across cultures. Therefore, how it may impact the mother-infant interaction and influence maternal frame of mind, attachment and infant development is not fully understood (Bilgin & Wolke, 2019; Van Hemert, van de Vijver & Vingerhoets; 2011).

Parenthood can be a complex and challenging journey (Kurth, et al., 2010), and research has suggested that more often than not challenges that are experienced in early infancy may be precursors of the development of mental health problems for both the infant the mother (Leerkes, Parade, & Gudmundson, 2011). This knowledge, while useful in matters of aetiology and intervention, has become accessible to the public through the internet, and many mothers access this knowledge, aspiring to be an 'ideal parent' with the 'perfect' child, despite this being unachievable and unrealistic (Madge & O'Connor, 2006). Related to this, excessive infant crying has been linked to increased feelings of incompetence and shame in mothers (Liss, Schiffrin & Rizzo, 2013). Crying is considered to serve an important cue for the mother to respond to her baby, but what has been found is that in instances of persistent infant crying, the naturally occurring, nurturing service of a child, which may feel noble at first, can ultimately lead to maternal feelings of resentment and bitterness, and, in some instances, mental health issues for both mother and baby (Kurth, et al., 2010).

Excessive crying in infants is a common phenomenon and it comprehended differently by the diverse cultures. However, much of the research into the issue been done in Western populations (Daelemans, Peeters, Hauser, & Vandenplas, 2018; Van Dijk, Faber, Tanke, Jeurissen & Westert, 2016; Wolke, Gray & Meyer, 1995), and thus it remains indistinct how much shame local mothers feel with regards to persistent crying. It is, however, likely that their understandings will be influenced by the child-rearing practices condoned within their respective cultural backgrounds. As proposed in Vaughn et al. (2009) all cultural groups have disease theory systems that include 'attributional concepts' which are situational conceptual

schemes used to explain the causality of illness. In addition, parenting is a universally culturally- and contextually-embedded activity (Bornstein, 2012). As an indicator of the differences in expectations of parenting, for many African cultures parenthood includes far more prominent community sharing and obligation than in their white European and North American counterparts. The responsibility of mothering and child nurturing practices extend beyond the primary caregiver or mother (Magwaza, 2003). The various child-rearing practices reveal how culture assumes an influence in mothering but also how a mother decides to frame these experiences and how she chooses to raise her infant (Magwaza, 2003). Although culturally derived understandings of excessive crying exist in the indigenous narrratives passed from each generation to the next, these knowledge sources are not recorded in the academic literature.

There appear to be multiple aetiologies for persistent or excessive infant crying, making the topic all the more complex. Amongst these, medicalized understandings are often prioritised, so the majority of cases of excessive infant crying are captured under the term 'colic' and are therefore assumed to be associated with gastrointestinal discomfort, even when the crying has persisted beyond the age requirements for a colic diagnosis (Vandenplas et al., 2015). Western psychological explanations for excessive crying have linked it to preceding and concurrent elevated maternal anxiety, and concurrent and subsequent maternal depression (Petzoldt, 2018). However, psychological interventions for persistent crying are often avoided by mothers, due to fear of judgement and stigma (Bain, 2020). In South Africa, most individuals, as a result of the values of their specific culture, still adhere to cultural illness prevention practices in all phases of life; from pregnancy, early stages of infant development, through to adulthood (Lyons, Bike, Johnson & Bethea, 2011).

The majority of ethnic groups in South Africa have been shown to rely heavily on their traditional healing methods and practices as the first line of help-seeking patterns. This is more so in child-rearing stages where the vulnerability of the weak infant and mother to ailments and other damaging childhood disorders are generally accepted. These ailments are often complex to explain outside of culture (De Villers & Ledwaba, 2003). Many South African mothers see it as a crucial cultural requirement to carry out customary defensive measures for their infants, whom they consider to be weak and vulnerable to different kinds of danger. As part of treatment, cultural protective traditional practices are endorsed or

suggested, such as rituals, incisions and amulets worn or used to remedy or avoid certain illnesses (De Villers & Ledwaba, 2003). Current dominant understandings of excessive crying fail to include the traditional practices of South African mothers who may adhere to such cultural beliefs. Since traditional healers are positioned to be prominent and significant in the lives of numerous Africans, a joint effort between them, and western-oriented health workers have been regarded as important, so as to provide relevant interventions to the community (Van Huyssteen et al., 2004). This study hopes to explore how current health practitioners who work with local South African mothers understand and negotiate both culturally embedded and western derived understandings of the phenomenon of persistent crying.

In summary, excessive infant crying has not been sufficiently studied on the African continent from a traditional and culturally embedded perspective, and there are no studies of traditional local South African understandings of persistent crying in infants from the perspective of health professionals. Parenting is shown to be highly culturally- and contextually mediated, hence it is likely that understandings of and responses to excessive infant crying will also be embedded within culture and context. There are suggestions that concepts such as excessive crying and its components may be moderated by cultural variables which include whether the crying is perceived as normal or abnormal in non-Western contexts (Hewlett & Lamb 2000). Thus, this research aimed to provide knowledge on the interfacing of local culturally-informed understandings and western-derived understandings of persistent infant crying, which could help other healthcare practitioners, who are not exposed to different infant and maternal healthcare perspectives, to incorporate cultural sensitivity and more relevant understandings in their approach to care.

1.4. Structure of the report

The above description serves to contextualise the study and following this the report proceeds to the literature review, Chapter 2. Chapter 2 describes, in more detail, local South African understandings of persistent crying in infants. This chapter includes definitions and various understandings of the aetiology of excessive crying. These are presented from a number of different models, namely traditional local understandings, the Western medical understanding and psychological understandings, from within the South African context. Additionally, the importance and challenges of working with mothers within these contexts is discussed. The review concludes with a review of health care work in South Africa, focusing on the ideas of

the merging of biomedical and traditional healing paradigms which provides for a complementary system of plural health care.

The method adopted in this study is presented in Chapter 3. An interpretative thematic content analysis was conducted on interview material in order to elicit broad themes and the qualitative approach that was utilised is discussed. The ethical considerations of the study are also detailed in this chapter.

The report then presents the results of the study. Chapter 4 presents the central themes that emerged from analysis of the interview material, namely the Traditional understandings; Western medical and Psychological understandings explored using extracts from the interview material.

Following from this, Chapter 5 focuses on the Discussion. The study shows that there are convergences and divergences in understandings of persistent infant crying. This chapter further considers the findings of the study in relation to the theoretical material. It illustrates the ways in which the current study has added to the literature on perceptions of understandings of persistent crying in infants specifically within South African local mothers' contexts. The implications of the study and further research are detailed. Finally the limitations of the current research are identified and elaborated upon.

2. Literature Review

This chapter provides a review of the relevant literature and includes definitions of excessive crying from Western medical and psychological perspectives. The various understandings regarding the aetiology of excessive infant crying are also discussed. The context of the study focus is also explored through a brief review of literature on mothering in South Africa.

2.1 Definitions of excessive crying

There are many different definitions and framings of excessive crying, which influence perceptions of the problem. Crying in infants is generally regarded as an ordinary psychological and physiological (facial muscles and tears are involved) reaction to communicate numerous discomforts, and is the most compelling of infant signals (Daelemanset al., 2018). Crying is considered to serve an important survival function in early infancy (Barr, Konner, Bakeman, & Adamson, 1991). Research has demonstrated that a baby who has no ailments, at about six weeks of age, may cry for an average of three hours of the day peaking between the hours of 3 PM and 11 PM (Reijneveld, Brugman & Hirasing, 2001, Wolke, Gray & Meyer 1995). When this degree of crying persists beyond early infancy, however, it can become problematic.

What we know about excessive crying in infants is largely based upon empirical studies that investigate this phenomenon (Wolke et al., 1995). Literature reveals that perpetual crying is one of the common explanations for mothers seeking regular advice from healthcare professionals from both western medical and traditional healing orientations during the first year of life, due to its prompting of extensive parental stress and anxiety (Helseth & Begnum 2002). Despite the ubiquity of the problem, however, there is very little agreement about the aetiology and meaning of excessive crying in the literature (Wolke et al., 1995).

Indicated in global consensus, the logical criteria for separating everyday normal crying from excessive crying in infants are outlined in the ‘rule of threes’: crying and fussing beyond three hours every day, for over three days per week, over three weeks, in a new-born baby who is very much taken care of and all other clinical symptoms have been excluded (Reijneveld, Brugman & Hirasing, 2001). Other definitions have been utilized that include the parents’ experience of the crying, for example, to what degree parents can reassure their infant, believe that their baby is ‘colicky’ or cries excessively, have frequent contact with

health experts, or experience the crying of their baby as problematic (Kim, 2011). Excessive crying is also known as ceaseless crying, persistent crying, unreasonable crying, and problem crying (Daelemans, Peeters, Hauser & Vandenplas, 2018). The presented definitions seem to centre on the extent of the duration and the inconsolable nature of the cry.

The incidence of persistent crying is described as fluctuating and dependent upon the circumstance and often the explanations are based on infantile age. It is highest in newborn babies under three months old and diminishes past age five (Reijneveld, Brugman & Hirasing, 2001). The formal diagnosis of 'excessive crying' is, however, only applied once the issue continues past the time of three months of age, as issues of immature gastrointestinal systems (i.e. 'colic') can then be excluded (Wolke, Bilgin & Samara, 2017).

Excessive crying of infants has been identified as a major concern for infant and maternal health, due to its adverse effects on parental emotions and its potential to mark the baby as vulnerable or labelled as problematic (Smarius, 2017). Almost every paper that has been written on excessive crying includes a section relating to the emotional and psychical aspects of its effects (Kim, 2011). However, the role of parental mental health in the aetiology of excessive crying is not as clear, although it is often assumed that parents' way of coping and ability to think about or respond accurately and sensitively to their infants' communications might influence or exacerbate the duration and intensity of the infant's crying (Helseth, 1999).

The medicalized basis of excessive crying in infants is poorly understood and no research has found it to be an illness. A need has been identified to clarify the concept of 'colic' and develop a definition that is applicable in all settings where interdisciplinary intervention is required for the mother-infant dyad, beyond the clinical lens (Helseth, 1999). Existing accounts fail to resolve the contradiction between the behavioural and physiological aspects of it. Hence, prior work in the dominant Western approach appears to be divided into two main categories: the medical and psychological perspectives. Very little literature that accounts for excessive crying from non-Western perspectives exists. This indicates a need to better understand excessive crying and the various perceptions of it that exist in the South African context.

2.2. Aetiology/causes of excessive crying

There is no generally accepted, universally applicable aetiology or characterization (clinical picture) of excessive crying in infants (Daelemans et al., 2018). Although common and often referred to as 'colic', the exact underlying cause of 'infant colic syndrome' or 'excessive

crying' remains controversial. Diverse opinions exist in the research about the inconsolable infant, mostly from traditional western medical and psychological perspectives (Kim, 2011). These two approaches are outlined below.

2.2.1. *Western medical conceptions of excessive crying*

Excessive crying in infants as one of the most common reasons for regular contact with health experts has made discussion of the topic in medical literature highly medicalised (Van Dijk et al., 2016). Most research on this topic has been conducted to investigate underlying mechanisms from a medical perspective and have mostly attributed infant cries to biophysical aspects such as hunger, gastrointestinal reflux, and pain (Helseth, 1999). The customary Western methodology places prominence on 'scientific' findings and pathological diagnosis, and from this point of view this depends strongly on 'clinical representation'. The conceptualising of this phenomenon in the medical literature can be seen in terms of three central themes, namely aetiology, symptomology, and management. Defining a problem in medical terms, usually as an illness or disorder, or using medical intervention to treat it, regardless of it being benign and the aetiology remaining unknown, constitutes a problem for these clinical approaches because they are usually founded on assumptions (Vandenplas, et; al 2015).

The initial work on excessive infant crying was published by Wessel (1954), in which excessive crying in babies was described as infantile colic. Despite the progression of research since the 1950s, there is still no consensus on the best way to conceptualise excessive crying in babies and the literature on excessive baby crying has continued to refer to repetitive crying disorders like colic, with mention of 'the difficult baby' (Steven & Poole, 1991).

Infantile colic is now medically delegated a functional gastrointestinal disorder (FGID). FGIDs happen in about 20-50% of new-borns, and up to 75% of these babies present with signs of more than one FGID, (Daelemans et al., 2018; Vandenplas, et al., 2015). According to this framing, excessive crying in very young babies is due to an immature gastrointestinal system and often settles before the third month is over without continuing effects. Hence, excessive crying is now only noted as problematic after three months of age and is now understood as characterized by a triad of symptoms, including the mothers' overload and psychosocial distress, as well as the frequent interactional failure that maintains or exacerbates the behavioural problems. A growing body of research in maternal and infant

health is suggesting that this condition probably represents the extreme of normal infant temperament or behavioural development (Barr, 2002).

2.2.2. Western psychological understandings of excessive crying

Psychological interest in excessive crying seems to have started with the idea that it might have detrimental consequences to the mother-infant connection and can prompt disorders of behavioural and emotional regulation at the toddler stage (Modell, et al., 2001). There is a notable debate with regards to appropriate management, understandings and conceptualisations of excessive crying in infants within the research. Alongside this, infant and maternal wellbeing are increasingly being recognised as a serious, worldwide public health concern (Benham, Leikauf, & Romanowicz, 2017).

Within psychology models, the importance of early intervention is emphasised, predominantly in light of the fact that the early weeks with a baby are a crucial opportunity with regards to forming a solid bond and infant mental health (Winston & Chicot, 2016). Excessive crying may have adverse consequences for infant development as well as parental competence and confidence, and the resultant attachment style. Much of the research implies that there is an association between excessive crying and depressive states in the caregiver either as antecedent or consequence of the depressed state (Shonkoff et al., 2012). It is also suggested that inconsolable and excessive baby crying may be brought about by an anxious caregiver, on edge and inappropriately responsive (Phelan, Khoury, Atherton, & Kahn, 2007). It seems most useful to acknowledge that excessive crying occurs in the complexity of a caregiving relationship, thus it is crucial to consider the degree to which the nature of care buffers or exacerbates the impacts of excessive crying. This approach sees the parent and infant both as dynamic accomplices who together shape the process of attachment (Crockenberg & Leerkes, 2000; Harrist & Waugh, 2002; Kochanska & Aksan, 2004). This is notable in light of the fact that a considerable amount of literature suggests that early parenting difficulties are associated with longer-term insecurity in the mother-infant attachment relationship (Cooper, et al., 2014).

It is therefore essential to identify risk and to distinguish improper parental reactions and to support and recommend alternatives (Patel & Rahman, 2015). In less severe cases, parental coaching may assist caregivers to recognise differences in the efficacy of their baby soothing methods, because effective calming methods may be different for each infant (Reijneveld et al., 2004). However, in more serious cases, the risk may need to be monitored, since some

parental reactions out of frustration may be potentially lethal, such as abusive behaviours. In severe cases smothering and shaking threaten the very survival of the infant (Lee, Barr, Catherine, & Wicks, 2007).

2.2.3. Traditional local South African understandings of persistent crying in infants.

Virtually the entirety of the investigations on excessive crying has been done from a Western industrialized social perspective, utilising samples from North American or European countries. There is a gap in knowledge around how non-westernized parenting models influence how this phenomenon is perceived and understood (Barr, Konner, Bakeman & Adamson, 1991).

It is important to note that culture, usually referred to a set of shared community beliefs, is not a static phenomenon. Rather, it is fluid and constantly being revised through assimilation of other understandings and practices (Lehman, Chiu & Schaller, 2004). Culture is regarded as influencing child-rearing practices like response to infant emotion, breastfeeding and infant carrying (Bain & Richards, Fouts, Hewlett, & Lamb 2012; Yovsi & Keller, 2003). Caregivers' beliefs about their babies and their feelings usually represent their childrearing ideas. Hewlett and Lamb (2000) propose that cultural perspectives of child-rearing incorporate parental social constructs and parental interests in particular contexts. The context wherein a baby is brought up also impacts the type of parenting style. In the harshest circumstances, where high levels of poverty predominate, parents will, in general, prioritise baby survival (Richter, 2002).

Though crying in infants is a universal emotional articulation, it has not received much consideration in non-conventional research (Bylsma, Vingerhoets & Rottenberg, 2008). Little is recorded in the literature about South African mothers' cultural understandings of excessive crying. Thus the examination of traditional local women's popular construction of persistent crying is important lest it continues to exist in the margins where reliance on indigenous herbal remedies remains invisible underground. Research on infant crying more generally suggests that responses to crying are largely culturally determined: some cultures may let new-born children sob for a longer timeframe to assist babies with creating regard for the necessities of others, while others may prioritise sharing closeness prompting speedy reactions to baby whining and crying (Hewlett and Lamb, 2000). These differences in responses suggest varied representations of the needs of babies.

Cultural representations are significant on the grounds that they influence parenting reasoning and knowledge about what is fundamental and suitable for child-rearing in that context. Shore (1996) suggested that such primary mappings construct cultural practices and that these are impacted by social models, and form the core beliefs shared by individuals from a certain community. Most traditionally-oriented parents' behaviour is reported to be of multigenerational influence; passed from one generation to the next. Traditional beliefs and enactment of these as practices is the norm in African communities, and appear to focus on the protection of the infant. For example, traditional beliefs such as the fear of people with 'bad eyes' transmitting sicknesses to the new-born when they see the baby, or the fact that the new-born is not yet considered a human being and parents/caretakers shouldn't expose them to others too early, are common (Penxa-Matholeni, 2019). Another belief with regards to the protection of the infant is the practice of keeping the new mother and infant in isolation, spending the first 10 days of the infant's life away from the rest of society because of the impurity and vulnerability that comes with childbirth (Penxa-Matholeni, 2019).

Unsettled infant behaviours are common across cultures, and many culturally embedded explanations tend to attribute excessive infant crying to the mother not being physically, spiritually or emotionally healthy, and therefore transmitting her negative feelings to the newborn infant (Bartholomew, 2016; Hassim & Wagner, 2013). Bogopa (2010) indicates that African people have a belief that diseases and misfortunes are linked to angry ancestral spirits thus ancestral amulets are worn by the infant to appease the ancestors, to ensure that they recognise the infant and protect him or her from diseases and misfortunes. In a study by Ramaube (2018) on traditional disease prevention, infant whining was ascribed to teething, presentation of evil spirits, contact with individuals applying harmful and strong *muthi*, in addition to an inability to satisfy the ancestors (Elter, Kennedy & Chesla, 2014).

Many Black African mothers consult traditional healers during pregnancy and soon after birth in order to access protective treatments to ensure safety from evil spirits and to help in their infant's development. Others don't have faith in traditional practices, and instead use Western medication and practices. A significant number opt for a mix of approaches (de Villiers & Ledwaba 2003). This bilateral health seeking behaviour occurs when infants are experiencing a variety of illnesses and may be complex for health workers to manage. Mothers report to health clinics, often for the immunisations of their babies, after having consulted different healing resources, mainly traditional healers. The most commonly given reason for consulting the traditional healer was treatment for *inyoni* and *ibala* (Bland et al, 2004). *Ibala* is the Zulu

word for capillary naevus (red mark) found at the back of the neck in infants. The common belief in mothers is that the ibala can move up the infant's head and become fatal if it reaches the anterior fontanelle. *Inyoni* means "bird" in isiZulu and is associated with evil spirits that may enter through the fontanelle and is often blamed for severe diarrhoea and dehydration which may lead to a sunken fontanelle (Bland et al, 2004). Caregivers believe that inyoni and ibala make the child vulnerable to evil spirits and that only traditional healers have the capability to treat these conditions, as they are beyond conventional (Western) medical practice. Within Western medical frameworks, these conditions are generally considered to be 'normal' and non-pathological, and healthcare workers who work from these frameworks often try to stress the normality of these conditions to reassure parents. Traditional treatments include the use of enema (spuits) and cuts and incisions on parts of the body into which shoe polish-like mixture known as *mohlabelo* is rubbed (Bland et al, 2004). A study found that 52% of mothers consulted the traditional healer for the treatment of ibala and sought advice for inkaba (an imaginary internal wound believed to be caused by the severance of the umbilical cord), abdominal pains and inyoni (Bland et al, 2004). The most frequently given reasons for administering traditional oral medications were 'wind', 'colic' or perceived abdominal pain (de Villiers & Ledwaba, 2003). Much traditional treatment is understood to be for the protection of the baby against evil spirits and because 'the weather was changing' (de Villiers & Ledwaba, 2003). De Villiers and Ledwaba (2003) note that mothers do not readily disclose consulting alternative healing systems to health workers but that rather the use of traditional healers is evident upon observation when the baby is presented at the clinic; scarification at the back of the neck or on the forehead or elsewhere on the body into which black burnt herbal preparations were rubbed, was seen. Others were seen to have been given talismans/amulets by the traditional healers to wear for protection (de Villiers & Ledwaba, 2003). Mothers' reluctance to disclose traditional care to public sector healthcare workers is significant and may be linked to fear of judgement. It is possible that better understandings of traditional community newborn care practices amongst healthcare workers would assist mothers to be more forthcoming with information.

2.3. Working with mothers in South Africa

It is imperative for any social study to consider the social context, and to be sensitive to social factors that may inhabit, interact within and influence any social phenomenon (Ally & Laher, 2017; Cowan & Murdoch 2006). In order to contextualise this study, it is fundamental to consider the context within which South African mothers are mothering and in which the healthcare workers in this study are working (Barr, 2006).

2.3.1. Motherhood in South Africa

Bornstein (2012) emphasises that motherhood is an encounter that is said to be significantly formed by social setting and culture. South Africa has one of the most reliably inconsistent economies on the globe (Nknoni, Chopra, Doherty, Jackson & Robberstad, 2011). There is mass unemployment in South Africa leaving much of the population living below the poverty line; these dire conditions position numerous mothers in South Africa to face extensive challenges in their struggles to fulfil their caregiving role (Nkoni et al, 2011). While there have been attempts to address socioeconomic inequalities, the distribution of income has nonetheless remained unbalanced along racial lines (Nknoni et al., 2011). Poverty increases the pressure that parents experience and in some cases, can result in emotionally distant and conflicted parenting (Kotchick & Forehand, 2002; Richter, 2002). While parenting in South Africa has been found to prioritise children's emotional and physical safety (Meinck, Cluver, Boyes & Mhlongo, 2015), it is acknowledged that practices, ideas, and connections in parent-child relationships are dependent on the well-being of parents, that of the infant and the health of the relationship. Additionally, the environment may play a vital role. Research has shown that how mothering is experienced and perceived may differ due to certain factors, including culture, personality, mothers' parental background, educational level, socio-economic status, and family size (Cherry 2012).

Many Black South African women place an incredibly high significance on parenthood (Walker, 1995). Walker (1995) demonstrates even though motherhood discourses may be presented differently, for different women it remains central to their identity. The practice of mothering that women develop and perform is cultivated by various variables. Amongst other social constructs, the term 'mother', in the isiZulu language *uMama*, conveys specific attributions among individuals depending on to whom it is directed and from whom it comes. Widely in the African setting, the term is often related to a woman and is accompanied by the

expectation that the woman has a child of her own. There is admiration related to the nurturing role and the supernatural occurrence of childbirth, and for this reason, a mature woman will be respectfully addressed as '*Mama'* (Meyiwa, 2011).

Boyd-Franklin (1989) discovered more than once in her work with Black mothers that motherhood was a significant and fulfilling role for them, and that regardless of historical traumas and difficult upbringings, they felt strongly about the need to bring up children. However, motherhood is complex and not isolated. It is additionally observed as a period of change within which women grapple with the loss of individuality, in that motherhood entails a relationship in which she is one way or the other joined to another, her infant.

Cherry (2012) describes mothering practice as a culturally underlying framework that helps define the generally accepted principles of mothering and the care of children. In South Africa, mothering is informed by a core principle of African philosophy, *Ubuntu,* which emphasises the importance of connection in the community (Mabovula, 2011). Letseka (2012) explains *Ubuntu* as a part of the idiosyncrasies of traditional or communal African customs, and as part of a philosophy that positions an individual's humanity as ideally expressed in relationship with others. Collective parenting is common in African culture. African mothers experience mothering in multigenerational models of 'mother' and multi-mothering is regular as many raise their babies from a distance and grandmothers often assist in child-rearing (Amos, 2013). Grandmothers are thus continuously mothering in the Black communities. The grandparents are then often significant figures of solidarity and security for Black children (Boyd-Franklin, 1989). Therefore mothering is not individualistic yet a shared event particularly in the extended family of these communities. These families see culture as the underlying framework that helps define the generally accepted principles of childrearing and care. Family survival has depended on the interchangeability of parental roles and functions among adult family members, particularly grandmothers. Grandmothers have also been found to provide continuity and consistency in child-raising (Everett, Chipungu & Leashore, 1991). Culture-specific approaches to the mother role have thus been identified as being sensitive to psychological, environmental and spiritual influences (Pretorius, 2004).

2.3.2. Healthcare work in South Africa

Many health systems in sub-Saharan Africa are understaffed: "Africa has 2.3 healthcare workers per 1000 population, compared with the Americas, which have 24.8 healthcare workers per 1000 population" (Naicker et al, 2009, p. 60). Work settings are stressful and

burn-out rates are high (Dubale et al, 2019). Although employed, many of the health care workers originate from and still live in communities where there are high levels of poverty. A study conducted by Kim and Motsei (2002) highlights that healthcare workers "are women and men first—and as such, experience the same cultural values…as the clients, they are expected to counsel and treat" (p. 1243). Thus, many healthcare workers also straddle personal, culturally-informed beliefs regarding health and illness and the western-based models they have learned through professional training. Some healthcare workers formalise this 'straddling' through dual qualification as a healthcare worker and a traditional healer.

Traditional healers or sangomas, known as traditional health practitioners (THPs) in South Africa, are being increasingly acknowledged as providers of health care. However, there is still little evidence-based research on traditional healing practices, which results in mistrust from western approaches to healthcare (Moshabela, Zuma & Gaede (2016). Reviews on the role of THPs emphasise that while the biomedical paradigm uses a scientific approach, traditional healing uses indigenous knowledge, and arguments have been made for greater integration of these two systems: "…the merging of biomedical and traditional healing paradigms provides for a complementary system of plural health care, which could offer patients a truly holistic and comprehensive form of care" (Moshabela et al, 2016, p. 83). Thus, healthcare workers from local South African communities, are uniquely placed to comment on the multiplicity of beliefs that surround excessive infant crying.

3. Methodology

3.1. Theoretical framework

The aims of this research study are best achieved through a qualitative approach underpinned by a social constructionist lens that is premised upon the conviction that research discoveries are in every case effectively incomplete and arranged; that they effectively build the social world which is itself a translation and needs understanding (Jankowski et al., 2000). In essence, social constructionism is an understanding that people develop knowledge of the world in a social context, and that much of what we perceive as reality depends on shared assumptions (Parton, 2003). Social constructionism provides a framework for the current study's assumptions regarding the reports provided by healthcare workers (some of whom are also mothers), of their experiences of mothers who had excessively crying babies.

Constructionism is a worldview or theory of research in which information isn't viewed as an understanding of some target reality, rather that it is built by people, mostly through friendly collaborations. Thus, the reproduction of information and what is thought of as being 'realistic' are determined by people through social practices (Gergen, 1994). If all reality is socially constructed and historically bound, "knowledge is not something people possess somewhere in their heads, but rather, something people do together" (Gergen, 1985, 270). This knowledge can be viewed as the result of a procedure of social development, which gives the premise to our assumptions that how the world is grouped and classified shifts socially. Since information is socially built, it can fluctuate over time and vary across cultures (Gergen, 1985). Cromby and Nightingale (2002) claim that social constructionism is a methodology that likewise stresses how language is used and understood in both the obvious and implicit ways, which means, language is used to make meaning of our encounters. Social constructionism proposes that realities are constantly uncovered through human language (Young & Collin 2004).

A social constructionist approach works well when exploring cross-cultural understandings of illness and distress. Truter (2007) proposes that there are three commonly held patterns in explanations of the construction of ailments, that have been found across many cultures i.e. natural, personal and emotional (Truter, 2007). From traditional African perspectives, wellbeing is not just about the proper functioning of bodily structures. Good health for the African comprises of mental, physical, spiritual, and emotional stability, not just of an individual but of his community. Thus African systems of disease and healing are interlaced

with strict social convictions encompassing individuals, families and communities (Truter, 2007). Social constructionism provides a framework for understanding subjective experience, gaining insights into people's motivations and their actions in social settings, exploring shared meanings.

3.2. Research Questions

The research question is an essential early phase of the research that gives a point of direction to an investigation. It assists in connecting the reviewed literature to the variety of data that will be gathered (Creswell, 2003**).** In qualitative studies, the research question communicates the studies' objective as an exploration (Ratele, 2006) and is much broader than a theory, is less organized and does not desire to have a positivistic outcome (Bryman, 2007). It is rather about engaging in an investigation and does not have an anticipated answer. Holding in mind that understandings of phenomena are socially constructed, the proposed research questions for this study are as follows:

1. What are local South African healthcare practitioners' understandings of persistent crying in infants?
2. What are local South African healthcare practitioners' perceptions of the understandings of persistent infant crying in the mothers with whom they work?
3. What are the convergences and divergences between Western medical and psychological understandings and the South African traditional cultural understandings of excessive crying in infants?

3.3. Research design

de Vaus argued: "The function of a research design is to ensure the evidence obtained enables us to answer the initial question as unambiguously as possible" (2001, p. 9). Thus, in order to capture the healthcare practitioners' cultural understandings of excessive infant crying, and their perceptions of the understandings of the mothers with whom they work, the proposed study will use a qualitative design that will use words, language, portrayals, and reactions directly from the participants (Whitley, 2002). This research paradigm is therefore congruent with the studies' theoretical framework. A social constructionist approach, that holds the assumption that meanings and understandings of phenomena are socially constructed (Jankowski, Clark & Ivey, 2000), will form the theoretical framework for the study.

Qualitative research is associated with context and occurrence (Creswell, 2014). Information obtained via qualitative research often provides valuable representations of the social worlds of the participants. Thus, this research design places emphasis on perceptions, attitudes, beliefs, feelings, and behaviour as well as the meanings and interpretations of lived experiences (Davis & Klopper 2003). The researcher is concerned with the health care workers' understandings of persistent crying and their perceptions of the mothers' understandings of their excessively crying babies. Thus a qualitative analysis is applicable in that it empowers the analyst to get to and decipher the emotional implications offered by the participants through recorded interviews (Fossey, Harvey, McDermott, & Davidson, 2002). The translation of these meetings will involve explicit inquiry, understanding, reflection and conceptualisation (Parker, 2003). Furthermore the impact of the researcher's suppositions, comprehension and translations will be reflexively examined in order to increase the credibility of the study (Fossey et al., 2002).

3.4. Participants

The participants in this study consisted of a purposive sample of eight Black South African expert healthcare workers above the age of 25 years, with at least three years' experience in their field, drawn from both Western medical and traditional healing orientations. The main inclusion criterion was that participants needed to be healthcare practitioners drawn from Western medical and traditional healing orientations or both, who had exposure in working with mothers of infants who are 'colicky' or have cried persistently /excessively. Participants fitting these inclusion criteria were identified through colleagues/associates of the researcher and were invited to voluntarily participate in this study. Additional participants were recruited using a snowball sampling approach where participants recommended other potential contributors (Babbie, 2015).

In the end, the participant group for this study included one male primary healthcare clinician, three female early childhood specialists, three female traditional healers with interests in infant care, one specialist advanced midwife and one training male psychologist who is also a traditional healer. Half of the female participants, over and above their professional experience had personal experience of an excessively crying baby. These healthcare practitioners are knowledgeable individuals who have worked with local South African mothers of babies under the age of five years.

3.5. Data collection

Following ethics approval for the study through the University of the Witwatersrand's School of Human and Community Development Ethics Committee, health care practitioners who had characteristics of the study interest were recruited by means of purposive sampling. The researcher requested colleagues and former colleagues to approach individuals who met the inclusion criteria and invite their participation. Contact details of those potential participants who expressed interest in the study were passed to the researcher, who then made contact. Additional participants were acquired by a snowball sampling approach and were referred by participants in the study. With their permission, their contact details were passed to the researcher, who then made contact and explained what participation in the study would entail.

After explaining the study, informed consent was obtained via email correspondence. Informed consent forms were explained to participants where the need arose. Each participant was interviewed online individually by the researcher, using telecommunications/online methods to conduct a semi-structured interview. Interviews were conducted predominantly in English, and depending on the participant's preference, there was some flexibility around the use of other languages. The sections of the interviews where participants used their first languages were translated by the researcher during transcription of the interviews.

The interviews lasted approximately 45-60 minutes and explored the participants' understandings and perceptions of excessive infant crying. An interview guide consisting of a few demographic questions (to establish inclusion criterion) and approximately 18 open-ended research content-related questions was used (see Appendix). Participants were encouraged to tell their stories in their own words and prompt to encourage detail were used. The purpose of the interviews was to obtain the healthcare workers' understandings of persistent crying in infants as well as their perceptions of the understandings of the mothers with whom they work. Questions were posed to elicit what they regarded and understood to be excessive crying, their thoughts about the cause of the crying, what had the consulting mother reported to have done to try to comfort the infant and address the problem, whether anyone else had been consulted in an attempt to find answers and support for the mother's distress, and the effects of the baby's crying on the mother and all other members of the nuclear family. Upon completion of the interview, participants were asked if they might know of any other health worker who has a similar experience of working with mothers of babies who cried excessively, and who might be interested in participating in the study. With the participants' permission, all interviews were recorded and transcribed verbatim using

pseudonyms to protect their identities. The recordings will be destroyed after the examination of the final report. With the participants' permission, anonymised transcripts of the interviews will be archived by the researcher and her supervisor for possible future research use.

3.6. Data analysis

Mayan (2001, p. 21) portrayed data analysis as "a procedure of observing designs in the information, questioning those patterns, constructing suppositions, purposefully gathering data from chosen experts on the subject, affirming and breaking down the information through arranging, thinking, developing and testing presumptions". As indicated by Mitchell et al. (2005), this incorporates diminishing the volume of crude information, sifting significant from immaterial irregular information, perceiving basic topics, building designs, and creating a framework for conveying the substance of what the data reveals. Interpretive thematic analysis was utilized for distinguishing and breaking down patterns in the subjective interview data collected in this study. This method of analysis is characterized by Carey (2009) as a typical sort of information investigation utilized in social sciences research. Moreover, this procedure works best when investigating large and in-depth information from smaller samples (Blanche, Durrheim & Painter, 2006). Thematic analysis as described by Braun and Clarke (2006) is a sophisticated method of data analysis used to identify, analyse and report patterns that emerge, answering and interpreting various aspects of the research topic (Clarke & Braun 2014). This approach was advantageous in that it offered an accessible and theoretically flexible approach to analysing qualitative data.

Braun and Clarke's thematic analysis follows an iterative process, as explained through a six-step guide (Braun & Clarke, 2006). These start with the researcher familiarizing themselves with the recordings through constantly listening to the recorded audio interviews. The accrued information was then transcribed verbatim.

The second stage involved marking or coding the data shared in the course of the interview. Through analysis, the researcher was enabled to recognize variances and consistencies among reports and perceptions of the phenomenon under investigation. This entailed assessing codes from every participant's interview transcripts, labelling them and linking for uniformity in different transcripts (Hancock, 2002). Data coding allowed for the reduction of the information, focusing only on applicable data for the study (Clarke & Braun 2014).

The third phase focused on merging the codes into prospective themes. This was achieved by searching for recurring points of view, accounts, beliefs and emotions that were shared by participants in the interviews. Codes that contained comparable ideas were grouped together forming themes. This development of themes allowed the researcher to develop a thematic plan to produce the emergent findings.

The fourth step was the revising of themes through analysing all the excerpts from the transcripts gathered under each theme. This segment of the analysis process was concerned with checking that the themes 'worked' with regard to both the coded quotations and the full data set. This stage required some splitting and combing of themes to form new broader themes.

The fifth phase involved the depicting of themes, requiring the researcher to note a point by point exploration of each theme, making sense of the essence of each subject and building an outline and effective conceptualisation for each theme.

Finally, in the sixth step, the themes were written up. Writing-up entailed weaving the analytic narrative and extracts to form a coherent and persuasive research report and contextualising it with regards to existing literature (Whittaker, 2012).

These levels of analysis ensured that the collected information was fittingly coded and successfully interpreted (Clarke & Braun, 2014).

3.7. Credibility, trustworthiness and reflexivity

Qualitative research tends not to concentrate on validity and reliability, but instead focuses on the trustworthiness or dependability of the study (Guba, 1981) In order to ensure the credibility, transferability, dependability, and confirmability of this study (Cope, 2014), themes were confirmed by the researcher's supervisor, and quotes were included in this final report to evidence interpretations made and to allow readers to follow the process of analysis. In addition, researcher reflexivity was considered throughout.

"Reflexivity requires an awareness of the researcher's contribution to the construction of meanings through the research process, and an acknowledgment of the impossibility of remaining 'outside of' one's subject matter while conducting research" (Willig, 2001, p. 10). The reflexive researcher constructs interpretations of her experiences in the process and does not simply report 'facts' or 'truths'. Within qualitative methodology, reflexivity becomes a continuing mode of self-analysis and political awareness and forms a crucial aspect of any

genuine scientific study (Harré, 2004). Positional reflexivity drives the researcher to examine the location of the self within the context of the research. This could be in terms of role, culture, background and personal experiences in understanding how these positioning may shape or influence the study (Macbeth, 2001).

As a Black South African mother and health worker going into this study, I have tried to remain aware of my own experiences, presumptions and beliefs about challenges in parenting and how these may have influenced interpretations of the understandings of the participants, about mothers and their parental practices, and experiences of excessive crying of their babies. I was cognisant that reflexivity infuses every aspect of the research process, and was challenged to be more fully conscious my personal positioning while conducting the research. I was therefore mindful that my positioning as a former professional nurse, a student psychologist and an African mother would likely influence responses to the data. Throughout the process, in addition to keeping an open mind, a research journal documenting the process of this research study from the researcher's perspective was used as part of the reflexivity process**.** I noted the influence of my positioning, personal beliefs and understandings on the data collection, the participant's responses and the resulting analysis (Eagle, Hayes & Sibanda, 2002; Frosh & Baraister, 2008),

Since I am a Black mother with children of my own, and a healthcare worker from the South African cultural background but also trained in the western orientations, there were instances where I felt that my own experiences as a mother and healthcare worker came to mind during the research process. At times, I did not share some of the sentiments as illustrated by my participants. Thus as a researcher I had to monitor my own personal opinions in order to make space for those of the participants. This was achieved by keeping interview records that were supplemented by reflexive notes, which were written soon after each interview. Furthermore, I was aware of my own perspectives towards the research topic and had to ensure not imposing them on the participants. Additionally, where I felt a strong pull towards interjecting my opinions because of similar shared experiences I was careful to try and regulate biases informed by my understandings and lived experiences which may have negatively influenced the study. I found that sharing the same cultural background with the participants often led to the participants at times assuming that I was familiar with their narratives and thus they would fail to give detailed and thorough elaborations. I made use of reflections, clarifying and probing to get more coherent and in depth responses from the participants. My research supervisor additionally provided a space where all aspects of my

own subjectivity were reflected upon and could be thought about and explored for their meaning. Supervision provided support and guidance where needed.

3.8.Ethical considerations

This study complied with the University of the Witwatersrand's standards of ethics for research, and ethics approval was granted by the University's Human Research Ethics Committee (Non-Medical) through the School of Human Community Development's ethics process. Issues of informed consent and voluntary participation were of ethical importance.

The researcher contacted participants by telephone and gave information about the research. The information highlighted that participation in the study was voluntary and participants were informed that they may choose not to answer any questions or withdraw from the study at any time before examination of the report without personal consequence. Informed consent was gained from the participants before the interview and the recording of the interview, and they were asked to sign and return the emailed consent form indicating that they agreed with the conditions of the study. This written consent was gained following the provision of both verbal and written information which emphasized the voluntary nature of participation and the participants' rights to confidentiality. Some time was granted to the participants who needed to think about participation in the study and who sought further information.

Confidentiality and anonymity in reporting were assured and upheld through the use of pseudonyms, and omitting of any names and any identifying information in both the transcripts and the final report. Audio recordings were only heard by the researcher and will be deleted after examination of the research report. Anonymised transcripts with no identifying data were made available only to the supervisor. With the participants' permission, the anonymised transcripts of the interviews will be archived on the researcher's and supervisor's password-protected computers for possible future research use. There was no anticipated psychological risk to participants, as they were asked about their opinions on matters encountered in their day to day lives. None of the participants exhibited distress during the interviews.

4. Results

4.1. Introduction

The present study investigated local South African health care practitioners' understandings of persistent crying in infants and their perceptions of the understandings of the mothers with whom they work. The study employed a qualitative research approach where semi-structured online interviews were conducted with eight health care workers from traditional African and Western orientations of health training. Several main themes with subthemes were identified as having a role in the participants' understandings of excessive crying. These themes are discussed within the following structure: cultural beliefs, medical and psychological understandings, and how the mothers and the infants were positioned in the various explanatory models as narrated by the participants. Firstly, however, definitions of persistent crying as understood by the participants are discussed.

4.2. Definitions of persistent crying

Participant definitions of excessive crying in infants drew upon a combination of understandings, often including a mix of traditional cultural beliefs and medical definitions. Across participants, it was noted that crying is regarded as excessive when an infant would continue to cry despite all obvious physiological needs being met:

> *This would be the type of children that despite being changed a nappy, despite being fed, despite being comforted will have a prolonged cry. In terms of duration, I may not be certain but normally you will expect a child that has been fed and comforted when they are crying to stop crying probably after 15-20 minutes not unless there is an underlying reason why the child could be crying. Which could either be probably the child is not feeling well or the child could be overly dressed during warmer seasons or the child could not be adequately fed or the child is not warmly dressed during colder seasons and despite the child being comforted will cry for more than probably about 30 minutes without the mother showing the necessary skills on how to manage their child when the child is crying* (PP4).

Descriptions of persistent crying in infants were consistent with the medical definitions of persistent crying that associate the diagnosis with the period/hours in which the baby was said to cry, although the excerpt above notes a significantly shorter time than the Western criterion of three hours. Suggestively, as noted in the above quote, crying was also often regarded as persistent or excessive when it cannot be managed by the mother. Consistent with this narrative, PP6 expressed that she would describe an excessively crying baby according to the mother's complaint: *"when a mother comes in and she says 'I have a problem with my child that cries uncontrollably'"* (PP6).

Excessive crying was also regarded as distinguishable through tone from normal crying:

> *Well, it would be a baby who is crying none stop without anything that is provoking the baby to cry, but the baby will be crying non-stop and there'll be a different type of cry. Maybe we can differentiate the cries. Whereby there is this high-pitched cry, it is so excessive you can even see that the baby is losing some breath because of this crying. There's just an ongoing crying that is not stopping* (PP8).
>
> *Probably the child could have a certain tone in which they will be crying, probably a pitched sound or an irritable sound that the mother themselves is unable to handle* (PP4).

Participants also noted that the nature of excessive crying that was related to supernatural causes could be differentiated from the everyday cry of a baby in relation to its volume and tone: "*and they usually say they cry for a long time until they have what we call in isiZulu, Isibibithwane. "Isibibithwane and habiya" (hysteria attributed to sorcery), uncontrollably to a point where they are just breathing heavily, like gasping for air even"* (PP6).

4.3. Traditional understandings

There were a variety of traditional understandings of persistent crying in all the participants' narratives. These included beliefs reported by the health care professionals themselves, and the various beliefs of the mothers with whom they work. The themes that emerged in this area were: evil spirits, ancestral beliefs, ibala /hlokwoana (strawberry mark), inkhaba (umbilical cord care rituals), inyoni (enemas), and umdlezane (the 3 months following the baby's birth).

4.3.1. Evil spirits

There appeared to be a shared common knowledge with regards to the need for the protection of infants from evil spirits. Witchcraft and evil spirits were said to play an important role in traditional beliefs about unsettled babies. A common belief in the cause of persistent crying as explained by the health care practitioners was "evil spirits in the infant's environment" or "bad energies". Most interviewees indicated that witchcraft was frequently attributed as the cause of irritability, agitation, and excessive crying in babies. Sometimes this was attributed to babies' sensitivity to spirits: *"…the child cries when they are in public and we say someone has an evil spirit around the child because we believe children can sense spirits. To us we say the child is sensing some evil spirit around"* (PP6); *"The communities that I deal with it is mostly black people. They believe that maybe the baby is seeing evil spirits"* (PP5); "*children are very spiritually attuned. Anything, that is like bad vibes or bad spirit will most definitely affect the child and the way that they would communicate that is through crying"* (PP6), and at other times it was attributed to bewitchment of the child: *"…has been exposed to bad spirits, you understand? So, this child "*uhabulile*-, bewitched", they need to calm this baby"* (PP2),

PP1 explained that excessive crying that was related to supernatural causes, such as evil spirits, bad energies or witchcraft is usually a result of negative emotions in someone around the mother-infant dyad, such as jealousy and envy. This was supported by PP2 who stated: "*Mostly its evil spirits or like a bad aura around them or someone bewitching them or someone just wanting to do bad to them"* (PP2).

Most of the participants (PP3, PP4, PP5, PP6 and PP7) suggested that traditional cultural systems were the primary explanatory model used by mothers to make sense of the phenomena: "*most of us believe in tradition and cultural things our first instance when a child cries uncontrollably for a very long period of time we suspect imoya emibi, evil spirits"* (PP6). PP6 explained that evil spirits caused agitation and irritability in infants and that protection against these spirits was the first line of treatment from as early as pregnancy to after birth, and involved using herbs, concoctions and smears, which ranged from simple to more complex treatments, such as incisions in the baby's skin: "*Some of the mothers, some of them will suspect witchcraft hence traditionally when they go out they apply some 'muthi' on the ulterior fontanel of the child. So, at times you'd find the mother when relating maybe that, will say the baby started crying we were out to the clinic and then we met a lot of people*

there" (PP8). It was also commonly believed that adults including the mother could bring 'bad spirits or bad energy' with them from outside the house and that this may endanger the infant: *"Spiritually that is because remember that when you leave the house as a person you pick up a lot of energy…So, when you bring back those energies it actually disrupts the child in such a way that the child might scream a lot and needs to be calmed down"* (PP1).

A number of measures to protect the infant from evil spirits were explained: *"the mother would have to burn this incense with the intention of repelling any other external forces or evil forces that according to their belief system"* (PP4). Another participant noted that *"There's something that we use that it's like a legume oil moisture ke serokolo (muti)…Serokolo you can either grate it or you can chew it and spit it on the child almost, saying 'I'm coming in, but can I cleanse myself and my energies, so I can see or be accepted by the baby"* (PP1). It was also notable that the mother was not excluded as a potential source of harm to the infant as she could also be tainted from the environmental harmful spirits. Participant 6 highlighted that in their working with mothers post-natally they advocate for rituals that clear off bad breast milk before feeding the baby: "*When mom comes home from wherever she has been she has to express and discard some milk before she can even breastfeed*" (PP6). PP1 also agreed with the idea that mom could pass on bad spirits into the infant through her breast: "*her contaminated breast milk to a vulnerable infant, until she had washed and squeezed "off the bad milk" or used the protective essence or has drank boiled herbs (serokolo)* (PP1).

Drawing on the above narratives, it was clear that there was a commonly held belief that there is a need to protect babies as much as possible against "bad spirits". As mentioned earlier, most African societies strongly believe in evil being present in everyday life and the most common manifestation being witchcraft (Caldwell & Caldwell, 1987).

4.3.2 Ancestral beliefs

It is widely accepted in the diverse and numerous cultures in South Africa that ancestors bless and can curse individuals, and that this can impact health. PP5 indicated that many African people have a belief that diseases and misfortunes are linked to angry ancestral spirits. Persistent crying is one of the infant illnesses that are associated with ancestors. Participants in this study also highlighted African traditions that appear to place a strong emphasis on cultural rituals relating to the birth stage, such as that of introducing the child to the ancestors

and appeasing and showing respect to ancestors: "*You need to sort of have a ritual that will include slaughtering to introduce this child to the person who has passed on*" (PP4). In most of the participants' narratives, there was a mention of the ceremonial ritual called 'Imbeleko' that is performed to welcome the new-born infant into the family and to appease or introduce the child to their ancestors: A number of striking commonalities were evident in the participants' descriptions of this ceremony. PP1 described this ceremony as follows: *"Imbeleko is what you need to do after umntwana, a (a birth)…you cleanse a child with whatever you've slaughtered to introduce the child to the ancestors. With African cultures it is very important we realise which surname the child is taking on*" (PP1). PP4 gave a similar description:

> *…so imbeleko it is usually a ritual that is done when a child is born, and they are being introduced to their ancestors, so that is a very serious ritual. We take it seriously in our culture and one of the reasons that come up is when the child is crying and the elderly women, the grandmothers would start saying, was this child introduced to the right family?* (PP4).

The dissatisfaction of the ancestors due to unfulfilled requests or failure to comply with cultural rituals were linked to excessive crying in infants: "*So, it is very important to know how you introduce your child to the world… if a child still has that [ceremony] outstanding it will always cause them to cry because there is a discomfort*" (PP1); "*they believe that the child was not done a ritual, called imbeleko. Some will say maybe it is because the child did not have imbeleko done for them. Most will believe in traditional stuff as the reason why the baby is crying so much*" (PP5).

All participants described the ancestors as having an influence on the overall wellbeing of the infant and noted that failure in the appeasement of ancestors through traditional rituals could result in infant agitation and distress that is not easily explainable in Western medical and psychological worldviews. Incorrect introduction or failure to introduce the infants to their rightful ancestors meant that ancestors may become displeased or angry and these unfulfilled ancestral requests can be passed down within family names (Bogopa, 2010). This notion was mentioned by PP4: "*the ancestors become a bit angry because now you've taken their child and given them away almost. It is very important the surname that you give to a child"* (PP1).

A common explanation for persistent crying that was shared by many of the respondents was that the child was introduced to the wrong ancestors: *"the child was introduced to the wrong*

family, the ancestors of either families are fighting for this child so that will cause discomfort for the child and the child will cry" (PP4).

It is then understood that from the ritual introduction, during which there is a ceremonial slaughter, the animal's skin can be worn to protect the child or to identify him or her as having a symbol of being connected to the ancestors. By respecting the ancestors, it is believed that the infant is afforded protection: *"Those are usually what they do, imbeleko…… they do that, they strengthen the child. They say if they are doing that there won't be any evil spirits"* (PP5).

Thus, according to the participants, ancestral amulets are worn by the infant to appease the ancestors, to ensure that they recognise the infant and protect him or her from diseases and misfortunes. Notably, this ritual was associated particularly with the paternal side of the infant's family, perhaps signifying the importance of acceptance and support from the infant's father and the paternal side of the infant's family:

> *…if a baby cries a lot for instance there would be a belief system from the mother that probably the child akenzelwanga usiko. Meaning that there is a ritual that has to be performed for this particular child. Normally that ritual will have to come from the paternal side of the dad with the hope that that would appease the ancestors so that the baby would cry less. The rituals will come in the form of imbeleko (ritual to introduce the newborn to the ancestors) for instance* (PP4).

> *When this baby was just fussy and not sleeping at night, was crying a lot despite being healthy. The mum had to consult traditional healers on what the cause of the infant's continuous crying. We were informed that the particular ancestor from their clan was not pleased with the name given [to the infant] by the father* (PP5).

4.3.3. Ibala /Hlokwoana (strawberry mark)

The results discussed above demonstrate that across the study participants there was a shared understanding of local beliefs and practices around early childhood ailments. Respondents also described a grouping of childhood conditions that were understood and explained using traditional perspectives and were thought to be other causes of inconsolable crying in infants. One such childhood condition was that of *ibala:* "*like Ibala we do have it medically which is a vascular nevus it can appear on the occipital of the child or on the forehead it is just a*

reddish patch" (PP8). Local health practitioners recognized this as a related issue for which mothers consulted and explained that mothers linked this red mark (capillary naevus in Western medical terms) to the persistent crying. Mothers believe that ibala can manifest in a sunken fontanelle ("thlogoana"), which is understood to be dangerous and life-threatening by the mothers to their babies. While mothers attribute this to bad spirits that are present in the environment, from a Western medical perspective a sunken fontanelle is associated with dehydration (Kiesler & Ricer, 2003). It was indicated by the participants that thlokoana/ibala is a common traditional ailment that can produce the phenomena of excessive crying and is often treated by traditional methods. One participant described ibala/hlokoana the, red mark on the back of the infant's neck, as very common in infants and mentioned that it is often called a 'stork bite'. Ibala is also traditionally believed to originate from bad blood that is passed from the mother to the infant. "*Yes, it is blood but this blood is passed down from you as a mother, You need to alleviate it otherwise the child cries a lot because the child is uncomfortable*" (PP1). A sense of urgency with regards to the need to attend to *ibala* is evident in the participants' narratives as is further highlighted in this extract by PP8. Here the ibala is described as fatal in nature and is believed to travel to the baby's fontanelle and eventually causing death if not treated in the traditional ways:

> *Ibala… traditionally they would say the child has, to undergo that ritual that they do, they perform a small cut around that vascular patch that is there and then they drain out that blood around that vascular patch because it is believed that ibala would travel from the occipital and then once it reaches the frontal fontanelle then it will get sunken then the baby might die* (PP8).

Interviewees suggested that traditional healers went about healing this common ailment by providing herbs or making incisions using a razor blade on the affected area to relieve the infant from the "bad blood" flowing in their bodies. This use of traditional healing practices was demonstrated to be very significant to the infant caregiving processes of local mothers in South Africa. PP1 reflected on the common practice of this tradition and spoke about it being passed on generationally.

> *….I could recall, I always knew that our parents at home or even black parents, would feel that, ha ngwana ala ulisa ke hlogana,(when a child cries it is because of the fontanelle) ke dinto tse di ngata tse mo lisang (it's the things that are oppressing him/her that make him/her cry)*(PP1).

All participants in the study acknowledged the issue of *thloakoane/ibala* in their narratives. There was a general sense that mothers believed in traditional cultural healing practices and that intervention in the early stages of the infant's life seemed to help. Participants noted the use of herbs, rituals like incisions and the wearing of amulets around the various parts of the body, which vary according to the mother's particular custom and culture, that are intended for healing and protection purposes against such ailments.

4.3.4. Inkaba (umbilical cord care rituals)

Inkaba (the umbilical cord) was also attributed to crying *"..... because some of them usually when they cry to that extent especially the infants between less than 6 months you usually notice their inkaba (navel)is painful"* (PP6). In the Nguni languages the term 'inkaba' is the term for the umbilical cord, and also refers to the ritual custom of burying the umbilical cord and placenta to protect the infant. Participants indicated that overall illness, and specifically excessive crying, was believed to be caused by evil spirits and the deliberate use of spells and harmful substances. Inkaba represents the connection between the individual, his/her tribe, the land and the spiritual world and if the ritual surrounding the inkaba is not correctly adhered to the baby is vulnerable to any spiritual attacks that will manifest in the babies' navel area: *"..it [excessive crying] is inkaba or is it because of an outstanding ritual or perhaps it is just that there is evil in the child's surrounds"* (*PP7).* One participant explained that inkaba is the African traditional custom of burying the dried off umbilical cord, which is important for protection, as it prevents it from falling into malevolent hands. Inkaba is also considered symbolic for belonging and identification to the infant's ancestral roots: *"You don't just bury it nje, anywhere. So, those things are also part of the reason why we say maybe if the correct procedure was not followed with inkaba and that could cause discomfort to the child and excessive crying"*(PP6).

Participants noted that while the navel area heals the baby remains vulnerable to infections as well as evil contamination and needed traditional protection: *"we would rather go and ask them to give the baby either a white cloth around the waist for protection, there is a little white cloth that is sewn together and the mother would buy things like a stape, doepa and serokolo. So that assist the baby with the energy, if people are coming with the energies it assists the baby to protect itself against those energies*" (PP1).

Most participants in the study stated that most of the mothers with whom they work adhered strictly to the prescribed rituals and advice with regards to the care of the umbilical cord, as the baby could get seriously ill if the umbilical cord were exposed to evil intentions. PP6 highlighted the importance of adhering to rituals around inkaba:

> *…inkaba,…. to us African people when it dries, we use herbs to help it dry and when it does dry and fall off, also you just don't discard it anyhow. You have to give it to the father [of the] child or an elderly grandparent, let's say the child is born out of wedlock and the mother is still at home and there is a certain ritual that is performed where it is buried in the homestead… the correct procedure was not followed with inkaba and that could cause discomfort to the child and excessive crying* (PP6).

4.3.5. *Inyoni*

Continuing with the dominant themes of traditional beliefs and evil forces as responsible for babies being agitated and crying excessively was the concept of *inyoni*. Participants explained that mothers believed this could be one of the causes of an inconsolable newborn. Inyoni was explained as resulting in the baby being "nervous" and restless, having accumulated irritating wind in the stomach due to supernatural elements. Respondents noted that mothers believed that if not protected against or treated inyoni may cause ailment to a vulnerable infant. Thus mothers often go to great lengths to seek protection and to maintain good health in their infants.PP2 narrated that from as early as pregnancy a practitioner is able to ascertain the kinds of beliefs that a mother has, based on prenatal rituals and protective amulets that she wears around her waist throughout the pregnancy. In her narration PP2 explained that some mothers believe that during pregnancy the '*inyoni*' or evil spirits can enter her body contaminating the breast milk and even affecting the baby in her womb, therefore there is a need for early protection. PP2 reported that:

You get to see a mother who is in an antenatal, attending an antenatal that gets to be wearing a lot of cultural ropes and beads, we call them iy'ncweba (protective charms), it's like they are protecting their pregnancy to say anything cannot happen to this baby. Already when you see such a mother you already know that when this baby is born certain rituals are going to be done before the baby has turned a month (PP2).

In addition to excessive crying, other symptoms of an infant with the issue of inyoni as described by these health practitioners included an aching or grumbling stomach: *"Some of them literally have stomach cramps, and they do not know how to literally explain this but what do they do, they literally cry. They become like crying babies, from the onset they'll be like "ingane ekhalayo, its khali" (an inconsolable baby, a crier)* (PP2). PP3 also gave an example of a case she had worked with where the child cried constantly and the mother described what was happening to her baby, "*The symptoms she mentioned to me it was like there was something eating the baby inside the stomach"* (PP3). PP5 also added that *"for example, stomach cramps, when you look at the baby, the baby crying in so much agony, the baby showing some signs that the stomach is not fine but for them when they look at the child they think that the child is being attacked or something"* (PP5). Interestingly, both PP5 and PP3 appear to attribute the excessive infant crying to gastrointestinal physical discomfort but explain that the mothers attribute this to an 'attack' on the baby.

However, excessive crying stemming from inyoni appeared to be an issue that was understood to be manageable by the participants. PP8 pointed out that

"*Nowadays you find that in most pharmacists there is Umuthi Wenyoni (antacid traditional mixture) that is being sold that you give to a child, you don't necessarily have to go to a traditional healer to take out inyoni. You just give them muthi (medicine) from the pharmacy and the child will be okay"* (PP8).

PP5 also spoke about the availability of treatment for inyoni at pharmacies: PP5 "*Umuthi Wenyoni (anxiety concoction) for nervous and crying child they also use such things they get this at traditional chemists"* (PP5). However, PP5 also acknowledged that many mothers "*take the child to a traditional healer or a community older woman, they do that, they strengthen the child. They say if they are doing that there won't be any evil spirits*". PP4 also explained that some mothers do approach traditional healers for assistance with inyoni: *…there is another concept they call Inyoni, I don't know what they call It in English. What mothers would do is they would take a child to a traditional healer and the child would either be given medicinal herbs to be applied on the forehead or they might also perform an enema on the child using herbal medicine to perform on the child with the purpose of saying they are removing Inyoni, for the child to become easily manageable and for the child to cry less and to be easily manageable by the mother* (PP4).

Enemas as treatment to remove inyoni was spoken about by a number of the other participants. PP7 mentioned "*evil wind [which] is said to accumulate in the stomach and it must be purged through enema keep a baby's stomach clean and therefore prevent isues of inkaba and Inyoni" (*PP7). PP8 explained how this is done:

> *There is a certain muthi that is mixed and then they take the child into the veld, an open space, they dig out that hole and they give a child an enema and the child will pass stools into that hole. Then it is believed that the inyoni is out…I think the child will pass out a greenish stool of which medically the greenish stool it's a normal thing for a new-born to pass a greenish stool on their own but traditionally the child has to pass all of the greenish stool and then it is buried there and then the inyoni is healed maybe the baby was crying excessively, the baby has inyoni and so forth* (PP8).

What was most striking in the interviews, however, was the common description of inyoni as emotional in nature. Infants struggling with inyoni were described as anxious and easily startled, suggestive of a child with low sensitivity thresholds. PP8 stated: "*there is another called inyoni whereby the child is excessively anxious, the small baby, even when you bang the door that small baby will start screaming. So, yes, there are different traditional things they label as to why the baby is crying excessively*" (PP8). PP7 also commented about infants with inyoni: "*They also cry in a certain way and seem to fear separation from their mothers* (PP7). PP8 also explained how inyoni can stay with a child into adulthood if not removed, suggesting a developmental component to the condition:

> *…little ones who have inyoni you wouldn't even cough in front of them, they are very nervous and on other side if that inyoni is not taken care of or that traditional thing is not done for them to remove that inyoni they grow with that.…Even when they are adults, you'll find a person who is saying, I am so afraid of thunderstorms I cannot stand it and the elders would say, this one the inyoni was not taken out on this child* (PP8).

4.3.6. Umdlezane (Maternal support)

Another theme that surfaced strongly was the importance of the support that mothers need to receive from their own mothers, who were perceived as wiser with more knowledge.

Participants narrated Ubudlezane (a time of maternal seclusion and rooming in with an older maternal figure) as an important time that the Umdlezane (newly delivered mother) bonds with the child, which is facilitated by much needed maternal support. PP4 explained the purpose of Ubudlezane as a time of training or mentorship: "*Like we know that in our African culture we have what you would call, "ho ontsa mosadi otswetsi/Ubudlezane"(maternal rooming in). Like when a woman has just given birth she usually has a supporter or a mentor of someone who will either be an aunt, a mother, a grandmother who will induct her in such instances"* (PP4). Participants also highlighted the traditional practice of ubudlezane as a time for the mother to be purified and protected from the evil spirits, and they felt that this practice greatly influenced mothers' decisions around whether to follow traditional, culturally-informed care practices or western health system new-born care practices. However, PP4 commented on how changing societies, increased urbanisation and migration have resulted in separation from extended family for many mothers and lamented this as problematic:

> *The isolation should not be seen as a woman being separated from the rest of the society. I think it should also be looked at from an African perspective because when the woman is isolated she usually has some form of support from an elderly person that mentors this individual but now that we have become urbanised and even in our African communities we no longer exist as a kinship society by as a nuclear family, I think that is where this problem emulates from* (PP4).

Although PP5 was not against traditional practices she pointed out that there are often challenges with a conflict between generations, in that mothers who may want to adhere to different (more western) ways of child-rearing practices that are not consistent with the traditional views find the support offered by older generations unhelpful: "*You'll tell them, 'You are staying alone you need help or somebody to support you'. And they'll tell you, 'No it is fine, I'll go to my mother or grandmother or aunt'….* usually they don't go for that, they are reluctant" (PP5). She acknowledged the difficulty experienced by mothers who are often straddling differing world views:

> *Young mothers they are really under a lot of pressure, they don't even know what to do. When they go to the clinic they are told that as a new mother you need to do 1,2,3. They go home the aunt or granny is telling them you need to do 1,2,3. Then social media is*

> *telling them another thing. So, they are caught in between they don't know what to do, there is a lot of pressure from many different directions* (PP5).

Despite the potential conflict, the respondents stated that grandparents who became actively involved in caring for an infant often helped in making sense of some of the traditional ailments and assisted in alleviating the anxiety and the distress of the mother. The participants stated that mothers of infants relied on the elders in the family to guide them in the types of traditional interventions methods to be used and, where necessary, they consulted traditional birth attendants: "*I'd noticed that there's certain things when we abide by or listen to our elders, can save a child's life"* (PP1). In the following excerpt, PP3 shared her own daunting experience with a persistently crying baby and highlighted the role that a close relationship with her mother played, which helped her better cope with her crying baby. She noted how having adhered to the traditional practice of *umdlezane* became helpful when she felt that she had exhausted all measures in consoling her baby:

> *For example, as I am making an example about myself but because uMa wam' wayesaphotivu (my mother was very supportive), even though I also had a crying baby. I have 3 kids, and angikaze ngaba nomntwana othulayo (I have never had a quiet baby)…after giving birth, for the first month at least I had support because I would sleep in the same bedroom with my mother. So, he would cry, I would be upset and uMa would say I could take a break while she took over ngilale (and I would sleep) for like 2 hours, she'll look after the child until I would wake up. I used to get a break. But for someone who doesn't have that kind of support, uyambona ukuthi uzoba (you can see that they are going to be) depressed, during the day, during the night, on the other hand, maybe the father is not like a present father* (PP3).

PP1 and PP5 also shared their experiences and emphasised the importance of having an experienced older mother with them after birth: *"My mom knew because she came in and assisted me"* (PP1); "*When you are a mother and have a new baby at home you need a support system. A support system in a manner of somebody who is older, matured, somebody who will handle a crying child and not be emotionally detached"* (PP5).

PP7 highlighted the importance of emotional containment of the mother as well:

> *This practice is to help the mother, to watch over her and to show that she brought the child in the world and watch if she is also healthy and is okay in order to deal with the child. So the idea isolation is then important as a holding and securing space. But, is*

> *also as I've said an important part of the attachment with mum more but like it differs from culture to culture background. There are some people who stay 10 days* (PP7).

PP7's perceptions and insight seemed to reflect a combination of psychological and African traditions. This overlap will be explored further below:

4.4. Medical understandings.

The interviewed health care practitioners generally appeared to be aware in their narrations that their own personal training experiences as professionals or traditional health care workers as well as being mothers were the factors influencing their understandings of persistent crying. Due to their formal training in western knowledge systems, they explained that in their views persistent crying had medical explanations and attributed excessive crying to infantile colic and explained that it may be associated with organic causes that are related to a disturbance in the infant's biological system.

4.4.1. Colic

Abdominal pain in newborns was often attributed to gastrointestinal issues like constipation, milk intolerance, reflux, and structural abnormalities like rectal constrictions. The pain was understood as a possible cause of excessive crying in babies. According to the participants, the most common cause of excessive crying infants was ascribed to 'wind': *"the doctor would assume that it is just colic*" (PP6). PP7 explained that questioning of mothers aligns to Western definitions of excessive crying:

> *...from the professional or the medical perspective I can tell you that if a baby that cries for too long this is measured by time, in, for instance, whether the child has been crying for up to three hours nonstop and the tone or nature of the cry is also taken into account. This is as well as excluding any other factors that could be contributing to the child crying. For example, is the diaper changed? Is the baby hungry, baby is well-fed?* (*PP7).*

This was reiterated by PP2 who stated that when mothers present with complaints about their infant crying a lot "*we always start assuming colic, that is one thing*" (PP2). This diagnosis was often confirmed through mothers' descriptions of tension in the baby's abdomen, and

that in these instances she would suspect milk allergies, or maternal diet and poor feeding techniques as the cause of intestinal colic.

Another participant drew on a familiar case example with a mother who brought in an excessively crying baby and it was speculated to be due to a wide range of causes aligning with typical medical understanding. She noted:

> *When she was interviewed, I interviewed her I realised that when she was explaining, I suspected that maybe the baby has got like a regurgitation reflux… From the medical perspective this would have been called colic but…you find that the perhaps the mothers were not entirely satisfied with the medical explanation of their babies' agony and would seek advice elsewhere…So, instead of the mother intervening, doing some interventions that are related to colic like they've got some beliefs maybe from the grandmothers or something* (PP4).

PP4's comment highlighted that although the health care practitioners who were trained in Western medical approaches often assumed colic to be the cause of the excessive infant crying, they had to hold in mind that many of the mothers would not find this diagnosis satisfactory.

4.4.2. Feeding problems/difficulties

Medical explanations given by the participants included feeding problems, dehydration, the swallowing of air based on the mothers' inexperience with breastfeeding, and mixed feeding as some of the common issues. PP4 stated that: "*A lot of these babies, especially that are being mixed fed will have such problems…the way in which they explain what is going on with the baby…[also] medically this is explained that due to dehydration from excessive crying* (PP4). PP2 agreed that feeding problems are often a cause of excessive crying: "*the milk is not flowing nicely we start mix feeding and some of these babies actually don't get to really tolerate everything that is being given at a certain point and some of them literally have stomach cramps"* (PP2).

PP2 also implicated some of the treatments given by traditional healers for the excessive crying, explaining that "*Only to find that the baby is not getting enough food, the baby is getting dehydrated from the actual thing that has been given by this traditional healer"* (PP2).

PP3 also supported this notion of feeding problems stating that a child may continue to cry due to incompatible formula which mothers did not correlate with the persistent crying in their infants therefore delaying the process of resolving the issue. PP3 expressed that:

> *You find sometimes the baby will cry a lot, maybe it is because of the formula that the mother is giving to the child, it is not the right formula but because in her mind it is not like related to those things, they just believe that it is cultural or it's something traditional. Then you find the problem is not solved. This mother will end up with a baby crying for more than 3 months without the solution* (PP3).

PP3 suggested that often the solution was as simple as a change in feeding options, but that this was not always accepted by the mothers:

> *So, it's just a matter of the mom changing the formula. So, you advise this mom on changing the kind of formula, on the other side the problem that comes, you see these other medical formulas they tend to be expensive. They end up choosing not to believe what you are advising them on instead believing what is culturally related, because maybe it's easier or cheaper to that traditional woman (PP3).*

PP5 also spoke about feeding issues, highlighting latching problems. Explaining that watching the mother baby interaction they were often able to diagnose that there is swallowing of air during feeding and that the crying is the infant's means of communication of thirst, hunger, and pain from cramps:

> *…if the mother is saying that she is breastfeeding. You'll see it immediately there, they can't attach the baby, already I am thinking it has been 3 days, how have you been feeding this child in the past three days and the mother will talk, "You know this child is stressing me. You know this child is crying". And you be like okay now you are further, you are not new to this what is happening? I think breastfeeding is the most natural thing that is supposed to happen in the first hour after birth. Now it is 3 days, but you are still struggling to breastfeed. So that is where you are able to pick it up….. you'll be able to pick up that there is something wrong here* (PP5).

4.5. Psychological understandings

This theme captured the participants' narrations of the struggles and exasperations that mothers of infants have experienced in caring for a persistently crying baby. They mentioned emotional distress on a continuum including anxiety, depression, anger, self-blame, disappointment, vulnerability, frustration and resentment. In the interview participants relayed how they made psychological sense of the whole experience. In the excerpt below, for example, PP4 provided an elaborate psychological understanding that implicates emotional distress as both the cause and consequence of excessive infant crying:

> *…maybe the possibility might be that the mother herself has her own psychosocial stressors. Either it could be a mother who is a teenager and has not planned the pregnancy and as a result, is not getting adequate support from their own biological mother or from their own guardian and as a result, they are also highly stressed and because children are very perceptive they can sense the mother's emotions. As a result, they also react by becoming highly anxious children themselves and are not easily handled by their mothers and they would constantly cry. And when these children are crying the mothers themselves will react especially if they are first time mothers or having other dimensions in their lives, will also cry which will exasperate the very problem that the child is also presenting with which is crying…… Depression made or resulted in her neglecting her child unintentional. As a result, this child will continuously have outbursts of constantly crying because the mother somehow failed in comforting this child* (PP4).

Connected to the above, PP3 spoke openly about her emotional experiences. This participant drew on her personal experiences to explain her psychological understanding and the impact of excessive crying on both the mother and baby. The themes in her narrative demonstrated that sitting with an inconsolable infant often came with feelings of resentment towards the baby and feelings of inadequacy, guilt and shame. PP3 explained that she had a sense of guilt because she could no longer respond with sensitivity towards her baby. She made mention of feelings of being anxious and depressed, as expressed in the following excerpt, showing the great extent to which she was psychologically affected by the experience:

> *With baby X, the second born, I felt depressed for the whole year, I felt depressed for the entire period of his early years, it was frustrating…I had run out of options and I*

> *would see that I would end up spanking him a two-month-old. So would decide the best is to let him be and go outside, it was very difficult for me (PP3).*

Many participants pointed out that repeated failure to control infant crying can lead to feelings of ineffectiveness and helplessness, which in turn impairs parental response to future episodes of crying. Participants mentioned that the emotional state of a mother will have a fundamental impact on the child:

> *Children are very perceptive they can sense the mother's emotions. As a result, they also react by becoming highly anxious children themselves and are not easily handled by their mothers and they would constantly cry* (PP6).

In the participants' narratives, there was a prominent thread of lack of maternal emotional readiness and inexperience, as well as mothers that felt judged and unsupported, that seemed to factor into excessive crying as either an antecedent or a maintaining element. This is reflected in PP4's statement:

> *A planned pregnancy, if this happened unintentionally…a woman is carrying an unwanted baby, the child somehow right from utero they have the feelings and the senses that, "I am an unwanted baby". As a result…there is some form of disconnection where there would be that connection between the mother and the child. And if the mother is showing feelings of un-readiness or some form of anxieties the child somehow can sense those feelings from the mother and as a result respond in that way of the child being constantly easily irritable, highly anxious, requiring more attention from the mother, constantly crying, high pitched crying because the child is somehow feeling the mother's emotions. As a result, will also manifest those feelings by constantly crying continuously irrespective of how much the child can be comforted by the mother* (PP4).

Further, the participants noted that when the woman felt that they were not well-received and supported by their support structures it would result in post-partum depression and then the mother would, in turn, fail to take good care of the infant in a way that is attuned and that the baby is sensitive to this emotional imbalance. To demonstrate the above thought PP5 noted that when working with mothers and their infants she picked up in interviews that the mother is not attached to the baby:

> *What've seen is that kids they pick up on this. They are able to pick up on a mother who is sad, anxious; who is any other thing, the child is able to pick up on those things that are why I'm saying that some kids it's because of emotions…The child was forever crying because she could feel, sense that the mother is emotionally distanced from her* (PP5).

However, there was a notable ambiguity when it came to the psychological understandings, as participants often had contradicting narratives in their explanations of persistent crying in infants. Some participants in their expressions located the issue with the mother and others within the infant's "sensitivity". This sensitivity appeared at times to allude to physical and spiritual vulnerability, while at other times it was a reference to an emotional vulnerability and baby's temperament.

Participants felt that depression was one of the causes as well an outcome of persistent crying, suggesting a possible confusion regarding an existing mental problem and the baby's cry causing the psychological disturbance. This was evidenced in the narrations of participant PP3, who implied that there was something unique with an inconsolable baby and that her distress was particularly due to the experience of having an inconsolable baby: *"I have 3 kids but with Baby X, I enjoyed more of the pregnancy than him physically…. Ungidepressile a lot.(he depressed me a lot) I felt depressed for the whole year, I felt depressed for the entire period of his early years"* (PP3). PP6 explained that a depressed mood was common in mothers presenting with excessively crying infants: *"I think sometimes they feel despondent, some of them they tell me that even cry when they don't know what the baby is crying for, some of them feel like they are not good enough"* (PP6).

In many of their explanations it was understood that the excessive crying was related to the infant's temperament. PP2 explained that: *"…from the onset they'll be like "ingane ekhalayo, its khali" (an inconsolable baby, a crier), basically it is just certain "things" surrounding the baby"* (PP2). This propensity to cry was understood to be as a result of innate traits that affect their behaviour, and many participants used terms like "fussy" and "difficult baby". Nonetheless, they all agreed that there was a lot of psychological impact on the dyad and described feelings of despondency and sometimes anger in mothers, some crying, and that sometimes these mothers would respond by just leaving the child there to just cry after all efforts to soothe the baby have failed:

> *Some have said that out of frustration and anger that would be the reasons why they either just let the baby to self soothe because they say that the babies and usually cried themselves to sleep, and that is why then they will just let the baby be. So it's a belief that by ignoring the baby you're actually teaching them a valuable lesson on how to soothe them so that they don't need to continue crying* (PP7).

Furthermore, PP7 and PP4 expressed an understanding that excessive crying can be a traumatic experience that has the potential to disturb important psychological processes between the mother and baby:

> *Baby will attach or bond with that person who is their main caregiver and this initial bond will always determine how that child becomes better person and how they regulate their feelings so that safety and security in that space that is just available for mum and baby to teach the baby how to be and to understand the world becomes important* (PP7).

All participants noted that excessive crying placed a great deal of pressure on mothers who feel that they need to be a good mother, even though they may lack skills or not have been adequately prepared to be a mother. They noted that this resulted in the mother becoming despondent as a result of the failure to console her infant and that some then responded in an emotionally distant manner: "*If you let the child just keep on crying, then something which is unnecessarily frustrating can drive a wedge between the child and the mom and this can continue and it has consequences like a weakened connexion between the two, the mum and the child"* (PP7). PP7, who has both a traditional healing and psychological training background, clearly described the experience of maternal withdrawal as traumatic for the infant and stated that this could result in a lot of fear and anxiety for the baby emotionally because this baby literally thinks that they're going to die. Participant 8 agreed and stated that: *"The mother would describe that it is "like the baby will scream like something is eating them up" or "the baby is crying as if they are dying"* (PP8).

The narratives also showed that crying was understood to be infants' means of communication. The crying pitch and tone were understood to give important information about the baby's emotional distress.

4.6. Positioning of infants in the various explanatory models

Infants were positioned by all participants as vulnerable from all the explanatory models. Participants emphasised the importance of protecting the infant even before birth from all harmful influences: From a traditional perspective PP7 noted that *"babies come in weak and they are very vulnerable to whatever it is that can happen in the environment mainly in the form of evil spirits*" (PP7). PP2 also emphasised how babies do not have any capacity to protect themselves from evil influences: "*in the babies environment who is practising or has been using a muthi that is too strong for the baby. Then the baby uyahhabula, (inhales this) remember the baby then is too weak and has not developed enough spiritually to fight off whatever those evil influences*" (PP2). Infants were understood to be good, and any badness must therefore come from the 'outside': *"So, it is believed that when a child is born, they're born with pure intentions, nothing has infiltrated their soul or spirit"* (PP6).

Thus, in the traditional cultural models of infant development, the vulnerable infant is believed to need protection in the form of traditional amulets, traditional marker/incisions, beads and herbal concoctions. It appeared commonplace that mothers would take their infants to a traditional healer/sangoma to be 'protected': PP7 described that*"...to make their babies strong; we "cover" their children in a way that they are protected from whatever spirits that they may come across. This process is done even before they go to seek for immunization, which is equally meant to strengthen them"* (PP7). PP2 also narrated that mothers believed that protection started as early as in utero, and are were expected to take measures to ensure the protection of their pregnancies: *"you get to see a mother who is in an antenatal, attending an antenatal who gets to be wearing a lot of cultural ropes and beads, we call them iy'ncweba (protective charms), it's like they are protecting their pregnancy to say anything cannot happen to this baby*" (PP2).

PP1 also noted that a woman is discouraged from immediately breastfeeding if she has been out and about, as she may transfer badness from the environment through her contaminated breast milk to a vulnerable infant until she had washed and squeezed off the 'bad milk' or used the protective essence or has drank boiled herbs (*serokolo, imbiza/muthi*) from either the traditional birthing attendant or traditional healer.

In the medical discourse, infants were also framed as a vulnerable group who are at high risk. At points in the narratives, the traditional health practices were sometimes in tension with the medical discourses, as the professional healthcare workers sometimes felt that traditional

practices endangered the infants. At points the health care practitioners appeared to advocate against the traditional health practices:

> *We give health education on the certain aspects that a child should not do this and this, for example, the using of, we call them stapes, on a newborn baby, the Entress (liquid medicine), the Haarlemensis (Lennon medicine for kidney and bladder). So, medically we would say it is not suitable to be used on the kids but traditionally at home they are used on every newborn baby* (PP8).

These practices seemed to be perceived from Western medical understandings as factors that pose health risks to infants due to the lack of scientific evidence for their safety. PP8 also noted that *"infants…get to be given traditional medicine which you don't know how it was mixed, was it measured properly".* This concern for infants was supported by PP1, a practising traditional healer specialising in mother and infant care, who also and raised concerns around a lack of standardised practice guidelines and measurements of treatment given to infants in traditional methods of healing.

The participants showed empathy towards infants who were seen as defenceless and could only communicate by crying. From a Western medical perspective, excessive crying was considered communication about discomfort or unmet needs: "*It might not even be about spirituality, we know that he's either unhappy, his nappy needs to be changed or he needs to eat, that is a cry that you can even sense*" (PP2). PP2 even advocated for medicating excessive crying in case there is pain: "*they get to be given certain medication because the child is crying excessively and they don't even know that sometimes you can give maybe a 0,5 Panado to just soothe the baby maybe the baby just needs that soothing"* (PP2).

PP7 drew from a more theoretical psychological explanatory model and noted that:

> *…our understanding is that the baby comes being fully dependent and trusting the mum to navigate through this unknown world that they have come through. If they come to the world all they depend on is the mother or depending on whoever is the main primary caregiver to sort of like hold that space for them and show them and understand or show some understanding to them. So it's a lot of fear for the baby* (PP7).

Evident within the medical and psychological discourses is the dependency of infants upon the mother for all their physical and psychological needs to be met. Within this discourse, babies are also said to be a risk of neglect, insensitive, and delayed responding from mothers

who are annoyed and by a persistent crying. When probed about soothing and consoling infants, respondents pointed out that babies were at times left to self soothe. While the frustration of mothers was noted as a reason that some babies are left to "cry it out" or self soothe, this was also positioned, at times, as a necessary lesson for infants to learn:

> *Even though some have said that out of frustration and anger that would be the reasons why they either just let the baby to self soothe because they say that the babies and usually cried themselves to sleep, and that is why then they will just let the baby be. So it's a belief that by ignoring the baby you're actually teaching them a valuable lesson on how to soothe them, so that they don't need to continue crying and the baby is cried out* (PP7).

This was, however, a contentious issue and PP5 proposed that such a response could result in a mother who is less emotionally available for her infant; which has long-term effects on the mother-infant bond development.

4.7. Positioning of mothers in the various explanatory models

Interestingly, mothers were positioned in two different and fairly opposing ways in the narratives: the first was as responsible for their infants' crying, and secondly, as affected by their infants' crying and unsupported.

4.7.1. Mothers as responsible for the crying.

Noteworthy in the interviews, was a discourse around *mother blaming* narrations in relation to the mother as being a possible source/cause of the phenomena of excessive crying in infants. When identified with the mothers, some of the health care practitioners related their own experiences as a mother to an excessively crying baby. One of the health care practitioners, who was a mother to an excessively crying infant herself, described feeling responsible when her infant cried and finding it difficult to access support from her partner: *"I feel like I am failing as a mother, I feel like I am not doing my best because I have other issues and sometimes it is not easy to talk to a male perspective to really make them understand"* (PP5). Mothers' guilt and feeling responsible was common as re-iterated by PP7 *"they feel shame and there is self-blame as well. Because the mum feels like she did not protect baby enough, and questions what it is that she had done wrong"* (PP7).

This positioning of mothers as responsible was subtle, as the health care practitioners were generally empathic towards mothers of excessively crying infants. However, when identified

with the infants, the healthcare practitioners appeared more sensitive to a negative emotion that mothers may feel towards their infants, and the implication was that this may exacerbate the infant's crying. PP3 asserted that infants may feel frustration, resentment and distrust towards parents who fail to understand and soothe them. On the other hand, participants recognised that mothers may indeed come to resent their baby for crying excessively. Excessively crying infants were sometimes positioned as burdensome by their mothers, as reported by PP8: "*on their opinion when you are talking about a child they just say, it is trouble, trouble, trouble, I am never going down that route again because this child is crying"*(PP8). This was recognised as a vicious cycle, as the mother's resentment or fear of her infant's crying may then lead to disengagement and further misattunement:

> *Unfortunately, that child is like being consumed by this emotion which you have as a mother and you giving it to the baby. It is like the baby becomes tense on their own, am I making sense? So, we are saying, when the mother gets emotionally frustrated, they can tend to withdraw things like feeding and attending to the baby in fear of transmitting the very same emotional frustrati*on (PP2).

Other subtle indications that alluded to mothers being held ultimately responsible for their infants' excessive crying were comments that implicated the mother in 'passing negative energy to her child'. This included transmission through blood: *"Yes, it is blood but this blood is passed down from you as a mother"* (PP8); Or through bringing negative energy into the home: "*Spiritually that is because remember that when you leave the house as a person you pick up a lot of energy…So when you bring back those energies it actually disrupts the child*" (PP1). While these comments acknowledge the role of 'outside' energies and ancestral legacies, it was implied throughout the narratives that mothers are responsible for managing these through cleansing and rituals in order to ensure the safety of their infants.

4.7.2. Mothers as affected by the crying and unsupported

As previously mentioned, empathy for mothers of excessively crying infants was also evident throughout the narratives. Most practitioners emphasised the important role of maternal support and noted the relational problems that came with having an excessively crying baby. The psychological effects on the mother of the crying were acknowledged. These effects included feelings of helplessness and inadequacy: "*So when you feel so helpless being able to see your child deteriorating it's something totally different to a mother"* (PP8?) and this was

clarified by PP5 who noted that mothering in and of itself left more inexperienced mothers feeling a degree of incompetence: "*So, there is also that feeling of inadequacy in most mothers especially the younger ones because everybody around you is telling you that your child is crying because of something that you are not doing right"* (PP5).

Excessive crying in infants was also linked to depression in the mothers. PP2 drew on one of her cases as an example and described this mother as highly despondent and the situation as having taken an emotional toll on her:

> *"she lost a lot of weight because the baby was constantly crying. So, it led to stress and she was always frustrated. She doubted her ability to be a mom to this child. She always said to me that 'I'm incapable of being a total mother to this child because this child is always crying'"* (PP2).

Thus, the participants appeared to demonstrate in their explanations that the phenomena had an emotional impact on the mother and that this, in turn, influenced her abilities to perform basic caregiving that is essential to her infant's development. PP3, a health care practitioner and a mother, reflected on her experience of having had an infant who cried excessively. In this excerpt she also mentions how her emotional state had influenced her thoughts and responses to her baby:

> "*With baby N, the second born, I felt depressed for the whole year, I felt depressed for the entire period of his early years, it was frustrating*" *...I would leave him in the house alone, close the door and sit outside in the veranda because I had no clue what else I could do for him. I had run out of options and I would see that I would end up spanking him, a two-month-old"* (PP3).

Some of the health care practitioners seemed to hold in mind that excessive infant crying may put enormous strain on intimate partner relationships and that this may result in the exacerbation of the mothers' feelings of helplessness and frustration. PP2 clarified how this anxiety transfers onto interpersonal relationships: "*But because of their frustrations and anxiety has just spiked everything, even the relationship within themselves and partner it has cracks* (PP2).

At times, the health care practitioners were aware that mothers with excessively crying babies were likely to feel lacking and be sensitive to criticism. Speaking from the perspective of a

mother, PP5 stated that *"you feel that guilt yourself, and the people who are around that are older had children before you, they tell you that you are not treating this child right"* (PP5).

The participants were also very aware that the mothers' circumstances and mental states influenced how they experienced their infants' crying and highlighted situations such as unplanned and/or teenage pregnancies where support for the mother may be compromised: "*Either it could be a mother who is a teenager and has not planned the pregnancy and as a result is not getting adequate support from their own biological mother or from their own guardian and as a result they are also highly stressed*" (PP4).

A similar association between infant planning, readiness and emotional turmoil was made by PP2 in narrating her case example. She describes: "*from the onset of the whole thing, the pregnancy was not great she felt that it's not her best decision, her falling pregnant. Already this pregnancy comes with a lot of other baggage*" (PP2).

4.8. Navigation of various explanatory models of excessive crying

From the themes noted above, it is clear that the health care professionals, like the mothers, also straddle traditional African and Western medical and psychological models of infant care, with at times opposing views. However, many of the participants had discovered overlaps in these worldviews and found ways to negotiate the areas of divergence. PP4 was able to offer all-encompassing insight into the complexities of excessive crying in infancy. In his accounts, he noted the intersectionality of traditional cultural beliefs, medical and psychological perceptions that exist within the South African context. Thus suggesting that there was some overlap in the understanding of the phenomena and that, most mothers tended to conform to one or the other explanatory principles to account for excessive crying as explained in the following excerpt.

> '*…my experience with women is that they first go to their African inclined intervention. Such as, if a baby cries a lot for instance there would be a belief system from the mother that probably the child akenzelwanga usiko, meaning that there is a ritual that has to be performed for this particular child. Normally that ritual will appease the ancestors so that the baby would cry less* (PP4)

He further laid out from the medical perspective that the baby may cry despite all efforts and noted that

> *This would be the type of children that despite being changed a nappy, despite being fed, despite being comforted will have a prolonged cry. In terms of duration, I may not be certain but normally you will expect a child that has been fed and comforted when they are crying to stop crying probably after 15-20 minutes not unless there is an underlying reason why the child could be crying. Which could either be probably the child is not feeling well or the child could be overly dressed during warmer seasons or the child could not be adequately fed …despite the child being comforted will cry for more than probably about 30 minutes without the mother showing the necessary skills on how to manage their child when the child is crying (PP4)*

He additionally attributed the issue to having a psychological disparity stating that

> "*….women and their readiness and their psychological impact especially with babies that are crying …. the child could then have a certain tone in which they will be crying, probably a pitched sound or an irritable sound that the mother themselves is unable to handle and maybe possibility might be that the mother herself has her own psychosocial stressors. Either it could be a mother who is a teenager and has not planned the pregnancy and as a result, is not getting adequate support from their own biological mother or from their own guardian and as a result, they are also highly stressed and because children are very perceptive they can sense the mother's emotions. As a result, they also react by becoming highly anxious children themselves and are not easily handled by their mothers and they would constantly cry"* (PP4).

The participants seemed to suggest that the idea of being informed, knowledgeable and respecting the mothers' respective worldviews is one way of managing divergences. All participants made reference to the fact that the majority of mothers' preferential mode of treatment was their African traditional interventions. Traditional treatment was most often sought prior to seeking any western or medical interventions: *"women before they seek for any intervention, European/western intervention they would normally go to their African inclined intervention"* (PP4).

PP5 agreed with this thought and put it as follows*:*

> *Well from us for excessive crying they don't usually come. If they come it is because they are from the traditional healer first that is where they start then they come to us as a last resort because they feel that, "Okay, I've tried this one and it is not working*

> *let me go to the clinic". When they come to the clinic they don't say that the baby is excessively crying, they will come up with all sorts of things* (PP5).

PP8 also pointed out that mothers usually bring the child to the clinic complaining of something else, trying to conceal their other explored routes of treatment, as they felt that 'crying' was not taken seriously enough to warrant any treatment at clinics:

> *So, most of the time they start the traditional route and then once maybe they see there's some complications that is when they become medically, it is to correct what has been done traditionally. And we have so many cases of babies passing away due to the traditional routes that were taken, it was too late for them by the time they reach the clinic* (PP8).

Supported by PP4 *"the only instance where they would get to disclose of such practices would be when they realise that either it didn't serve the purpose intended for and the situation from their side has and the situation has worsened"*

While these comments did indicate a slight sense of judgement towards mothers for utilising traditional treatments, some of the health care practitioners did acknowledge that it was sometimes not possible for mothers to access public health facilities. PP6 cited a lack of accessibility to health centres and clinics as a rationale for seeking assistance from traditional birth practitioners and acknowledged that it was not always easy to visit the western medical and psychological health clinics in their communities: "*mainly because at times in the rural areas these Western medicines or the clinics and the hospitals are not easily accessible to most of us"* (PP6).

5. Discussion

5.1. Introduction

This exploratory study intended to answer the following questions: Firstly, what are local South African healthcare practitioners' understandings of persistent crying in infants, and those of the mothers with whom they work? And, what are the convergences and divergences between Western medical and psychological understandings and the South African traditional cultural understandings of excessive crying in infants? The discussion that follows examines the ways in which the resultant themes that arose from the interviews answer the aforementioned research questions, and how they can be situated within the current literature.

This discussion section is laid out in three sections. Section one discusses local understandings of persistent crying. Section Two describes convergences and divergences and overlaps in the understanding of persistent crying infants. Section Three deliberates the implications of the findings and includes the conclusion of the study.

5.2. Local understandings of persistent crying in infants.

The analysis of this study's results suggested that despite being an under-researched area, persistent crying is an issue of significant concern. It was a common thread amongst participants' narratives that persistent crying is a widespread cause for concern amongst mothers of infants and was one of the main reasons that mothers seek healthcare advice for their infants. This is consistent with the documented literature stating that mothers regularly visit a range of health professionals seeking advice for infants with inconsolable crying during their infants' early stages of life (Fisher, 2011).

The results of the study show that although the practitioners tended to ascribe to Western forms of training, their understandings of excessive crying included a combination of Western medical, psychological and African socio-cultural beliefs systems. Therefore, the practitioners held various explanatory models for distress in infants; both traditional spiritual and Western medical understandings were reflected in their explanations. Some of the participants believed in some of the traditional explanations along with the mothers and had similar practices for their own children. In a few cases it seemed that some of the health care practitioners did not share the mothers' beliefs, but on the whole, respected them and made space for them. Most participants' narratives demonstrated openness allowing for persistent

crying to be constructed, interpreted and understood in different ways. Some frustration towards traditional beliefs was noted in some narratives, where traditional forms of healing were constructed as potentially dangerous for infants.

All of the participants were knowledgeable about the various views on the condition. The information collected in this study extends the existing limited literature available on cultural understandings of persistent crying. As found in previous studies, such as Burns and Tomita (2015), the findings of this study also showed that many of the mothers who make contact with local health practitioners consider traditional medicine as a valuable component of the health care delivery system, complementing modern scientific medicine (De Villiers & Ledwaba, 2003).

Swartz (2002) argues for the importance of recognizing the significance of cultural context in the understandings and perceptions of any human experience. Beliefs and practices are to varying extents incorporated into frames of reference and impact an individual's discernment and conceptualisations of issues, including that of unsettled infants. The attribution of persistent crying to supernatural causes, evil spirits, ancestral beliefs and a lack of protective ritual practices within cultural traditional beliefs was common amongst the mothers treated by the participants, and amongst some of the participants themselves. Other studies affirm that in the traditional African beliefs, wellbeing is not simply about being free of physical illness but is, however, an incorporation of mental, physical, emotional, and spiritual soundness (Omonzejele, 2008). This was supported by the findings of this study. From the narratives of the interviewed practitioners, mothers with whom they work, hold the view that excessive crying in infants is more often than not entrenched in the complexity of cultural traditional beliefs systems and is frequently understood as more than the baby 'being sick'. Reasons for excessive crying were understood to be situated in African traditional and supernatural domains that incorporate black magic and witchcraft, and attacks by evil spirits, which necessitate protection from this domain. Thus, constructed understandings of persistent crying reflected complex understandings from their cosmological worldviews.

A number of traditional cultural beliefs about persistent crying in infants were found in this study. Firstly, persistent crying was believed to be as a result of *hlokoane* (a sunken fontanelle) due to *inyoni* (exposure to evil spirits) or exposure to people using strong *muthi*. Mothers were reported to be scared of this condition as it is believed to be a major killer disease in infancy. These traditional understandings of excessive crying were based on beliefs

that the baby is sensitive to bad energies and spirits and can be harmed through inhalation of vapours from powerful herbs. The baby was understood to feel unsettled, agitated and to continually cry until removed from the harmful or 'wicked' environment. These results are concurrent with research conducted four decades ago in Zimbabwe amongst the Shona culture where, according to their local traditional healers, 'nature' and evil people are understood to cause illness and infantile colic (Chavunduka, 1978). The infant cries because it is believed that they are able to sense and see evil spirits such as ghosts and evil people like witches and wizards (Gelfand, 1979).

Three of the participants (PP1, PP6, and PP7) described how many mothers go to traditional healers so that the mother-infant dyad can be protected from evil harm. It was noted by participants that there are practices adhered to by mothers that may help in healing and protection of the infant from harmful experiences or difficult situations. The results elaborated that these incorporated the use of herbs, rituals like incisions, and the wearing of amulets around the various parts of the body (depending on the particular custom and culture) and were intended for healing and defensive purposes. Similar findings were reported by Bogopa (2010), who found that a significant portion of the South African population adheres to cultural norms, and hold reverence for ceremonial rituals, as well as have an awareness of their meaning.

Another integral part of the health of a large population in South Africa is ancestor belief (Bogopa, 2010). Similarly, in this study, many of the participants referred to ancestors or the influences of ancestral spirits. Edwards et al.'s (2004) comparative results note that many African societies think about ailment and sicknesses as originating from spiritual tensions. Ancestral spirits are considered to have the capacity to impact healing or bestow ailments (Wager & Ngcobo 2010). Most of the local health practitioners referred to various cultural explanatory models of persistent crying in infants that included ancestral beliefs. These included non-adherence to rituals such as *Imbeleko,* where a failure to appease the ancestors is understood to cause persistent crying. This understanding is also noted by Bogopa (2010), who explains that if rituals to appease the ancestors are not conducted properly, it may result in the displeasure of ancestral spirits and contempt transferred to the child and withdrawal of protection from evil in the environment. A number of the participants referred to the importance of introducing the infant to the ancestors. This custom is thought to provide a sense of security and a sense of belonging for the infant. This is documented in other studies

wherein many indigenous African cultures ancestors are regarded as guardian angels that welcome and protect their living descendants in life (Wanbugu, 2010).

All of the participants also reported understandings of excessive crying from within the Western medical model, likely due to their formal training in western knowledge systems. Congruent with Miller and Newell (2012) they categorised excessively crying infants into subgroups, with the crying as a result of either: infant colic, irritable infant syndrome or gastro-intestinal problems related to inefficient feedings, such as constipation, cow milk protein intolerance, gastroesophageal reflux, lactose intolerance and other physical developmental immaturities (Miller & Newell, 2012). Moreover, the definitions of excessive crying in infants as given by the participants drew on the Western traditional seminal works of Wessel (1954), whose definition of colic is still used in the medical field to describe problematic crying. Participants also referred to the notion that the baby is still developing and may have an immature gastrointestinal system that fails to process air when sucking breast milk from the mother; the air is ingested and discomfort ensues (Helseth & Begnum, 2002). These diagnoses related to infant crying were based on the mothers' reports and physical findings. Practitioners in this study asserted that colic was assumed to be a primary diagnosis if the infant was said to cry for over thirty minutes at a time despite having had all their basic needs attended to and when there were no other notable physical symptoms that were a cause for concern. It was reported that interventions for 'colic' by health professionals follow treatment guidelines that recommended a health care worker only provides reassurance for the mother with no further interventions as the issue is said to resolve eventually. Some of the participants in this study noted that this may lead to a discrepancy between the actual felt needs of the mother and the helping process offered, leaving the mother dissatisfied with the explanation of colic. When using this approach practitioners noted that many mothers would express feeling hopeless and many desperately search for other interventions that might stop the crying.

While medical models primarily look at the biological basis of excessive crying, the interviewees also drew on psychosocial understandings of persistent crying. Local health workers in the study acknowledged the involvement of emotional distress in persistent infant crying. This included anxiety, depression, anger, self-blame, disappointment, vulnerability, frustration and resentment. Additionally, it was assumed by participants that mothers' inadequate parenting skills and poor support in their environment tended to contribute to

excessive crying. Three of the participants also made a link to infant temperament as a cause for this emotionally daunting experience for the mother-infant dyad.

Kaley, Reid and Flynn (2011) in their study concur that psychosocial distress of the mother during pregnancy and postpartum have been hypothesized to increase infant crying. However, it is often not clear whether the emotional distress is a result of the crying or if it was an antecedent. What was prevalent in this study was that participants described how mothers expressed that having an infant classified as an excessive crier came with experiences of maternal depression, hopelessness, exhaustion, and frustration/anger towards themselves and their babies and states of anxiety and overprotection, or withdrawal. The importance of social support for mothers is well-documented in the Western psychological literature (Kerr et al., 2008; Demers, Bernier, Tarabulsy, & Provost, 2010; Winnicott, 1960). Notably, participants in this study brought up the cultural practice of *ubudlezane* (rooming in -maternal support) and overall, it was perceived to be a good holding environment for both mother and baby. Penxa-Matholeni (2019, p. 5), supports this notion and denotes *umdlezane* as the secluded nursing mother in the care of an elder woman, entrenched in African cultural practices as being "in the space, in the presence, in the comfort, in the vulnerability and pain of each other" and she is able to be fully present with her newborn (Dolbin-MacNab, 2006). Participants maintained that without social support and a holding environment for the mother-infant dyad, the issue of an excessively crying infant can be exacerbated and result in the perpetuation of maternal distress. It is significant to note that the practice of *ubudlezane* creates a structured holding space for the mother to focus on her infant and adapt to motherhood, which appears to be aligned with Winnicott's (1960) notions of maternal preoccupation and the holding environment.

Participants recognised in addition to poor parental support, maternal readiness and strained relationships between parents were potential factors that could cause or exacerbate the issue of persistent crying in infants. Suggesting that now and again, it may very well be a case that a mother feels overpowered by the demands of providing care for her baby and then psychological processing is disturbed and she is not able to provide emotional regulation of for her infant (Stern 1998). For instance, a mother who repeatedly experiences troubles in alleviating her baby's distress may develop a sense of herself being incompetent, so she is discouraged and would then react to her newborn child with evasion to escape from the helplessness. These interactional patterns can then influence the infant's psychological

development, as is well-documented in the Western psychological literature (Winnicott, 1988; Ainsworth, 1973, 1978; Bowlby, 1980).

Overall, the health care practitioners tended to move fairly easily between the various cultural understandings of the problem of persistent crying in infants. They recognised that these mothers suffered with their babies, and felt powerless and overwhelmed by strong feelings of being neglected and unsupported.

5.3. Convergences and divergences in understandings of persistent infant crying

While remarkable similarities occurred across the various approaches, there were also striking differences. In all the worldviews, participants' descriptions of the presentation of excessive crying were similar and characterized by recognisable symptoms (types/quality of infant cry), durations (quantity of crying) and complaints of the mothers. These descriptions matched those described in the medical diagnoses of colic (under three months of age) and persistent infant crying (over three months of age) (Wessel, 1954; Gwandure,2006; Poole, 1991; Leung, 2004; Stein, Wender, & Carey, 2001).

Divergences between viewpoints were most notable in the beliefs about the causes of excessive crying, and the treatments for it. Reasons for the crying across traditional African and Western medical and psychological understandings included feeding difficulties and implicated maternal mental states. These were seen as linked and also associated with social support. While culturally situated understandings, including ancestor beliefs and evil spirits or bad energies, appeared to be specific to local African worldviews, there were some resonances with psychological understandings of excessive crying in infants, in that the infant was understood to be vulnerable to the 'mental states' or 'energies' of others. Overall, research participants demonstrated an ability to link their understandings of persistent crying to traditional spiritual processes, psychological disturbance and as well as to physiological causes.

It was noteworthy that in all worldviews, the health professionals believed excessive infant crying to be an issue that required an understanding of its context before a suitable resolution or remedy could be found. This implies making space for the mothers' understandings and fears, so that appropriate healing method can be found. Depending on the mothers' situations this may include consulting a traditional healer for healing or protection against evil spirits, consulting elders in the family for opinions and support, performing rituals to appease ancestors, and/or consulting Western medical health practitioners.

This study revealed a shared view of infants as vulnerable in all three perspectives (medical, psychological and African cultural). From African cultural viewpoints, there was a sense of the infant being spiritually vulnerable and susceptible to evil. Medically, it was explained that the infant in its biological developmental process remains physically immature and dependent. Furthermore, it is understood psychologically that the infant in its emotionally immature state is in a state of complete dependence upon the caregiver in early life, is reliant on the mother for absolute care and protection, and is vulnerable to the mental states of caregivers.

5.3.1. Susceptibility to outside forces: Convergences and divergences

While from a Western medical perspective infants are seen to have immature immune systems and need to be protected from exposure to too many pathogens, this was depicted in the African traditional worldview as the need to protect infants from bad spirits/energies outside of the home. While Western perspectives recommend breastfeeding for the transfer of immunity from the mother to the infant, traditional care involves the use of protective amulets, washes and medicines to remove evil energies from both mother and child.

5.3.2. Feeding difficulties and maternal mental state: Convergences and divergences

Interestingly, all perspectives implicated feeding difficulties in excessive crying. The medical view is that babies have immature gastrointestinal systems, immature immune systems and may present with stomach cramps or gastrointestinal problems related to inefficient feeding, poor breastfeeding techniques, or allergens in the milk, which may cause dehydration that may appear clinically as sunken eyes and fontanelles (Miller-Loncar, Bigsby, High, Wallach, & Lester, 2004).

The above clinical presentation in a crying infant was aligned with the African cultural view that describes the problem of *ibala*, which is understood to move towards the fontanelle and cause death if left untreated, and the belief that bad energy in the breast milk caused by the mother's anger or tainted breast by bad spirits/energies from outside, that is transferred to the infant through the breastmilk and can cause harm such as diarrhoea and later a sunken fontanelle.

Within both the Western medical and traditional African worldviews, a sunken fontanelle is understood to be life-threatening. According to the study participants, out of extreme anxiety,

consulting a traditional healer and a medical doctor for the same illness was not an uncommon practice amongst the mothers.

Interestingly, from a psychological perspective, emotional distress in the mother has been linked to feeding difficulties, both as an antecedent and consequence (Bain & Richards, 2016; Fallon et al, 2016). From an African worldview, participants in Bain and Richards (2016) study referred to the transmission of negative maternal emotion through breastmilk as the problem when there are distressed mothers failing to provide good enough mothering.

The participants in this study reported that mothers with crying babies often suffer from severe anxiety and can develop negative attitudes toward their babies. This supports findings by other studies which have found that anxious and depressed mothers can be detached from their infants (Nicol-Harper, Harvey, & Stein, 2007). However, unsupported, depressed mothers may also then be more at risk for experiencing feeding problems with their infants. According to a study by Islam et al (2017) women who experienced physical intimate partner violence (IPV) and psychological IPV after childbirth and women who reported childhood sexual abuse and post parturm depression (PPD) were significantly more likely to experience difficulty with breastfeeding and were significantly less likely to exclusively breastfeed their infants than those who had not reported these experiences. Moreover, women with an unintended pregnancy and lower social support exhibited a lower likelihood of exclusive breastfeeding. The results of the Islam et al. (2017) study suggest that preventing physical IPV, PPD and childhood sexual abuse may improve the duration and experience of breastfeeding. It was significant that the health care practitioners in this study all acknowledged that the mental states of mothers (traumatised and/or depressed and lacking social support) can have a significant effect on infant care, including feeding, and thus on the mental state of the infant, and that in some instances this can be implicated in excessive infant crying.

From all perspectives there was an acknowledgement of the mutual emotional effects that the mother and baby have on each other, highlighting links between the mother's behaviour, the quality of the feeding and the health of her baby (Stewart, 2007; Whipple, Bernier & Mageau, 2011).

5.3.3. Maternal mental state and social support: Convergences and divergences

Participants noted that from both Western medical and African traditional worldviews, persistent crying is not regarded as a 'medical' disorder, and is therefore also not seen as a

condition for which help should be sought within the biomedical healthcare system. Rather, such conditions are conceptualised as either a result of gastrointestinal immaturity or as psychological and are expected to improve over time through infant development and through social and emotional support from medical staff and support of relatives, or as supernatural, requiring intervention from ancestors or traditional healers. From these perspectives, the emotional and spiritual state of the mother is considered important, as she can bring 'polluting mystical forces' in the traditional cultural understandings, or misattuned, negative mental states, according to psychological explanations, both of which are understood to affect the infant. Within African worldviews, evil energies are often attributed to bewitchment or the ill intentions of others (Truter, 2007; Mkhize, 2003). Overwhelmed, unsupported mothers may feel persecuted or neglected by partners, family members, the community at large, or even ancestors, and understand this to be the result of bewitchment or displeased ancestors.

Support for the mother after birth is considered important for both psychological and African traditional spiritual reasons; a newly delivered mother (umdlezane) is considered to be weak and highly polluted (with potential evil – as during childbirth the mother is considered to straddle the worlds of both life and death), and her 'pollution' is contagious to her baby (Ngubane, 1976). The mother is considered to need time to recover and adjust to her new mother role. This demonstrates some convergences with psychological theories, such as those of Stern's (1998) 'motherhood constellation', where it is reported that the new mother necessarily experiences heightened states of anxiety, obsessing about ensuring the physical and emotional safety of her infant, as her new mother 'psychic organization' develops (Stern, 1998). The participants in the study seemed to emphasise an understanding and appreciation of the important value and in the need for social support around the mother-infant dyad that extends as far as being held and contained within their ancestral realms. Clear adherence to cultural beliefs and practices in understanding and treating ill health was observed in this study (Bojuwoye & Sadi, 2010). The notion that mothers require support was equally expressed and advocated for in all worldviews. Clear convergence between psychological understandings of the need for the mother to be supported and held (Winnicott, 1963, 1965), so she can hold the baby and the African cultural practice of *ubudlezane* were evident.

5.4. Implications of the findings

That there are a variety of beliefs about the causes of persistent crying that need to be held in mind when working with mothers in the South African setting. The research highlights the

value of mother-infant mental health education awareness and depicts mothers as independent decision-makers in the treatment of their infants; however, it also shows the reality of their reliance on information structures in a more collectivist group structure, in which these mothers seldom make such decisions without assistance.

While for the most part, the health care practitioners in this study were able to remain open to different belief systems, in some cases straddling their own traditional cultural beliefs with their Western informed medical training, in some instances frustration was noted with mothers who seek traditional interventions and then only bring their infant to the clinic when traditional treatments fail to solve the problem or exacerbate the problem. This is likely to contribute to the stigma and secrecy around traditional health care, resulting in mothers continuing to hide information about traditional interventions from healthcare practitioners. While increased regulation of the traditional healing system is required (to ensure safe dosage and sanitary treatment of infants), it is thus important that health care practitioners respect cultural beliefs and ask about them and the treatments already sought in a sensitive and culturally sensible manner that does not feel judgemental and attacking of the mother's choices.

Although much empathy was evident for mothers with excessively crying infants, mother blaming is evident in all the various worldviews, as either incompetent, depressed, excessively anxious, a source of 'pollution', a carrier of evil energy to the baby, or as having failed to carry out the necessary rituals for ancestral appeasement. Further judgement or a dismissal of their concerns from healthcare professionals is unlikely to increase mothers' trust in or feelings of being supported by the health care system.

The results also suggest that health care practitioners should enquire about feeding, social support and the mental state of the mother, as mothers' emotional states often missed when not properly screened for at a primary health care level. Interventions that incorporate medical, psychological and traditional understandings are more likely to be able to 'diagnose' the source of infant excessive crying for each mother-infant dyad within their respective contexts and provide more holistic and relevant intervention.

Additionally, an increase in communication between various kinds of health care practitioners would assist mothers in feeling supported. Motherhood is regarded as an important function and a cultural obligation for most women of childbearing age across South Africa. Thus, in order to promote the use of biomedical health systems alongside indigenous

traditions, and promote maternal and infant physical and mental health, women's voices need to be heard and an awareness of cultural constructs of care is needed.

5.5. Limitations of the study and recommendations for further research

It is hoped that this study has contributed to the literature on persistent infant crying by providing relevant understandings of the issue from the perspectives of local health care practitioners. However, conducting a study in a culturally diverse context such as South Africa with a small sample will always reflect limited understandings. Thus, it is recommended that this study be replicated in future with a larger sample group in order to further explore variations within traditional cultural understandings of excessive crying in infants. Studies that directly source understandings from mothers themselves, as opposed to healthcare workers are also recommended and should be used to explore mothers' cultural perceptions and lived experiences in their management of persistent infant crying, so as to expand the data.

Additionally, in future, similar studies should incorporate some longitudinal and quantitative elements to provide statistical data about the impact of the issue of persistent infant crying, in relation to parent demographics and contextual factors and whether or how any of these intersect with cultural understandings.

While it was helpful that the researcher's positioning as a Black mother, a previous professional nurse, and a training clinical psychologist, likely allowed for a degree of identification with many of the participants, likely increasing understanding both linguistically and empathically, it is also possible that this identification influenced participant narratives and the interpretations made in this research.

5.6. Conclusion

The purpose of this study was to explore healthcare practitioners' (drawn from both Western medical and traditional healing positionings) understandings of persistent crying and the cultural constructions of persistent crying of the South African mothers with whom they work. Additionally, the study intended to capture, through the perspective of health care practitioners, the convergences and divergences in Western and African understandings and

the common overlaps in held beliefs, customs, and practices around childbirth and care that relate to excessive crying in babies.

The study used a qualitative design and a social constructionist approach (Whitley, 2002). This methodology reflects the dynamic nature of how societies comprehend and construct issues and allows for various understandings of phenomena, as interpreted by the individuals' social viewpoints. The findings were considered to reflect the co-constructed understandings of the participants and the researcher (Cohen, Manion & Morrison, 2011). Data collection was done through conducting in-depth semi-structured online interviews with eight local South African health care practitioners, who had experiences of working with mothers of excessively crying infants. Thereafter, thematic content analysis enabled this data to be categorised into themes.

The results revealed that local health care practitioners understand persistent infant crying from Western medical and psychological worldviews, but at the same time, many hold understandings from beliefs in traditional health care, like many of the mothers with whom they work. It was noted that many mothers of infants appeared to utilise both the services provided by Western medicine through the medical practitioner, the hospital and clinics as well as traditional healers for issues of excessive infant crying. Theoretically, overlaps between the Western and African traditional understandings were found, in the areas of infant vulnerability, maternal mental health and maternal support. Practitioners acknowledgement of the evident concurrence of Western medical and psychological worldviews with those of African traditional beliefs in infant care practices appear to be of great significance in providing sensitive and relevant interventions.

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Appendices

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG
SCHOOL OF HUMAN AND COMMUNITY DEVELOPMENT
PSYCHOLOGY

Participant Information Sheet

Good day,

My name is Cynthia Nompumelelo Mbongwa. I am currently doing my Master's degree in Clinical psychology at the University of the Witwatersrand. As part of my studies, I am required to conduct a research project. My research intends to focus on Local South African health workers Traditional understandings of babies who cry too much. I would like to invite you to participate in my study. Participation is voluntary and will involve an online Zoom, WhatsApp video call or telephonic interview of approximately 45 minutes to an hour, about your perceptions of how babies who cry a lot are understood. All information will be treated confidentially. Your anonymity will be ensured in that no identifying information about you will be revealed in the transcripts, the report or subsequent publications. Although quotes from your interview will be used, you will be referred to by a pseudonym, e.g. participant A or participant B. Even though the interviews will be audio-recorded, only I will have access to the recordings. These recordings will be transcribed (typed out) and will be anonymised (no names or identifying details will be included) and only my supervisor (Prof Katherine Bain) and I will have access to these. Both the audio recordings and transcripts will be kept on password-protected computers. The recordings will be deleted after examination of the report, and with your permission, the anonymised transcripts will be kept on and my supervisor's and my password-protected computers for possible future research use. You are free to answer only the questions you feel comfortable with and to withdraw any information you provide at any time before submission of the research report with no consequence. There are no benefits or risks associated with participation in this study. If you have any further queries or you would like to know the overall results of the study, please feel free to contact me. My contact details appear in the signature below.

Thank you for taking the time to read this. Your participation will be highly appreciated.

Kind Regards,

Cynthia N. Mbongwa
(Clinical Psychology Student)
mbongwac@gmail.com

Professor Katherine Bain.
(Research supervisor)
Katherine.Bain@wits.ac.za

If you have any concerns, the Wits Ethics Committee can be contacted at shaun.schoeman@wits.ac.za

Consent Form

I, _____ hereby consent to being interviewed by Cynthia Mbongwa, for her study exploring Local South African health workers Traditional understandings of excessive crying in infants. I understand that:

(please circle)

- I agree to participate in this research project. The research has been explained to me and I understand what my participation will involve. YES NO
- I agree that my participation will remain confidential. Only the researcher will know my name and she will keep this confidential YES NO
- I agree that the researcher may use anonymous quotes in her research report YES NO
- I agree that the interview may be audio recorded YES NO
- I agree that the information I provide may be kept by the researcher and her supervisor for future research use YES NO

_____ (participant signature)

_____ (name of participant)

_____ (date)

Interview schedule

Introduction

I am Cynthia we spoke on the phone. I would like to thank you for agreeing to participate in my study. With your permission, I am going to record the interview but I would like to assure you that everything you say during this interview will be kept confidential, and only my supervisor and I will have access to the information.

I would like to remind you that you have the right to withdraw from the study at any time during the interview. You also have the right to refrain from answering any question/s should you wish to do so. I would like to discuss with you your experience of working with mothers of babies who cry too much, from this I would like to get your thoughts and understandings of those encounters. If you do not understand any of the questions you may ask for them to be explained differently and if there are any questions you do not feel comfortable answering, that is also OK, and this is a safe space and you will not be judged. I am interested in your perspectives on this experience as a local health worker. You can take your time in answering the questions and please try to answer in as much detail as possible.

If you are ready we can begin the Interview.

Interview Schedule

1. Could you kindly describe your work and experience in working with mothers and their infants?
2. Could you describe in what circumstances do you think babies might be regarded as babies who cry too much?
3. How have you come to understand the reasons or causes for babies to cry too much or more than what feels normal?
4. Can you please give me some examples of cases you have worked with?
5. What do you think a mother's feelings would be towards her baby that is considered to cry too much?

6. What do you think might have been the baby's feelings at that time?
7. How do you think mothers may make sense of their babies who cry too much, what are some of their traditional beliefs around infant ailments with regards to a baby that does not stop crying?
8. What are some of the common traditional disease prevention practices performed on the infant?
9. How often do you think mothers seek any professional help with regards to the baby crying maybe from a doctor, nurse or Isangoma? If so what sorts of advice are they given as to what could be the cause and treatment?
10. Does your understanding of crying involve any traditional cultural understandings as a cause? E.g. imbeleko, inkaba and ibala?
11. Do you think mothers who adhere to traditional amulets feel supported and not judged for their choices?
12. What is your understanding of a newly delivered mother going into isolation as customary practice? Do you think this may relate in any way to a baby crying too much – would it help or harm the situation?
13. Society places a lot of responsibility on the mother when it comes to good parenting, do you feel that there is pressure to be a good mother?
14. Dealing with babies who cry too much for unknown reasons can be emotionally draining and physically exhausting leaving the mother feeling helpless, were there times when mothers expressed distress about their infant?
15. What are your opinions on letting the baby self soothe? Have you come across other opinions in mothers with whom you have worked?
16. Did mothers of crying babies ever express having any feelings of guilt about how and when they responded to their baby?
17. Do you think this experience may influence a mothers decision to have another baby, if yes, how so?
18. Is there anything else about the topic of excessive crying in infants that you think would be useful for me to know?