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Exploring the cultural validity and utility of the Ububele New-born Behavioural Observation programme



Research Thesis

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Research Thesis submitted in partial fulfilment of the requirements for the degree of Masters in Community-based Counselling Psychology in the Department of Psychology, University of the Witwatersrand

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: 26/03/2021



ABSTRACT

The task of caregiving and establishing a good caregiver-infant attachment becomes increasingly more challenging in contexts characterised by extreme poverty, unemployment, trauma and violence. During this time, early caregiver-infant interventions may be influential in providing support to caregivers which results in the ability to address problems early in the caregiver-infant relationship that affect normal infant development. Currently a community-based organisation situated in Alexandra Township in South Africa, seeks to enhance the caregiver-infant relationship and promote healthy developmental outcomes for the infant. One way in which this is achieved is through the use of a caregiver-infant programme namely, the Ububele New-born Behavioural Observation Programme (NBO). However, there are different discourses about caregiving and infant development across. This holds particular importance when considering the applicability of a western developed programme such as the NBO within a non-westernised context. To gain a better understanding of this programme, it was considered important to take a phenomenological approach and explore the perceptions and experiences of eight caregivers who have completed the NBO programme with their infants. The evaluation of the validity and utility of western developed interventions in South Africa that aims to support caregiver-infant dyads such as the NBO is of critical importance.

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CHAPTER 1: INTRODUCTION

1.1 Introduction to the study's research aims and methodology

There has been research that has explored the nature of child development. However, the beginning stages of childhood is a significant period for a child's overall development (Dugmore, 2011). It is within this stage that interventions that focus on caregivers and their relationship with their infants holds the opportunity for forging the underpinning of emotional and physical health for infants (Winnicott, 1963; Stern, 1985). This opportunity is created by focusing on challenges in the infant-caregiver relationships that may pose a threat to these relationships (Dugmore, 2011). Considering the above statement in mind, this research aimed to explore caregivers' perceptions and experiences of the NBO programme. Specifically, the perceived effectiveness and cultural applicability of the programme for participants was explored. This was achieved through analysing the transcriptions from interviews that were done with caregivers. The analysis of the transcriptions were conducted through thematic analysis. At this point in the introduction it becomes imperative to differentiate between validity and cultural validity.

Methodological validity is defined as the extent to which a measure or instrument accurately measures the concept under investigation in a quantitative study. (Heale & Twycross, 2015). If the researcher was assessing the methodological validity of the NBO programme then one would determine how accurately Ububele NBO accurately measures the bonding between primary caregiver and infant.. Cultural validity refers to whether the measure is sensitive to how the cultural context influences the construct under investigation.

In a society such as South Africa where African cultural values co-exist with modern Westernised values, collective differences may influence participants' experiences of a Westernised developed NBO programme.

They are conceptualised in the competencies, forms of knowledge and are written in the language in the context of those who develop them (del Rosario Basterra et al., 2011). The way in which caregivers respond to bonding with their infants and therefore the NBO is mediated by cultural factors that may not be integrated into a Western developed NBO programme (Solano-Flores & Nelson-Barber, 2001).

Background and Rationale of the study

The first 1000 days of life is a time of transition and uncertainty for parents and greatly informs children's development over time (Tedder, 2008). This is a time where parents have to transition to the maternal or paternal role which offers an opportunity to positively influence the future development of children (Sanders & Buckner, 2006). The task of transitioning into this role requires that parents negotiate the task of becoming attuned and engaged with their infants. Although there is research that has explored this topic, there are limited studies of caregivers trying to bond with their infants in low socioeconomic contexts. (Barlow et al., 2018). The ability of caregivers to engage successfully in this role is important for their wellbeing and that of their infants. The failure to do so has been found to contribute towards poor bonding experiences between the infant and their caregivers, which is associated with delays in development (Amos et al., 2011). In considering the importance of this parental transition is the need to consider the situatedness of caregivers as;

> The changing ecology of childhood and family relationships (divorce; single-parent households, redefined gender roles, a more individualistic outlook on life); socio-

> demographic change (parental unemployment and joblessness; poverty); health issues (such as HIV and AIDS, hypertension, and cardiovascular diseases); substance abuse; the incarceration of young mothers and fathers; trauma and violence are significantly associated with wellbeing and mental health of young people (Jithoo, 2018, p.455).

The quote highlights the importance of examining contextual factors that may influence parenting and evaluating programmes that improve mental health in communities (Bain & Richards, 2016). In multicultural contexts such as South Africa, caregivers who face challenges due to the burden associated with poverty, often struggle to find the emotional capacity to acknowledge the necessities of their children. This occurs even though caregivers might have knowledge about adequate ways to provide care for their children (Richter, 2003). The use of the term caregiver is important here, as many infants in South Africa are raised by their grandmothers or other individuals who have no biological connection to infants (Frost, 2012). Therefore, for this paper the term caregiver refers to mother figures. Currently the Ububele Education and Psychotherapy Trust, a psychoanalytically informed, non-profit organisation in South Africa runs a community-based caregiver-infant intervention in the Alexandra Township (Bain & Richards, 2016). This intervention aims to support and provide education to caregivers to enhance caregiver reflective functioning and establish secure caregiver-infant attachment relationships (Bain & Richards, 2016). The organisation provides early parenting support that is based on the evaluation of sensitive maternal caregiving and makes use of the New-born Behavioural Observation (NBO) system as an intervention (Dawson et al., 2018). The NBO system was conceptualised in a westernised context and was administered in a non-westernised context to be used as an early caregiver-infant intervention at Ububele (Nugent et al., 2017).

An important aspect of the evaluation of maternal sensitivity is maternal responsiveness towards infants' behavioural cues (Dawson et al., 2018). Research has shown that in some western contexts caregivers' responses to infants' behavioural cues are more verbal which is

an unusual way of responding to an infant in non-westernised contexts (Dawson et al., 2018; Mesman et al., 2015; Mesman et al., 2016). Therefore, caregivers' perceptions of parenting and how they respond to their infants is influenced by the context in which they are situated. This suggests that what might be perceived as 'normal' caregiving is shaped by contextual factors and may not be perceived as 'normal' caregiving in a different context (Keller, 2018). This highlights the importance of evaluating the use of a western developed programme such as the NBO programme that has been transplanted into a non-westernised context.

The transition to parenthood comprises of building relations become confident in providing care for infants (Bowlby, 1969). However, given that there are many languages, the dialogue that focuses on the significance of embedded meanings of infant development differs across cultural and linguistic groups (Bain & Richards, 2016). Peoples' knowledge of parenting is impacted by their socio-economic backgrounds so caregivers from underprivileged backgrounds have few resources. This limits their support and understanding the influence that parental knowledge has children's development (Knerr et al., 2013). In contexts where there are insufficient material and emotional resources such as in South Africa, several risks have been found to be associated with infant development (Foster & Brooks – Gunn, 2015). These include poverty, malnutrition, violence and trauma in communities, poor health, low levels of education and compromised caregiver-child relationships (Meinck et al., 2015). These physical, psychological, social and economic circumstances affect parenting efficacy and development trajectories for the first 1000 days for the infant in question. Children from these disadvantaged backgrounds are less likely to have successful outcomes in life (Grantham et al., 2007). This bears significance for analysing maternal knowledge about parenting and fostering good infant developmental outcomes for fostering infant mental well-being in a multicultural context (Bain & Richards, 2016).

Previous studies Aspoas and Amod (2014), Dawson et al (2018), Dugmore (2012) and Frost (2012) have explored interventions that aim to promote healthy infant attachment as well as challenges that caregivers face in caring for infants. Bowlby suggested that all infants have motivational systems that leads the infant to form an attachment with their primary caregivers (Bowlby, 1969). For the infant, patterns of attachment become an internal reference guide that the infant relies on as support for maintaining well-being when the attachment figure is not available (Bowlby, 1973). Caregivers' early experiences of being cared for are often brought into their parenting experience with their infants (Bowlby, 1973). Research has indicated that when theses early experiences were painful, this often results in the caregiver reacting defensively towards their infant (Bowlby, 1980). This affects the caregivers' ability to be emotionally available for the infant and an infant might experience this reaction as dangerous (Bowlby, 1973). Brazelton recognised that infants can communicate and express themselves even in the first three months of life, and this is done with the intention of receiving a response from the caregiver (Cheetham & Hanssen, 2014). Brazelton was worried about caregivers who were struggling to provide care for their infant and the cultural ramifications of the role of the caregiver (Nungent et al., 2014).

Researchers have advocated for the necessity of evaluating the effectiveness of interventions in developing countries where there are different perceptions of how culture influences parenting and attachment development (Minde et al., 2006). The evaluation of interventions in South Africa such as the NBO programme becomes relevant in a context where there is risk to the caregiver – infant relationship (Barlow et al., 2018). However, currently there is no research that has explored caregivers' perceptions and experiences of the NBO programme in South Africa. Although, research has demonstrated the universality of attachment theory, what is considered an indication of insecure attachment in a western context might not be the same in a non-western context (Keller, 2013). It is thus very important to hear from participants

themselves as to whether the programme is useful and valid. It is anticipated that the results that emerge from this research could be used together with other studies to further develop the service being described. Perhaps these results could add to the caregiver-infant attachment collection of literature in particular; multi-cultural experiences of caregiving and perceptions of infant behaviour. Furthermore, this research is not interested in classifying attachment relationships between participants and their infants. Rather, the objective of the study was to report on participants' experiences of the validity and utility of the NBO programme.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

The broad area of attachment theory has increasingly become an important area of study for the role it plays in child development and more evidence has shed light on the influence of the caregiver-infant attachment on all areas of the child's development (Sroufe, 2005). Initially attachment theory only spoke to the connection between a mother and her infant (Bowlby, 1979). Nonetheless, through the acknowledgement and awareness that children can develop an attachment towards multiple caregivers, the concept was expanded towards; father, other family members and day carers (Santelices & Perez, 2013).Ultimately the relationship that a child develops with a caregiver has the potential to alter or perpetuate previous attachment patterns. This holds true for caregivers too who had formed a particular attachment relationship with their early caregivers in the past, and has the potential to influence how these caregivers develop an attachment relationship with their infant in the present (Quiroga & Hamilton-Giachritsis, 2016). Infant mental health has been conceptualised in the following way:

> ... the ability to develop physically, cognitively, and socially in a manner which allows [infants] to master the primary emotional tasks of early childhood without serious disruption caused by harmful life events. Because infants grow in a context of nurturing environments, infant mental health involves the psychological balance of the infant-family system (Dugmore, 2012, p. 3)

Nelson (2003, as cited in Barlow et al., 2018) suggested that engagement is a process of maternal role transition. Engagement focuses on the caregivers' experience of the infant and the caregivers ability to care for the infant (Sanders & Buckner, 2006). Bonding has been

described as the process of caregivers learning about their infants, accepting their infants and loving their infants. It is suggested that this bond is unique to all caregiver-infant dyads and is promoted through fostering an attachment (Bowlby, 1969). This bond that is created between infants and their caregivers was described by Bowlby (1958) as attachment. Central to bonding with infants is the idea that coming to know infants can only be established through the relationship. Thus, meaning that both infants and the caregivers have to respond to each other to form a bond (Waters & Sroufe, 2017). Therefore, one can suggest that engagement may be associated with the role of the caregiver as well as attachment (Sanders & Buckner, 2006). Longitudinal research has explored the relationship between children's' developmental outcomes and the caregiver-infant bond during the infants' first start to life (Cheetham & Hanssen, 2014). Research has also provided evidence for the neurobiology of attachment to support the attachment relationship between infants and caregivers (Gerhardt, 2006). Thus, it is beneficial to explore the early beginnings of attachment and why the attachment relationship is so significant for the children's' development.

2.2 The beginnings of Attachment

Within the field of psychoanalytic theory it is known that John Bowlby created the concept attachment as he was dissatisfied with psychoanalytic theoretical prepositions (Bowlby, 1958). Bowlby was dissatisfied with psychoanalytic theory's lack of focus on relationships or bonds between infants and their caregivers (Bowlby, 1958). John Bowlby alluded to the theory of attachment as a paradigm that could assist clinicians in developing a greater understanding of the bond between an infant and caregivers. Paradigm can also mean a group theorists and researchers who are seen as a collective based on their collective understanding of principles and methods (Kuhn, 1962/2012; Masterman, 1970). Thus, attachment theory as a paradigm gives reference to Bowlby and Ainsworth's thoughts about attachment. A group of clinicians agreed that Freuds' propositions on development lacked the inclusion of relationships. Through

Bowlby's clinical observations he discovered five types of proximity seeking behaviours that could assist the infant in maintaining closeness to their caregiver. Bowlby (1958) suggested that with time and with adequate experience the infants' behaviours would become connected to form a system that are sensitive to internal and external cues. Mary Ainsworth's observed infants and their mothers in their environments, first in Uganda and then in Baltimore (Ainsworth, 1967). Ainsworth's, theoretical understandings of a secure base as well as maternal care, cemented the premise for attachment theory (Ainsworth et al., 2015). Together, these theorists' integrated observations and theoretical understandings gave rise to the construct, which is known as attachment.

In Uganda, Mary Ainsworth was intensely focused on gaining in depth knowledge of maternal and infant behaviour and these behaviours are influenced by time and the environment (Bretherton, 2003). Ainsworth thought that Bowlby's construct of attachment theory was quite remarkable, however she realised that the way in which children responded towards their caregiver differed to what she had known (Ainsworth, 1967). To assess why these differences had been evident, Ainsworth tried to recreate the Uganda study in Baltimore. This proved to be more challenging as Ainsworth needed to recreate a context where mild stress was evident as this was needed to activate children's network of attachment behaviours (Bowlby, 1969). However, the environmental context of Baltimore differed from the highly unsafe environmental context of Uganda. Ainsworth (1967) realised that in order to replicate this study in the Baltimore population she had to find an environment where infants were exposed to stress, an unknown environment for infants, separations between the infants and caregivers and lastly introducing an unfamiliar person to the infants. This became what is known as the Strange Situation Procedure which led to the conceptualization of attachment patterns. These patterns were developed as a result of the infant's responses towards the caregiver leaving the

infant and returning to the infant (Ainsworth et al., 1978). Ainsworth's work on attachment through the Baltimore observations set the foundation and support for viewing attachment as a reliable base for the development of the relationship between the infant and caregiver. Ainsworth's observations also showed evidence for the reciprocal links between proximity seeking, exploration, and sensitivity to emotion, behavioural and physical context. This evidence opened a new path for future research as these reciprocal ties had not been mentioned or explained by psychoanalysis, nor learning theory.

2.3 Patterns of Attachment

Researchers have found a link between attachment theory and its significant impact on human relationships and emotional regulation. Through infants early interactions with their caregivers, infants are able to form an image in their minds of who they are in relation to others (Bowlby, 1988). This early relationship between infants and caregivers is important and sets up the foundation for infants to develop an internal reference guide which helps infants learn about the world and their interactions with others (Danquah & Berry, 2013). Through infants responses to their caregivers leaving, whether or not a stranger is present, patterns of attachment have emerged. This is due to the fact that infants have learnt that their caregivers will return even though they have left them. Infant responses are formed through different working models and methods of regulating distress which arose and was observed through the Strange Situation. These responses were formally classified according to secure, insecure, avoidant, or insecure attachment patterns (Berry & Bucci, 2016).

Bowlby suggested that all infants have motivational systems that leads infants to form an attachment with their primary caregivers (Bowlby, 1969). Barlow et al. (2018) have argued that the nature of the relationship between infants and caregivers may make the infant feel safe or threatened. Infants develop a healthy attachment which is known as secure attachment, only

if infants perceive their caregivers as being available and responding to the needs especially when infant are distressed (Bretherton & Munholland, 2008; Fearon & Belsky, 2018; Meins et al., 2018). If infants feel that their needs are not being provided in the caregiver-infant attachment relationship then an insecure attachment pattern is likely to be formed (Bretherton & Munholland, 2008). Consequently, this leads infants to form negative views about self and a lack of trust in others to support the infants' needs (Granqvist, et al., 2017). Behaviourally, this would be evident in infants who do not seek out their caregivers in times of stress or seeks their caregivers but do not respond to their caregivers soothing attempts. Infants who form a secure attachment tend to have confidence, are able to regulate themselves and tend to have good relationships throughout childhood and adulthood (Waters & Sroufe, 2017). Infants who have an insecure or disorganized attachment tend to have adverse outcomes later in childhood; such as poor scholastic performance, behavioural as well as social challenges (Barlow et al., 2018; Zeanah et al., 2011).

Four stages of the development of the attachment process between a children and their caregivers were constructed and these patterns of attachment are associated with Bowlby's patterns of attachment. The ante-attachment stage, the stage of attachment being formed and the stage of well-defined attachment are evident in the children's first three years (Ainsworth, 1973).The last stage is known as the achievement of fixed alliance which occurs at the start of children's second year of life. The first sage is the pre-attachment stage. This stage has been described as the stage of "orientation and signals without discrimination of figure." This stage starts when the infants are born and continues for a couple of weeks (Bowlby, 1969). During this stage infant are aware and responsive towards their environment and seem to be more responsive to stimuli from people. Initially the infants cannot tell the difference between people and so responds to its caregivers in the same way that it responds to others (Ainsworth, 1967). Infants tend to focus on people who are close to them and gaze in their direction and track the

person's body movements. Infants are able to display certain behaviours such as crying, smiling and babbling which are used to alert caregivers to these cues and therefore realise that infants are trying to get their attention (Ainsworth et al., 2015). These behaviours are also elicited by infants to ensure that infants are able to connect with their caregivers, which allows infants to be close to their caregivers. For example, infants may be placed in a cot in a room away from their caregivers. Infants will begin to cry which alerts their caregivers to respond to infants by picking up infants and holding them close to their body. The fact that these behavioural cues are meant to initiate closeness to the caregivers is what gives them the name as attachment behaviours. Infants trust that these behaviours would ensure that they are able to be within consistent proximity to their caregivers.

The stage of Attachment being formed is known as the second stage and has been described as "aligning and directing one's attention towards one or more individuals in the infants' life who are seen as a caregiver" (Ainsworth et al., 2015). In this stage infants are able to tell the difference between those individuals in the infants' world who infants know and those in the infants' world who are seen as strangers (Ainsworth, 1967). One would be able to see that infants know this difference through the way that infants are more or less comfortable being close to a certain person. This discernment allows infants to form different types of attachments to different people in the infants' life (Ainsworth et al, 1978). Moreover, these people may also initiate different ways of being close to caregivers and so their ability to provide comfort for infants when the infants are distressed may also differ from person to person (Belsky, 1999). For example, infants may signal hunger through crying and when responded to by a male figure infants may not be soothed. However, when infants are responded to by their caregivers the infant associates their caregivers with food as infants are focused on the breast or bottle. This

depends on which caregivers are perceived by infants as being consistent and reliable in providing a particular form of care.

The third stage is called the stage of Well-defined Attachment and this stage has been explained as the task of ensuring closeness to a caregiver or another person by initiating maintenance of proximity to another individual through the use of movement (Ainsworth, 1967). During this stage the infant is more focused on achieving closeness to the caregiver and the infant also shows which caregiver the infant prefers to be close to (Baradon, 2016). The infants' mobility or use of their mobility could be significant for other behavioural networks. However, when the infant experiences the caregiver moving towards the infant or leaving them then the infant uses body movements to inform the caregiver of the presence of the infant, and therefore hoping to receive or make some connection with the caregiver (Bretherton, 1985). One could observe movements such as the infant clenching parts of their body, grasping the caregiver, the infant merging their face with the chest of the caregiver or attempting to touch the caregivers' face or other body parts. For the infant, this is to elicit a response from the caregiver (Bowlby, 2005).

The last stage is the Achievement of a fixed alliance. According to Bowlby (1969) the most significant aspect of the last stage of the development of the caregiver-child attachment is the reduction in the child's capacity to perceive themselves as being the most important person in the word. The child begins to realise that their caregiver also has a perspective of the world around them and so the infant starts to observe the world from the primary caregiver's view (Cassidy & Shaver, 2002). What starts to take place in the child's mind is the process of thinking about the caregivers feelings towards the child and how this may influence the caregiver's behaviour or responses towards the child.

It should be noted that the child's understanding of their caregiver is not initially this view of the caregiver being idealised but rather this perspective begins to shift over time (Ainsworth et al., 2015). There is a point where the child has developed their ideal model of their caregiver to include deductions, the child is able to make the caregiver alter or put aside their plans so that the child's plans are seen as most important. This may also involve reaching a compromise with the caregiver. Bowlby (1969) suggested that when the child reaches this point of development, the mother-child dyad develops into a complex relationship, which can be called an alliance". Bowlby (1969) proposed that the achievement of fixed alliance highlights the grading scale of the child's attachment behaviour and of the caregiver's reciprocity which may be embedded in their way of organising things.

Disorganised attachment has been conceptualised as a new form of attachment patter that has emerged in relation to the insecure-disorganised category (Cassidy & Shaver, 2002; Granqvist et al., 2017). As a new form of attachment pattern is characterised or seen in infants who do not respond behaviourally or emotionally to the caregiver after being separated (Fonagy, 2018). In fact, an infant who displays a disorganised attachment pattern displays frightened behavioural cues when being approached but the caregiver or upon the return of the caregiver. Disorganized attachment is thought to develop in infants who experience chaotic breakdowns as result of being scared for or of the caregiver whom they so greatly depend upon (Ensink et al., 2016). Many avenues lead to the development of such perplexing behaviour, such as when a child who is distressed attempts to move towards their caregiver for comfort but also recalls a time in which their caregiver's behaviour had frightened them. For the child this may have led to a desire to refrain from being close to the caregiver. Main and Hesse (1990) conceptualised this behaviour as 'fright without solution'. Children in this situation were seen as struggling to focus on the caregiver or not on the caregiver and for the child this led to conflict and confusion in the child's internal world (Reijman et al., 2018). Disorganised

attachment was eluded to, based on this theory in a study of maltreated infants including physical, sexual or emotional abuse, insensitive caregiving behaviours as a result of unresolved trauma experienced by the caregiver (Berry & Bucci, 2016). Main and Hesse (1990) hypothesized that over time children would form ways to cope with the difficulties through aggressively controlling their caregiver. It has been suggested that contextual circumstances e.g. poverty, HIV/AIDS, poor mental health, abuse and violence influence the attachment formed within the caregiver-infant dyad. This is significant when analysing the propositions of attachment theory amongst cross- cultural research (Leerkus et al., 2017).

2.4 Attachment within western vs non-western contexts

Although most research has been conducted on attachment within western contexts, limited attachment research has been conducted within non-western contexts (Keller, 2018). With this in mind is the questioning of whether attachment theory can be applied within non-western contexts and are there any implications to the endeavour this application (Mesman et al., 2016). The area of cultural differences in defining healthy attachment between caregivers and their children has been largely ignored in the psychiatric and psychological literature. Ohye (2001) suggested that the image of the independent child is the "gold standard, the litmus test" (p. 149) of whether children are well adjusted and whether caregivers are good enough in many westernised cultures (Tummala-Narra, 2004). The differences between western contexts and non-western contexts spans across social and physical conditions, culture, socioeconomic circumstances and family structure.

Interestingly, one proposition of attachment theory is that of the Normativity hypothesis. Researchers have hypothesised that children from diverse contexts should form a secure attachment to their primary caregiver (Mesman et al., 2016). However, this hypothesis was proposed only for children who are situated in contexts where there are no risks to the

caregiver-infant attachment relationship (Mesman et al., 2016; Van IJzendoorn & Sagi-Schwartz, 2008). In communities and contexts that are characterised with poverty, infants may be primed to form an avoidant attachment pattern in order to survive in harsh socioeconomic conditions and this could be seen as the norm (Keller, 2013). It can be argued that what has emerged from attachment theory is a sense of bias in the belief of the Normativity of attachment, as not all infants form secure attachments (Mesman et al., 2016).

Although it is not current research, Rothnbaum et al (2000) argued that attachment theory could not be transplanted into caregiver-infant relationships in non-western contexts. Caregivers from the US, a western context, would display being responsive to their children by acknowledging the individuality of their children and their wishes and encouraging children to express emotions overtly (Mesman et al., 2016). It is argued that in Japan, a non-western context, the way of caregiving is likely to be viewed in the US as insensitive and could contribute to a child forming an insecure attachment (Keller, 2013). Otto (2014) argued that the US display of responsive caregiving would be inappropriate for children from the Nso villages in Cameroon, a non-western context. These children experience responsive caregiving that is similar to the Japanese way of displaying responsive caregiving as these children rarely experience separations from their caregivers. Behrens (2016) proposed that in viewing these different displays of caregiver sensitive responsiveness, an argument could be made that perhaps perceptions of sensitive caregiving which differs across contexts, promotes secure attachment.

Sanders and Buckner (2006) have proposed that one of the challenges that women face when becoming a mother to a new infant, is the nature of the infant. in the transition to motherhood can be infant temperament. Infants can be seen as being difficult to care for because they portray behavioural characteristics such as being ill – tempered. It has been suggested that this

perception is due to limited maternal responsiveness towards infants' behaviours and may contribute towards a difficult attachment relationship with the children (Waters & Sroufe, 2017). The concept of caregiver sensitive responsiveness was conceptualized by Ainsworth et al (1978). It was believed to be evident in caregivers who respond to the needs of their children which allows children to develop trust in their caregivers to meet their needs. Responding to children in such a manner was believed to encourage the formation of secure attachment within the caregiver-infant dyad.

Several South African early child development studies have focused on parenting, but few have focused on the influence of parental knowledge on infant attachment development (Knerr et al., 2013; Meinck et al., 2015; Murray et al., 2015). Parental knowledge of infant development and parenting has been linked to parental responsiveness (Bain & Richards, 2016). This has been suggested as;

> caregivers who know what is best in terms of providing care, the kinds of environments that promote healthy development and the impact of interactions within the first three years on child development (Bain & Richards, 2016).

Caregivers who are aware of these aspects attempt to accurately interpret and provide a response to an infant's behaviour more appropriately. Appropriate maternal responsiveness and maternal sensitivity is associated with better cognitive and psychosocial development for the infant (Perry et al., 2015; Schore, 2015; Tronick & Beeghly, 2011). Bain and Richards (2016) have suggested that inadequate maternal knowledge of infant development and parenting has been linked with limited maternal sensitivity (how quickly and appropriately a mother reacts to an infants' behavioural signals). This seems to be common for caregivers who perceive themselves as having less parenting efficacy. A potential solution to inadequate maternal knowledge is to assist caregivers in gaining insight into their infants' unique behaviours and

calm themselves and their infants (Nugent, 2015). In addition, Dugmore (2014) has argued that parental representations or their earlier attachments to their own parents, influences how sensitive a caregivers' responses are to their infants. This impacts on the attachment formation between caregivers and infants. This aspect on its own becomes a fundamental aspect for assessment, when considering how to work through challenges in the relationship between infants and their caregivers (Barrows, 2003; Fonagy et al., 1993).

Disturbances in caregiver-infant relationships or infants who form a disorganized attachment to their caregivers, may be in danger of developing conduct problems as well as experiencing problems in their relationships with their peers (Blandon et al., 2010; Lyons-Ruth, 2008). Therefore, it then becomes crucial to identify caregiver characteristics that could pose a risk to caregiver and infant attachment relationships, thus influencing the risk for infant psychopathology. Moreover, this is most beneficial for early screening of these risks to the caregiver-infant attachment and for the implementation of interventions that focus on promoting infant attachment (Leerkes et al., 2017).

2.5 Attachment across culture and socioeconomic circumstances

One proposition of attachment theory is that all infants form a connection with their caregivers within a year of their start to life, as a means of survival (Keller, 2018). Thus, attachment is formed despite the cultural background from which infants have grown up in and has been described as the universality hypothesis (Jin et al., 2016). Researchers have suggested that despite the differences between cultures, the results of cross-cultural research provide support for the universality hypothesis.

There are insufficient studies that have explored cross-culture attachment relationships between infants and their caregivers in low socioeconomic contexts (IJzendoorn & Sagi-Schwart). Mostly because these studies have been conducted in affluent contexts. However,

there are studies that suggest that in adverse contexts children are likely to display poor attachment behaviours (Jzendoorn & Sagi-Schwartz, 2008; Zreik et al., 2017). In addition, there are few studies that have explored cross-culture attachment relationships between infants and their caregivers (IJzendoorn & Sagi-Schwart).Their results offer an opportunity to further explore how attachment patterns are formed within multicultural and low socioeconomic contexts. Culture is a difficult to define, however three different perspectives have been described below.

> Culture is the collective programming of the mind which distinguishes the members of one group or category of people from another (Hofstede 1994).
>
> '... the set of attitudes, values, beliefs, and behaviours shared by a group of people, but different for each individual, communicated from one generation to the next.' (Matsumoto, 1996.p.16)
>
> Culture consists of patterns, explicit and implicit, of and for behaviour acquired and transmitted by symbols, constituting the distinctive achievements of human groups, including their embodiment in artifacts; the essential core of culture consists of traditional (i.e. historically derived and selected) ideas and especially their attached values; culture systems may, on the one hand, be considered as products of action, on the other, as conditional elements of future action' (Kroeber & Kluckhohn, 1952.p.144; cited by Adler, 1997.p.14).

As humans we experience emotions such as sadness, joy, anger and fear feel. We also feel the need to connect with others and explore the nature around us. fear, anger. However, what one does with these feelings, how one expresses fear, joy, observations are modified by culture.

In the Xhosa culture, there is a certain belief of how parents should make meaning of their infants cries (Tomlinson, 2003). If the infant's physical needs have been met, then the infants' cries are perceived as a verbal message to let the parents know that the infant is alive. The infants' cries are also seen as a way of preventing harmful spirits from targeting the infant (Tomlinson, 2003). Tomlinson (2003) describes an interview with a Xhosa mother, where this cultural belief influenced how she responded to her infant, in the interview with the mother:

> She said that she had always believed that infants cry for various reasons. The reason why she had left her infant to cry was that she was living in the house of her mother-in-law. Her status within the house required her to respect the childcare views of her mother-in-law even if they contradicted her own (Tomlinson, p.46).

Perhaps it could be argued that indeed an infants' attachment to a caregiver is influenced by sensitivity and responsiveness, however the way in which it is displayed differs across cultures (Keller, 2013). Researchers found that in Japanese caregivers being responsive towards their child is displayed through caregivers' encouraging emotional dependency and responding to their needs before the child has expressed them (Rothernbaum et al., 2000). It is argued that Japanese caregiving is likely to be viewed in western cultures as insensitive and could contribute to a child forming an insecure attachment (Keller, 2013). In comparing the different responsive caregiving approaches, it could be perceived that the there is a lower chance of Japanese children disconnecting from their caregivers than children from western cultures. In Tomlinson, Cooper, and Murrays' (2005) study within the community of Khaylitsha, the Xhosa cultural way of life influenced the high rate of secure attachments of infants. Amongst members of this community there is a spirit of "Ubuntu", a sense of compassion for community members that exists in the consciousness of individuals and an infant's welfare is viewed as a collective responsibility of the community (Tomlinson et al., 2005). Aspoas and Amod (2014) presented

that people who are part of this group tend to support one another, which may encourage the formation of a healthy attachment style in adverse circumstances.

2.6 Assessing attachment in infancy

The most common form of measuring attachment in infancy is through the use of observational measures. Two measures namely the Attachment Q – sort and the Strange Situation are utilised to describe the child's pattern of attachment and are both well validated measures. Bretherton and Munholland (2008) argued that as a result of these measures relying on infant behavioural observation, Bowlby's (1979; 1973; 1988) propositions about internal working models did not feature in research. However, Main et al (1985) argued that overtime the delineation of attachment begins to shift. It was at this point that Bowlby's propositions about the child's inner guidance system were enlivened, thus leading to a growing interest in measures that assessed attachment at the representational level (Bowlby, 1979). However, the early measures of attachment in infancy have become the most well used measures to compare against other measures. Researchers have found that different types of classifications from the Strange Situation to be linked to developmental outcomes such as physical and mental well-being, adequate social skills and moral thinking. The attachment classification has been used in many countries , with figures of secure attachment being most evident, with the exception of environments characterised by adverse circumstances for individuals (Mesman et al., 2016). Main and Solomon's (1990) research findings showed that infants who displayed uncertainty in their behaviour were more likely to have a breakdown in their response towards their caregiver. For example the child might seek out the caregiver but is unable to make eye contact with the caregiver. This lead to the conceptualization of a fourth attachment pattern namely; disorganized attachment (Reijman et al., 2018).

For decades, researchers have engaged in the heated debate of whether attachment theory, being based on Western perspectives is applicable across diverse cultural contexts (Rothbaum et al., 2000). It has been contested that attachment theory is not relevant within a non – western context. Although the argument by Rothbaum et al (2000) remains central in this heated debate, there is a growing body of findings displaying that attachment theory holds validity when conducting research in multicultural contexts. The attachment studies done in African countries have provided evidence for the support for theory (Cassidy & Shaver, 2008). Research that has been done in South Africa produced findings that the use of the Strange Situation procedure and the Attachment Q-Sort on the South African population are valid (Minde et al., 2006; Tomlinson et al., 2005) However, according to Van Ijzendoorn et al (2006) further research needs to be conducted, as there are not enough studies that have been done on the African continent. Researchers have proposed that the formation of any attachment relationship is most notably influenced by how sensitive a caregiver is towards the infant's behavioural cues (Ainsworth et al., 1978; Bowlby, 1969/1982, 1988; Zreik et al., 2017). In practice, assessing attachment is typically done through the observation of the caregivers interaction with the infant. Most caregiver-infant interventions aim to promote parental sensitivity and responsiveness so that caregivers can make meaning of their infant's responses which aims to establish attachment security between the infant and caregiver (Wright et al., 2017).

2.7 A caregiver-infant intervention

Brazelton recognised that infants can communicate and express themselves even in the first three months of life (Cheetham & Hanssen, 2014). The New born Behavioural Observation (NBO) system having its roots in the Neonatal Behavioural Assessment Scale, was developed by Nungent et al (2007) as an adaptive intervention that could be used to assist caregivers in building a relationship with their infant (Cheetham & Hanssen, 2014). The NBO system provides a way of using the infants' behaviour to improve their relationship with their caregiver

(Nungent et al., 2014). The NBO system focuses on the infants 18 behavioural observations, which gives insight into the infant's responses based on four facets; the autonomic nervous system, kinaesthetic states, concentration and interaction (Cheetham & Hanssen, 2014).

The NBO system is relatively quick to administer but this may differ according to what state the caregiver or infant are in. The system is administered on infants from the moment they are born and until three months and can be done in a clinic, as home intervention or in settings that focus on infant care (Nungent, 2015). The trained professional that administers the NBO will focus on observing the infants' responses when sleeping, when being awake, when the infant is crying and how the infant is able to regulate themselves (Nungent et al., 2014). In doing so, the professional will gather information on the infant's capacity to adapt, the infants reflexes, the way the infant communicates, when the infant cannot tolerate any more stimulation, automatic stress signals, the infant's ability to self-soothe and how the infant responds to visual and auditory stimuli (Nungent, 2015).

2.8 The NBO Programme in South Africa

Ububele Education and Psychotherpy Trust, a psychoanalytic, non-profit organisation in South Africa runs a caregiver-intervention in the Alexandra Township. It aims to support and offer education to caregivers to increase caregivers reflective functioning and foster a healthy attachment between infants and their caregivers (Bain & Richards, 2016). Ububele focuses on supporting the caregiver-infant relationship by using the NBO system as an intervention (Dawson et al., 2018; Nugent et al., 2017). The NBO that is administered at Ububele was developed in a Westernised context and was transplanted into the South African context at Ububele, thus there is limited research on the system in a multicultural context.

The first training of practitioners in the NBO system in South Africa was facilitated by NBO practitioners from the United States. However, currently the training at Ububle is offered by

the Ububele NBO programme manager which is facilitated through a psychoanalytic understanding of infant and maternal mental health.

A psychoanalytic orientation towards working with people is rooted in working through unconscious thoughts within the patients inner world and the relationship between the patient and the therapist (Dugmore, 2011). When focusing on the area of caregiver-infant and child psychotherapy, one cannot separate infant mental health from the mental health of the caregiver (Cheetham & Hanssen, 2014). One's early or past experiences are significant and therapeutic interventions involving children, infants and their caregivers are rooted in the ideas outlined in Fraiberg et al (1975) *Ghosts in the Nursery*. These researchers suggested that when individuals transition to parenthood, their experiences and unresolved challenges from childhood emerge through their relationship with their child. This carries the potential of harming the caregiver-infant relationship (Dugmore, 2011). The inter-relatedness and depictive world of the caregiver and the infant are grounded in a psychodynamic understanding of the dyad (Winnicott 1960; Bowlby 1982). According to Stern (1995) there are two depictive worlds, one which is real and visible with the human eye and the other is constructed in the mind of a person, based on figures of the persons' imagination. This is luded to in Stern's (1995,p.18) statement;

> There is the real baby in the mother's arms, and there is the imagined baby in her mind. There is also the real mother holding the baby, and there is her imagined self-as-mother at that moment. And finally, there is the real action of holding the baby, and there is the imagined action of that particular holding. This representational world includes not only the parents' experiences of current interactions with the baby but also their fantasies, hopes, fears, dreams, memories of their own childhood, models of parents, and prophecies for the infant's future.

Although Sterns' (1995) representational world of the mother influences how the mother relates to her infant thus influencing the mother-infant relationship. Stern suggested that by fostering a positive relationship between mother and infant, mutual love could be developed between mother and child (Cheetham & Hanssen, 2014). Caregiver-infant interventions that aim to promote a positive relationship between infant and caregiver can be seen as what Daniel Stern refers to as a port of entry. Stern (1995) first introduced this term in his book, 'The Motherhood Constellation' in which he conceptualized the term 'ports of entry'. Stern described one aspect of the ports of entry as changing a mothers' unrealistic representations of their infant by focusing on what the infant can do developmentally. In doing so, the mother is able to see the uniqueness of their infant and come to know that the infant is an induvial that is primed for reciprocity. Thus, the shift towards a positive mother-infant relationship can begin.

In fostering a positive mother-infant relationship, Donald Winnicott, a British paediatrician psychoanalyst suggested, that mothers should provide "good enough mothering". In his conceptualization of the "good enough mother", he believed that a mother should form a connection with the infant. This should be done in such a way that the infant perceives the mother to provide consistent and reliable caregiving, this allows the infant to feel held and understood (Winnicott, 1960, p.595). An important aspect of "good enough mothering" is the caregivers' ability to display sensitivity towards the infant. However, an important aspect of the evaluation of maternal sensitivity is maternal responsiveness towards the infants' behavioural cues (Dawson et al., 2018). These two aspects have been combined to suggest that a "good enough" mother displays sensitive responsiveness towards the infant. However, research has shown that in some Western context's a caregivers' responses to an infant's behavioural cues are more verbal and of positive affect whereas verbal responses are less common in a Non-Westernised context (Dawson et al., 2018; Mesman et al., 2015; Mesman et al., 2016). Previous studies have explored interventions that aim to promote healthy infant

attachment, explored challenges that caregivers face in caring for infants and the assessment of maternal sensitivity towards infant's behavioural cues and how this can be used to enhance the caregiver-infant relationship (Aspoas & Amod, 2014; Bain, 2015; Cooper et al., 2009; Dawson et al., 2018; Dungmore, 2012; Frost, 2012). It's the caregiver's responsiveness and sensitivity to the infants' behavioural cues that impacts on the attachment formation within the caregiver-infant relationship, thus influencing infant mental health. However, researchers have advocated for the necessity of evaluating interventions in developing countries where there are different perceptions of how culture influences parenting and attachment development (Minde et al., 2006).

2.9 Infant-mother interaction

Although attachment theory looks at the nature of the infant-caregiver relationship, the psychological state of the caregiver also is significant, when exploring what influences the relationship between an infant and a caregiver. Main et al (1985) hypothesised that a caregivers life experiences may be associated with a caregiver's capacity to sensitively communicate with their infant that would foretell the infant's attachment pattern. However, it was realised that instead it was their ability to integrate and make meaning of their early childhood (Berlin & Cassidy, 2009).This integration and meaning making was reflected in the quality of how a caregiver organized their own understanding of their life story, thoughts and memories when the attachment was formed (Slade et al., 2005).

Fonagy and his colleagues shed light on a person's relational dynamics, both internally and with others which enhanced thinking about a person's own experiences and that of others when relating with one another (Fonagy et al., 1995). These researchers emphasized that it was not appropriate to only view the links of attachment patterns between generations as merely a cognitive process. Rather, the way in which one thinks about how attachment patterns are

formed across generations should also include a focus on emotions and how emotions are linked with behaviour (Slade et al., 2005). The capacity to think about and process intersubjective and interpersonal experience has been conceptualized as reflective functioning (Fonagy et al., 2002). Reflective functioning is a process and a developmental skill that allows the child to reflect on their own and others' thoughts (Mandler, 1985). This term also applies to caregivers and could be thought of, as a caregivers to recognise their mental states and that of their child and become aware of how their behaviours are connected to their thoughts (Fonagy et al., 2002). Caregivers capacity to engage in the process of reflective functioning, gives them the opportunity to think about how to carefully respond to their child's. This becomes most beneficial in the caregiver-child relationship when the child is in distress as the caregiver is able to put aside their own thoughts and feelings and focus on the feelings of their child (Fonagy et al., 1991).

Reflective functioning allows children to gain a better understanding of how other people's minds work. Through thinking about the mental states of others, children are able to derive meaning from people's behaviour which may also provide insight into how people will respond in the future (Fonagy & Target, 1997). Caregivers who are not able to show appropriate reflective functioning tend to lack awareness that their thoughts and feelings are separate from that of their child's and seem to believe that emotional experiences are divorced from parenting. The opposite seems to occur for caregivers who are able to display high reflective functioning This suggests that these caregivers are aware of the fact that their own and other individuals' emotions and thoughts are not always understandable or visible, may change over time and with development (Fonagy et al., 1991). Although caregiver reflective functioning is an understudied research area it is significant in the field of attachment, more importantly in fostering secure attachments and carries the possibility of being altered through interventions (Stacks et al., 2014). This becomes crucial in the study of interventions such as the NBO that

seeks to promote a healthy attachment between an infant and caregiver. This means that through the caregiver-infant interaction a reciprocity of the behaviours between the caregiver and infant is supposed to develop. In simpler terms the behaviours of infant and child "complement" each other. Thus, a child's attachment behaviour is adapted to a caregiver in their environment who is seen as having the ability to provide a safe space for the infant and is available and responsive to the infants' behavioural cues. In the case that an infants' physical environment complements their psychological environment, the infants' social development is expected to take a normal course (Ainsworth et al., 2015). However, in the case that an infant's physical environment is different from the infant's environment of rearing, developmental outcomes may not be reached. An infant who's experience of a parent that is limited to a caregiver in an institutional setting and is perceived by the infant as being occasionally available, may fail to develop a secure attachment to anyone (Goldfarb, 1943; Provence & Lipton, 1962.). What has been stated above, highlights the importance of the state of the environment in which the caregiver and infant lives and how important it is for the caregiver to be able to have the necessary emotional capacity to be responsive and sensitive to the infants behavioural cues, even in an environment that is characterised by difficult circumstances.

2.10 Mother and Mothering

One should question how the construction of the term "the good enough mother" applies in a culture for example, the Xhosa culture where the term mother is not an acceptable concept (Tomlinson, 2003). Within the Xhosa culture, caregiving tasks are shared by the caregivers within the community and not only performed by the infants' primary caregiver. Western-based psychological theories emphasize the importance of a mother's capacity to help her child achieve a strong sense of autonomy and independence. Winnicott's idea of "good enough" parenting (1962) requires a deep understanding of how the mother-child dyad is formed across different cultures, yet has not been considered in most traditional Western psychological

formulations of the mother-child dyad. Across different cultures and in various contexts, mothering is a role that is not only performed by the child's biological mother. Some mothers who face difficult socioeconomic circumstances, send children to be cared for by their grandparents or other family members (Tummala-Narra, 2004).

Byrne (2006) argued that the notion of motherhood and mothering has been associated with ways of parenting that are embedded in class and privilege. Mothers who occupy the working-class are criticized for their role of motherhood because they do not meet the motherhood standards of mothers from middle-class backgrounds (Walkerdine & Lucey, 1989). However, motherhood is more than merely a social construction of what it means to be a mother, it is also integrated with race. It is argued here that at the centre of ways of mothering lies the cross road of gender as well. It is seen as "a 'women's' responsibility and requires individuals to re-orientate their identities, their sense of being a women and their relationship to other women, particularly perhaps their own mothers" (Woodward, 1997, p.243 in Byrne, 2006).

Feminist writers have argued that motherhood has been constructed socially, historically and culturally rather than a natural result of maternal instinct (Veitch, 2016). Instilled in societies' fantasy of motherhood is the idea that mothers are 'perfect' nurturers, who are naturally capable of being available and providing for their children's needs regardless of their circumstances (Grosz, 1994). When motherhood is perceived as an innate process then the reality of the mothers' hard work, material and emotional resources that are needed to provide caregiving to children goes unnoticed (Ruddick, 1989). Veitch (2016) suggested that what is communicated by society is that mothers should cope regardless of the challenges in their lives. This idea of motherhood contributes to mothers who are struggling in their new role as a mother to feels that they could never be a good mother. Often, well certainly in poverty stricken communities these mothers feel guilty and are not afforded the space to express their struggles and negative feelings about their children (Glenn, 1994; Hayes, 1996). It is therefore important that this

study and interview process does not impose a Western or critical ideal of what motherhood is onto the participants.

The term caregiver is significant to this paper and the study of an intervention that focuses on caregivers and infants and not merely mothers. Parenting is influenced by thoughts and practices, which are multidimensional and are influenced by a caregiver's personality, the caregivers experience of being parented and cultural notions of parenting. Caregivers thoughts may be about their desires, perceptions, needs and ideas about child development. Caregivers' way of providing care allows for the emergence of ideas about good or bad parenting and contribute towards the child's understanding of the world around. They occur across rearing, physical, social, educational, verbal, and material dimensions of caregiving (Bornstein, 2017). However, there is a need to consider whether the field of psychology is imposing Westernised views on caregivers whose perceptions of parenting are culturally embedded. Prevention and intervention programs in impoverished contexts attempt to improve parenting in the caregiver-child relationship (Berg, 2003). As is apparent in the NBO programme. However, caregiver behaviours such as sensitivity and responsiveness may only be applicable and considered as important in middle-class Westernised parenting style and may not be appropriate or valid for parenting in other contexts. (Carlson & Harwood, 2014). Thus, it becomes beneficial to explore the Ububle NBO programme in order to provide a service that best considers the socioeconomic, psychological and cultural factors that influence the caregiver–infant attachment relationship amongst members of the Alexandra Township and surrounding communities.

CHAPTER 3: METHODOLOGY

Methods

This section speaks to the methodological approach of this study. The start of this chapter focuses on the research design, the sampling method and the procedure for data collection. Each aspect is described in detail and subsequently by a discussion of the data analysis method that was used. The last part of this chapter ends with a section on reflexivity challenges and the ethical considerations.

3.1 Research Design

The aim of this research was to explore the perceptions and experiences of caregivers who had accessed the NBO programme at Ububele. It is the intention that the results will give greater insight and understanding into the way in which the NBO programme is being experienced by caregivers within the community. Elliot (1999) and Fossey et al (2002) suggested that when exploring phenomena about which little is known, qualitative research is best suited. For this research a qualitative research design which used the caregivers' responses would be most beneficial for the aim of the study. In order for the researcher to interpret the meanings within the caregivers words, transcribed interviews were analysed using a thematic content analysis.

This study made use of an exploratory descriptive research design and utilized a qualitative methodological approach (Terre Blanche et al., 2006). Qualitative research tries to make meaning of and describe the feelings and emotions within the participant's experiences as opposed to, through statistical analysis (Terre Blanche et al., 2006). Richter & Tyeku (2006) suggested that there are many ways to evaluate a programme but a method should be chosen according to the milieu where the programme will be initiated.

In the case of the New-born Behavioural Observation programme, the utilization of an interpretative phenomenological approach seemed best as the focus of this study was to ascertain that a thorough understanding of the caregivers experiences and perceptions of the Ububele NBO programme could be gathered. Phenomenological research draws attention to the lived experience of individuals and therefore the researcher can gain in-depth meaning of the topic being studied (Moustakas, 1994). One strength of this approach is that a person's recollection of their experience is considered as significant to truly understanding the experiences of individuals (Knaack, 1984).

A phenomenological approach involves processing the data through different stages e.g. analysing interviews, themes and finally connecting the themes to theory becoming attached. according to the content that emerges and then finally connecting themes to social psychological theory such as attachment. A phenomenological approach allows the researcher to gain insight into the lived attachment experience between infants and their caregivers.

3.2 Participants

For this research study, participants were recruited through a systematic non-probabilistic sampling method namely; purposive sampling. Sampling for this research was purposive in nature as participants were selected based on specific criteria. This purposive sampling method provides the opportunity to include a range of individuals who may supply diverse perspectives on the topic under study, thus enhancing the depth and detail of information gained (Mays & Pope, 1995). Caregivers who live in the Alexandra Township and surrounding communities were asked to be a part of the study. The sample size consisted of 8 caregivers who have been through the NBO programme with their baby and interviews took place until data saturation had been obtained. The following sample inclusion criteria was used: (a) participants have completed the NBO programme with their infant at Ububele; (b) the participants are able to

converse in English. The researcher only started gathering participants once ethical clearance had been obtained from the University of the Witwatersrand Human Research Ethics Committee (HREC non-medical).

At this point it is important to describe the context in which the caregivers are situated in to provide insight into the characteristics of the potential participants. Alexandra Township is a peri-urban settlement within South Africa that contains extreme poverty. The township is home to individuals from diverse cultural and linguistic backgrounds e.g. Malawian, Nigerian, Zimbabwean, Mozambican and South African individuals. Most of the individuals living in the township reside in informal shacks with a lack of water supply and inadequate sanitation and housing (Aspoas & Amod, 2014). There is also overcrowding within the township, poor nutrition, limited health care resources and services and limited information regarding child development could influence a caregivers' capacity or resourcefulness to provide care for their infant (Donald et al., 2010).

3.3 Interview procedure

3.3.1 Developing the research questions

Research Questions

The following research questions were constructed to produce an outline for the interview schedule:

Thus, the questions this research addressed are:

1. What were caregivers' experiences of the Ububele NBO program?

2. How did the Ububele NBO programme impact the caregiver's relationship with their infant?

a) In what ways, if any, did the intervention help their relationship?

b) In what ways, if any, did the intervention not help their relationship?

3. What cultural knowledge do the caregivers feel the program did not include?

4. How could the programme change to accommodate cultural practices?

3.3.2 Interview

The interview with the participants was thought about very carefully, thus the researcher thought it would be best to develop an outline of the interview schedule that could be used to guide the interviews with the caregivers. Due to this research being qualitative in nature, the interviews took place with each participant for a period of 45 minutes and these interviews were done in person. Parker (2005) proposed that interviews could be viewed as a dialogue that takes place between the interviewer and the research participant. However, most dialogues take place in one's day to day environment were each person has an equal chance of raising questions and offering a response. In a qualitative research interview, the interviewer asks most if not all the questions and the participant responds, thus interviews are different because information is not shared reciprocally between two people. Although the interview schedule was used as a guide for the interviews it also provides the opportunity for new information to come to light (Liamputtong & Ezzy, 2005).

The interview schedule provides a frame for the interviews but the participants have the freedom to share all their thoughts about the particular questions that was asked. At times, this may lead the interview to being shifted in a different direction from what the interviewer had asked. Parker (2005) suggested that it is important for the researcher to think about three questions before constructing the interview schedule. Firstly, the researcher needs to think about the focal point of the interview. Secondly, the researcher should wonder about what information might become known. Thirdly, the researcher should think about what would occur in the interviews that the researcher had not expected to occur. These questions are important for the building a connection between the researcher and the participant.

Semi-structured interviews allow for more flexibility in the interview. For the current research open-ended questions were used in the interview schedule as well as the inclusion of a debriefing question. The qualitative nature of the research, the available literature as well as conversations between the researcher and her supervisor, influenced the development of the research questions. While semi-structured interviews do not have a definitive end and beginning, for this research the semi structured interviews had a defined open-ended question at the beginning of the interview. This was used to initiate the interview process between the research and the caregiver. The interview schedule also had a debriefing question to close the interview process and this was also used to see how the caregiver was feeling after the interview.

Permission to conduct the study was given by Ububele which can be seen in the appendix. Interviews were conducted in a private room at Ububele on days and times that suited the participants. Individual interviews are suitable for qualitative research as they are able to generate "rich, vivid material" (Gillham, 2000, p. 10). This offers the opportunity to capture rich, descriptive data about people's behaviours, attitudes and perceptions, and unfolding complex processes (Moustakas, 1994). The formulation of the interview questions guides the frame for the interview set up as well as the degree to which something new will be produced through conversation (Parker, 2005). The goal of the interviews was to develop an understanding of the participants' perceptions of the NBO programme through telling their story through their own understanding of what they experienced, consistent with the phenomenological approach (Knaack, 1984).

3.4 Procedure

Before the interviews were conducted, the director of the NBO programme at Ububele was contacted and informed caregivers who have been through the NBO programme within the last

year, about the study. Once the caregivers had given their verbal consent to the NBO programme director to distribute their numbers to the researcher, the caregivers were then contacted and asked if they would be interested in participating in the study. Interviews took place in a private room and were conducted on a day and at a time that was most suitable for the participants. All participants were reimbursed for their transport costs; however, the participants were only informed about this after the interview had taken place. This was to ensure that there was no incentive to join the study.

3.5 The Position of the researcher

Self-Reflexivity

Self-reflexivity is a crucial aspect for the researcher as it gives the researcher an opportunity to be cognisant of any bias that may emerge during the study (Harre, 2004; Parker, 1994). The researcher is also placed in the position of not only conducting the interviews but also analysing the data. In both instances the researcher must prevent their thoughts about the participants or feelings about the research, influence any aspect of the research process. Therefore, it is crucial that the researcher remains subjective (Terre Blanche et al., 2006).

The findings presented in the study were based on the direct quotes of the participants without any influence from the researcher, this gives credence to the outcome of the study. To increase the validity of the qualitative data, the researcher-maintained openness both in the interview setting and in this report about potential biases, personal experiences with the topic under study. Reflexivity is described by Creswell (2013, p. 229) as when researchers 'position' themselves in writing. The researcher has a personal interest in the subject of attachment and fostering a healthy caregiver – infant relationship. Her personal interest motivated her to be truthful when reporting the participant's words and the findings that emerged from the study. The researcher

wrote all her reflections about the research process in a journal, which allowed her to maintain self-awareness.

3.6 Data Analysis

Thematic Analysis

The interviews with all eight participants were transcribed and the method used to analyse the date that emerged from the interviews was thematic content analysis. Thematic content analysis is used to identify themes within qualitative data and is useful as it is not grounded in a particular theoretical framework (Maguire & Delahut, 2017). The aim of using thematic content analysis is to group information together, under a common subject or otherwise known as themes "e.g. patterns in the data that are important or interesting and use these themes to address the research or say something about an issue" (Maguire & Delaht, 2017, p. 3353). For this research, Braun and Clarke's (2006) six step thematic content analysis framework was used to analyse the data and an inductive approach to identifying themes was utilised. An inductive approach was used so that the researcher could identify the themes from the data, as opposed to the themes being constructed based on a particular theoretical framework. Themes emerged from the data rather than being prescribed by theory from the research. These six steps are described below.

1. Start with getting to know the data: read the transcripts a couple of times, gain an understanding of the information and make notes about the data.
2. Produce initial codes: organise the information in a meaningful way by reducing it to chunks of information. This should be related to the concern of addressing the research question therefore for this study this was a theoretical thematic content analysis. Code each aspect of the data that was relevant to the research question. During this stage as

one works through the data, new codes can be generated and existing ones can be modified.

3. Search for themes: Codes should be grouped under different subjects that speak to the research question in a particular way.
4. Review the themes: Review and modify the themes created in step three. Consider whether the data is related to each theme and think about; do the themes make sense? And are there sub themes?
5. Define themes: in this stage the themes need to be refined. It is important to develop a good understanding of what each theme means.
6. Writing up: discussing the findings of the research is the final stage.

3.7 Trustworthiness of the research

To increase the validity and reliability of this research, trustworthiness of the findings of qualitative research was maintained through the application of the following criteria in the research process; credibility; dependability; authenticity; transferability; and confirmability. Credibility in qualitative research has been referred to as the truthfulness of the findings (Guba & Lincoln, 1989). The researcher must determine if the findings produced from the study form an accurate portrayal of the group being studied. Thus the researcher needs to assess the validity and reliability of the research. Increasing the time of the interviews and using a semi-structured interview schedule, are two ways in which the researcher can enhance the degree of validity and reliability. In doing so, the participants have the freedom to decide what information they want to speak about in the interviews and was used in the current study.

Dependability was maintained through triangulation in the data analysis phase. The data generated from this study was compared to previous research of the phenomena under study and compared to journal entries of the research process, produced by the researcher. It is

important to mention that no assumptions were made about the capacity of the participants to forge secure attachments as this research was only interested in describing the experience of the participants. Authenticity was maintained by using Braun and Clarke's thematic content analysis process (Braun & Clarke, 2006). This process assisted the researcher in maintaining accurate reflections of the participants' experiences. Confirmability of the results of the study was continued through the use of direct quotations and the recording of the participant's own words during the interviews. Following these crucial aspects, trustworthiness of the study was thus strived for by the researcher.

3.8 Ethical Considerations

Before this study could commence ethics clearance was obtained from the University of the Witwatersrand Human Research Ethics Committee (HREC non-medical). The executive director of Ububele as well as the director of the Ububele NBO programme have received a detailed letter explaining the researchers' proposed study. Formal permission was obtained from Ububele through the signage of a permission slip, this can be seen in the appendix. The caregivers were provided with information regarding the study through the provision of an explanatory statement. The researcher explained that she is from the University of the Witwatersrand and has no affiliation with Ububele. Consent from all the participants was obtained through the signage of a consent from before conducting the interviews. Consent for audio – recordings that took place during the interviews was also requested from the participants through the signage of a consent form. The interviews were initiated at private and secure space that was agreed upon between the researcher and participant. Discussions about the purpose of the research and how the interviews would take place were conducted with each participant before the interviews.

All the participants were informed that the discussions they would have with the researcher would remain confidential. The researcher explained this concept and ensured that each

participant was sure what the term meant. It was further reiterated that the caregivers are volunteering to participate in the study and that they will not be coerced to participate. The researcher informed the participants that should they feel the need to remove themselves from the study, then they could do so at any stage without telling the researcher why and there would not be any consequences.

The participants were encouraged to speak freely about their experiences and were informed that they do not have to answer any question that they do not want to answer. All information that was discussed during the interviews remained confidential and the participants were informed about this. To protect the participants, the researcher masked the names of the participants by using pseudonyms to avoid the possible identification of the participants in the analysis files. However, complete anonymity cannot be assured as the NBO practitioners may be able to know who the participants are, through the data. All of the participants were informed about this aspect but reassured that third part anonymity will be protected. The researcher also explained to each participant that their interview needed to be recorded and a discussion was had about what would be done with these recordings and transcripts once the study was finished. The participants were told that the researcher would ensure that the transcripts and recordings were kept safe and secure. This was done by keeping the data in file on a computer that only the researcher would have access to. The file contained a password that only the researcher was privy to and the computer could not be accessed without the use of the researchers fingerprint.

The data from the recordings were kept in a password protected file on a computer to which only the researcher has access to. The researcher asked the participants for permission to use direct quotations and that no information that may compromise their anonymity would be made available to anyone. The interview schedule was not expected to expose the participants to any threat or cause distress. A debriefing session was done at the end of the interview to assess if

the caregiver was feeling any distress. All participants were told that if they felt negatively affected by the interview in any way then, they could be referred for counselling. The contact numbers of no-cost counselling services appear on the information form and participants were informed about these services. Should the participants request access to information of the study they were offered a summary of the findings upon once the report had been finished. A full report was given to Ububele.

CHAPTER 4: RESULTS

The data collected in the form of semi- structured interviews was analysed using thematic content analysis. The themes were structured around the following research questions: 1. What were caregivers' experiences of the Ububele NBO program? 2. How did the Ububele NBO

programme impact the caregiver's relationship with their infant? a) In what ways, if any, did the intervention help their relationship? b) In what ways, if any, did the intervention not help their relationship? 3. What cultural knowledge do the caregivers feel the program did not include? 4. How could the programme change to accommodate cultural practices? These four research questions were held in mind during the analysis and led to the emergence of core themes based on the interviews that were conducted.

The main themes were placed into three overarching areas of focus, namely: 1) Caregivers perceptions and experiences in working with their infants and the practitioners. 2) Caregivers perceptions and experiences when using the Ububele NBO programme. 3) Caregivers perceptions and experiences of the Ububele NBO programme. These three core themes were split further into subthemes to answer the research questions. In Table 1. below each participant and their demographics are listed.

Table 1. Sample characteristics

PARTICIPANT & their gender	**NUMBER OF CHILDREN**	**HOW LONG AFTER BIRTH**	**LOCATION OF SESSIONS**	**NUMBER OF SESSIONS**
Participant 1	2	7 weeks	Edenvale Hospital	2
Participant 2	1	1 week	Edenvale Hospital	2
Participant 3	4	7 months pregnant	1 Session at Thoko Mngoma Clinic, 5 Sessions at home	6
Participant 4	1	1 day	3 Sessions at Edenvale Hospital, Session 4 – Session 6 at Ububele	6
Participant 5	1	2 days	Edenvale Hospital	1
Participant 6	3	6 weeks	8th Avenue Clinic, Alexandra	2
Participant 7	1	8 weeks	Masikane Clinic, Alexandra	1
Participant 8	2	6 weeks	Ububele, Kew	3

It is important to acknowledge and address the variation in number of sessions attended by participants and how this may have influenced the results. Six of the participants had between 1-3 sessions with the NBO practitioner, however only two participants had six sessions. Due to the fact that there is no studies providing information about the Ububele NBO programme, the following explanation has been written based off a conversation that the researcher had with the manager of the NBO programme at Ububele. Typically, NBO practitioners have between 1-3 sessions with caregivers, however there are instances where more sessions may

be required. The latter occurs in the case of caregivers who have experienced a trauma and need more sessions with the practitioner to feel supported. Sometimes, a practitioner may be seen when the caregiver is concerned about the birth, the birth is risky, the baby is overdue or the caregiver does not have someone who is able to provide guidance regarding infant development (Bromley, 2010). In these cases, the practitioner will provide support to the pregnant caregiver prior to the birth and then after the birth with both the infant and caregiver. Caregivers may have one or three sessions and feel that they have gained a lot, however building rapport with caregivers takes time and this might not be established in the first session, thus more sessions are required before the NBO can be done. There are also cases where the caregiver is struggling due to their contextual circumstances and is not able to attend more sessions.

The variation in number of sessions attended is likely to impact perceived benefit from the programme as some caregivers had more time to develop rapport with the practitioner and may therefore have experienced the NBO programme as more beneficial. Those who had one session and were not interested in a second, may have felt that the programme was not beneficial. However caregivers could have had one session or 6 sessions and still not perceived the programme as beneficial. It is suggested that the variation in the caregivers sessions could be attributed to the caregivers contextual circumstances. However given the nature of this study and the socioeconomic circumstances of these caregivers, it was important to see whether context or culture influenced the caregivers experiences of the programme. Thus it was seen as most beneficial to include the experiences of all the participants.

4.1 Our experiences of the Ububele NBO programme with our infant

In order to obtain patients for the NBO, caregivers were approached by an infant mental health practitioner in the clinics or at the local hospital. Many were approached just after giving birth

to their infants. They were informed about the programme and asked if they were willing to experience it with their infant. Some caregivers reported that they were initially sceptical about the programme especially because they were approached by a stranger and not a nurse or sister in the clinics or hospitals. Some caregivers felt that the experience helped them learn how to form a relationship between themselves and their infant. This was facilitated by the practitioner when working with the infant and caregiver and allowed the caregiver to learn how to respond with more sensitivity towards the infant's behaviour. Through this experience caregivers came to see their infants as a little person who has thoughts, feelings and is aware of the world around them.

4.1.1 At first, we were skeptical of the NBO programme

Initially most caregivers were hesitant to experience the NBO with their infant. Caregiver 6 and Caregiver 5 felt unsure about the NBO programme. Caregiver 6 stated:

> I would just that that in the beginning I was just a bit sceptical… but after we warmed up to each other then I felt ok. As much as we are living in a very dangerous world it is so nice where you can just have a space where you can just be real.

> Caregiver 5 expressed: I was scared… I didn't know what to expect (pause) I was sceptical, not scared of going because I thought it was going to waste my time, but it didn't.

Both Caregiver 6 and Caregiver 5 spoke about their initial perceptions of the Ububele NBO programme in that they were hesitant about the programme. Caregiver 4 expressed;

> Yes, yes but at first, I was sceptical because you know I mean this day and age with everything happening around us (pause) you can never be too sure about what is real

> and what is not you know. I mean you can trust some and give them your child and then the next thing you turn, and you will never get to see the baby again so…

The caregiver's uncertainty did not seem to surround the fact that they were entering a new experience but more that they were entering a new experience with their infant and a stranger which made them feel vulnerable. The caregivers were used to seeing sisters or nurses but were not prepared for infant mental health practitioners. These caregivers were concerned for their infant's safety and seemed unsure about trusting a stranger with their infant, even though they were willing to experience the NBO programme with their infant and the practitioner.

4.1.2 It was educational

Through their experience with their infants and the practitioners, most caregivers were able to reflect on what they knew about their infant. When this was shown through their infants' behavioral responses, it was perceived that it can feel quite validating for the caregiver. Some caregivers gained an awareness of what their infant can do developmentally while others did not. Caregiver 6 stated:

> It was a real eye opener (pause) it taught me a lot about small babies (pause) things I was not even aware of. So, I did not know that kids can see at that age… so there was an exercise that she did as well where she put some light over the baby's eyes and that actually showed that she could see the light. So I think there were a few exercises that she did with the child (pause) um so um to show her strength (pause) and by pulling on his legs and the child actually pulled back his legs so there was a name for it but I can't remember what it was but it was quite interesting to see that a child at that age can have that kind of strength. We were very happy to know that he could hear me (pause) it's not that I am talking to a small baby that doesn't respond or anything like that… as well as the exercises that Zanele taught us.

> Caregiver 8 expressed: So, it was all new because we thought that the baby would start hearing or start seeing around three months or maybe two months so she kind of opened a new avenue for us.
>
> Caregiver 4 : He was using his face a lot, so I was not aware of that. I was just thinking that ah not every child does that, so I was not aware that this baby knows me, this baby knows his father you know. I was just thinking (pause) yah he is a baby he is still young; he does not know anyone but after the NBO I realised that this baby knows me, knows his father and knows his sister.
>
> Caregiver 3 expressed: I could say like ya (pause) it did impact a lot (pause) because like when sis Thandiwe came and it was bathing time it was just like ok bathing… just bath the baby and that's it- I didn't have an attachment towards him. There were like little things like when baby is born, I didn't know that he would recognise me (pause) I thought ok like maybe at two months or three months that's when they would recognise me.

In describing their experience, Caregiver 6 and Caregiver 8 highlight the importance of maternal knowledge and how having an awareness of what the infant can and can't do within the 0 – 3-month stage of development, influences how the caregiver responds to the infant. Specifically, it appears that these caregivers were unaware that their infants could hear or see when they were born, and therefore recognise them. It appears that this may have influenced the caregivers' sensitivity and responsiveness towards their infants. It appears that based on the accounts from these caregivers, caregivers were unaware that their infant can see at birth, hear at birth and that the infant knows their caregivers from birth. Caregiver 7 also shares what she has learned through her experience of the NBO with her infant, expressed as follows;

> You know what until up until a certain age maybe three months or two months is when they start seeing people and colours so up until then you just bath the child and put them to bed. But after the NBO programme I kind of thought of babies very differently because it is quite amazing that with everything that they have taught me and showed me… every time I tickle him or move his leg then I can see how he pulls back… so that was quite interesting to learn those exercises that we do and I could see how when dad talks to him and how when mom talks to him then he lightens up and stuff…so I don't have to wait for him to actually grow older to start realising that…

Caregiver 2 also highlight a lack of knowledge of premature infant development:

> It was kind of eye opening for me and a very different experience because she is my first baby so you don't really know much and she's a premature so there is always something to learn about premi's and how they change overtime. So, having to see her… because where we are there is much sound so having to see her react to noise was really cool, like how she can react to certain sounds was really cool.

This caregivers' experience highlights the importance of how a caregiver's knowledge about infant development influences how the caregiver responds towards the infant. Caregiver 7 learned through her experience of the NBO with her infant that her infant can see and was able to respond to the sound of her voice. This caregiver expressed that before the NBO she was unaware of all the things that her infant could do and so would not engage with her infant during playtime or bath time, instead the infant was just put to bed. In learning new information, these caregivers seemed to have a better understanding of their infant's development as well as the uniqueness of their infant

4.2 In some ways the Ububele NBO programme was useful in my relationship with my infant and in other ways it wasn't

Through the analysis of the interview material it became clear that most caregivers found the programme useful in terms of helping them form a relationship between themselves and their infants. Through the analysis it emerged that some caregivers responded well to the NBO and these caregivers were able to notice how the NBO programme impacted their relationship with their infant. However, some caregivers did not feel the NBO had an impact on their relationship with their infant. For these caregivers, it seemed that transitioning into the maternal role was difficult due to the caregivers' individual circumstances.

4.2.1 "It opened my heart and my eyes to see my little person" **: Becoming sensitive and responsive towards their babies**

During the interviews it became apparent that through the caregivers' experiences of the programme a lot of them were not aware that they needed to have a relationship with their infant. For the caregivers' this felt like an abstract concept. They were not sure why the practitioners were asking them about their relationship with their infant because for them, this was a concept that was not known within the Alex community. It seemed that the shared opinion of most of the caregivers was that an infant is so small and does not know anything, therefore it did not make sense to form a relationship with their infants. In caregivers' thinking about a relationship, it was a bond that was formed between two people who can interact with each other as opposed to a person and an infant. However, through the programme they were able to understand why it was important to bond and form a relationship with their infant. It seemed that for these caregivers, they came to see their infant as an individual and thus began to understand the importance of interacting with and responding to their infant. In being aware of and responsive towards the infants' needs, caregivers were able to see that displaying sensitivity towards their infant's behavioral signals had helpful consequences for the family. For example:

> It helped a lot even with my husband you know. It helped him because even now he can talk to the baby and play with him more after NBO. Katharine was playing and talking with the baby during NBO and at home I was doing that alone. At home he would just carry the baby and keep quiet but now he is talkative with the baby (caregiver 1).

Caregiver 1 spoke about how when she was told that she needed to develop a relationship with her baby, it was almost as if she was hearing a foreign concept. However, she realised that through the NBO, part of developing a relationship with her baby involved being sensitive and responsive towards her infants' behaviour. This gave her the opportunity to use what she had learnt during the NBO at home too, to build this relationship between herself and her infant. Through this experience Caregiver 1's significant other became more aware of the importance of interacting and responding to his infant. Thus, for Caregiver 1, the responsibility of building a relationship between the infant and herself as well as with her partner became a shared responsibility. She was able to see how her partner changed and developed sensitive responsiveness towards the infant. Caregiver 2 also expressed during the interview that through her experience of the NBO programme with her infant, she was able to recognise and become more aware of her infant's behaviour and this allowed her to get to know her infant. Caregiver 2 expressed:

> It gave me a foundation as to how to entertain her and understand her better because there are certain things that she likes and certain things that she doesn't like for example loud sounds. So, she would fist up and I would never have known that because she kind of fists up when she hears a loud sound and that's really cool because I know what she can and can't tolerate.

Caregiver 2's experience of the NBO programme was shared by Caregiver 8 as through this experience they were both "becoming to know their infant". Caregiver 8 reflected on the fact that through doing the NBO programme with his partner, he was able to develop sensitivity and responsiveness towards his infant. The caregiver felt that this was crucial for being able to recognise when the infants start to see and if infants can hear, thus the caregiver would become aware of any challenges in development that the infant has and respond to these at an early age. Thus, for this caregiver, the NBO programme served as a protective function for his infant. Caregiver 8 reflected;

> so I think it could help in terms of recognising the sight and the hearing you know… ya I think it's a…I think it's with more of the things that are coming I think it's important to highlight the importance of noticing your child's behaviour at an early stage and almost everybody would be able to benefit from it you know…pay attention to the child so if there is a problem you can pick it up early. Ya I think people just teach you a very simple way of raising kids but with this NBO you kind of get (pause) get things that are relevant for these times and that can be applied to everybody. Regardless of the race or gender so I think it was quite refreshing.

> Caregiver 5 stated; It was fun (pause) because it broadened my mind as how I should be with my kid and how I should play with my child. I have never experienced such… but it brought it to my attention as to how I should handle such situations with a new-born baby.

Caregiver 5 shared her experience of the NBO with her infant. Caregiver 5 is a first-time mother and she was able to share that she learned how to play with her infant and how she "should be" with her infant. Through the programme caregivers shifted their view that infants are quite fragile beings that are not aware of the world around them and don't know anything. After

participating in the NBO, caregivers began to see their infants as little people who can think and are aware of their environment. A sense of robustness in relation to their infants was expressed by caregivers.

> Caregiver 6 reflected; So, doing that every day now and again has obviously strengthened the bond between us as well (pause) so it allowed me to pay more attention to the child when bathing the baby and changing nappies (pause) instead of thinking that they are just little babies and they don't even know anything.

Caregiver 6 described an activity that she does with her infant that she learned through the NBO programme which has improved their bond. This caregiver has become attuned and aware of her infant's behavioural signals and it is through these signals that her infant was trying to communicate with her. This experience has allowed this caregiver to form a new image of her infant as a capable little person who knows a lot about his environment. While both Caregiver 6 and Caregiver 4 found that they became sensitive towards their infants and began to see their infants as a "little person" their experiences of how they arrived to form this perception was quite different. Caregiver 6 learned that her "little person" actually does know a lot about his environment whereas Caregiver 4 learned that her "little person" is quite resilient and can communicate with her caregiver. Caregiver 4 expressed;

> It was my first time doing the NBO so I honestly didn't expect much (pause) I felt that Ububele made a difference in our lives because I think if Ububele wasn't there I wouldn't have understood what I have gone through. It opened my heart and my eyes to see my little person as a full-term baby. So, I would speak to her and she would respond, and she would turn her head towards me. It opened my eyes to see her as a little person and not someone who might die tomorrow. It gave me a big something… a big light.

Through practitioners facilitating the NBO with caregivers and their infants, what emerged was the idea that caregivers were able to take the information that they have received through the NBO and use it at home during instances of caregiving such as play and bath time. The caregivers were happy to engage in a discussion around this topic as they could share what they had gained from their experience. Most caregivers seemed to be quite thankful for the NBO programme for influencing their relationship with their infant

4.2.2 The NBO as a port of entry: It helped me bond with my infant

As mentioned above, most of the caregivers perceived the programme as being useful in fostering a relationship between themselves and their infant. Caregiver 5 expressed that she felt that the NBO was useful for facilitating a bond between herself and her infant: Caregiver 5 stated: "The NBO helped with bonding with my baby because we groom our kids in such a way so that they can be strong. So, the NBO (pause) it teaches us to be more comforting." Caregiver 8 expressed that the NBO helped her understand her experience as a new mother and bond with her infant: "We bond a lot and now I understand my situation better. I am grateful for this journey with Ububele…". Further, Caregiver 1 expressed how the NBO helped in creating a bond between herself and her infant and thus began the start for this caregiver in coming to know her infant and growing the caregiver-infant relationship. Caregiver 1 stated:

> It helped me to bond…most especially to bond. My daughter is like seven years, so I forgot everything about like smaller babies (pause) about infants. So, after the NBO I realised no, this baby knows me very well. More than I think you know. So NBO helped me so much to bond with him.

The accounts of the previous caregivers addressed the fact the NBO helped facilitate the development of a bond between themselves and their infants. Caregiver 3 spoke about

"attachment" in relation to forming a bond and the need to form a "relationship" with her infant. Whilst she felt that, she did not have a relationship with her other children, after the NBO programme, she was able to respond more meaningfully, become more aware of his behavioural cues and form a bond with her new infant. Caregiver 3 expressed:

> Everything was good. The bonding the attachment (pause) like love was formed. I do love my kids, but the love that I now have for my baby is not that kind of love or attachment that I have with my other kids, it is different. I didn't have a relationship with my other kids but now with my son, it is different.

Caregivers two and four reflected on the challenges faced when transitioning to the maternal role and having to look after their newborn infant. Moreover, there are additional stressors when looking after a premature infant, especially trying to bond with such a small infant. Caregiver 2 stated:

> I think more of these programs should be there for prem moms, first time moms. All the stuff you know about a normal baby isn't what you can apply to a prem baby. So those are the things that helped me in a way because my niece was born before her so I kind of had the mom experience with her but she was a full term baby and then you come and have your daughter and she is a premature baby and everything is completely different. To have that NBO it just made me feel better.

> Caregiver 4 reflected: My experience with them was good because at the hospital it wasn't very nice (pause) I had been there three months and my water broke and I was only 23 weeks…So the stress of not knowing if I would get a baby and would it actually look like a baby or will I just come out with nothing. I stayed at the delivery ward until I was 29 weeks and then I gave birth. So, when Katherine came like she helped me to understand what I was going through. I knew there are premature babies,

> but I had only seen them from afar (pause) it becomes different when it is your own baby. So, it was a very traumatic, emotional experience but Katherine helped me through it, she helped me bond.

Reflected in the accounts of the caregivers mentioned above is that most caregivers found their experience of the Ububele NBO programme to be critical in helping them to bond with their infants.

4.2.3 I struggled to be emotionally available for my baby due to additional stressors

Trauma or a difficult birth process was experienced as an obstacle in connecting emotionally with their infants. It was suggested by the caregivers that due to the caregivers' circumstances and environmental stress, transitioning into the maternal role was quite challenging. Emerging from these accounts is also the reality that many caregivers didn't have the necessary support to transition into the maternal role and thus it is challenging to bond with their baby. Caregiver 4 stated: It has been a tough journey (pause) you see a lot of babies dying in that ward. I kept my family away because I didn't want them to worry… Caregiver 4 explained how hard it was for her to be in a ward where babies were dying and how hard it was for her to connect with her infant that could die, to the point that she kept her family members away from her and her infant.

> Caregiver 1 said: So, when after giving birth you develop this thing of eish this baby is crying too much, and you are short tempered for a period of time or because sleepless nights you are exhausted. So, you can't even bond very well with the baby because you can't sleep and you're always tired.

The experience of Caregiver 1 in becoming a mother and the birth process as difficult was shared by Caregiver 7. Reflected in the accounts of Caregiver 7 and Caregiver 3 is the reality that often caregivers have gone through trauma during the birth and environmental

circumstances further impact caregivers emotional availability and how they feel about their babies. Caregiver 7 stated:

> I was in pain my nipples where peeling off, so it was difficult to feed her, and she was hungry you see. In the clinic the nurses they were telling me (pause) I don't know… that they need to give me nipple cream.

> Caregiver 3 expressed: It takes more time to adjust into this new role of having to look after this new person that has so many needs. So, I think there is a lot of emotional stuff, but I think the physical stuff as well like the pain or not having milk to breastfeed the baby or if milk is not coming out or because of stitches you can't walk or hold your baby.

4.3 The cultural knowledge I have was not included in the NBO

During the interviews the caregivers expressed gratitude for the programme. They were surprised to learn that they could take some of the activities used in the NBO and repeat them at home with their infants to track their development. Caregivers noticed their infant's behavioral cues and practiced what they had learned through the NBO during play and bath time with their infant. However, the caregivers expressed that there were certain aspects about what they had learned from the NBO that were different to their cultural practices. This seemed to leave the caregivers uncertain about what they should believe with regards to the right way of providing care for their infants.

4.3.1 Cultural differences in caregiving

Most caregivers explained that what they had learnt from their culture about child development and how to care for an infant, and what they had learnt through the programme, was completely different.

> The bathing part was different from my culture because when we bath babies, we just bath them, and the baby makes a noise then we keep quiet. That's not the case I learned that no we also need to talk to them and bond with them while bathing (caregiver 3).

The accounts of Caregiver 3 highlights that that there are cultural differences in providing care towards infants. It seems that this was not included in the NBO programme which made the caregivers form a new perception or understanding of how to provide caregiving, possibly one that may conflict with their cultural understandings. Caregiver 2 stated;

> But for example, with feeding in my culture we feed them before six months and then we have complications (pause) like I had complications with my other two kids because I fed them before six months. But with Ububele now I don't have any of those complications.

Caregiver 3 and caregiver 2 shed light on the fact that caregiving and knowledge about caregiving is culturally informed. Different cultures have different ways of providing care to infants. Caregiver 5 reflected;

> "You shouldn't breastfeed your baby when you are upset" (inaudible) and culture well (inaudible) ask why and the elder people would say, "No you just don't do it don't ever breastfeed a baby when you are upset"

For some these differences were experienced as conflictual. Caregiver 5 speaks to the idea that she was taught in her culture that a mother should not feed her infant when she is upset. Caregiver 5 questions what she has been taught in her culture "my mother lied to me, has my mother been lying to me this whole time" when she experiences something different during the programme. Caregiver 4 expressed that what she knows about infants and providing caregiving from her culture is different to what she experienced during NBO, especially with a premature infant. She stated;

> They need to teach our culture how to look after premature babies (pause) we only know that it is a premature baby that just needs to be warm. So, if they could educate more people in our culture to know that it is not [just] a premature baby… the baby has to develop a lot of things. In our culture the only thing they know is that you must just feed the baby, but they don't know if she will be blind in the longer years to come, is her head going to develop properly… they don't know these things.

Caregiver 4 reflected on her perception that there are limitations in some cultures when it comes to how to care for premature infants. This caregiver highlights the idea that what she knows about caring for an infant from her culture was not what she experienced during the NBO programme. She also draws attention to the need to recognize that cultural practices may be colonized. Caregiver 4 states that "they need to teach our culture how to look after premature babies". Caregiver 4 points out that her culture does not know anything about how to care for premature babies and their approach is wrong. However, the practitioners having knowledge about caregiving and infant development stemming from Westernised cultures is right. Caregivers may experience the tension between these ideas as conflictual which makes it hard to know what information to use, especially if the caregiver is young and does not have support. It becomes imperative for practitioners to think carefully about how they communicate information to caregivers. Practitioners should not impose but rather be culturally sensitive and be aware of how caregivers receive information.

4.4 I wish we could find a way to include culture in the programme

During the interviews it became useful to discuss caregivers' perceptions of the NBO programme and how this would relate to what they know about infant development and caregiving in their cultures. What emerged was the importance of considering that in South

Africa there are diverse cultural and linguistic backgrounds which may pose a problem when relating to others. This problem may become intensified when two people from different cultural backgrounds attempt to try and understand each other's worldviews and experiences. It was beneficial to engage in a discussion about what could be done within the programme to make it more culturally appropriate. This was not to suggest that the NBO was not culturally appropriate but to find out from the caregivers themselves what they thought about the inclusion of cultural practices in the programme.

4.4.1 "The baby cannot understand"**: The importance of including African cultures and languages in the NBO programme**

Most caregivers expressed that there needed to be knowledge of African cultures in the NBO programme. Given that a westernized programme was transplanted in South Africa, caregivers expressed that one needed to think about ways in which culture can be incorporated in it. Especially since there are different ways of providing care to infants across cultures. Caregiver's knowledge about infant care might have been different to what they were told during the NBO. Reflecting on their experiences during the NB, caregivers 5 and 6 expressed that it was important that the programme be culturally sensitive.

> even thinking about culture, I almost wish it could be something (pause) we could bring something about culture into the NBO I don't know how, and I don't know where, but I wish it could be more… (Caregiver 5)

> I wish it was more available um and administered by ordinary people that can really bring in culture and think about aspects culturally and engage more with them (Caregiver 6)

For caregiver 6, the programme needs to be administered in participant's vernacular and with awareness of cultural knowledge about caregiving and infant development. Perhaps, reflected

in the thoughts of this caregiver is the idea that if culture was embedded in the programme, then perhaps caregivers would be able to connect with the NBO practitioners more. This sentiment is shared by Caregiver 4.

> I wish there would be like a Zulu or Sotho NBO, like we'd have the NBO in different African languages to have more actually research around African parenting.

Caregiver 4 states more strongly that the NBO needs to be more culturally focused. Caregiver 2 poignantly reflects that if an infant has been communicated to in a specific language, then the infant may not understand an NBO practitioner who only speaks English:

> I can't really say much about that. I guess speaking in the kids' language. She knows English because I've never spoken anything other than English so maybe if you find that they are trying to connect with the baby, but the baby cannot understand then maybe they should speak another language.

In conclusion, three overarching themes emerged, namely: 1) Caregivers perceptions and experiences in working with their infants and the practitioners (some caregivers were sceptical while others thought the experience was educational). 2) Caregivers perceptions and experiences when using the Ububele NBO programme ("It helped me become sensitive and responsive towards my infant"; "It was a port of entry, It helped me bond with my infant, I couldn't bond with my infant due to environmental stress"). 3) Caregivers perceptions and experiences of the Ububele NBO programme ("I wish we could find a way to include African cultures in the NBO, there are cultural differences in providing care to infants")

In the next chapter the results will be integrated to provide a more comprehensive understanding of the caregivers' perceptions and experiences of the Ububele NBO programme. Connections will be made between the themes that emerged from the analyses and the

literature. It is hoped that the discussion of the results will provide a more in-depth understanding of the caregivers' perceptions and experiences of the Ububele NBO as well as provide answers to the research questions. In doing so, perhaps greater insight into the cultural validity of the programme can be made, as well as suggestions for the Ububle NBO team.

CHAPTER 5: DISCUSSION

The aim of this research was to explore the perceptions and experiences of caregivers who have been through the Ububele New-born Behavioural Observation (NBO) programme with their infants. This was achieved by conducting eight semi-structured interviews with caregivers who had taken part in the NBO with their infant. Currently there is no research on the NBO programme in South Africa. Furthermore, there is no research on the perceptions and experiences of caregivers who have undergone the NBO programme in South Africa. It was therefore seen as beneficial to offer insight into the perceptions and experiences of caregivers who have been through the Ububle NBO programme.

The results have been integrated to explicate the ways in which the caregivers perceived and experienced the Ububele NBO programme. The findings will be discussed under the following research questions: 1. What were caregivers' experiences of the Ububele NBO program? 2. How did the Ububele NBO programme impact the caregiver's relationship with their infant? 3. What cultural knowledge do the caregivers feel the program did not include? 4. How could the programme change to accommodate cultural practices?

Caregivers' experiences of the Ububele NBO programme

The results showed that most caregivers were initially sceptical of it but found the NBO programme to be an educational experience. Most caregivers were unsure of what to expect from the NBO programme as well as the NBO practitioner. The hesitancy from the caregivers seemed to stem from the fact that they were approached by the NBO practitioners and did not seek out the NBO programme themselves. This is one aspect of the programme that is different from most parent-infant interventions. The PremieStart programme (an adaptation of the Mother Infant Transaction Programme) (Caskey et al., 2011) aims to enhance mothers'

sensitivity towards their infant's behavioural cues (Milgrom et al., 2018). However, this programme is different to the NBO in that it facilitates communication development between the mother and the infant which begins in utero (Caskey et al., 2014; Hutchon et al., 2019). One benefit of this, is that when conducting the progamme with mothers, there is the opportunity for mothers' to be more responsive to the programme and start developing a relationship with their baby during pregnancy. This reduces the risk of not being able to engage mother's in the programme due to the trauma of the birth and stress that occupies their minds, which is the case in the NBO programme. Similarly, Egeland and Bosquet (2001) suggested that caregivers should be seen as early as possible, preferably during pregnancy, with enough time for therapeutic engagement. Interventions also seemed to be more successful when mothers could have the space in their minds to think about their baby. This could only be achieved if contextual factors such as poverty, housing, substance abuse and unemployment were addressed. The Nurse Visiting Program is a nurse home visiting programme for first-time, low income mothers, beginning antenatally and ending when the child turns two years old. This programme has been successfully introduced in New York, Colorado and Tenessee (Landman, 2009). These programmes seemed to have a high success rate; however, they exist in developed countries where perhaps caregivers are less concerned about mental health practitioners approaching them and their baby. The environmental risk of potential harm to these caregivers and their infant's may be less in these contexts.

In this study, the caregivers seemed to have many thoughts about who the practitioner was and where they came from. Also, without an immediate need to have a consultation with an NBO practitioner, the caregivers were hesitant to let someone who they had just met, touch their infant. It is believed that there are certain cultural customs that take place after the birth of a baby. In IsiZulu a woman is called 'umdlezane', which means a woman who has recently given birth. This new mother is seen as an outsider in her community due to the fact that she has just

given birth. During this time a woman is only assisted by the woman in her family, even her husband is not allowed to see her or the child until a certain period of time has passed (Mncwango & Luvuno, 2015). In AmaXhosa the birth of a child is an important time for a community and for the family. There are beliefs and customs about this beginning that tends to be different depending on each clan. 'Efukwin*i'* (meaning behind the door) is considered a sacred place because it is where the birth of an umXhosa child takes place. *Efukwini* is a space reserved only for the women who will help the mother-to-be give birth and for the older women of the family to help thereafter (Penxa-Matholeni, 2019). This restricts access from the outside world and serves as a safe place for the caregiver and the infant. The Watch, Wait and Wonder programme was developed to build caregiver-infant relationship and prevent any maladaptation's and is conducted up until the child is 3 years old (Cohen et al., 1999). The caregiver is asked to watch the infant explore her environment without interfering in this process. The session is video recorded and then the caregiver is given the opportunity to sit and think about their infants' behavioural cues (Tucker, 2006).This programme is different to the NBO in that the therapist does not touch the baby, thus the caregiver's anxiety of the therapist touching the baby is thwarted. In addition, it allows for cultural practices to take place before the caregiver and baby are exposed to the programme.

However, caregivers' perceptions that the programme had helped their relationship with their infants is comparable to that reported by Landman (2009) in a study of mothers from similarly deprived communities. In general, the mothers thought about their infants in a different way and they were able to recognize their infants behavioural signals. The mothers expressed that they had little knowledge about how to care for an infant and so the programme gave them an opportunity to learn (Landman,2009). The mothers also felt that they could be curious about their infants' behaviour and take a chance at interacting with their infants. Once approached by the NBO practitioner and having had the process explained to them, caregivers seemed quite

open to engaging in the experience with their infant and the practitioner. Most caregivers highlighted the importance of maternal knowledge and how having an awareness of what their infants can and can't do within the 0 – 3-month stage of development, influences how caregivers respond towards their infants. It seemed that through caregivers' experiences of the Ububele NBO programme they were able to attain information about their infants' development and learn what age appropriate developmental milestones to expect. Specifically, it appears that these caregivers were unaware that their infants could hear or see when they were born, and that the infant knows their mother from birth. Most caregivers had believed that their infants would only start to see or hear at about 2-3 months. In sharing this belief, the caregivers felt that it was not necessary to interact with their infants or talk to their infants. As a result of this, the infant may perceive the caregiver as being unreliable and not providing support which greatly impacts on the formation of a secure attachment relationship between caregiver and infant (Granqvist et al., 2017). The results support the findings of Bain and Richards (2016) who suggested that caregivers with adequate maternal knowledge of infant development are more likely to accurately interpret and respond to an infant's behavioural cues, thus increasing maternal responsiveness and sensitivity.

A lack of understanding of child development influences how a caregiver responds to their infant. However, culture influences one's beliefs about what is considered to be normal milestones of child development and parenting skills (Mesman et al., 2016). Most of the caregivers reported that they had learnt how to care for their children through their culture. It could be suggested that it is not to say that these caregivers lack knowledge about infant development but that their knowledge is different to western ideas or perspectives on infant development. Language is a crucial aspect of child development and the way in which children learn to socialise within the world. The caregivers mentioned that in Zulu and Sotho cultures, parents believe they only need to interact with their child when their child is able to speak in

full sentences. It is believed that an infant does not know anything about the world therefore, parents should rather talk to them once they can be seen as a child that can interact and communicate with the world around them. Thus the caregivers initially found it strange that the practitioners were speaking to their infants.

To add to this complexity of influences, parenting knowledge is also influenced by socioeconomic circumstances and research has found that parents from lower socioeconomic groups tend to be less aware of the influence that parental knowledge has on child development (Knerr et al., 2013; Kuchirko & Tamis-LeMonda, 2019; Waters et al., 2015).

It becomes important to highlight once again the context of the Ububele NBO programme and thus the context that the caregivers are situated in. The caregivers are from an impoverished context where resources are scarce and individuals come from underprivileged backgrounds. In deprived contexts, there is limited knowledge that is available to communities such as Alexandra Township. Caregivers in these communities are still at a disadvantage and probably have limited access to knowledge about child care and child development than caregivers living in affluent communities. It seems plausible to suggest that perhaps most caregivers who learned something about their infant through their experiences of the Ububele NBO programme, had limited understanding of infant development due to their socioeconomic circumstances.

Maternal Knowledge about infant care and development have been found to be significantly associated with the quality of parenting and quality of the home environment provided for infants (Nuttall et al., 2006). It is suggested here that caregivers who have access to resources in their environments are likely to have more knowledge regarding infant care and development. However, Alexandra Township offers little to no resources for caregivers regarding infant care. Thus it is plausible that the results that emerged from this study are more an outcome of the socioeconomic context as opposed to cultural factors. The added burden of

caregivers' socioeconomic circumstances prevents caregivers from accessing services in communities where these resources may be available. It is important to hold in mind that more than 90% of infants are born and live in underdeveloped or developing countries, while most knowledge about infant development comes from developed countries (Tomlinson, 2003). Infants born in developed countries who do not have the same threat to their well-being in terms of social and health problems (Landman, 2009).

The degree to which the mother can provide care for the infant – that being her emotional availability, varies greatly according to several factors. One of these factors is poverty and has the potential to negatively affect the mother's mental health and the nurturing experience for the infant. "Poverty is a powerful predictor of negative psychological outcomes for children … as a consequence of the multiple stressors associated with poor living conditions" (Dawes et al., 1997, p.193). Lehohla (2013) conducted a study and found that 58.6% of females in South Africa live in poverty. Tomlinson et al (2005) found that the adverse circumstances of poverty are associated with an increase in postnatal depression. Berg (2012) found that the inhibition of caregivers' ability to provide care for their infants was due to the caregivers' preoccupation and the impact of their life stressors.

The increasing rate of unemployment and widespread poverty are two of the many challenges that families struggle with daily (Landman, 2009). Additionally, schooling is inadequate, pandemics are not under control and there are high rates of crime and violence particularly against women and children (Dawes et al., 2006). These adverse contextual challenges make it difficult for poor, pregnant and new caregivers to feel sufficiently protected so they are able to attend to their infant and be emotionally available.

Impact of the Ububele NBO programme on relationships between caregivers and their infants.

Most caregivers reported that the programme had some impact on their relationship with their infant. For these caregivers, the programme helped them become sensitive and responsive towards their infant which helped with the bonding process. However, the caregivers also expressed that the Ububele NBO programme was not helpful when they were struggling to bond due to environmental stress.

The NBO programme helped caregiver's to build a relationship with their infant. Many of the caregivers couldn't understand what it meant to have a relationship with their infant and most did not have one. Thus, the programme was used as a port of entry into creating the caregiver-infant relationship by promoting attachment. This idea is advanced by Stern (1995) in his book, 'The Motherhood Constellation' in which he conceptualized the term 'ports of entry'. Stern described one aspect of the ports of entry as changing a caregivers' unrealistic representations of their infant by focusing on what the infant can do developmentally. Therapeutic approaches, such as the NBO programme, focus on observing the infants' unique capabilities as a port of entry to generate changes in the mother. These therapeutic approaches have been described by Stern (1995) as being like paediatric examinations, assessments and evaluations as well as behavioural interventions that evoke the infant's responses in order to alter representations in the mother. Thus, through caregivers exploration of their infant's behavioural cues with the NBO practitioner, the caregivers were able to respond appropriately and bond. Through the caregiver observing the infant, the NBO programme serves the aim of most parent-infant psychotherapeutic interventions in that it aims to alter caregivers' mental representations of their infant and promotes the development of a positive relationship with their infants (Cohen et. al., 1999).

For caregivers, the presence of the NBO practitioner was perceived as providing a sense of comfort. Caregivers were given a supportive space to speak about the trauma and difficulty of giving birth as well as their anxieties of being a mother. Crumidy and Jacobziner (1966) stated

that programmes which offer a sincere willingness to help and opportunities for empathy and understanding are more successful at reaching "unreachable" populations, such as caregivers in Alexandra township. Here "unreachable" refers to the fact that attempting to engage with caregivers in Alexandra on an emotional level is quite challenging. Caregivers are not focused on their own emotional wellbeing or that of their children, as they are understandably preoccupied with survival and providing for their children's' physical needs (Bain & Richards, 2016). NBO practitioners use empathy and understanding to attempt to gain access to caregivers and their emotional worlds. This created space in the caregivers' mind to be able to think about and take in what the NBO practitioner was doing and saying. An opportunity was created for the caregivers to be able to respond meaningfully to their infants and thereby begin to form a relationship with their infant. The importance of the relationship in facilitating therapeutic change is described by Winnicott (1965) as a 'facilitating environment' in which 'holding' and 'management' is critical (Winnicott, 1988). In this instance the NBO practitioner was seen as providing a holding environment for the caregivers.

Throughout the caregivers accounts, the NBO programme was experienced as facilitating a bond with their infants. Bonding has been described as "the mother's coming to know, love, and accept the new infant, and is defined as an enduring relationship between parent and child that is unique, positive and specific to the child and occurs through the process of attachment" (Bowlby, 1969). This bond that is created between infants and their mothers was described by Bowlby (1958) as attachment. Similarly, Stern (1998), suggests that it is mothers who in most families play a crucial role in determining the emotional development of the infant (Stern, 1998). The emotional development of the infant is facilitated by the caregiver through the infant-caregiver relationship. Two predictors of the strength or quality of this relationship is the caregivers' ability to provide sensitive and responsive caregiving.

Most caregivers described the NBO programme as helping them develop sensitivity and responsiveness to their infant's behavioural cues and needs. The first part of the discussion emphasised the importance of caregivers forming a relationship with their infants which is important when considering concepts such as caregiver responsiveness and sensitivity. These qualities are important for forming a healthy attachment pattern between infants and their caregivers. The relationship or bond that was formed between infants and the caregivers was a result of the NBO programme. Appropriate maternal responsiveness and sensitivity is associated with better cognitive and psychosocial development for the infant (Perry et al., 2015; Schore, 2015; Tronick & Beeghly, 2011). Leerkes et al (2015) and Bornstein (2012) proposed that caregiver's sensitivity to infant distress has been demonstrated to be predictive of infants' subsequent social-emotional adjustment, in association with infant-mother attachment security, better affective and physiological regulation, social competence, and the absence of behavioural problems (Barlow et al., 2018; Beebe, 2010; Beebe, 2012; Schore, 2015).

Ways in which the NBO programme was not helpful

Although most caregivers perceived the NBO programme to be helpful, there were instances where the NBO programme did not help caregivers with their relationship with their infant. Some caregivers found it hard to bond with their infant due to the stress of environmental circumstances and living in a dangerous world. Alexandra township is a densely populated underdeveloped semi-informal settlement (Frost, 2012). The township is made up of formal dwellings and informal shacks with little infrastructure (Statistics South Africa, 2011b; Wilson, 2011). Within this impoverished community, there are high unemployment rates and high levels of violent crime. More than half of the children in Alexandra are living in father-absent/female-headed households. It seems that while fathers may be physically present, many mothers have a negative relationship with their children's father (Berg, 2012). Alexandra is also a township that is associated with high levels of gun violence (Nyapokoto, 2014). When

people are afraid of gun violence, this can also have a negative impact on people's right to education or health care. Individuals may be too afraid to attend schools or healthcare facilities or if these services are not fully functioning due to firearm violence in their community. This also means that people are constantly living in a hypervigilant state, suspicious of everyone and concerned for their safety.

Furthermore, most mothers are seen by an NBO practitioner straight after having given birth to their infant, while others are seen in their homes or at the clinics. Gubb (2010) described how mothers accessing healthcare systems in Johannesburg are not assisted by the medical staff who are supposed to offer support. Participants in this research also reported these experiences. Thus the trauma of the birth and the stress of unsupportive clinics or hospitals hindered caregivers from being able to respond meaningfully towards their infants.

The caregivers shared that the time and place where they were approached by NBO practitioners for assistance prohibited their capacity to respond. For these caregivers it became difficult to bond with their infant because they were preoccupied with environmental stressors. These caregivers were not receptive to the possibility that the NBO programme could help them foster a relationship with their infant. This is supported by Bain and Richards (2016) who suggested that caregivers who face challenges due to poverty, trauma and stress are less able to respond to the needs of their infant even though they may know what is best for their infant. Perhaps for these caregivers, due to their contextual circumstances, they are in survival mode and are only focused on making sure that their baby survives from day to day (Berg, 2012; Leholha, 2013; Nuttall, 2015; Tomlinson et al., 2005).

Most mental health interventions for infants focus on the caregivers. Cohen et al (1999, p. 431) stated: "A challenge in mental health interventions for infants is that although it is infants who are of greatest clinical concern, the actual focus of treatment is on the parents." However, the

Ububele NBO programme focuses on the infant; their feelings and emotions. Although when caregivers were unable to mentalise and regulate their own emotions, their capacity to remain present and respond to the NBO programme was limited. In these instances, the focus of treatment could not remain on the infant. Stern (1998, p. 112) conceptualised the "motherhood constellation" as a "new psychic organization" which develops at, or prior to, the birth of the infant. This constellation ascertains that most mothers are focused with protecting their infant (Stern, 1998). However, the caregiver having to always focus on the infants' wellbeing is emotionally and physically taxing for the caregiver. In this, is the portrayal of the harsh reality of living in impoverished circumstances that even a caregiver who tries her best to be the "good enough mother" cannot focus on forming an emotional relationship with her baby. This affects not only the mental health of the infant but also of the caregiver (Amos et al., 2011).

Thus it is critical to provide caregivers in such circumstances a holding environment. The idea of a holding environment was described by Stern (2006), as the "psychological framing and contextualisation of the mother in such a way that she feels validated, supported and encouraged". In order to create a rapport with her new-born infant the mother needs to have the appropriate holding environment as well as the support of others to do so (Winnicott, 1953; Stern, 1998). Winnicott suggested that a mother needs to experience being emotionally held by her support system, before she can offer the same to her infant (Winnicott, 1960)]. In this is the idea that the NBO program attempts to serve as a holding environment for caregivers who are continuously transitioning into the maternal role.

Cultural knowledge the caregivers felt the program did not include

All mothers expressed that consideration of culture in the NBO was necessary. This was important to note considering that the Ububele NBO programme is offered in a multicultural context. However, throughout their interactions with the NBO practitioners, all mothers were

aware that what had been communicated to them by the NBO practitioners was different to what they had learnt from their cultures. What seemed to be expressed by most of the caregivers is that there is a difference between considering cultural information when speaking about infant development and caregiving, and including cultural information. It seemed that for these mothers, the Ububele NBO programme had considered cultural information about caregiving and infant development but did not integrate cultural ways of being a mother.

The results from this research was incongruent with what Bromley (2010) found in her study in relation to cultural beliefs and caregiving. Bromley (2010) stated that cultural beliefs and practices which allowed mothers to think about their infants and motherhood in a particular way were not considered as being useful for the caregivers. This finding was also highlighted by Long (2009) who argued that cultural beliefs and practices are still seen as important for many South African caregivers, however some caregivers may rely on them less than what they used to. Most caregivers spoke about their cultural beliefs around feeding and bathing an infant that were different to what they had heard from the NBO practitioner. The mothers spoke about how they had learnt in their cultures that a mother does not feed her baby when she is upset. What had been communicated to these mothers by their elders is that their baby can sense when their mother is not well, and the mothers' distress could be transferred from her breast milk to the baby.

Most caregivers also spoke about the fact that when they bath their baby, there is little interaction between themselves and their baby as it is a task that merely needed to be fulfilled. The functions of these caregiving practices were to feed the infant if the infant was hungry and to bath the baby to ensure that the baby is clean. However, through the Ububele NBO programme these caregivers were told that they needed to interact with their infants during these tasks and the infant must be fed no matter how the caregiver is feeling. It seemed that the difference in caregiving practices were centred around two concepts, namely sensitivity and

responsiveness. These two concepts need to be present in the caregiver in order to form a healthy attachment between infant and caregiver, according to Western perspectives of a healthy caregiver-infant relationship (Cooper et al., 2009; Keller, 2018; Mesman et al., 2016).

However, researchers have suggested that despite the differences between cultures, the results of cross-cultural research provide support the universality hypothesis of attachment. This conclusion was reached through the evidence that all infants formed an attachment to their caregiver (Van IJzendoorn & Sagi-Schwartz, 2008; Zreik et al., 2017). It is worth mentioning that research has shown that in Western contexts, caregivers' responses to infant's behavioural cues are more verbal and of positive affect whereas verbal responses are less common in a Non–Westernised context (Dawson et al., 2018). Perhaps it could be argued that indeed an infants' attachment to a caregiver is influenced by sensitivity and responsiveness, however the way in which it is displayed differs across cultures (Keller, 2013). It is suggested that concepts such as sensitivity and responsiveness were unknown to the caregivers because this is not what they have heard when speaking about providing care for an infant in their culture. It would make sense then for the mothers to have felt that not enough cross-cultural knowledge about caregiving and infant development was included in the Ububele NBO programme.

Suggestions for how the NBO programme could change to accommodate cultural practices

Most caregivers spoke about their experiences and perceptions that culture needs to be included in the NBO programme. In thinking about their experiences, caregivers suggested that they would like the Ububle NBO programme to be conducted in different African languages. This was important for the caregivers as they could express themselves fully when using their own languages.

Berg (2002) lists the following factors as essential in any intervention implemented across cultural lines: (1) team work with persons from the community who speak the language and

are familiar with the cultural traditions and attitudes; (2) consistent and reliable presence and attendance in the community clinic and (3) an openness to the other culture with an awareness of the relativity of one's own culture. One intervention that can be argued to have implemented all the above, in some form or another, is that of the Ububele NBO programme. However, while it can be argued that these factors are embedded in the Ububele NBO programme, from the caregivers perspective it does not accommodate culture enough. Thus there needs to be a much larger focus on integrating culture into the Ububele NBO programme such as through the development of an NBO programme in various South African languages.

If there are important cultural beliefs about how caregivers should respond to their infants that are different to westernised perspectives of what is needed to enhance the caregiver-infant relationship, how much of the information communicated to caregivers during the NBO is actually held onto and utilised? It becomes imperative to have the NBO programme conducted by practitioners who come from the community, who speak African languages and who can carefully conduct the Ububele NBO while drawing from cultural practices, especially African cultures.

Berg (2002) has highlighted and addressed difficulties with translating, or transplanting, Western parent-infant practices into the South African field, which Ububele has done with the NBO programme. Fitzgerald and Barton (2000) made the important point that it is clear that much more work needs to be done to capture the rich cultural variation in infant development and family life. This is needed so that the resultant knowledge of infant development, infant-caregiver relationships, and the cultural context of early development describes the collective, rather than a narrow account from a particular cultural context. This reflects the need to find a balance between westernised perspectives and multicultural perspectives of infant development and caregiving. Perhaps in finding this balance, the Ububele NBO programme can foster healthy attachment relationships between infants and their caregivers while

accommodating cultural knowledge of caregivers. In this way the validity and utility of the Ububele NBO programme in a multicultural context may be recognised.

CHAPTER 6: CONCLUSIONS

This research aimed to explore caregivers' perceptions and experiences of the Ububele New-born Behavioural Observation program. Semi-structured interviews were conducted with eight caregivers from Alexandra Township who had undergone the NBO with their infants. Significant findings of the research will be summarized to provide insight into the general validity and utility of the of the Ububele NBO programme and address whether adjustments to the programme are needed. Thereafter, the limitations of the study are presented, and lastly directions for future research are explored.

Overall, it was perceived as a valuable program. Caregiver's noted that initially they were quite sceptical to complete the NBO programme since the caregivers were unsure of what their experience would be. However, once caregivers had been through the experience, they found that they were able to internalise the information that they had learned through their experience of the NBO programme. Some caregivers were not aware of what their baby could do developmentally which then influenced how they responded to their infants' behavioural cues. Most caregivers did not know that their infants could hear or see them. However, it was proposed that culture and socioeconomic circumstances influences parental knowledge of infant development. The NBO programme was perceived as an educative experience for the caregivers, as they were able to learn about the uniqueness of their infants and add to their knowledge of caregiving and infant development.

Part of the value that participants found in the programme is that they thought it was most useful in helping them form a relationship with their infant. The caregivers felt that the programme helped them become sensitive and responsive towards their infants, which are two requirements for the development of a healthy caregiver-infant attachment. In this sense, the

Ububele NBO programme was perceived as a port of entry similar to that described by Stern (1995).

It was noteworthy to highlight the context of the Ububele NBO programme and the socioeconomic backgrounds of the caregivers as this shaped and influenced how the caregivers approached forming a relationship with their infant. Although the hope in the use of the programme is to foster positive caregiver-infant relationships, some caregivers were unaware that they needed to form a relationship with their infants. However it seems that the impoverished context within which these caregivers live, accounts for their focus on physical survival as opposed to attending to emotional needs.

Some caregivers responded well to the NBO while others did not. This was raised by caregivers who expressed that transitioning to the maternal role was challenging and seems to have been heavily influenced by the trauma of giving birth within an impoverished and dangerous environment. Caregivers found that the NBO practitioners provided caregivers with a much needed "holding environment" where little to no other support was available.

Cultural practices were an important aspect when considering the utility of the Ububele NBO programme in a multicultural context, such as South Africa. It was found that what caregivers had learnt in their own cultures about caregiving and infant development was different to what they were taught in the Ububele NBO. This was mostly expressed in relation to feeding and bathing infants. The caregivers felt the NBO did not include cultural practices, but rather acknowledged the influence of culture in caregiving. Caregivers also thought of ways in which the Ububele NBO programme could accommodate cultural practices. For most caregivers it was important to have an African NBO programme that could be administered in different South African languages. Caregivers felt that one crucial aspect of cultural inclusion, was to

have the NBO administered by individuals who came from the same community as the caregivers, who understood the culture and who could speak their language.

Consideration also needs to be given with regards to when the Ububele NBO programme is administered. Firstly, many African cultures have an Umdelazane period in which the infant is not allowed to be touched by anyone other than the mother. Thus the timing of the NBO needs to be considered very carefully. Secondly, while most caregivers viewed the presence of the NBO practitioner as supportive and calming after having just given birth, most mothers are also in a lot of pain after the birth and might not have the capacity to fully take in and learn from the Ububele NBO programme.

6.2 Limitations of the research

Only eight caregivers were interviewed for this study. Thus the experiences and perceptions obtained are specific to the eight caregivers and cannot be generalised. It is also acknowledged that the narratives of the participants reflected their subjective understanding of the research topic. However, in a qualitative approach, subjective data is regarded as valid.

An additional limitation of this study is that the practitioners may not have been able to express their criticism fully. The caregiver's may have restricted their criticisms of the Ububele New-born Behavioural Observation programme due to the possible misperception that the researcher is associated with the organisation. However, it should be noted that the researcher did outline at the start of the interview that she has no associations with Ububele.

A further limitation is that the interviews were conducted in English. The disadvantage of this may be that participants were probably not able to fully express their experiences in English. This also may have impacted participants understanding of the interview questions.

6.3 Suggestions for future research

From this study several suggestions could be made for future research. Future research could explore the differences and similarities between caregivers' and NBO practitioners' perceptions and experiences of the NBO program to gain a more comprehensive understanding of the program. Quantitative research could be conducted regarding the efficacy of the NBO program. Various measures that assess the quality of the caregiver-infant relationship, the infant's responsiveness and the caregiver's sensitivity could be utilised in order to examine the outcomes of the service offered. Caregivers could be interviewed and a follow up interview conducted to gain a deeper understanding of the long-term impact of the NBO practitioner's work with infants and caregivers. Future research could also explore cultural perceptions of parenting in order to gain a deeper understanding of how this influences the caregiver-infant relationship.

In conclusion, it is hoped that this study has contributed towards a more in depth understanding of the subjective perceptions and experiences of caregivers who have experienced the Ububele NBO programme with their infant. Since this programme is the first of its kind in the South African context, it is hoped that this study also contributed towards the limited body of knowledge of parent-infant interventions in developing countries. While the overall task of this study was to explore the validity and utility of a westernised based programme transplanted in an underdeveloped multicultural context, it is evident that this programme has a great impact on the lives of caregivers and their infants.

It is important for therapists and practitioners who are thinking about developing a caregiver-infant intervention in a multicultural context to think carefully about the context in which the intervention is developed and include a sensitive approach towards cultural practices in the intervention. Results suggest that many factors need to be held in mind when assessing the

validity and utility of the NBO caregiver-infant intervention, especially when implemented in a different cultural and underdeveloped context. However once successfully implemented, it shows potential to improve the development of children and their relationship with their caregivers.

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APPENDIX A
LETTER OF PERMISSION FROM UBUBELE

Dear, Nicki Dawson and Katherine Frost

Gooday, my name is Aimee Langkilde and I am currently enrolled as a student for a Masters in Community-based Counselling Psychology in the Department of Psychology at the University of the Witwatersrand. In partial fulfilment of the requirements for this degree, I need to complete a research project. I propose to conduct a phenomenological – based study on caregivers' experiences and perceptions of the Newborn Behavioural Observation programme. Your input into this research is much appreciated. The research hopes to address the following questions;

1. What were caregivers' experience of the Ububele NBO program?

2. How did the Ububele NBO program impact the caregiver's relationship with their new-born?

a) In what ways, if any, did the intervention help their relationship?

b) In what ways, if any, did the intervention not help their relationship?

3. What cultural knowledge do the caregivers feel the program did not include?

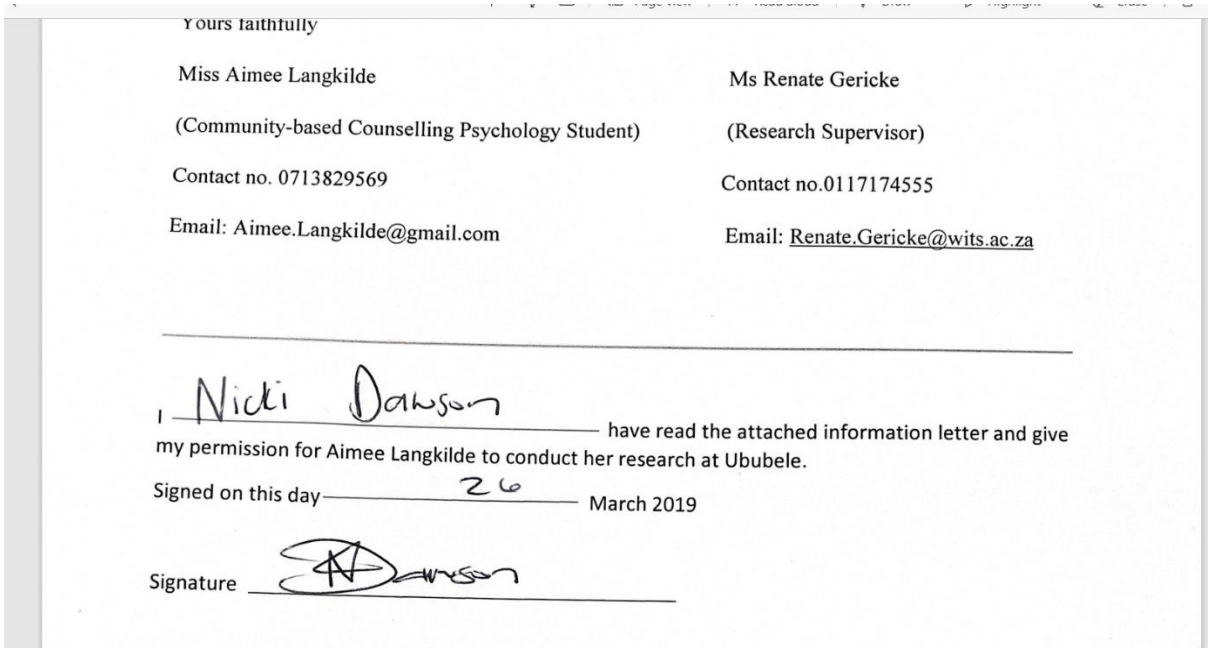
4. How could the program change to accommodate cultural knowledge?

Participants will be caregivers who have been through the NBO programme with their infant. They will be selected via purposive sampling and required to provide written consent in order to participate in this research. In addition, they will be required to provide written consent for audio recording of the data collection. I feel it is important to point out that when potential participants are approached, they will be informed that they will not be disadvantaged in any way if they chose not to take part take part in this study or rewarded if they do take part. Data will be collected by means of an individual interview. This interview will be conducted at Ububele and will be between 30 minutes to an hour.

Every effort will be made to ensure that confidentiality is maintained throughout this research process. The participant's identities will be protected as no identifying details will be included in the transcription of the recordings or quotes used to present the finding. The video recording of the focus group will be kept in a safe place and viewed only by myself, and if necessary my co-facilitator to assist with translations. Similarly the transcriptions will also be kept in a safe place and viewed only by myself and my supervisor. To enable publication, it will be necessary to keep the recording as well as the transcripts in a safe place for up to 7 years. To analyse the data collected, thematic analysis will be used to identify theses within the data. Once a final report has been compiled, I will provide a copy to your organisation. I look forward to conducting this research and potentially adding to the knowledge surrounding the NBO programme and would appreciate your approval to conduct this research. Should you have any questions regarding this study or wish to report any problems you have related to the study, please contact the researcher or research supervisor

Yours faithfully

Miss Aimee Langkilde	Ms Renate Gericke
(Community-based Counselling Psychology Student)	(Research Supervisor)
Contact no. 0713829569	Contact no.0117174555
Email: Aimee.Langkilde@gmail.com	Email: Renate.Gericke@wits.ac.za



Yours faithfully

Miss Aimee Langkilde — Ms Renate Gericke

(Community-based Counselling Psychology Student) — (Research Supervisor)

Contact no. 0713829569 — Contact no.0117174555

Email: Aimee.Langkilde@gmail.com — Email: Renate.Gericke@wits.ac.za

I Nicki Dawson have read the attached information letter and give my permission for Aimee Langkilde to conduct her research at Ububele.

Signed on this day 26 March 2019

Signature

APPENDIX B
ETHICS CLEARENCE

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

HUMAN RESEARCH ETHICS COMMITTEE (SCHOOL OF HUMAN & COMMUNITY DEVELOPMENT

CLEARANCE CERTIFICATE	**PROTOCOL NUMBER: MACC/19/004 IH**
PROJECT TITLE:	Exploring the cultural validity and utility of the Ububele newborn behavioural observation programme
INVESTIGATORS	Langkilde Aimee
DEPARTMENT	Psychology
DATE CONSIDERED	16 May 2019
DECISION OF COMMITTEE*	Approved

This ethical clearance is valid for 2 years and may be renewed upon application

DATE: 16 May 2019

CHAIRPERSON
(Dr Vinitha Jithoo)

cc Supervisor: Dr Rene Gericke
Psychology

DECLARATION OF INVESTIGATOR (S)

To be completed in duplicate and **one copy** returned to the Secretary, Room 100015, 10th floor, Senate House, University.

I/we fully understand the conditions under which I am/we are authorized to carry out the abovementioned research and I/we guarantee to ensure compliance with these conditions. Should any departure be contemplated from the research procedure, as approved, I/we undertake to submit a revised protocol to the Committee.

This ethical clearance will expire on 31 December 2021

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES

APPENDIX C
INTERVIEW SCHEDULE

1) What was your experience of the Ububele NBO program?
2) Was it different from what you expected?
3) How did the Ububele NBO programme impact your relationship with your infant?
4) How did you experience the practitioner during the NBO programme?
5) What information did you receive?
6) What did you think about the information you received?
7) What did you like about the NBO programme?
8) What didn't you like about the NBO programme?
9) If you could change something about the NBO programme, what would it be?
10) In what ways, if any, did the intervention help your relationship with your infant?
11) In what ways, if any, did the intervention not help your relationship with your infant?
12) What cultural knowledge do you feel the program did not include?
13) How do you think the programme could change to accommodate cultural practices?
14) How are you feeling now?

APPENDIX D
PARTICIPANT INFORMATION FORM

Hello,

My name is Aimee Langkilde. I am studying a Masters' degree in Community-based Counselling psychology at the University of the Witwatersrand and I would like to invite you to participate in my research project. Research is a process of finding out about something and I am interested in learning more about the Newborn Behavioural Observation programme. In order to do this, I would like to understand your opinion of the Newborn Behavioural Observation programme and what you think of this service. Participation in this study will be voluntary. You can choose to participate or not. If you decide not to take part in this study, you will not be disadvantaged in any way. Likewise, if you agree to participate there will be no direct benefits. Should you be willing to take part, I would like to invite you to come to an interview at Ububele. I will do the interview with someone else who can assist with translations as I only speak English. During the interview I will ask a few questions to guide the discussion.

It is important to point out that there are no right or wrong answers. At no time will you be forced to answer any questions. It will be your decision to respond as and when you wish.

The interview will take about 30 minutes to an hour. Like the NBO, you will be invited to bring your baby along. In addition, your identity will be protected as no identifying details will be included in the transcription of the recordings or quotes used to present the findings. So that I can remember as much detail as possible, it will be necessary for me to audio record the interview. However, this recording will only be heard by myself and if necessary my co-facilitator to assist with translations. This audio recording will be kept in a safe place. Later when I write up the details of what we discussed in the interview I will remove your name and use a pseudonym. These transcripts will only be seen by my research supervisor and myself. They will also be kept in a safe place. When I write up my report, I will use direct quotes from the interview. However, once again no identifying information will be included. After the final report has been written, it will be necessary to keep the recording as well as the transcripts in a safe place for up to 7 years to make it possible to publish the findings.

The finished report will be distributed to the therapists who run the NBO programme, the people who mark my report and a copy will be kept in the library at the University if the Witwatersrand. If you would also like an overview of the research results and findings or a copy of the full report, I will provide you with these with pleasure. My contact details and those of my supervisors are attached to this form. Should you choose to participate, please complete the two consent forms. The one is your consent to participate in this research. The other is your consent for the audio recording. If you would like further information, or have any other questions, or would like to report any negative experience regarding this research, please feel free to contact either me or my supervisor. I don't anticipate that the interview will harm you in any way. However, if you experience difficulties after participating, you may access one of the following free therapy services:

- Ububele Umdelzane parent-infant psychotherapy service (contactable on 011 786 5085)
- Emthomjeni Community Psychology Clinic (contactable on 011 717 4513)
- Lifeline (contactable on 0861 322 322)

Yours faithfully

Miss Aimee Langkilde Ms Renate Gericke

(Community-based Counselling Psychology Student) (Research Supervisor)

Contact no. 0713829569 Contact no.0117174555

Email: Aimee.Langkilde@gmail.com Email: Renate.Gericke@wits.ac.za

APPENDIX E
PARTICIPANT'S CONSENT FORM FOR INTERVIEW

Dear Participant,

Research Title: Exploring the Ububele Newborn Behavioural Observation programme.

Participant's Name (optional):
_____consent to my interview with Aimee Langkilde and (translator) for Aimee's study on the Newborn Behavioural Observation Programme. I understand that:

- The study has been described to me in language that I understand.
- I freely and voluntarily agree to participate.
- My questions about the study have been answered.
- I may withdraw from the study without giving a reason at any time and this will not negatively affect me in any way.
- I have the choice to not answer any questions I do not want to answer.

- I may stop the interview at any time.
- Direct quotes will be used in the report, however, no personal information that may identify me will be included in the research report, and my responses will remain confidential.
- I am aware that a copy of the finished report will be kept in the library at the University of the Witwatersrand and will be available to people who have access to this library.
- If a journal article is published the interview recording (or notes taken) as well the transcript will be kept in password-protected files as well as in a locked cupboard for 2 years. If no publication arises they will be kept in these places for 7 years and then burned thereafter.
- There are no direct benefits for me in participating in this study.
- There are no anticipated risks for me participating in this study.

Participant's signature: _____

Date: _____

APPENDIX F
PARTICIPANT'S CONSENT FORM FOR AUDIO RECORDING



Dear Participant,

Research Title: Exploring the Newborn Behavioural Observation programme

Participant's Name (optional):
_____consent to my interview with Aimee Langkilde and (translator) for Aimee's study on the New born Behavioural Observation Programme to be audio recorded. I understand that:

- The tape and transcript (these are written documents which contain what has been said in the interview) will not be heard or seen by the organisation or any other person at any stage.
- The tape will be heard by the researcher only.
- When the audio is used to write up the transcript, only the researcher will listen to it.
- Everything will be kept in a secure place, which only she will be able to access, while the study is ongoing.

- No personal information, such as names (yours, your infant's, your family etc.) or places (where you live, where you are from etc.), will be used in the transcripts.
- Only the researcher and her supervisor will have access to my transcript, however, the supervisor will not know any of my identifying information.
- After the report is finished my interview recording and transcript will be kept in a safe place, that only the researcher will have access to for 6 years.

I hereby agree to the audio- recording of my participation in this study:

Participant's signature: _____

Date: _____