An Investigation of the Experience of Osteopathically Treating Babies with Breastfeeding Problems

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Abstract

Aim – The aim of this phenomenological study was to investigate and describe the osteopath’s experience of treating a baby who has problems breastfeeding.

Background - Breastfeeding impacts positively on both maternal and child health in many ways. However the act of suckling is a complex sensory motor task for a baby and numerous problems can occur. Osteopathic practices commonly advertise that babies’ breastfeeding problems can be alleviated with osteopathic treatment yet there is little research regarding the osteopathic experience and the methods employed by osteopaths to diagnose and treat babies with breastfeeding problems.

Method – Participants comprised of five osteopaths who have practiced as a fulltime osteopath for at least five years and are experienced in treating babies with breastfeeding problems. Data was collected during five face-to-face semi-structured interviews that were conducted by the primary researcher. Interviews were transcribed and the textual data was analysed using the principles of van Manen’s (1997) hermeneutic phenomenology. Using this approach, significant themes were identified in the data and a description of the lived experience of osteopathically treating a baby who is having problems breastfeeding emerged.

Results – Three phenomenological themes were identified in the data and broken down further into constituent subthemes. Theme [A] Beliefs – The foundation, drew attention to the participant’s beliefs surrounding the self healing mechanisms of the human body, their role as an osteopathic practitioner and also a belief that they were unaware of a set protocol when osteopathically treating babies with breastfeeding problems. Theme [B] Communication – a necessity for a successful treatment, identified practitioner-mother-patient communication as the nucleus of a successful treatment outcome. Theme [C] The Process explored the non-verbal conversation the participants employ when treating babies and also identified the treatment providers the participants work with and refer their patients to when working with babies who have breastfeeding problems.

Conclusions – For osteopaths treating babies with breastfeeding problems the importance of trust between themselves and the mother permeates the osteopathic experience. Through verbal and non-verbal communication the osteopaths are able to establish a positive therapeutic environment so that a successful treatment can transpire. Furthermore the osteopaths identified employing a non-verbal conversation with the baby throughout the treatment session that is expressed through their intention and touch. This non verbal conversation was identified as a critical component of the therapeutic interaction.
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Chapter One:
Introduction
This project is a qualitative investigation of the experience of providing osteopathic treatment for babies who have problems breastfeeding. Osteopaths were interviewed to gain knowledge of the experience of diagnosing, treating and managing babies with this particular complaint.

This chapter will outline the research project undertaken and introduce the rationale behind the study and the methodology used to gather and analyse the data. The literature review in Chapter Two will discuss findings of recent research relevant to the experience of osteopathically diagnosing and treating babies with breastfeeding problems. The third and fourth chapters outline the research methodology and philosophy that guided this study and the process that was drawn upon to complete this project. The fifth and sixth chapters respectively analyse and discuss the themes that emerged from the data. The seventh chapter concludes with a discussion of the main findings of the study, the study’s limitations, directions for future research and the implications for osteopathic practice.

**Outline of the Study**

Breastfeeding impacts both maternal and child health in many ways and is the most cost-effective, health promoting, and disease-preventing activity new mothers can perform (World Health Organisation, 2007). Research has demonstrated the significant nutritional, developmental, psychological, immunologic, social, economic, and environmental benefits of breastfeeding (American Academy of Pediatrics, 1997). However, early breastfeeding disturbances are quite frequent in the infant population, affecting around 25% - 35% of children (Ammaniti, Ambruzzi, Lucarelli, Cimino, & D'Olimpio, 2004).

In this research project a breastfeeding problem is classified as when a baby is unable to effectively remove milk from the breast during breastfeeding and/or is unable to obtain enough milk through breastfeeding to gain weight (University of Virginia Health System, 2004).
The act of suckling is a complex sensorimotor task for a neonate, involving coordination of sucking, swallowing and breathing (Medoff-Cooper, 2004). Numerous problems in sucking can occur and many women consult physicians for assistance with breastfeeding difficulties (Dennis, 2002).

Lactation consultants anecdotally report that osteopathy offers success in treating neonates with breastfeeding problems which have not responded positively to correction of basic issues such as appropriate positioning, attachment and milk supply (Brussel, 2001). Osteopathic practices commonly advertise that neonate breastfeeding problems can be alleviated with osteopathic treatment (Brussel, 2001; Frymann, 2008; Wescott, 2004). However, there is little research regarding the osteopathic experience and the methods employed by osteopaths to diagnose and treat babies with breastfeeding problems.

The researcher employed a hermeneutic phenomenological method to analyse interviews of five osteopaths. The participants selected have practiced as fulltime osteopaths for at least five years and are experienced in treating babies with breastfeeding problems. Analysis of the data collected from the interviews suggested that the participant’s were not aware of utilising set protocols’ when treating babies with breastfeeding problems, but that the communication methods utilised by the participant’s when conversing with and educating the mother, and the non-verbal conversation between the practitioner and the baby were highly influential in the treatment outcome.
Personal Background

I am a twenty-six year old female New Zealander who as a five year old experienced the ‘magic hands’ of an osteopath. I remember walking into the osteopath’s treatment room with nausea generated from the pain in my neck caused by a fall the previous day. I walked out of the room with minimal pain and the ability to move my head in every direction. It felt as if I had been introduced to something enchanting and delightful, much like the Easter bunny and fairy lands that had been a part of my life up until this point. This one thirty minute consultation imprinted itself on my life and the path that I would create for myself.

From that particular experience, I developed an interest in the power of one human to help another without the aid of “western medicine”. As I grew into adulthood the mystical illusion of osteopathy was replaced by the knowledge of its primary tenets, however I still remained passionate about this treatment modality. Throughout my years of study a new interest started to resonate inside me, and that was the osteopathic treatment of women through their pregnancy and also the treatment of babies.

Throughout my tertiary education I worked part-time as a nanny, and have listened to many mothers talk about the positive experiences they have had when taking their baby to an osteopath for treatment. One particular mother had experienced a lot of trouble breastfeeding her baby and it was only out of pure desperation she decided to take her baby to an osteopath. The treatment was successful and the mother could happily breastfeed and provide for her child from her own body as she had always expected to be able to do.

This mother felt a little like I did as a five year old: the osteopath had ‘magic hands’. She therefore asked me to explain to her how the osteopath could hold her baby’s head and fix the breastfeeding problem. My explanation was poor, and left her more confused than she previously had been. I realised that I personally did not understand the concept of Osteopathy in the Cranial Field (OCF) and this lead me down a research path to inform myself in this particular area.
As with many areas of osteopathy there was only a small amount of literature regarding the treatment of breastfeeding problems. Through reading research in other health disciplines I understood that there was usually more than one issue that lead to a breastfeeding problem. From this awareness I wanted to understand the experience of an osteopath treating a baby with breastfeeding problems and how they achieved a successful outcome. It is only through knowledge that an understanding can be gained and then passed on for the benefit of other osteopaths.

**Rationale**

Ninety percent of newborns are exclusively breastfed when discharged from hospital in New Zealand (Ministry of Health, 2002). However, despite the known benefits of breastfeeding, breastfeeding prevalence drops dramatically in the first 4-8 weeks postpartum, with fewer than 35% of woman exclusively breastfeeding their child at four months of age. Most woman cease breastfeeding due to difficulties with feeding rather than maternal choice (Dennis, 2002).

New Zealand has breastfeeding rates at birth that are consistent with other Organisation for Economic Co-operation and Development (OECD) countries, but low rates at six weeks, especially among Māori and Pacific Island women (National Breastfeeding Advisory Committee, 2007b). Exclusive breastfeeding prevalence drops sharply in the first six weeks post-partum and then continues to decline as partial and artificial feeding becomes more common.

In 2002, the Ministry of Health recommended the following New Zealand breastfeeding targets:

- Increase the breastfeeding rate (exclusive and fully) at six weeks to 90% by 2010.
- Increase the breastfeeding rate (exclusive and fully) at three months to 70% by 2010.
- Increase the breastfeeding rate (exclusive and fully) at six months to 27% by 2010.
It is suggested that some of the problems found to cause breastfeeding problems in babies could be treated osteopathically. A literature search revealed limited research into the effectiveness of osteopathy in the treatment of babies with breastfeeding problems. In most of the research relating to this subject, authors recommend treatment methods but provide no gold standard evidence of their treatment effects. The authors do not offer solid evidence for the mechanism of action of the treatment they recommend and do not discuss the experience of treating this particular complaint. A pilot study by Fraval (1998) using six participants, successfully treated babies with breastfeeding problems using osteopathy. Fraval stated that larger scale research in this area is needed to validate his results.

At present The British School of Osteopathy offers a validated two year Master of Science in Paediatric Osteopathy. Part of the curriculum involves learning to treat babies with feeding problems (The British School of Osteopathy, 2008). This would imply that there is a body of knowledge specific to this subject. As previously stated there seems to be only a small validated knowledge base in this particular area of paediatric osteopathy.

It is hoped that the descriptions that are revealed in this study will help the osteopathic profession to understand more fully the experiences of osteopaths treating babies with breastfeeding problems and their role as primary health practitioners.

**Methodology**

The focus of this study was to elicit the lived human world of an osteopath who provides treatment for babies with breastfeeding problems. To effectively reveal this experience, a qualitative methodology was selected through which the phenomenon could be explored within context. The researcher chose hermeneutic phenomenology as a qualitative approach to data collection and analysis in an effort to understand the significance of the osteopathic treatment experience by the osteopaths involved.
As a guide towards ensuring a methodological fit within the tradition of phenomenology, the study utilised Colaizzi’s (1978) process of data generation and thematic analysis. Descriptions of hermeneutic phenomenology by van Manen (1997) were also used as a guide to the application of reflection and the use of language in writing this phenomenological text. The theory and application of the methodology is detailed in Chapter Three.

The next chapter will discuss the findings of recent research regarding breastfeeding problems, including the benefits of breastfeeding, specific aetiologies for breastfeeding problems, and then the management of these problems within health care literature. The chapter concludes with a more detailed examination of the manual therapies literature.\(^1\)

\(^1\) In the current study manual therapy will refer to all therapies which use manipulative techniques including physiotherapy, osteopathy and chiropractic.
Breastfeeding is the physically connected relationship between a mother and child for the establishment of life outside the womb and for the transition from dependent infant to secure independent child (James, 2007). This literature review sets out to explore and examine infant breastfeeding problems and the management and treatment of these problems in different healthcare modalities. In an attempt to organise this broad review into a coherent structure, the study will begin by examining the benefits of breastfeeding to child, mother and society, and prevalence rates of breastfeeding in New Zealand. The review then examines the physiology and anatomy of breastfeeding and identifies specific breastfeeding problems. To conclude the review, infant breastfeeding management and the treatment of breastfeeding problems is explored in healthcare literature, beginning with the initial management (by midwives, lactation consultants, nurses and physicians) followed by a more specific examination of the manual therapies literature.

**Benefits of Breastfeeding for Child**

Breastfeeding impacts on both maternal and child health in many ways. It is the most cost-effective, health promoting, and disease-preventing activity new mothers can perform (World Health Organisation, 2007). Research has demonstrated the significant nutritional, developmental, psychological, immunologic, social, economic and environmental benefits of breastfeeding (American Academy of Pediatrics, 1997). Compared with formula-fed children, those who are breastfed:

- Score higher in cognitive and IQ tests at school age, and also on tests of visual acuity (Anderson, Johnstone & Remley, 1999; Drane & Logemann, 2000).
- Have a lower incidence of Sudden Infant Death Syndrome (SIDS) (Dennis, 2002).
- Are less likely to suffer from infectious illnesses and their symptoms (E.g. diarrhea, ear infections, respiratory tract infections and meningitis.) (Heinig, 2001).
- Have a lower risk of the two most common inflammatory bowel diseases (Crohn’s disease, ulcerative colitis) (Heinig, 2001).
• Have a lower risk of juvenile onset diabetes, if they have a family history of the disease and are breastfed exclusively for at least four months (Heinig, 2001).
• Have a lower incidence of Hodgkin’s disease and childhood leukemia (Davis, 1998).
• Are significantly protected against asthma and eczema, if at risk for allergic disorders and exclusively breastfed for at least 4 months (Oddy, Holt, Sly, Read, Landau & Stanley, 1999).

Systemic reviews and meta-analysis by the World Health Organisation (WHO) suggest that there are long-term benefits for individuals who are breastfed including:

• Lower blood pressure
• Lower total cholesterol
• Less likelihood of being considered as overweight and/or obese
• Less likely to present with type-2 diabetes
• Better school performance in late adolescence or young adulthood (World Health Organisation, 2007).

The psychosocial benefits of breastfeeding are also significant. Nursing can provide a valuable source of security and comfort for a baby (Medoff-Cooper, 2004). The tactile system is one of the earliest and most primitive senses the human embryo develops. A classic study by Harlow (1958) discovered an infant monkey’s need for “contact comfort” (physical contact for reassurance) outweighed their need for either food or warmth. In fact the results were so remarkable that Harlow concluded “the primary function of nursing as an affectional variable is that of ensuring frequent and intimate body contact of the infant with the mother” (Harlow, 1958).
Chapter Two: Literature Review

**Benefits of Breastfeeding for Mother**

Mothers and babies form a beneficial biological and social unit; the health and nutrition of one group cannot be divorced from the health and nutrition of the other (World Health Organisation, 2003). Women who breastfeed experience lower rates of post-partum hemorrhage, and in the longer term, lower rates of breast and ovarian cancer (Labbok, 2001). Findings from a collaborative reanalysis of individual data from 47 epidemiological studies in 30 countries suggest that the longer women breastfeed, the more they are protected against breast cancer. The authors suggest their findings indicate that the lack of, or short lifetime duration of breastfeeding typical of women in developed countries, makes a major contribution to the high incidence of breast cancer in these countries (Collaborative Group on Hormonal Factors in Breast Cancer, 2002).

Along with psychosocial benefits for infants who breastfeed, there has been a concurrent increase in literature regarding psychosocial benefits for mothers. Breastfeeding is linked with increased maternal sensitivity, responsiveness and bonding with their infants (Britton, Britton, & Gronwaldt, 2006), and with women’s and familys’ social and cultural connectedness. Ellison-Loschmann’s (1997) study on the experience of Maori women in breastfeeding claimed that the women received emotional comfort from breastfeeding and held the belief that they were providing something special for their infants.

**Benefits for Society**

Breastfeeding is economically beneficial. Artificial feeding is expensive for families and can contribute additional costs to the health system. Artificially-fed infants are significantly more likely to be seen in primary care and/or admitted to hospital and experience health problems in later life (Cattaneo, Yngve, Koletzko, & Gusman, 2005). In addition, women who breastfeed demonstrate to families, friends, communities and society at large that breastfeeding is the normal and healthy way to feed infants and young children (National Breastfeeding Advisory Committee of New Zealand, 2008).
Breast milk is the most ecologically sound food source available to humans. It is produced and delivered to the consumer without any pollution. It is a natural resource of enormous value and its use has only positive effects on the environment (Baumslag & Michels, 1995). However, breast milk is threatened by social attitudes towards breastfeeding and more significantly, by the promotional tactics of baby-milk companies (Radford, 1992).

Bottle-feeding causes the deaths of 1.5 million babies, and ill health in countless others, every year. It pollutes the air, water and land, wastes resources, creates disposal problems and increases population levels; packaging of baby-milk formula reduces resources such as tin, paper and plastic; while feeding bottles, teats and related equipment require plastic, glass, rubber and silicon (Radford, 1992). These materials are rarely recycled, so they increase the already huge waste problems. The milk and packaging materials often travel considerable distances before processing and once ready for the market, have to be transported to the consumer. Ecuador, for example, imports milk from the USA, Ireland, Switzerland and Holland (Frank & Newman, 1993).

**Breastfeeding Prevalence in New Zealand**

In the early 1970s, fewer than 50 percent of infants had received any breast-milk when first seen by a Plunket nurse or clinic within the first six weeks of life. New Zealand now has a high rate of exclusive breastfeeding initiation with 94 percent of mothers breastfeeding when discharged from hospital. However, there was a significant decline in the prevalence of exclusive breastfeeding through the first six months of infants’ lives (Ministry of Health, 2002).

In 2006 the National Breastfeeding Advisory Committee (NBAC) was formed by the Ministry of Health with the purpose of providing expert advice and guidance on breastfeeding to the Director-General of Health. The Ministry of Health guidelines recommend for infants’ to be exclusively breastfed for six months (National

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\(^2\)Plunket refers to services provided by the Royal New Zealand Plunket Society (Inc).
Breastfeeding Advisory Committee, 2007a). In 2008 the Ministry of Health launched a breastfeeding campaign. This campaign aims to increase the number of women breastfeeding at: six weeks to 74 percent or greater, three months to 57 percent or greater and six months to 27 percent or greater (National Breastfeeding Advisory Committee of New Zealand, 2008).

At present New Zealand has breastfeeding rates at birth that are consistent with other OECD countries. There are however low rates of breastfeeding at six weeks, especially among Maori and Pacific women (National Breastfeeding Advisory Committee, 2007a). Exclusive breastfeeding prevalence drops sharply in the first six weeks post-partum and then continues to decline as partial and artificial feeding becomes more common.

**The Art of Feeding**

The importance and benefits of breastfeeding for child, mother and society have been clearly established; however, as previously stated, in New Zealand there is a significant decline in the prevalence of exclusive breastfeeding through the first six months of infants’ lives. The reasons for this decline will be discussed later in this chapter. Firstly, the complexity of breastfeeding and nutritive sucking\(^3\) will be discussed. Because this study focuses on the osteopathic experience of diagnosing and treating babies with breastfeeding problems, this study will now focus on the physiology and anatomy of the baby in the act of breastfeeding rather than both mother and child.

The act of suckling involves coordination of sucking, swallowing, and breathing. In the embryonic period the fetus begins to prepare itself to perform tasks of sucking, swallowing, breathing and crying, which make possible its survival after birth. The newborn is born with oral reflexes, which guarantee their feeding at the initial stages of development and have distinct anatomical features, which facilitate feeding in the neonatal period (Sanches, 2004).

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\(^3\) Nutritive sucking is characterised by repetitive mouthing on a nursing nipple to get fluid from the nipple despite negative intraoral pressure (Sergueff, 2007).
The complexity of the neonatal sucking mechanisms was distinguished in early, classic research by Logan and Bosma (1967), more than five decades ago. They describe these mechanisms as involving sucking movements that precede swallowing with inhibition of respiration. Nipple compression by the mandible and intraoral suction facilitates the delivery of fluid into the mouth. The fluid is carried to the back of the pharynx by action from the tongue as it presses against the palate. With closure of the pharyngeal walls, the fluid is then propelled towards the oesophagus.

Several different methods have been employed to analyse and observe neonatal sucking behaviour in natural conditions. Methods such as radiological studies, ultrasonographic studies and measurement of the sucking pressure flow and volume consumed by the infant have been used to analyse the sucking behaviour. Eishima’s (1991) study utilised a special camera and fibroscope to analyse the sucking movements and to observe the total sucking behaviour. The advantage of this method is the ability to take pictures safely in natural conditions very similar to the usual feeding situations. Eishima’s results found methods of oral movements similar to those described in previous work in this area. Eishima also ascertained that infants engage in trial and error and show complicated responses in order to adapt to different conditions.

As well as engaging in trial and error, in the first year of life feeding is also influenced by the natural process of neural and anatomical maturation (Kelly, Huckabee, Jones, & Frampton, 2007). Kelly et al’s (2007) study provided the first documented report of the maturation of breathing-swallowing coordination. The study examined ten healthy “term” human infants through their first year of life. The data obtained suggests that while post-swallow expiration is a robust feature of breathing-swallowing coordination from birth, two major shifts in the precise pattern occur. In the first, after 1 week of postnatal feeding, mid-expiratory swallows decrease rapidly. The second pattern is between 9 and 12 months where swallows were followed by expiration which is an adult-like characteristic.

The change observed within the first week of life in the above study, highlights the potential impact of early postnatal experience on the central pattern generators that coordinate breathing and swallowing. Cadwell (2007) claims that “oral feeding for the newborn is entirely reflexive”. Immediately after birth, however, the learning process
begins with its dependence on experimental opportunities, sensory inputs and nervous system maturation so that feeding and swallowing gradually changes from a reflexive to a volitional process. Another likely contributor to the maturation of breastfeeding in the first year of life is the changing and growing anatomy, specifically the decent of the hyoid bone and larynx (Medoff-Cooper, 2004).

**Breastfeeding Problems**

While our understanding of human lactation and breastfeeding has expanded recently, most interventions relevant to nursing difficulties emphasise the mother. Little focus has been placed on the baby as the source of dysfunctional breastfeeding (Hewitt, 1999). This particular study focuses on the experience of osteopathically treating a baby with breastfeeding problems. I do acknowledge that the mother can be the primary source of dysfunction, but for this study I will focus on the baby as the primary source of breastfeeding dysfunction.

Barber, Abernathy, Steinmetz, & Charlebois (1997) argue that a major factor for the early use of formula when feeding an infant is because of difficulty breastfeeding rather than maternal choice, Bick, MacArthur, & Lancashire (1997) also agree with this reasoning. There are many different reasons why a baby cannot breastfeed, this study will now explore different classifications and hypotheses established for analysing and diagnosing breastfeeding problems.

Walker (1998) used broad categories to classify breastfeeding problems. His six common clusters of breastfeeding situations or problems commonly seen in clinical practice were: inadequate infant weight gain, insufficient milk supply, nipple problems, latch-on and sucking disorganisation, high risk situations and the “good baby” syndrome. Inadequate infant weight gain included both dysfunction in mother and baby. Dysfunction in baby included interference to proper latch on due to decreased oral sensitivity, orofacial abnormalities (such as temporary facial nerve paralysis, cleft palate/lip, and short frenulum, high or grooved palate) and sucking disorganisation or dysfunction. Sucking disorganisation or dysfunction is described as occurring when a
baby has a suck pattern or lack of suck pattern that prevents them consuming enough milk for adequate weight gain (University of Virginia Health System, 2004). The “good baby” syndrome may be described as the infant failing to act hungry, sleeping much of the day or longer than six hours at night as a newborn and rarely crying. In this situation the potential exists for the infant to be underfed and fail to gain weight adequately.

Medical and nutritional problems causing feeding difficulty with failure to thrive have traditionally been defined as organic, whereas psychological and behavioural causes have been defined as nonorganic (Bithony, Junkin, & Michalek, 1989). Numerous authors have stated that efforts to reduce a disorder to a simple organic/nonorganic dichotomy has been unsuccessful. This is because feeding is a highly integrated, multisystem skill, and there may be one or more contributing systems that is dysfunctional. Clinicians have also suggested that oral motor and sensory based feeding disorders have been identified. The concept of introducing oral feeding problems as a separate category is still controversial because they are not recognised in earlier studies or are misclassified as medical or behavioural problems (Rommel, De Meyer, Feenstra & Veeremen-Wauters, 2003).

In a 2003 study, Rommel et al. examined the aetiology of feeding difficulties in 700 children. Fifty percent of the sample were under one year of age, with the mean age being four months. Each child was first evaluated by a physician (a fully trained paediatric gastroenterologist). The children were then examined by a speech-language pathologist trained in paediatric feeding problems who performed a clinical examination and a feeding observation to assess oral motor and sensory functions. A dietician and a behavioural psychologist also performed functional analysis.

Based on the clinical evaluation, the patients were classified into three categories: medical, oral and behavioural. Medical causes were specific diagnoses based on clinical findings and confirmed by diagnostic examination when indicated. An oral problem was any oropharyngeal functional abnormality diagnosed by a feeding specialist. A behavioural psychologist performed a functional analysis of the child and caregiver’s behaviours by interview and direct observation. The results obtained by Rommel and colleagues established that: 81% of the patients had a medical problem (the most
common being a gastrointestinal problem; Gastroesophageal Reflux Disease). 61% had an oropharyngeal dysfunction and 18% had a behavioural problem. In 1.6% of the participants no problem could be identified. Of the oral feeding problems, the most frequent isolated oral feeding problems were related to sucking and were sensory based. From these results Rommel and colleagues proposed that feeding problems be classified as medical, oral and behavioural. They also stated that oral problems are a major contributing factor to feeding difficulties in children. The results and conclusion obtained from this study were reputable due to the multidisciplinary team approach and large number of participants involved.

Sanches (2004) also categorises feeding problems (breastfeeding only) differently from the classic categorisation of organic and non-organic problems. In her review article she states that there are several factors that may cause sucking disorders during breastfeeding: intercurrent clinical events, low birth weights, metabolic disorders, neurological disorders, syndromes and congenital abnormalities such as cleft palate, submucosal fissures, ankyloglossia and laryngomalacia. She states that the use of orogastric and nasogastric tubes in the treatment of preterm babies can also interfere with the normal development of the suck/swallow/breath pattern. In addition to factors above, there may be a more specific suckling disorder in healthy full term babies without intercurrent clinical events, known as oral motor dysfunctions.

Oral motor dysfunctions are argued to be the consequence of a newborn’s neurological immaturity, facial pain, individual anatomical features or iatrogenic factors, such as the use of artificial teats. Immediately after birth, some newborns show uncoordinated oral reflexes. It can take the newborn some days to develop a more mature pattern which may occur concomitantly with milk let-down, on the third or fourth day after delivery. Oral anatomical dysfunction can also occur in the baby (high-arched palate, retracted jaw, or short or excessively tight frenulum – ankyloglossia) resulting in inappropriate latch on (Sanches, 2004).
Initial Management of Breastfeeding Problems

I have discussed aetiologies with regard to breastfeeding problems in babies. I will now discuss management of those breastfeeding problems by physicians, nurses, midwives and lactation consultants. These four groups of healthcare practitioners are generally the first to diagnose and provide education, treatment and support for babies with breastfeeding problems (Sinusas & Gagliardi, 2001).

Hospital practices are very influential when new mothers are establishing and initiating breastfeeding. Support and encouragement by informed healthcare workers, the reduced influence of artificial feeding practices, keeping the mother and infant together and feeding early and frequently by infant-led demand, are practices promoted in many hospitals for successful long term breastfeeding (Narramore, 1997).

Another initiative that is suggested to increase the long term success of breastfeeding is the utilisation of the “Ten steps to successful breastfeeding” (Philipp & Merwood, 2004). The Ten Steps to Successful Breastfeeding are evidence-based best practice standards developed by UNICEF and the World Health Organisation. They are designed to enable improved practice in maternity units in order to promote, protect and support breastfeeding. Maternity services that adopt the Ten Steps to Successful Breastfeeding can apply to be assessed and accredited as “Baby Friendly”. “Baby Friendly” accreditation requires that maternity units implement all ten steps and practise in line with the International Code of Marketing of Breastmilk Substitutes (World Health Organisation, 1998).

The ten steps are:

- Maintain a written breastfeeding policy that is routinely communicated to all health care staff.
- Train all health care staff in skills necessary to implement this policy.
- Inform all pregnant women about the benefits and management of breastfeeding.
Help mothers initiate breastfeeding within one hour of birth.

- Show mothers how to breastfeed and how to maintain lactation, even if they are separated from their infants.
- Give infants no food or drink other than breastmilk, unless medically indicated.
- Practice “rooming in” - allow mothers and infants to remain together 24 hours a day.
- Encourage unrestricted breastfeeding.
- Give no pacifiers or artificial nipples to breastfeeding infants.
- Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic (World Health Organisation, 1998).

From the literature reviewed it appears that most of the treatment for breastfeeding problems focuses on support and education for the mother. Hodinott and Pill (1999) believe successful breastfeeding depends on the mothers acquisition of basic skills and accurate information. This success is strongly influenced by the quality of help and support provided during pregnancy, childbirth and the postpartum period. Many authors state that the correct position of the baby on the breast is very important in successful breastfeeding (Narramore, 1997; Sinusas & Gagliardi, 2001). While Henschel and Inch (1996) state that “it is the secret to breastfeeding”.

Although lactation experts suggest that correct positioning and attachment techniques reduce breastfeeding problems and enhance long-term breastfeeding, evidence from randomised trials is lacking (Henderson, Stamp & Pincombe, 2001). The objective of Henderson’s et al., (2001) study was to evaluate the effect of postpartum positioning and attachment education on breastfeeding outcomes in first-time mothers. The randomised controlled trial performed in a public hospital concluded that structured one-on-one education (experimental group) compared to the usual postpartum care (control group) did not increase breastfeeding duration at any assessment time or demonstrate any differences on secondary outcomes (nipple pain, trauma and satisfaction of breastfeeding) between groups.
While Henderson’s et al (2001) study found no increase in breastfeeding duration with structured one-on-one support, Bonuck, Trombley, Freeman & McKee, (2005) carried out a similar trial and found contradictory results. The objectives of this study were similar to the previously discussed study. This being to determine whether an individualised, prenatal and postnatal lactation consultant intervention resulted in increased cumulative intensity of breastfeeding up to 52 weeks. The study was a randomised, non-blinded, controlled trial in which a sample group of 304 women were recruited from prenatal care. The intervention group completed two prenatal meetings with a lactation consultant, a postpartum hospital visit and home visits and telephone calls. The control group were provided with the standard care for that particular community health centre. This included a mandatory prenatal care class which did not address infant feeding. At the site there was no established protocol for breastfeeding education or support. From their results, Bonuck and colleagues ascertained that the intervention group were more likely to breastfeed through to week 20. However, exclusive breastfeeding rates were low and did not differ according to group. They concluded that best-practice intervention was effective in increasing breastfeeding duration and intensity.

Literature regarding the diagnosis and management of breastfeeding dysfunction in babies was minimal. Most literature reviewed discussed how to manage problems such as inhibited let-down, engorgement, blocked ducts, mastitis and sore nipples (mother focused problems). When infant focused problems where discussed they included poor weight gain, neonatal jaundice, infant gastroenteritis, failure to latch, anatomical abnormalities causing feeding problems, sleepy baby and prematurity (Cadwell, 2007; Paiman, Pincome, Thorogood & Tracy, 2006). Management and treatment of the above problems included assisting with feeding techniques, providing support and encouragement to mother, education on the benefits of breastfeeding, avoiding bottles, pacifiers and formula to stop nipple confusion (Cadwell, 2007; Dann; 2005, Paimen et al, 2006; Sinusas et al, 2001).
Management of Oral Dysfunction

Most literature regarding management for breastfeeding problems relates to the clinical management of breastfeeding as a whole, with correction of position and latch-on being the most commonly corrected problems. This is because, in general, the cases of healthy full term babies with improper latch-on are related to inappropriate mother/infant positioning. The clinical management of breastfeeding as a whole allows for improvement in these situations (Glass & Wolf, 1994).

In addition to the factors that were formerly mentioned, there may be more specific sucking disorders in healthy full-term babies without any concurrent clinical events, known as oral motor dysfunctions. As already identified, a baby must achieve a wide-open mouth gape as a condition for optimal attachment at the breast. Optimal attachment means that the baby’s oral cavity is filled with breast tissue and the nipple rests at the “S-spot” throughout feeding. The “S-spot” is positioned at the midline of the baby’s mouth at the junction of the hard and soft palates. Stimulation of this spot during feeding promotes normal suck responses and forms the basis of successful breastfeeding. When the baby’s gape response is poor, inadequate attachment results, as too little of the breast is taken into the baby’s mouth. This usually compromises the baby’s milk intake and damages the mother’s nipples (Bovey, Noble & Noble, 1999).

Traditionally, therapists developed exercise programmes to stimulate and improve movement patterns in the orofacial musculature of babies with severe neuromuscular impairment or significant prematurity (Gorga, 1994). Many orofacial exercises for babies with breastfeeding problems appear to be adaptations of these original therapy programmes. Bovey, Noble and Noble (1999) suggests these exercises should be used when an isolated muscular movement needs correction, the abnormal movement is a natural response to some undesirable event or the baby has no significant neuromuscular deficits.

The small amount of literature offering insights into these special problems suggests that orofacial exercises - generally a selection of stroking and massage exercises for the baby’s face and/or mouth, are likely to help restore normal suck responses. Marmet
and Shell (1993) state the correction of oral dysfunction may be easy and occur within a few days, provided that the exercises and manoeuvres are performed continuously and that the mother and family members be properly instructed. In more persistent cases, it may take several weeks and specialised care.

**Chiropractic Treatment**

It is argued that newborns can experience subtle birth-related trauma in normal vaginal delivery (Sullivan, 1997; Upledger, 1996). Complicated labour and delivery can also increase the chance of birth trauma. Birth trauma can be caused by in-utero malposition or malpresentation, from the use of complementary procedures such as forceps and suction, or because of delivery by caesarean section (Hewitt, 1999). When the subtle birth trauma manifests in the spine or cranium it is classified by chiropractors as spinal or cranial subluxation (Hewitt, 1999). A subluxation is “a motion segment in which alignment, movement integrity, and/or physiological function are altered although contact between joint surfaces remains intact”, (Gatterman, 1995). When a spinal or cranial subluxation interferes with the nerve supply to the anatomical components of the suck reflex, namely the tongue, soft palate and pharynx, disorganised suckling may result (Vallone, 1997).

A review of chiropractic literature revealed a small number of case studies that described the treatment of infants with breastfeeding dysfunction on implementation of chiropractic care. Hewitt (1999) described two cases where both babies (one four weeks old and one eight weeks old) were unable to latch properly. After two upper cervical and/or cranial adjustments the breastfeeding dysfunctions were both resolved. Vallone (1997) also describes two infants whose breastfeeding difficulties both improved after their first chiropractic treatment. Vallone describes a four month old boy who’s sucking difficulties resolved after one visit. Her treatment involved adjusting the upper most vertebrae in the child’s neck (C1), combined with internal pterygoid trigger point therapy and nursing counselling. She also described a two day old whose sucking troubles disappeared after five cranial adjustments.
Miller (2001) also a chiropractor states, that breastfeeding dysfunction is a common diagnosis in her clinic. But rather than parents complaining of breastfeeding difficulties, they complain of symptoms which are the result of breastfeeding difficulties. These symptoms include: excess crying, colic, excess spitting, restlessness during or between feeds, acting hungry all the time, pulling off the nipple frequently, excessively long or short feeds, falling asleep at the breast and taking the bottle directly after feeding. Miller substantiates Vallone’s (1997) assertion that delicate tissues required for infant breastfeeding can be traumatised in the birth process. It is suggested by Miller that chiropractic adjustment of the upper neck vertebral joints may decrease the nerve irritation and allow for improved tongue coordination and thus improve breastfeeding.

**Osteopathy**

_Osteopathy to me is a very sacred science. It is sacred because it is a healing power through all nature (Dr Andrew Taylor Still, 1899)._  

Osteopathy is a manual healthcare modality that aims to examine and treat the patient holistically (Parsons & Marcer, 2006; Stone, 2007). Osteopathy was founded by a medical doctor Andrew Taylor Still in the nineteenth century. Still created osteopathy because he saw necessity for a safer, more effective, more holistic profession (Jealous, 1999). Osteopathic medical philosophy is centred on holism, treating the whole person not just their physical body. Classic osteopathic philosophy identifies the human being as a “triune being”, including body, mind and spirit (Gallagher & Humphrey, 2001).

The American Osteopathic Association (1998) mirrors Still’s expression of treating the whole and defines osteopathy as:

_A philosophy of health care and a distinctive art, supported by expanding scientific knowledge; its philosophy embraces the concept of the unity of the living organisms structure (anatomy) and function (physiology). Its art is the_
application of the philosophy in the practice of medicine and surgery in all its branches and specialties. Its science includes the behavioural, chemical, physical, spiritual and biological knowledge related to the establishment and maintenance of health as well as the prevention and alleviation of disease.

Another imperative osteopathic principle that Still preached was that the patient treats themselves. He believed that humans have their own “Primary Physician” within them and that the osteopathic practitioner merely gives the orders for treatment (Brooks, 1997). One of Still’s eminent quotes “Man should study and use the drugs compounded in his own body”, reflects this principle. Jealous (1997) also suggests that as practitioners, we do not create the treatment process, we uncover it.

**Osteopathy in the Cranial Field**

Osteopathy regards disease and injury as “involving some degree of impairment in the free flow of the material and energetic elements within the body, thereby impeding the self-correcting process within” (Brooks, 2000). Since 1874 (when the science of osteopathy was founded) many different osteopathic manipulative approaches have been developed to apply the principles of osteopathy to the treatment of patients – osteopathy in the cranial field is one such approach (Brooks, 2000).

This study will now discuss osteopathy in the cranial field (OCF), also known as craniosacral therapy (CST) as this domain of osteopathy is used principally when treating babies (Frymann 1966; Upledger, 1996; Sullivan, 1997). The disarticulated bones of a human skull mimicking gills of a fish started a lifelong study into cranial osteopathy for William Sutherland, a student of Still’s. The conception of this idea is passed from osteopathic lecturer to osteopathic student as almost a narrative: William Garner Sutherland was examining a temporal bone from a disarticulated skull when the thought struck him that its edges were bevelled like the gills of a fish. He believed that he had found evidence of a very definite design for motion (Sutherland, 1990), despite
medicine both then and today believing that these bones were fused and immovable (Sullivan, 1997, Wilson, 1999).

Sutherland studied the subtle movements in the cranial bones and through strapping certain bones (usually on his own head) to limit their movement, he was able to recreate symptoms seen in his patients (Sullivan, 1997). Through his exploration, Sutherland established that gentle manipulation of the cranial bones lead to profound physical and psychological effects. Sutherland describes OCF as a mechanism with five components: the articular mobility of the cranial bones, the mobility of the cranial and spinal dural membranes, the inherent mobility of the central nervous system (CNS), the fluctuation of the cerebrospinal fluid (CSF) and the mobility of the sacrum between the ilia (Brooks, 2000).

Like Still, Sutherland also acknowledged that the body had its own ‘unerring potency’. Sutherland was able to take the vital potency that Still had described to the level of palpable diagnosing and treatment (Sutherland, 1967). He believed that the subtle movement he perceived were manifestations of the basic self-regulating, self-healing mechanisms within the body in operation. This mechanism is termed primary respiratory mechanism (PMR) or craniosacral mechanism because of its fundamental mature and rhythmic quality (Brooks, 2000). The cranial rhythm can be palpated anywhere in the body, give clues to the body’s functioning and can be isolated and used in diagnosing. The five components discussed above must be present and work harmoniously for optimal body function (Coppinger, 1998).

It must be acknowledged that even within the osteopathic profession there is debate upon whether OCF exists. The lack of evidence regarding the effectiveness of OCF can be seen in inter and intra rater reliability studies (Rogers, Witt, Gross, Hacke & Genova, 1998). The Education Council on Osteopathic Principles (as cited in McPartland & Mein, 1997) have defined the Cranial Rhythmic Impulse (CRI) as “a palpable, rhythmic fluctuation: (p. 40) that is most apparent while palpating a person’s head. While others such as McGrath (2003), suggest that the absence of reliability and validity may be because the CRI as an inherent biological entity does not exist. Hartman and Norton (2002) also completely dispute the existence of OCF.
Upledger, an important dignitary in the theory and research of osteopathy in the cranial field, provides evidence that validates the existence of Sutherland’s mechanism and the five components (Upledger, 1996). Upledger supports OCF as a treatment modality and concludes that positive patient outcomes as a result of OCF should weigh greater than the data from designed research protocols involving human subjects as it is not possible to control all the variables (Upledger, 1995). “Absence of proof does not necessarily demonstrate proof of absence” (Virchow, cited in Upledger, 1995).

**Osteopathic Treatment**

There is a small amount of osteopathic literature that explores treatment techniques for babies with breastfeeding problems. Sullivan (1997) and Upledger (1996) discuss osteopathic aetiologies that have been taught traditionally, but do not quote research findings. Early work by Frymann (1966) describes the anatomy of the infant cranial base and the compression and torsion forces that this area is subject to as a result of the birth process, particularly when aided by medical intervention. These forces in birth may cause compression of various important structures within the skull including: the jugular veins, the brainstem, carotid arteries and cranial nerves. The glossopharyngeal and vagas nerves work jointly to control swallowing and airway function and to control the larynx, pharynx and oesophagus. The accessory nerve innervates some of the neck muscles and its compression can result in muscle spasms and torticollis. The facial nerve assists in mouth and tongue movements and according to Upledger (1996), compression of the occipital base can compromise the function of any or all of the cranial nerves and severely interfere with the normal sucking process.

Fraval (1991) describes a nine day old neonate unable to feed effectively from birth whose mother was on the verge of discontinuing breastfeeding. After her first CST treatment the neonate was able to effectively attach to the breast and after her second treatment she had established a normal sucking rhythm. The only published quantitative research (rather than a case study) that is specific to the osteopathic treatment of sucking dysfunction is Fraval’s (1998) study. Fraval conducted a pilot study of six neonates with dysfunctional sucking all of whom had been treated without success by
Fraval’s study utilised the findings of Woodward, Boon and Rees (1989) which demonstrates that the fat content of foremilk is far lower than that of hind milk (that is, the more milk that is taken from the breast at a feed, the higher the fat content of the milk at the end of the feed). Following four weeks of CST there was a substantial increase in the pre to post feed fat estimations in the milk of five out of six of the infants. All the infants continued breastfeeding for five months or more following treatment. Although Fraval’s treatment was successful, his pilot study did not include discussion about diagnosis, nor describe osteopathic techniques utilised for the successful treatment of these neonates.

This chapter has outlined the broad literature base that examines problems infants may have with breastfeeding and the management of these problems by different healthcare modalities. Initially the chapter reviewed the imperative impact breastfeeding can have on child, mother and society as a whole. The physiology and anatomy of infant breastfeeding were then elucidated before the classification and diagnoses different healthcare systems employ for this particular problem were examined. The review subsequently focused on initial management of infant breastfeeding problems concentrating on midwives, lactation consultants, nursing and physician literature. The review concluded with a description of osteopathy and reviewed the small amount of literature in manual therapies and more specifically the osteopathic literature. The next chapter will explore the philosophical paradigm and practical underpinnings of the research process.
Chapter Three:
Methodology
This chapter will explore health as a research phenomenon as well as introduce the methodological philosophies and practical foundations that guided this research project. The chapter begins by examining interpretations of health and discusses two main principles underlying health research. Introductions to early research in health and discussing both qualitative and quantitative approaches will then follow. A prologue to phenomenological research and a justification for its use in this research methodology will then transpire. The chapter will conclude with a description of hermeneutic phenomenology as the approach taken for this research.

**Research in Health**

If taken to a raw, basic level, health research can be viewed as work conducted to develop knowledge based on available evidence following certain rules and procedures (Allsop & Saks, 2007). There are many different paradigms or clusters of beliefs and assumptions that shape what is studied, how research is conducted, what methods are used to ground knowledge and how results are interpreted. These clusters of beliefs frame human life and also shape the world, thus leading to many different types of research (Allsop & Saks, 2007).

Richardson, Jackson and Sykes (1990) believe research is about “illumination”:

> If we don’t succeed in that we have failed. If a person reads something and doesn’t feel any wiser, then why was it done? Research should fire curiosity and the imagination … If people feel research illuminates their understanding and gets into their thinking, then it is of use (p. 132).

The definition and beliefs surrounding health have been conceptualised in many ways. Turner (2003) charts the manner in which the concepts of health and illness have changed historically. From primitive societies, where health and illness were linked to spiritual notions of purity and danger, to the dominant biomedical and scientific definitions that focus on disease and pathology. Turner notes that there are still many debates about the interpretation of health. Typically, social scientists view health as a
moral norm defining a socially constructed standard that tends towards an ideal of well-being or social functioning. People in different social groups define health very differently depending on variables such as social class, gender, ethnic group and age. Within this perspective, illness is usually conceptualised as the opposite of health, and as a socially sanctioned, but legitimated role. This may be interpreted further by different individuals and their significant others, such as family, friends, and health providers.

Allsop and Saks (2007) believe that two principles underlie all health research. Firstly, research is about producing new insights and new knowledge by setting answerable research questions, collecting data in a systematic way, analysing the data intelligently and rigorously, as well as identifying patterns and establishing associations. The research may contribute to a greater understanding of individual health and collective health behavior, the role and impact of health providers and the options for delivering health services to communities. Secondly, that the findings produced by research are always contingent on the context in which the research is carried out, the methods used and how the data have been analysed and interpreted. Therefore, the researcher has to be as explicit and transparent as possible.

Why a Qualitative Paradigm?

A paradigm can be defined as an overarching philosophical or ideological stance, a system of beliefs about the nature of the world, and ultimately, when applied in the research setting, the assumptive base from which we go about producing knowledge (Rubin & Rubin, 2005). An interpretivist researcher for example, will maintain that knowledge is socially constructed and reality is ultimately subjective, while a positivist researcher will maintain that reality is fixed and that objective knowledge can only be produced through rigorous methodology.

In the twentieth century health research was dominated by positivist approaches to knowledge production epitomised by the randomised controlled trial. However in recent decades, there has been greater skepticism about the positivist methods
associated with health and modern medicine. Streubert and Carpenter (1999) have said “the concepts of objectivity, reduction, and manipulation, which are fundamental to empirical science, defy the authentic fiber [sic] of humans and their social interactions” (p. 29). Streubert and Carpenter, like many other qualitative researchers acknowledge, human existence can be lived out and interpreted very differently. Neither qualitative (interpretive research) nor quantitative (positivist research) should be viewed as superior; they both serve a particular purpose and should be respected.

A major distinguishing characteristic between qualitative and quantitative approaches is the way in which the research phenomenon is identified for inquiry. Qualitative researchers challenge the assumption that human beings can be studied by a social scientist in the same way as a natural scientist would study theories. They argue that human behavior is different in kind from the actions of inanimate objects and that people are uniquely conscious of their own behavior (Minichiello, Sullivan, Greenwood, & Axford, 1999).

A basic premise underlying qualitative studies is that human behavior goes beyond that which can be directly observed – the significance of people’s actions lies in their individual perspectives and the meanings they attach to situations. Particular emphasis is placed in studying and documenting what people know, express and reflect about their subjective experiences; and how people give meaning to their situations. Qualitative research is inductive and has a primary aim of interpreting information and attributing meaning. This is supported by Baumgartner, Strong and Hensley (2002) who explain that qualitative methods generate richly detailed data about the group being studied and provide contextual understanding. Results are not generalised to a reference population, although findings can often be applied as an explanation for the behavior of other groups.

Within qualitative research the researcher is a tool, a “human measuring instrument” (Polgar & Thomas, 2008). There is complex interaction going on. The researcher is part of the phenomenon being investigated rather than a detached observer. A researcher will bring unintentionally their own social, racial, cultural and family history and in turn their unique perspective and philosophy about the world (Denzin & Lincoln, 1998). To understand personal meanings and subjective experiences one has to become
involved with the lives of the subjects being studied. Polgar and Thomas (2008) suggest that a researcher must have some degree of empathy in the situation, be able to put themselves in the person’s shoes or see things from the other person’s perspective(s).

As well as having empathy to the situation being researched, Denzin and Lincoln (1998) identify three distinct perspectives that define the qualitative research process and guide the researcher: ontology (what is the nature of reality), epistemology (what is the relationship between the researcher and the known) and methodology (how do we gain knowledge from the world). Furthermore, the qualitative researcher must acknowledge the above influences can critically reflect their beliefs, assumptions and understandings of the phenomena being researched as an intrinsic and necessary part of the research process (Schneider, Elliott, LoBiondo-Wood, & Haber, 2003).

There are several theoretical and practical motives which guided the decision to use a qualitative methodological approach for this particular research project. Qualitative methods are appropriate when studying topics when little or nothing is known about them (Minichiello et al., 1999; Schneider et al., 2003). This is because qualitative methods are not predominately used as hypothesis-testing modes of research, but as theory building ones. It is more usual to see qualitative methods being employed as part of an exploratory study where the researcher is attempting to gain understanding of the field of study, and to develop a hypothesis rather than test one (Green & Thorogood, 2004; Henn, Weinstein, & Foard, 2006; Minichiello et al., 1999). Given the current scarcity of information present about the osteopathic diagnosis and treatment of babies with breastfeeding problems, an explorative study using a qualitative approach was considered most appropriate for this investigation.

As well as building theory, the research tools used in qualitative research are designed to help the researcher gain access to an individual’s words, actions and interpretations. The object of qualitative research is to gain insights and understanding into aspects of the human experience and the focus is on deep understanding. The phenomena of interest can be studied holistically and contextually (Schneider, 2002). This approach fits the osteopathic philosophies of looking beyond a patient’s presenting complaint to other biopsychosocial factors that may have predisposing or maintaining influences (DiGiovanna, Schiowitz, & Dowling, 2005).
A Phenomenological Approach

The philosophy behind qualitative design recognises that there is more than one world view. Accordingly different researchers can interpret the same data in different ways. There are a variety of approaches to qualitative research and these take different positions concerning how data should be collected and analysed. There are also several diverse schools of thought that have contributed to the historical development and proposal of theory in the qualitative field (Hickson, 2008; Polgar & Thomas, 2008). While ethnography attempts to explicate meaning specific to cultures and grounded theory seeks to describe and understand key social processes and structures, phenomenology focuses on the lived experiences of individuals (Polit & Beck, 2004).

The aim of this research study was to enlighten, explore and investigate what happens in an osteopathic setting when an osteopath is treating a baby with breastfeeding problems, from the point of view of the osteopath. More specifically this study attempted to obtain findings that represent the perspectives and insights of the participants in order to explicate what it is like to osteopathically treat a baby that cannot breast feed properly. Thus, the aims of this research were therefore consistent with a methodology and philosophy that attempts to examine the explicit nature of a phenomenon.

Phenomenology is essentially the study of lived experience or the life world (van Manen, 1997). Phenomenology, which is both a system of philosophy and an approach to psychology, emphasises the direct study of personal experience and the understanding of the nature of human consciousness. Research in this area involves putting aside the usual preconceptions and prejudices that influence everyday perceptions, so that the pure constituents of conscious experience can be uncovered (Polgar & Thomas, 2000). This idea is supported by Moran (1999) who describes phenomenology as a process rather than a system, a way of getting to the truth of the matter to describe phenomena as it appears to the experience. In order to achieve this, the researcher attempts to avoid presuppositions placed on the experience in advance. These assumptions may come from the previous experiences of the researcher, religious or cultural traditions, beliefs or from science.
Phenomenological Background

Phenomenology has been employed for many centuries. When Hindu and Buddhist philosophers reflected on states of consciousness achieved in a variety of meditative states, they were practicing phenomenology. When Descartes, Hume, and Kant characterized states of perception, thought, and imagination, they were practicing phenomenology (Smith & McIntyre, 1982).

Husserl, often referred to as the father of phenomenology (Koch, 1996; Scruton, 1995) along with another phenomenological pioneer, Kierkegaard, rejected the reductionistic tendencies of the natural science in the late nineteenth century. The salient point of Kierkegaards’ philosophy is that men’s existence is unique. While Kierkegaard was insistently antiscientific, Husserl denied that natural science was the only form of science to exist. Husserl believed that natural scientific measure was not a suitable vehicle to understand the human being since man cannot be reduced to a measurable object. He proposed that in order to understand one’s fellow man one needs to look at the quality of experience and as such he placed great emphasis on consciousness (Koch, 1996).

The main focus for Husserl was the study of phenomena as they appear through consciousness. He purported that minds and objects both occur with experience, thus eliminating mind-body dualism (Laverty, 2003). According to Speigelberg (1960) phenomenology was not founded but instead existed, grew and continued changing until the end of Husserl’s life. Many later philosophers and others were drawn to Husserl’s phenomenology. Heidegger, who is considered one of the main contributors to the theory of phenomenological psychology, was successful in merging existentialism and phenomenology (Mohamed-Patel, 2002). He expanded on Husserl’s phenomenology to include not only consciousness but also the world in which the individual lives.
Chapter Three: Methodology

**Hermeneutic Phenomenology**

Hermeneutic phenomenology is concerned with the life world or human experience as it is lived (Laverty, 2003) and while it’s early use was in the examination and interpretation of scriptural texts, it is now used to interpret and investigate human action through dialogue and text (Rice & Ezzy, 1999). According to van Manen (1997), phenomenology describes how one orients to lived experience and hermeneutics describes how one interprets the texts of life. Thus, it is the interpretation element that makes hermeneutics a unique philosophical and methodological practice. Also important in hermeneutic phenomenology is the idea that there is never any truth independent of interpretation (Rice & Ezzy, 1999).

Hermeneutic theory also suggests that the human realm can never fully be understood and known since it is ever evolving, and the tools for accruing this knowledge are part of the changing human conditions (Valle, King & Halling, 1989). This postulate positions both hermeneutics and phenomenology in the post-positivist framework where truth and knowledge is a matter of perspective (Mohamed-Patel, 2002).

Kockelmans (1987) describes hermeneutics as the science of interpretation or understanding, an example of the interpretive method of inquiry. Interpretive research makes that which is implicit, explicit (Morse, 1997). Many human actions are not directly accessible in ordinary perception however this method of inquiry allows its theoretical abstraction to be accessible and understood by the reader. Hermeneutics can therefore be defined as a method involving formal procedures that enables an understanding and interpretation for research (Mohamed-Patel, 2002).

Hermeneutic methodology applies skilled judgement and responsible principles rather than rules to guide the research process (Madison, 1988). This initiative is embraced by Polkinghorne (1983) who supports the term methodology rather than method when describing hermeneutic phenomenological practices. Methodology is a creative approach to understanding, using whatever systems are responsive to particular questions and subject matter, while method implies there are an approved set of
procedures to follow. Methodology in this sense requires the ability to be reflective, insightful, sensitive to language and constantly open to experience (van Manen, 1997).

A qualitative research design for this project was considered the most effective and appropriate research approach for a project exploring a topic that has received little previous investigation (Pope & Mays, 1995). Because of its applicability to previously unexplored topics, interpretive description provides a suitable method to guide data collection and analysis.

This research project will examine a complex human experience where a health practitioner is providing treatment for a patient (the infant), with a third party (the mother) initiating and managing the treatment. By using qualitative methodology this experience can be more fully comprehended by studying its social, cultural and experiential aspects (Domholdt, 2000). Furthermore, it is anticipated that this research project will be a useful platform to highlight important areas of practice for later empirical studies.

This chapter has outlined methodological philosophies and practical foundations for the current study. The chapter examined the definition of health in previous and present societies and then reviewed two main principles underlying health research was examined. Subsequently twentieth century health research and a qualitative paradigm were then discussed. The study then reviewed phenomenology with a brief exploration of its history and concluded with a succinct description of hermeneutic phenomenology and its methodological basis. Chapter four will now outline the practical processes that were completed to undertake the study and in addition, more comprehensively discuss the methods utilised in the current study to achieve academic quality.
Chapter Four:
Embarking on the Study
Embarking on this study proved to be a challenging but very rewarding task. This chapter will outline the protocols and processes used in the current study to collect and analyse the interview data. Beginning with discussion of the ethical process and procedures utilised to ensure participant anonymity, the chapter will then discuss the salient pragmatic features of conducting the interview. A description of the theme development and data analysis methodology will follow. The chapter will conclude with a brief description of the process that was employed in the current research to attain academic rigour.

**Ethical Considerations**

This research was granted ethical approval on the 17 of June 2008 by the Unitec Research Ethics Committee (UREC) for completion (of data collection) between the 16 June 2008 and the 1 December 2009 (see Appendix A).

Given that the research involved an in-depth discussion of the osteopathic diagnosis and treatment of babies with breastfeeding problems, I acknowledged that potentially sensitive information could be recollected by the participant (for example, their own problems breastfeeding their child). However, the risk was considered small and it was anticipated that the sampling method employed would avoid participants who would find the topic uncomfortable.

Due to the nature of qualitative research, there is a possibility that participants may be recognised. In this study anonymity was protected by the removal of the participants’ names. Pseudonyms were used so that the participant’s maintained their individuality while allowing the reader to follow their responses within chapters five and six. Recorded interviews did not include information that could directly, or by inference, identify an individual. A separate file containing identifying information of the individual participants was maintained, with access limited (password protected) to only the principal researcher. If the participant felt that any information they gave throughout the interview process would identify them, they could ask for that piece of information to be discarded from analysis.
Participation Selection and Recruitment

According to Minichiello, Sullivan, Greenwood and Axford (1999) most qualitative research relies on non-probability, purposeful sampling. This is consistent with Rice and Ezzy (1999) who also agree that qualitative research methods typically employ non-probability sampling, because the aim “is not to generalise about the distribution of experiences or processes, but to generalise about the nature and interpretative processes involved in the experience” (p. 42). Purposeful sampling or selection is based on “the intimate relationship between the person, the event, or the situation with the phenomena under study” (Minichiello et al., 1999, p. 176). Participants are selected who have specific knowledge about the research question. Consistent with this idea, the current study utilised a purposive sampling technique which endeavours to select information-rich cases for in-depth study (Patton, 1990).

For the current study two different methods of recruitment were employed. Firstly, osteopaths who were known to specialise in the care of babies or those that have a high infant caseload, were approached via an email. Recruiting osteopaths whose practice included treating babies with a high infant caseload was an attempt to ensure that there was an appropriate level of ‘richness’ to the data. Obtaining richness in data collection is achieved by exploring the phenomenon in all its experiential ramifications. The interviewer must be able to capture from the participants their story, which is unique, particular and irreplaceable (van Manen, 1997).

It was expected that each of the osteopath’s professional voices would reflect a collection of experiences (Flick, 2006). The small number of osteopaths who replied with interest to the email were then forwarded information about the study (Appendix B) including a description of inclusion/exclusion criteria (Appendix C). The interested osteopaths (participants) were then asked to contact me by email to confirm they were interested in participation.

The fundamental purpose of qualitative research is to understand in-depth, a selected phenomenon (Hickson, 2008). Unlike quantitative research, qualitative researchers begin analysis of their data almost immediately, as it proceeds alongside data collection.
(Baumgartner, Strong & Hensley, 2002). Making decisions about when to stop sampling is therefore related to the depth in which the phenomenon is to be understood, “sampling continues until theoretical saturation occurs” (Minichiello et al., 1999, p. 177). Theoretical saturation is a term used to denote that the themes or categories emerging from the research are developed in their entirety. It is said to exist when “similar instances recur and all attempts have been made to look for the most diverse instances of data” (Minichiello et al., 1999, p. 177). In this study theoretical saturation was achieved by firstly transcribing each interview before the next interview took place. This assisted in determining when the same points were being illustrated repeatedly by different participants. Although each participant brought to the interview their own beliefs and ideas about the phenomenon, by the third interview, it was evident that key themes were being repeated.

In order to gain more participants, snowball sampling (also called nominated sampling) was employed. Snowball sampling involves asking key informants (participants) to identify future participants that they believe may be interested in participating in the study (Minichiello et al., 1999). An email was forwarded to the suggested participants after verbal consent was given by the interviewees. If the osteopath replied with interest to the email, information about the study was forwarded to them.

Once participants had contacted me for the second time, I outlined the interview process and their involvement in the research. I also clarified any queries or concerns they had regarding their participation. Preliminary agreement for participation in the study was then obtained and a convenient time and location for the interview to take place was organised. This is consistent with Streubert and Carpenter’s (1999) recommendation, who suggest that conducting interviews face-to-face at a time and place that is convenient for the participant facilitates sharing of information by the interviewee.

All participants were adults, had consented freely (both over the phone and again at the interview) and were given time between the phone conversation and the interview (approximately one week) to reconsider their participation in the study.
Chapter Four: Embarking on the Study

Data Gathering: The Interview

Qualitative research brings to light the beliefs and social realities of participants within the boundaries of a particular research topic. This knowledge can be gained through the interview process (Minichiello et al. 1999). van Manen (1997) describes two distinct purposes for data gathering through interview: Firstly “it may be used as a means for exploring and gathering experiential narrative material that may serve as a resource for developing a richer and deeper understanding of a human phenomenon” (p.66) and secondly, “the interview may be used as a vehicle to develop a conversation relation with a partner (interviewee) about the meaning of an experience” (p. 66).

There are a number of different interview methods suited to the varied goals of different styles of research. A semi-structured interview was chosen for this study, allowing some guidance by the interviewer, but not limiting the responses of the participants by employing a rigid structure. The interviews were guided by the questions in an ‘interview guide’ (Appendix D). To enable participants to introduce thoughts or observations that were particularly relevant to their personal perspectives, participants were informed that they were not limited to talking specifically about questions in the interview guide, and typically a conversational style of interview ensued.

According to Minichiello et al (1999) novice researchers can experience the interview process as somewhat intimidating. An interview can take on a life of its own and interaction between researcher and informant inevitably introduces unpredictability. In preparation for a positive data collection outcome, foundation reading about qualitative interviewing, discussions with supervisors and a pilot interview was conducted. For the current study, a pilot interviewee was chosen who had experience in the osteopathic treatment of infants, as well as experience performing interviews for qualitative research. Following the interview, the interviewee critiqued my interviewing skills and provided feedback on my style and performance. The interview and critique were digitally recorded for review and reflection. The interviewee’s feedback included a recommendation to employ a conversational approach to the interview rather than a question and answer style. The interviewee suggested that this technique (conversation)
would help the participant become more comfortable in their surroundings and therefore find it easier to “tell their story”. The interviewee also suggested that I changed the wording of one of the questions as he found it difficult to answer and suspected the participants may also have difficulties. The initial question was worded: How successful are you in treating babies with breastfeeding problems? The interviewee suggested I instead ask: Are you able to describe to me what you believe is a successful treatment for babies with a breastfeeding problem? It was assumed that by asking the second question the participants would provide more information on this particular subject.

The data for the study was collected during five face-to-face, in-depth, semi-structured interviews. The interviews took place at either the osteopath’s practice or their own home. Six interviews were initially conducted and digitally recorded. The fourth interview was removed from the study at the request of the participant. Following further conversations with this participant, it was established that the participants mother had past away just prior to the interview and because of this they felt that the interview did not accurately reflect their thoughts, feelings and beliefs on this particular phenomena.

All interviews commenced with an introduction outlining my background and a description of the aim of the study. A consent form (Appendix E) was then signed by the participants. An explanation of the interviewee’s involvement and reiteration of their right to withdraw from the interview or research transpired. Participants were also assured at the start of each interview of their anonymity.

In addition to recording the interviews and using a guide, field notes were used as a prompt at the end of the interview to ensure all avenues of data had been explored fully. Each interview lasted approximately forty-five minutes. The sample size in the current study was guided by the principles of recruitment listed above (theoretical saturation), as well as by the number of participants that had been utilised in previous research of a similar nature (Cardy, 2004; Consedine, 2008).

Transcription of data was completed before the commencement of the next interview. This process was carried out in an attempt to learn more about both my interview style
as well as the lived experience of the phenomena. In addition, I was able to reflect on my own developing ideas about the phenomena. I observed following the first official interview (not the pilot interview) that I was not explicit in my interviewing skills; numerous times I did not finish asking the intended question. I also used a number of leading questions and did not explore important cues presented to me by the participant. For example when I asked participant A if being a mother had affected the way in which she now treated as an osteopath, she replied “yes, it has immensely”. At this time I did not enquire further about what specifically had changed. The observations noted in the first official interview were not observed in the pilot interview it was likely due to my inexperience, apprehension at interviewing well-informed participants and desire to produce quality data. Over the subsequent interviews I concentrated on avoiding these pitfalls and enjoyed a more exploratory and conversational style.

Transcription and Data Analysis

As previously mentioned, following the completion of each interview I transcribed the voice recorded data into a Microsoft Word document. I considered it important to transcribe the data myself as a way of beginning the process of immersion, and in addition ensuring confidentiality for participants. Hickson (2008) affirms that there is a strong argument for researchers to transcribe their own data, particularly when they are learning as it helps the researcher to reflect and become familiar with data more rapidly. Oppie (cited in Davidson, 1999) suggests that personal transcription enables the researcher to review and change the conduct of their interviews and pick up on issues for further inquiry.

Initially to ensure a methodological fit within the tradition of hermeneutic phenomenology, I employed Colaizzi’s (1978) method of data generation and thematic analysis. Colaizzi outlines seven stages that allow the essence of the phenomena of interest to be accessed. They are:

- **Step 1**  Acquiring a sense of each transcript
- **Step 2**  Extracting significant statements
Making decisions about how to collect and analyse interview data is informed by the theoretical assumptions held by the researcher (Kvale, 1996). Hickson (2008) describes qualitative analysis as a process “of construction, followed by deconstruction, followed by reconstruction” (p. 144). Unlike statistical analysis, there are no specific rules to follow as “it is a creative process which is reliant on the thoroughness and skill of the researcher” (Hickson, 2008, p. 144). In fact, van Manen (1997) has argued, “grasping and formulating a thematic understanding is not a rule-bound process but a free act of ‘seeing’ meaning” (p. 79, 1997). As I acquired more knowledge about qualitative analysis and the hermeneutic approach, my data analysis became less influenced by Colaizzi’s structural steps and a more exploratory, unregimented approach was taken.

Verbatim transcripts of each interview were listened to several times during the transcription process giving an initial insight into the lived experience of the participants. Once transcription was complete, the transcribed interviews were compared with the verbal recording for accuracy. As each interview was listened to and read, I recorded my initial thoughts and responses to the lived experience. These were noted in a research diary and formed the beginning of the analytical and reflective process. Following this initial process, three qualitative research papers including; An exploration of the experience of mothers and osteopaths in the treatment of unsettled, fussy or irritable (UFI) infants (Gibbons, 2008), The experience of practitioner intention in Osteopathy in the Cranial Field. A Preliminary investigation (McFarlane, 2006) and Knowing Hands Converse with an Expressive Body – An experience of osteopathic touch (Consedine, 2007) were examined to help give insight and provide inspiration and initiative for the next step in the analytical development.
According to Polit, Beck and Hungler (2001) “the analysis of qualitative materials generally begins with a search for themes or recurring regularities. Themes often develop within categories of data but sometimes cut across them” (p.388). Once each interview had been analysed, themes identified in the first interview were compared and contrasted with those found in the second and subsequent interviews. Significant statements were also drawn from the interviews. These statements were selected because they appeared to best represent the participants’ thoughts and feelings on the lived experience of osteopathically diagnosing and treating babies with breastfeeding problems.

The significant statements were then cut out and organised into initial themes on a large poster under various themes and subthemes. These themes and subthemes were then rearranged and reorganised in an attempt to most accurately represent the participants’ experience.

The data was left alone for a week before re-visiting and re-engaging transpired once more. The second experience with the data involved more reflection as I examined the statements in more detail, attempting to analyse and understand their true meaning and how they fit into a wider frame work of the research. This process was supported by van Manen (1997) who states that “The insight into the essence of a phenomenon involves a process of reflectively appropriating, of clarifying and making explicit the structure of meaning of the lived experience”, (p. 77).

Throughout this process I constantly attempted to examine my own thoughts and reflections of the meaning of the experience of osteopathically treating babies with breastfeeding problems. I found it an extraordinarily hard process as my own assumptions about not comprehending and appreciating this subject kept obstructing my reflective path. Particularly, I did not truly believe that the human body contained within it the primary respiratory mechanism (PRM). This mechanism is the fundamental detail utilised by osteopaths to treat babies. It was therefore hard to examine and process the data because I could not appreciate the participant’s method of treatment. By observing osteopaths treating babies using the primary respiratory mechanism (although this was not part of this research process), and after exploring my beliefs about this subject (and osteopathy in general), as well as discussing emerging
themes with an osteopath, I was able to move on and process my thoughts on this particular phenomenon.

The next phase of the analysis was constructing the written text. When writing qualitative research, efforts are made to reflect and represent the voices and perspectives of the study participants, “Respecting their knowledge, opinions and viewpoints, and enabling the reader to determine the plausibility of the researchers’ interpretations and conclusions” (Hammell, Carpenter & Dyck, 2000, p. 66). van Manen (1997) expands on this statement by arguing that the writing process is intrinsically connected with phenomenology and mediates a deeper reflection and action:

> In an oral culture, in a society dominated by orality, phenomenology would be quite impossible. Why? Not only because phenomenology is a certain mode of reflection done traditionally by scholars who write. But also because a certain form of consciousness is required, a consciousness that is created by the act of literacy: reading and writing (p. 124).

The writing process helped to enhance my confidence in the themes and subthemes that I had interpreted and established from the data. An appreciation of the interweaving and interdependence of each of the themes and how they contributed to the phenomena was gained. In addition, I began to sense how the themes were bringing me closer to a deeper and more comprehensive understanding of the phenomena in experiencing the osteopathic diagnosis and treatment of babies with breastfeeding problems.

**Maintaining Rigour and Credibility**

Qualitative researchers acknowledge that objective reality and subjective experiences potentially exist together in research data (Holloway & Wheeler, 1996). They understand that because the social world is dynamic, two researchers who interview the same participants at different times using the same questions will invariably collect different data (Becker cited in Allsop & Saks, 2007). Therefore qualitative researchers must “satisfy the standards of synchronic reliability – the similarity of observation
within the same time period” (Allsop et al., 2007, p. 83). In keeping with this spirit, this section will briefly outline the steps taken in the current study to achieve academic quality.

A number of strategies have been identified that can be used by qualitative researchers to enhance rigour of their studies. Allsop et al (2007) identify five key techniques to enhance validity and reliability so that the reader can assess the overall credibility of the findings. They are:

1. Audio taping interviews and taking comprehensive field notes.
2. Systematic transcription and analysis.
3. Triangulation or using a combination of methods.
4. Using inter-judge or inter-rater techniques.
5. Using a ‘member test’ or informant validation. (Here analysis and early findings are assessed through the informant’s confirmation that these reflect accurately their perspectives and experiences).

Throughout this dissertation I have endeavoured to provide a clear audit trail which is evident through the written material, interviews and transcripts. This is to ensure my findings have credibility (Holloway & Wheeler, 1996; Koch, 1996) as well as being an accurate reflection of the experience of the five participants. The written material provided a clear trail of the thoroughness of the data and allowed emerging themes to be identified to ensure the authenticity of themes established. For the duration of the study I documented experiences, thoughts and insights that occurred to me about the research topic in a journal.

Informant validation was accomplished by presenting a hard copy of the transcripts to the participants to read before the analytical process commenced. All five participants then confirmed that their experience of the phenomena was represented accurately. Theory triangulation was also used to increase the rigour of the study. This involved using multiple perspectives to interpret a single set of data (Janesick, 1998).
To confront my own bias, I first examined my own beliefs and preconceptions about the topic. I then spent time discussing and exploring these ideas with an osteopath. The discussion was audio-taped so that it could be reflected on throughout the analytical process to identify how my own history and understanding was influencing the progression of the study. Finally, the analysis of themes in the following chapters include verbatim quotes from the participants to ground the themes more firmly in the data and to increase the rigour analysis.

**Introduction to the Study’s Participants**

As previously discussed, five participants were involved in the research process and their experiences and knowledge provided the basis for the themes generated in chapter five (data analysis). To ensure their anonymity, all participants were given a pseudonym which indicates their gender only. It was considered important to identify the participants’ gender because their experience of treating and diagnosing babies with breastfeeding problems maybe gender influenced. Many people find breastfeeding a very personal experience (World Health Organisation, 2007), and in an osteopathic setting, personal questions specifically related to breastfeeding would have been asked by the practitioner. A male practitioner may need to utilise different communicative skills (compared to a female practitioner) in order to gain the mother’s trust and provide comfort in this particular situation.

<table>
<thead>
<tr>
<th>Interview</th>
<th>Participant</th>
<th>Name</th>
<th>Gender</th>
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<tbody>
<tr>
<td>1</td>
<td>1</td>
<td>Sarah</td>
<td>Female</td>
</tr>
<tr>
<td>2</td>
<td>2</td>
<td>April</td>
<td>Female</td>
</tr>
<tr>
<td>3</td>
<td>3</td>
<td>Jenny</td>
<td>Female</td>
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<tr>
<td>4&lt;sup&gt;4&lt;/sup&gt;</td>
<td></td>
<td>Participant withdrew from study</td>
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<tr>
<td>5</td>
<td>5</td>
<td>David</td>
<td>Male</td>
</tr>
<tr>
<td>6</td>
<td>6</td>
<td>Harry</td>
<td>Male</td>
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</tbody>
</table>

<sup>4</sup> As previously explained, participant four requested for their interview to be withdrawn from the study.
A Guide to reading Chapter Five

The following chapter provides an investigative exploration of the themes that emerged from the participants’ interviews about their experience of osteopathically treating babies with breastfeeding problems. The chapter is organised into three major themes with a brief discussion of how each theme is represented in the data. Each major theme is represented by a letter of the alphabet in square brackets: [A], [B] and [C].

The subthemes that follow then explore various aspects of the major themes in more detail. Each subtheme is indicated with square brackets and is typed in italics. Each subtheme is also numbered under each major theme, for example: [A1] Belief – A baby’s ability to heal.

All participants’ quotes are indented and italicised to distinguish them from the researcher’s analysis and interpretation. In addition, each quote has been referenced with the participants’ pseudonym and transcript page number.

Symbols used in the text include:

... Pause in the dialogue
../... Omission of dialogue
[Text] Text is added or altered for clarification

The chapter has outlined the protocols and processes that ensued in the completion of this research project. The chapter commenced with a description of the ethical considerations employed for the study and then summarised the process of participation selection, data collection and transcription. Exploration of the data analysis and the processes utilised to maintain a high level of rigour and credibility throughout the study was then discussed. The chapter concluded with a brief introduction of the participants and a guide to reading the next chapter.
Chapter Five:
Data Analysis
This chapter represents the fruition of the thematic analysis as described above. The lived experience of each participant osteopathically treating babies with breastfeeding problems involves an intricate and complex communicative interaction between themselves, the patient’s mother and the patient. In exploring this interaction the study revealed three main themes: [A] Beliefs - your foundation, [B] Communication - a necessity for a successful treatment and [C] The Process. In the following discussion each of these themes will be broken down further into subthemes in an effort to describe the experience of osteopathically treating babies with breastfeeding problems. It utilises an approach that presents the detail of the experience in a way which is meaningful for others who share that similar experience.

The chapter is organised into three major themes with a brief description of how each theme is represented in the data. The subthemes that follow will then explore various aspects of the major theme in more detail. The chapter will finish by summarising the themes in an attempt to elicit the fundamental structure of the phenomenon.

**THEME [A]: Beliefs - your foundation**

Theme [A] draws attention to the importance of certain beliefs about the osteopathic diagnosis and treatment of babies with breastfeeding problems. Subtheme [A1] Belief – A blueprint for health explores the participants’ beliefs surrounding a patient’s own ability to heal from within themselves. The participants’ beliefs regarding osteopathy as a treatment modality and the difference between treating adults and babies is also investigated. Subtheme [A2] Belief – Treat what you find; there is no protocol, establishes that there is no distinct osteopathic procedural protocol that is utilised for treating babies with breastfeeding problems. This subtheme also explores the relationship between protocol and the beliefs surrounding a common phrase articulated by the participants: ‘treat what you find’. Finally subtheme [A3] Belief – The Practitioner’s Role examines what the participants believe their role encompasses as an osteopathic practitioner who is treating a baby with breastfeeding problems.
[A1] Belief – A blueprint for health

The participants described passionately and individually an energy, a strength in the human body to heal itself. They linked this force to the developmental processes of the embryo and also with their evolving osteopathy treatment modalities. In conjunction with explaining this force, they also included how it is different to treat babies compared to adults. They described babies as having a different energy, being more “whole”.

Jenny firstly acknowledges that her osteopathic treatments involve working beside or utilising an embryological force within the baby. By using this approach, her treatment is more successful as she is able to treat the source of the problem. Jenny also talks of a ‘blueprint for health’; this is her way of acknowledging a belief that the human body has its own self healing mechanism. When she treats babies she is working with the forces that actually formed the baby, the forces that created the embryo and its development, which she also reports is an element of the blueprint for health. Jenny articulates why she employs this method for her treatment of babies:

What you tend to get is that, yes you will see that the face is squashed, but then you will also see why that might be. And so you are able to go more to the heart of the matter to get the whole to change, rather than just one bit, and therefore you get better results (Jenny, p. 3).

April also identifies working with an embryological force in her treatment. She further explains that this force that she treats along-side, is the same force of human growth and development:

Through more understanding of the power in them to grow and that comes back to the embryology that the forces in embryology are the same forces of growth and development. Those forces are more powerful than anything else. They’re the forces that say we get our first tooth at six months or we learn to crawl at eight months. So if we can work with those forces it’s far more powerful than me pushing from the outside in (April, p.8).
April’s use of the adjective “powerful” twice in this paragraph is interesting; the double word use helps to illustrate her inherent beliefs in the healing capabilities of individuals and also highlights her beliefs in the strength of the described force. In the next quote April explains further the force utilised in her osteopathic treatment. When April describes the initial development of this force or power within a person to grow and heal, she reports that it begins at conception when the two “forces” (the sperm and the ovum) meet. At this moment of conception there is a spark or ignition that commences the process of blastocyst separation, organ formation and onto the creation of a human being. By describing the conception of this innate force she is able to relate on a biological level the process toward human dysfunction:

*But it’s that surge initially that keeps going and that continuum all the way through till after birth and till we die. So it’s a mechanism but it is also innate forces, its powerful, that sometimes gets trapped and that’s the babies or people that are decompromised and just unhappy in terms of pain, strain and they come in. The ones that are still full and those innate forces can heal every day, they don’t really need to come in because they’re fairly free* (April, p.10).

The participants identify a belief that there is a difference between treating babies and adults. The participants used words such as “whole” to describe babies and use narrative such as “greater vitality” to describe treating babies. The participants also noted that a baby’s ability to reach the “blueprint for health” is easier compared to an adult. David describes his beliefs about treating babies and talks of babies having “regional trauma” rather than specific problems:

*And it is because they still, you might say, are fresh or young. They are still evolving and developing on an embryological perspective, even though they have now been born. So their bodies respond differently. Occasionally you get these focal mechanical type of problems but they are in the minority. Usually you find regional trauma, so you might examine and be like; oh the baby has a curve through their whole torso like a banana* (David, p.3).
All five osteopaths stated that they used osteopathy in the cranial field (OCF) to treat babies; one of them stated that they used both structural and cranial osteopathy to treat babies. The participants spoke of their treatment as not fixing the patient but helping the patient to access their own ability to heal:

For me working cranially means getting the person, the patient to access that blueprint for health and allowing them to re-find their ability to heal from health...//...It is not about going in to fix the part. It is about enabling the person to reach their optimum health (Jenny, p.2).

When asked if she could explain the concept of cranial osteopathy April replied that through working on herself as a person, by completing courses and by practicing, her treatment had evolved. On an embryonic level the central nervous system (CNS), the fluids, the bones, the dura are all formed from one part therefore they function as one. April cannot separate these five phenomena or treat specific parts of the body. April reports she now examines and treats the whole body.

Like April, other participants spoke of their osteopathic beliefs and skills evolving and changing as they become more experienced. David described his journey of treating patients using OCF as vastly more holistic after fifteen years of cranial osteopathy experience, his diagnostic approach is different and his treatment methods are different. He reported that initially when he commenced his learning of OCF as a treatment modality, he palpated for structures and the movement of those structures underneath his hands. As his palpatory and sensory awareness improved he was able to move from palpating the movement of certain structures to palpating the whole. He describes an example where is he was holding the baby’s feet but he was not particularly concerned with what was happening in that particular location; he is observing the whole baby. Consequently the types of diagnosis that David arrives at are now different:

When you are first taught about treating babies, the basic cranial stuff, there is this great emphasis on condular parts compression. Trauma to the occiput with vagal nerve irritation and hypoglossal nerve disturbance at the jugular foramen causing tongue problems and disturbances at the gut. So there is this emphasis on anatomical detail to do with structural types of
lesions. That is a useful starting point to learn to go a step further but in actual fact babies do not get lesions like that in the first place. Because their system’s respond to trauma differently from an older child and in particularly from an adult. They do not lesion in response to mechanical trauma in the same way an adult does (David, p.2).

David explains how initially his treatment involved diagnosing particular anatomical lesions in the body but as he became more experienced the concept of treating the “whole” body became more relevant to his treatment approach. The idea of treating the whole person, the whole body is a belief that all the participants discussed.

[A2] Belief - Treat what you find; there is no protocol

Very early in the interviewing element of this study it became clear that there was not a specific protocol for treating babies with breastfeeding problems, there were no procedural steps taken that were used especially for this problem. The only diagnostic procedure that was different from an examination of any other problem related to a baby; was that sometimes the osteopath would observe the mother breastfeeding the baby to help establish a diagnosis. Observing the breastfeeding was also used as a tool to evaluate improvement after treatment.

Many of the osteopaths employed the phrase “treat what you find” to explain their diagnostic and treatment regime. The phrase indicates an underlying belief that no two people are the same and that the palpated “dysfunction” needs to be treated in order to eliminate the breastfeeding problem. When examining the baby, Harry reported that he treated what the mechanism showed him. He explains his belief of “treat what you find” and gives an example of specific anatomy that maybe found to be causing a breastfeeding problem within the baby:

So everyone is different otherwise it would not be osteopathy, it would be working to a recipe. Like oh, conjunctivitis I am going to do, step A, B and C. It is just not like that, you do what you find. I mean you might find that to
work with that you are going to have to unwind some of the stomach and liver area and work up through the fascias that come up into C2 and the occipital bone and release them before you are going to get a good release anywhere else. It is what you find (Harry, p.4).

Jenny also concludes that there are no procedural steps that can be taken to diagnose and treat a baby with breastfeeding problems. In this piece of her interview she also refers to a previously discussed belief of the “evolving osteopath” and how her treatments have changed as her beliefs about osteopathy have changed:

There is no A, B, C and that will mean everything is alright, but that is osteopathy, because that is people, everyone is different (Jenny, p.10). So I used to just look at palate, so palatine, vomer, and maxilla. And I would also look at the occiput, the hypoglossal nerve to see if that was irritated. But as my skill level has increased and my palpation’s increased, I see that it is not black and white (Jenny, p.1).

April describes a slightly different approach for the treatment of breastfeeding problems; interestingly she admits that she does not actually treat breastfeeding problems. Instead she works with the cranial mechanisms and believes that if the mechanism is healthy and working freely then the baby’s health will generally improve and thus breastfeeding will also improve:

I can’t say that I’m successful in correcting the breastfeeding. I think what I’d be more comfortable saying is, I think I can really help the baby with its health and that expansion that I was talking about. So the baby’s health and function improves generally...Breastfeeding, breathing and sleeping and if they get into that cycle then their breastfeeding improves as well. So I’d be less inclined to say I can help or sort out or fix breastfeeding but it’s part of that whole health (April, p.3)
[A3] Belief – The Practitioner’s role

A belief about your “role” as a practitioner can greatly affect how you diagnose and treat a patient. Previously discussed was an idea of looking at the whole - treating the whole being. This belief makes it hard to distinguish where the boundaries are placed for diagnosing and treating osteopathically within a scope of practice. The osteopaths discussed what they believed their role is as an osteopathic practitioner.

When Sarah spoke of her role as an osteopath, she immediately talks about management of breastfeeding rather than osteopathic treatment. She acknowledges that breastfeeding is challenging and perceives her role as a support person who can provide education and advice to a breastfeeding mother. Sarah also expresses a belief that osteopaths have more time to spend with patients, an idea discussed by other participants:

"We listen to them properly, we give them advice around the issue, and we give them ideas or strategies that they can use. We know that breastfeeding is best and is supported worldwide, and it is something that people often find quite challenging. So we’re often in a position to support that process or to encourage that process or to give treatment and also solutions because we have time with these parents, where as GPs often don’t (Sarah, p. 8)."

David identifies his practitioner role as a “doctor”, acknowledging that he does not merely diagnose osteopathic problems. David also affirms a belief expressed by other participants: that generally there is more than one component to a breastfeeding problem:

"So in a nutshell, there are other factors that are part of your doctoring. I firmly believe that an osteopath is a doctor and differential diagnosis is more than just identifying osteopathic lesion. You take a detailed case history, you do a detailed differential diagnosis (David, p. 6)."
And you must appreciate there is most often more than one thing involved, there can be more than one process disturbing a child. And your skill comes down to identifying all of the aggravating factors as early as possible

Harry also identifies with this belief that as a health practitioner you have knowledge in more than one area, and to him, helping a patient is far more important than keeping within his osteopathic scope of practice. He reports that some of the information he discusses with his patients is not within his scope of practice, therefore he has to be very clear, and inform them that he is not legally working within his scope. He states that it is for his own protection as a practitioner that he discusses scope of practice with his patients. Harry was the only osteopath to acknowledge a problem between osteopathic beliefs and working within a scope of practice:

*I think the scope of practice can be a hindrance in that it can limit you as osteopaths. If you cannot work eclectically and work and use the things you need to use, I do not think that is osteopathy. And I know that there are defined roles that we are suppose to be able to do and not do, if they have just come to you for some help, and if you know of something that you really think is going to help, then you have got to tell them about it* (Harry, p.4).

This piece of Harry’s transcript is particularly interesting; when reading Harry’s quote a sense of being pulled between what is right by law and what he truly believes is right for the patient can be seen as diametrically opposed. Harry gives an impression that he has experienced this quandary in his treatment of patients many times before but he has not yet resolved his inner tension.
Theme [B]: Communication - a necessity for a successful treatment

It seems that because especially working in the cranial field it seems a bit more difficult to grasp because it does not look very dynamic, you really need to talk carefully about getting them to understand at some level what you are trying to do and let them, not alarm them too much (Harry, p.4)

Theme [B] discusses the important role that communication between the osteopath and the third party (the mother) has in providing a successful osteopathic treatment for a baby. In this situation an intermediary person the mother, has initiated the treatment and is intimately involved with the well being of the patient, the baby. Therefore the importance of communicating diagnosis and treatment procedures in this context is explored. The Subtheme [B1] Trust – I need you on board examines the importance of trust within a therapeutic relationship (between the practitioner and mother) and also identifies the different ways in which gender can alter the therapeutic relationship and explores the different communicative processors utilised by practitioners in relation to gender. Subtheme [B2] Endeavour to explain the treatment explores the methods employed by the participants to communicate to the mother firstly the treatment modality; osteopathy in the cranial field (OCF) and secondly the diagnoses established for the baby’s problem.

[B1] Trust – I need you on board

Subtheme [B1] examines the “trust relationship” required between the practitioner and the mother. In their own words, all participants narrated that it is an essential part of the treatment process and is required for a successful treatment outcome. The participants also identified that the feelings the mothers experienced in the treatment setting

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5 It must be acknowledged that in an osteopathic setting when treating a baby, the third party may not necessarily be the mother, but all participants recognised that customarily it is the mother who accompanies the infant for osteopathic treatment.
affected the baby, therefore the mother has to be comfortable so that the baby too can be comfortable.

_They have to be relaxed [Mother] because if they are not relaxed it generally does not go well. It transfers to baby, and you have got a screaming baby for half an hour (Harry, p.2)._ 

Like Harry, David acknowledges how imperative the trust relationship is to the success of the treatment:

_But getting the mum on board is the most important part of your treatment (David, p.6)._ 

By disclosing this information David provides a perspective of the effect the mother can have in this situation. David also conveys how he communicates with the mother in order for a trusting relationship to ensue:

_Dealing with mothers and their babies is a diplomatic art form that comes with experience. .../...the skill is in educating them, and encouraging them, and giving them a belief in themselves (David, p.8)._ 

In the above quote David talks of how he gains the mother’s trust, he takes on a supportive counselling type role in order to get “the mother on board”. April also provides a very compassionate role towards the mother of the baby she is treating:

_Usually quite anxious, and under pressure and feels like if she is not a good breastfeeding or can’t breastfeed then she is not a good mum, so a lot of reassurance around that. You know and just love, you know and really acceptance of her helps enormously (April, p.3)._ 

April acknowledges an understanding of how the mother may feel; a sense of failure at not being able to feed her child. Like David, April first provides support for the mother through reassurance and encouragement with the intention that a positive treatment outcome will prevail.
Sarah felt that she had already gained a certain amount of trust between herself and the mother before the treatment commenced. She also spoke about what many of the other participants alluded to; that the mother has a unique bond with their baby and knows that something is wrong:

*Mothers I have found are usually fairly in tune with their babies and know that things aren’t right on some level. And they already trust you to some level when they come in. Most of our babies are personal recommendations rather than through the yellow pages and so on, so they’ve got some level of trust when they come in. And you can obviously explain your treatment as you go* (Sarah, p.3).

In describing her patients as “personal recommendations”, Sarah is implying that the babies that she treats are referred to her by either midwives that she works in conjunction with, or through recommendations from people who have previously had their child treated by Sarah. This is a form of social trust that is discussed in the next chapter.

In this study three female practitioners and two male practitioners were interviewed. Between the two genders, two distinct ideas were expressed about working with mothers in this treatment scenario: Female practitioners felt that they could easily communicate with the mother and child because they had a connection with the mother i.e. being female. Female osteopaths felt an even greater connection to the mother if they themselves were mothers. They acknowledged that it was easier to get the mother “on board” because they had experienced motherhood and understood the mothers situation. Male practitioners did not talk of “special connections” with the mother. Instead, they expressed that if they communicated that they themselves were comfortable with this situation then the mother and baby would also feel comfortable.

Jenny reports that while her treatment approach does not necessarily change because she is a mother, her response and empathy towards a mother who is having problems breastfeeding her baby, is without question better. Jenny describes that as soon as mothers know that she is also a mother, there is a change in the mother-practitioner
relationship, and that they can relax as Jenny is now “in their club”. Jenny describes how the mother may be feeling when she is in this clinical situation:

*I think there is an element of feeling like being judged, with breastfeeding. Like why aren’t you breastfeeding? So I will always do my upmost to just support them, in whatever decision. And I totally understand why they would just say that’s it, it is just too stressful I am not going to persue the breastfeeding and switch to bottle. And I think that helps them relax a little bit more, just feel a little bit more normal I guess. It can be quite lonely that breastfeeding time, you can feel quite unsupported* (Jenny, p.5).

This quote illustrates the sympathetic consideration Jenny provides for the mothers of babies with breastfeeding problems. Jenny presents an impression that she remembers accurately the experience of being a breastfeeding mother and therefore provides the mother with a compassionate environment to treat her baby in.

Sarah also talks about her experiences of being a breastfeeding mother and how this experience affects her as an osteopath. She reports being given large amounts of advice when she was pregnant and the feelings of frustration she experienced when she was given conflicting advice.

*And whatever it is, I think when you can speak from personal experience that adds a bit of weight to what you are saying to the parents* (Sarah, p.6).

When asked if there were ever any issues regarding working with mothers who have babies with breastfeeding problems, David responded with:

*It has never been an issue in essence. It seems to be that if it is an issue in the practitioners mind, it seems to be more likely to become an issue full stop...//... And I guess to some extent they have already made a decision that they are happy to come to a male osteopath in the first place, with a breastfeeding problem so I guess they are already ok about it* (David, p.8).
Harry also responded with a similar belief, that if he felt comfortable in this situation, then the mother would also be comfortable. He reported that if he thought there was a situation where the mother was uncomfortable then he would address this issue and try and find a different approach to change the situation. Harry felt that if he communicated his confidence and respect then the mother would feel more comfortable in what might be a sensitive situation. Harry also addressed the concern that as a male practitioner you have to be aware and “in tune” with how the patient is feeling:

They trust you, to do whatever you need to do, as long as you are clear. Tell them about what you would like to do so that you are getting some permission from them... But it is far more about how you come across in my opinion. I have not had a problem and I do not feel uncomfortable. If ever I thought they were feeling uncomfortable you do something else, it is not worth getting into. Especially being the way that I work: sole practitioner. I am a male, predominantly my client base is female, you have got to have your radar on (Harry, p.6).

[B2] Endeavour to explain the treatment process

As part of complying with the New Zealand Osteopathic Code of Ethics, an osteopath must explain to the patient the diagnosis obtained for the patient’s complaint and also provide a treatment plan (New Zealand Osteopathic Council, 2003). In this situation rather than explaining the treatment procedures to a patient, the osteopath has to explain the treatment outcome to the patient’s mother. Many of the participants viewed this communicative practice as a difficult part of their treatment.

David admits that he does not describe very much at all about OCF as a treatment modality. He explains that if he is asked to explain OCF by the mother then he will obviously give them a direct answer to whatever depth they require to be satisfied, as he believes this is part of the informed consent process. David also identifies what he calls a “big dilemma” with OCF with respect to consent and informed consent. He reports that osteopathy in the cranial field is a very difficult concept to understand, even
for someone who has had years of education in anatomy and physiology. He therefore finds it particularly difficult to explain in any sort of tangible description the model of OCF. He reports that at the end of the day, regardless of the depth and time he spends explaining OCF it still appears as if he were just laying his hands and healing in some way. Instead he explains in considerable detail to the mother what is wrong with their baby:

I have got a couple of different anatomy atlases in my room and on the first consultation with a baby it would be very rare for me not to get the atlas off the bookshelf and show them; ok, this is what is wrong, and this is why your baby is upset, and this is what we have to change for them to be happy. It is very important for the parent to understand, to appreciate there is a reason for their child having the problems that they have (David, p.5).

David has explained how he educates the mother to a point where she can feel comfortable with the osteopathic treatment. His communicative processes include pictures to help give understanding to the problems the baby is experiencing. Sarah also acknowledges that she does not discuss in detail the underpinnings of OCF. Like David, Sarah employs visual aids (in this case the patient themselves) to help communicate observations she has perceived. Sarah reports demonstrating decreases in a range of movement by turning the babys head one way and then the other, and noting the differences. Sarah gives the mother some sort of visual objectivity instead of describing cranial detail.

I steer away from cranial details, and I guess I can do that because I’m doing structural work as well. So I would use terms that they are really familiar with and steer away from the anatomical details of what I’m doing. And sometimes I’ll show them the exact pressure I’m using on baby on them, on their forearm or something so they can see how light it is, if I think I need to (Sarah, p.4).

Interestingly, Sarah has communicated with the mother through proprioceptive touch to provide education about the treatment application with the patient. This visual and proprioceptive example communicates to the mother exactly how much force is
experienced by her infant. The forces used in OFC are generally very gentle and by conveying this to the parent Sarah has firstly educated the parent on the treatment methods utilised and secondly provided a sense of faith that their baby is not being harmed in any way.

Harry acknowledges the difference between treating adults and babies. He reports that when working with adults he can utilise techniques such as soft tissue work or a high velocity thrust, where the treatment is obvious to the patient and they can perceive the treatment. But when employing OCF methods to any patient whether young or old the treatment is often imperceptible. Because Harry utilises only OCF when treating babies the treatment is always indistinguishable:

A successful treatment to me is something that I can perceive and it may not be obvious to them but you need to tell them about it. Give them some idea or otherwise they are going to go away pretty bewildered. So the best you can do is try and teach them [the mother] so that they have some level of understanding (Harry, p.5).

Harry has talked about what other participants also alluded to: that a problem with OCF is that visually it may appear that nothing is happening, therefore Harry recognises the importance of communicating treatment outcomes.

**Theme [C] - The Process**

Theme [C] examines two key subthemes the participants acknowledged when discussing the actual process of treating and managing babies with breastfeeding problems. Subtheme [C1] *Treatment – The conversation* reveals a non-verbal communication and an intention the participants employ when treating babies. Subtheme [C2] *Osteopathy is one part* examines other treatment providers the participants work with, and to whom they refer their patients when working with babies who have breastfeeding problems.
Chapter Five: Data Analysis

[C1] Treatment - The conversation

Subtheme [C1] Treatment – The conversation attempts to explore the non-verbal conversation osteopaths have with their patients whilst treating. All the participants spoke of a form of intentional respect they have when treating a baby, they described a non-verbal intention that was able to be acknowledged by the baby.

Harry recognises a non-verbal conversation he has with the baby when he is treating them:

*And a lot is how you contact them. I liken it a lot to, you know there is those people who you meet who are like this (Osteopath places hand in front of his face, to demonstrate a person coming into his personal space) far away from your face. And you feel like you just want to step back a little bit and give them space, if you grab hold of baby, it is too much to be just straight in there and they are generally going to react to that, you are going to have a session that is maybe not going to be very useful at all, they are going to scream (Harry, p.3).*

In this quote Harry has described what he believes a baby may experience when the treatment is not appropriate, or too forceful for the child. Harry’s analogy about being situated in the baby’s personal space was also elucidated by Jenny, who reported that at the baby’s first osteopathic treatment she does not hold the baby’s head:

*And if they start crying while you are holding the head basically, get off. I do not want you to treat from there [practitioner describing what baby is feeling]. And babies are so whole you don’t need to hold the head to treat the head. The ability for them to unmold and reach that blueprint for health is mostly very easy for them. And for them they are all head, you know? That is mostly what they are, so another osteopath said to me once; that is kind of like their whole world. So if you go straight in there, that is really quite invasive for them. But even adults I will always start at the feet first because I think it is polite. It is like a handshake, it is like hello I am here to*
help. Not HELLO (Osteopath demonstrates with hands in the air, an over exaggerated squeezing of the head), (Jenny, p.7).

Describing babies as “all head” illuminates the image of how it may feel as a baby when treated by an osteopath who is not sensitive to the treatment modality. The osteopaths all described what they have experienced in the past when they accidentally misjudged the intensity of their examination or treatment methods using OCF, the outcome usually being an upset and unsettled baby.

Jenny continues the subject of non-verbal conversation by describing “intention”. All of the participants concurred on this subject; when treating babies using OCF it is important to understand what your intentions are, your purpose for the treatment. Jenny expands on the intention of treatment:

*And I think babies are kind of very in tune with themselves and their environment and therefore, if I am going in to feel the motion present, it is all about intentions, what is my intention? So my intention is to have a look and feel the strain but without initially interacting with it* (Jenny, p.6).

April explains how she treats with virtuous intention:

*Trying to work from here (points to heart) and trying not to be responsible like I’ve got to sort something out and I’ve got to fix and I have got to push around and use force. Because it’s already got force in it.../...If that makes sense, it’s already got a compression or twist in it or whatever. So it’s like a piece of string that’s in a knot. You can feel the knot but if you pull the two ends it just going to get tighter. But if you feel the knot in the middle and you just go into a sense of ease and find it and just wait with it, it will soften* (April, p.8).

April has illustrated how she feels she achieves success in her osteopathic treatments, by having an intention that comes from a place of respect and integrity. She has offered an explanation for what she believes is the link between being reverent towards the
patient and also successfully treating the patient, the idea of alleviating strain in the physical body without providing force.

**[C2] - Osteopathy is one part**

This subtheme investigates additional support networks or health practitioners that the participants recommend or work alongside to treat babies with breastfeeding problems. As previously discussed breastfeeding problems may originate from more than one health problem therefore more than one practitioner may need to be involved for a successful resolution to the breastfeeding problem. The osteopaths themselves provide dietary advice, education on breastfeeding and support for the mother. The most common health practitioners that the osteopaths worked alongside with respect to babies with breastfeeding problems were lactation consultants and naturopaths.

David firstly explains why other health practitioners or health services may need to be involved. He describes that there can be many contributing factors that are affecting the child and their ability to breastfeed. He explains that medication such as antibiotics can affect the normal gut flora and thus cause pain and problems with digestion:

*For example the child may have been exposed to antibiotics if they were born by cesarean, if they were premature, if the mother has had mastitis. So most babies born by cesarean would have been exposed to antibiotics...//... And your skill comes down to identifying all of the aggravating factors as early as possible because then that gets the child happier as quick as possible (David, p.7).*

Jenny describes the support networks she employs when treating babies with a breastfeeding problem:

*If they are not already under the care of a lactation consultant then that would always be my next step. We used to recommend the herbal nursing tea to get the milk supply up, but normally you find that women are already*
doing that on the whole. It is very standard now, straight away as soon as there might be an issue with breastfeeding. They will kind of assume that mothers milk must be low. Which is another reason why women might get stressed, which of course then reduces milk supply. Other than that we would always be touching base with the lactation consultant and the midwife. It is a team effort really, they know how we work, we know how they work, it works quite well (Jenny, p. 5).

It can been seen from the above statement that Jenny does not feel that her profession is superior to any other health provider, she acknowledges that by working together with other professions a positive outcome is more likely to ensue. Sarah also identifies that osteopathy is not the only profession that is able to help babies in this situation:

Again it would be La Leche League or lactation consultant to check the finer points of babies positioning...//...Osteopathy is one component that can help towards it. So yeah that would be my next port of call, unless I thought there were other more complicated issues with the baby. Like you know significant reflux that was affecting their breastfeeding or something that I couldn’t manage, then I would be looking at a paediatrician involvement as well (Sarah, p.7).

Interestingly, Sarah was the only participant who discussed working beside or referring patients to a paediatrician. The other health professionals that were discussed were midwives (who are lead maternity carers), lactation consultants (primary support services) and naturopaths who are classified as complementary or alternative healthcare practitioners.
Summary

For the participants in this study the experience of treating a baby with a breastfeeding problem was one of care and respect. Theme [A] – Beliefs – your foundation explored the beliefs the practitioners encompass with respect to the human body, their role as an osteopath and treating babies. Theme [A] also brought to light the effect of these beliefs on the participants as osteopathic practitioners. Theme [B] Communication – a necessity for a successful treatment investigated the communication methods utilised by the participants to gain the trust of the mothers. This theme explored how the participants communicate during their diagnosis and treatment sessions and how the participants’ gender affects their communication practices. Theme [C] The process investigated themes revealed by the participants within the treatment session. These included the importance of using a non-verbal communication with patients and also an identification of support networks that osteopaths utilise.

The following chapter will discuss some of the concepts that arose from these themes and interpret the relevance of these findings in light of the current literature and thought. In the interest of structure, the following chapter will be divided into three sections to match each of the major themes from the current chapter. Each theme will then be divided into subthemes for in-depth analysis and discussion.
Chapter Six:
Discussion
This chapter presents and discusses, with reference to current literature, the main ideas that arose in Chapter Five. In this study osteopaths reported that trust between themselves, the mother and the baby was the “essence” of a successful outcome in an osteopathic session. The osteopaths describe “getting mum on board” as imperative. Although trust was regarded by the osteopaths as essential, the communicative measures employed to get to a place of trust between themselves and the family unit was also significant. Because these two key ideas are so tightly intertwined they will be discussed together. The osteopaths were unaware of set protocol they employed when treating a baby with breastfeeding problems, this observation will be discussed alongside the role that the osteopaths identify themselves within this treatment scenario.

Mother – Trust and Communication

This study highlights the importance osteopaths place on forming a trusting relationship between themselves and the mother of the baby being treated. In respect to a successful treatment outcome, some osteopaths place the formation of this trust relationship higher than their actual osteopathic treatment. David describes “getting mum on board” (p. 6), as the most significant part of his treatment.

The osteopaths described this particular transaction as the most challenging in terms of gaining trust through communicative measures. Firstly this patient-practitioner relationship is triangular in nature. The mother has entered a relationship on behalf of her child therefore the osteopath has to form a relationship with two separate individuals who have a very intimate relationship of their own.

Some osteopaths reported that to commence this relationship it was essential to first let the mother tell her story and then acknowledge that her story had been heard. Osteopaths in this study, (through their own personal experiences and previous experience treating babies with breastfeeding problems) spoke of needing compassion for the situation, and an understanding of how the mother may be feeling, as it is common for mothers who are having trouble breastfeeding to feel a sense of grief, failure and shame (Sturmfels, 2008).
A desire to communicate compassion and understanding early in the treatment session aids in the formation of the relationship between mother and osteopath. The participants’ ambitions for the mother can be connected to current data which suggests that positive effects occur in a health care setting when people feel empowered and believe that they have been heard, this positive clinical encounter leads to improved outcomes (Dieppe, Rafferty & Kitson, 2002).

One osteopath believed that the beginnings of a trust relationship between themselves and the mother had already been formed previous to the first meeting, as the majority of her patients were recommendations from midwives or the mother’s friends. Savage (2006) states that listening to other mothers’ stories is a common and valuable way for women to learn about pregnancy, childbirth and parenting. When a mother has been recommended by her midwife to visit an osteopath for her child this is considered an element of social trust (Pearson & Raeke, 2000). Her confidence in the professionalism of the midwife fosters her personal social trust of osteopathy and subsequently frames the expectant interpersonal trust she is to experience with the osteopath.

In Gibbons’ (2008) study, the decision making process that mothers’ undertook in order to find and select osteopathy as a potential solution in their infant’s unsettledness, fussiness or irritability (UFI) was also influenced by social trust. In this study absorbing social trust in osteopathy meant overcoming negative perceptions of osteopathy for children. For others the process involved integrating impersonal factual information with the experience of other mothers. And for some it involved the recommendation of their midwife with whom they had an established trusting relationship. Gibbons describes “that all of these influences constituted a framework upon which the mother entered the patient-practitioner relationship” (p. 111).

Lynn-Mchale and Deatrick’s (2000) description is that a trust relationship between the practitioner and patient required time and was a developing process: ‘…a process, consisting of varying levels, that evolves over time and is based on mutual intention, reciprocity and expectations’ (p. 217). Some osteopaths describe the trust relationship as having two separate but intertwined components. One is the already described social trust that is formed prior to the treatment session; the other element is the interpersonal interactions that the mother experiences directly and through the session. Goold (2002)
describes this component of trust formation as experiential trust, and Pearson and Raeke (2000) describe competence, compassion, privacy, confidentiality, reliability, dependability, and communication as the components that experiential trust may be judged upon.

Lee-Treweek (2002) argues that it is not the practitioner and their therapy that is the basis of trust within complementary therapies, but a combination of network trust (trust relying on the accounts of other people) and reflection on the experience that developed trust within these patients. Lee-Treweek’s phenomenological study examined trust within complementary therapies and interviewed sixteen patients who had experienced a cranial osteopathic treatment. The interview focused on questions regarding the development of trust between the participant and the practitioner within the osteopathic treatment session. While it is likely that the mothers of the baby being treated in this study reflected on the osteopathic experience, the osteopaths felt that the trust relationship and its success was based and influenced within the treatment session rather than after.

In contrast to Lee-Treweek’s network trust, a study completed by Thom and Campbell (1997) attempted to understand how trust effects the patient-practitioner relationship. Through examination of a focus group interview data the researchers reported that trust was a consequence of the physician’s professional competence as well as their interpersonal skills. Thom (2001) supported these initial findings by undertaking a quantitative study. Thom concluded that behaviours which increase trust in a physician included being caring, comforting, demonstrating competency, encouraging, answering questions and explaining treatments procedures. Interestingly, Thom reported that caring and comfort were just as important as technical competency for their participants when generating trust.

The osteopaths in this study had a far more complex patient-practitioner relationship to contend with than above (Lee-Treweek, 2002; Thom & Campbell, 1997). A mother has entered a patient-practitioner relationship on behalf of her child. The baby is having problems breastfeeding and is the person that the osteopath is providing treatment for, yet the verbal and most obvious practitioner-patient relationship is substantially with the mother, a third party. Interestingly, the osteopaths describe using similar behaviours
(caring, comforting, demonstrating competency, encouraging, answering questions and explaining treatment procedures) toward mothers that Thom (2001) describes as increasing a trust relationship with patients. The osteopaths in this study would strongly agree with Goold (2002) that “trust in the healer is essential to healing itself” (p. 79).

In this therapeutic situation with regard to both mother and child, if trust is symbolised as the cell, the core of a successful treatment outcome, then communication is the nucleus. The way in which the osteopaths communicated their compassion, empathy, diagnosis and treatment plan, like trust, held a critical influence over the treatment outcome.

It must be acknowledged that not all osteopathic neonatal treatment is OCF-based as structural osteopathy is also used to treat babies in this treatment scenario. However, in this study the majority of the osteopaths used OCF when treating babies with breastfeeding problems. The osteopaths highlighted the difficult situation their chosen treatment modality (OCF) puts them in. If working in a practitioner-mother-patient triad is the first barrier when osteopathically treating a baby with breastfeeding problems, the second is working with a treatment modality that is not well known in the community, not well researched and visually looks like the practitioner is merely holding parts of the patient’s body. As previously explained, within the osteopathic profession there is debate about whether OCF exists as there is a lack of evidence regarding the effectiveness of this form of treatment (Rogers, Witt, Gross, Hacke & Genova, 1998). The concept of OCF may be confusing and peculiar to some mothers who have brought their baby’s for treatment.

The osteopaths held different opinions about how to inform and educate mothers concerning OCF. They did however agree that the mother has a unique bond with their baby and understand that something is wrong: “Mothers I have found are usually fairly in tune with their babies and know that things are not right on some level and are willing to go with you on your treatment journey” (Sarah, p. 3).

When asked directly how they as osteopathic practitioners explain OCF to the mother of the baby being treated, the answers ranged from not describing the treatment modality whatsoever; to describing in detail the process of OCF. David expressed that he would only explain OCF “if cornered to do so” (p. 7). He elucidated that if he was
asked to explain OCF by the mother then he would obviously give them a direct answer to whatever depth they require to be satisfied, as he believes it is part of the informed consent process.

This description of being “cornered” to explain OCF is a curious term given that the breastfeeding mother in this treatment scenario is a consumer and a legal guardian of the patient. In New Zealand a consumer of health services has the right to effective communication, the right to be fully informed and the right to make an informed choice and give informed consent as part of the HDC Code of Health and Disability Services Consumers’ Rights Regulation, (1996). To comply with this code an osteopath must explain their diagnosis and treatment procedures. It seems that David is therefore obliged to communicate clearly to the mother, as a consumer of a health service, that there is little evidence of the effectiveness of OCF but experience and anecdote suggest it can help some babies.

David felt that particularly after five years of anatomy and osteopathic training some people found the concept of OCF hard to comprehend and therefore, he believed that it was unlikely the mother of his patients would truly understand the process of OCF. Instead he spent a lot of time explaining the diagnosis he had reached from examining the child. David employed the use of anatomy books to help communicate his diagnosis and the rationale for the baby’s symptoms. He felt that it was far more important for the mother to understand and appreciate what was wrong with their child, rather than understanding the treatment modality. “Dealing with mothers and their babies is a diplomatic art form that comes with experience. ...//...the skill is in educating them, encouraging them, and giving them a belief in themselves” (David, p. 8).

David has utilised a form of non-verbal communication (an anatomy book) to communicate his diagnosis. Nonverbal communication includes all behaviours that convey messages without the use of verbal language (Roberts & Bucksey, 2007). Attempts have been made to quantify the relative importance of non-verbal and verbal behaviours, however little consistency has been found between studies (Caris-Verhallen, Kerkstra & Bensing, 1999; Hall & Lloyd, 1990). Despite the variance in comparisons between these behaviours, nonverbal communication is consistently thought to be more influential than verbal behaviours.
David’s use of an anatomy book as a resource for education and understanding, has also introduced an authoritative figure into the therapeutic relationship. It is unlikely that a mother would challenge David’s description of what is wrong with the child when this particular resource is placed in front of them. David is a very successful and experienced osteopathic practitioner, his intentions of wanting to help educate with this resource are not doubted, but an awareness of the influence or subjection that the mother may feel when presented with this form of authority must be acknowledged.

Sarah admitted that she did not directly explain OCF but also recognised a need for the mother to feel comfortable in the OCF treatment scenario. Sarah explained that she sometimes placed a hand on the mother with the same pressure she would use to treat the baby. She believed this educated and provided a sense of faith in the mother that her child was not going to be hurt or harmed in anyway.

Other osteopaths also felt from the mother a conflict between desire for improvement and fear of harm. Mothering a newborn child is a time when the mother is developing a relationship with her baby and learning who her baby is (Sullivan, 1997). The mother’s relationship with others takes a radical shift due to the presence of an intimately dependent infant (Gibbons, 2008). Most mothers take on a courageous “lioness” role to protect their baby from harm. The mothers in Gibbons (2008) study disclosed that a sense of unknowing remained with them throughout the phenomenon of seeking and participating in osteopathic treatment for their UFI infant. It is likely that many of the mothers that the osteopaths in this study work alongside also feel this sense of unknowing. The gentle and very simplistic form of communication that Sarah provides to the mothers in her treatment session may bestow a sense of security in an unfamiliar lived world.

Touch is a non-verbal behaviour and is described as the most important non-verbal behaviour that the health professional can employ (Williams, 1997). Williams identifies seven forms of non-verbal communication used within the healthcare setting – proximity, touch, eye contact and eye-gaze, facial expression, gesture, body posture and head movements. She argues that these behaviours serve several functions including giving information, seeking information, expressing emotions, communicating interpersonal attitudes, establishing and maintain relationships and regulating social
interactions. Non-verbal communicative processes leave such an impression on people that according to Waddell (2004) when the nonverbal message conflicts with the verbal message, people will not believe what is said.

The other osteopaths verbally described the concept of OCF to mothers; they all attempted to use language that was basic and not saturated with anatomical and osteopathic jargon. All five participants agreed that OCF can look like an osteopath is just placing their hands upon the patient’s head and that nothing is actually happening. Consequently the three participants that did describe OCF believed it is important to educate the mother about the treatment modality to some level of understanding so that the mother can appreciate the process.

**Experience and Gender**

When a mother has placed faith in the osteopath to treat her child, there is an onus on the osteopath to be explicit about their role in treating the infant and supporting the mother. For the osteopath there is little research in the osteopathic treatment of babies with breastfeeding problems that can help provide a sense of security to the mother. The osteopath must rely on past experience to help create a clear sense of what can be achieved in this partnership.

In this study three female osteopaths and two male osteopaths were interviewed. Early in the interview process it became apparent that gender and experience with breastfeeding had an effect on the therapeutic connection that the osteopaths felt they possessed with the mother.

The female osteopaths felt at ease when communicating with mothers because they had a ‘connection’, both being female. If the participant was also a mother they spoke of an even greater connection. The mothers who were also osteopaths spoke of ‘being in the same group’, and said that subsequently this also helped to form a positive relationship between themselves and the mother. The osteopaths who were mothers reflected on their own experience of breastfeeding or not being able to breastfeed and the judgment that they felt from others. Jenny spoke of breastfeeding being a lonely time and feeling
quite unsupported, while Sarah remembers being supplied with large amounts of conflicting advice and the feelings of frustration she experienced at the time.

The osteopaths who are mothers felt that personal experience adds weight to the advice and knowledge they were articulating. And while their osteopathic treatment had not necessarily changed because they were mothers, their response and empathy toward the mother who is having problems breastfeeding had enhanced. Jenny felt that when she disclosed that she herself was also a mother, the mother-practitioner relationship changed and the mother was able to accept and feel comfortable in this particular partnership.

The male osteopaths used the same phrase when asked if there were any concerns when talking to the mother about what may be a sensitive issue (breastfeeding); they both replied “it is not an issue for me”. The male osteopaths believed that if they were comfortable in this situation then they could easily communicate this to the mother and subsequently the mother would also be comfortable. The importance of effective communication in forming a trusting relationship between themselves and the mother was communicated by the male osteopaths. The male participants also assumed that the mother did not have an issue visiting a male osteopath because she had knowingly booked an appointment with a male practitioner.

A search of the osteopathic literature reveals nothing specifically related to effects of gender within an osteopathic setting however there is a small amount of literature regarding this subject within western medicine, particularly primary physician gender in healthcare. Male and female physicians who deliver primary care have been shown to have different practice approaches (Schmittdiel, Grumbach, Selby & Quensenberry, 2000). Female physicians communicate differently with patients compared to male physicians. Female physicians are more likely to employ preventative services than male physicians, especially for female services like pap smears (Lurie, McGovern, Ekstrum, Quam & Margolis, 1993; Hall, Palmer, Orav, Hargraves, Wright & Louis, 1990). Female physicians are more likely to discuss lifestyle and social concerns with their patients and are more likely to give their patients medical information during the session (Roter, Lipkin & Korsgaard, 1991; Elderkin-Thompson & Waitzkin, 1999). Compared to male physicians, female physicians are more frequently employing a
participating decision-making style with their patients (Cooper-Patrick, Gallo, Gonzales, Vu, Powe, Nelson & Ford, 1999).

In this study the person who initiates the consultation and treatment is not the primary object of the event. The baby is receiving the physical treatment but the case history, information gathering and explanation of diagnosis and treatment methods is directed at the mother. In this situation, although the mother and baby are part of the same entity, it is the mother that the osteopath firstly has to form a trust relationship with. The mother needs to feel like they are in a safe, nurturing environment in order to feel comfortable about the treatment their baby is about to receive. A more verbal and group participation style that female’s practitioner’s practice may be beneficial in establishing this environment and trust relationship.

_Baby - guiding with intention to health_

Once you have your own children you appreciate, how significant the health of a child is to the wellbeing of the whole family. You might be treating an eight or ten week old that has never smiled. Those smiles help to sustain the parent, but when the child never smiles, never gives them anything positive, that is really tough. And if you are the person that has made the difference, you have done a good treatment, and the baby is feeling so much better, that they can actually now smile for the first time. It is a big thing; you have done a lot for those parents. Their whole journey is all intrinsically linked to the bonding process; it is very hard to bond well with a baby that is giving you a hard time. So as the osteopath if you are the one who has not just changed the child’s life, in the immediate sense, in getting rid of the symptom, you have actually done something much more profound for that family. And you have done something for that child, in
fact in a whole life sense, because they will have a different relationship with their mother over their life time (David, p. 15).

In this quote David has represented the lifeworld of an osteopath successfully treating a baby. The osteopath does not merely treat the child, he or she is treating, on some level the whole family.

The osteopaths held a belief that the body holds within it a blueprint for health, and that as the osteopath they were merely guiding the baby back towards that blueprint. The osteopaths spoke passionately about this energy, this strength that guides the healing process that is initiated at conception, when the sperm and the ovum meet. It is this force, spark, ignition that commences the process of blastocyst separation, organ formation and onto the creation of a human being. It is this force or mechanisms that the osteopaths work alongside.

The Western-centric view of this belief also recognises that the human body has a remarkable capacity for self-healing. Very early in the study of the human body, Hippocrates commented that the human body usually returns to a state of equilibrium by itself, and in turn recognised that people recover from illness even without the help of a physician (Saladin, 2001).

The innate embryological force that the osteopaths work in conjunction with, was termed the primary respiratory mechanism (PRM) by Sutherland (1967). Sutherland believed that the subtle movements he perceived were a manifestation of the basic self-regulating, self-healing mechanisms within the body in operation (Brooks, 2000). Turney (2002) also describes this vital force as a ‘blueprint for health’. She describes PRM as an internal breathing system that pulsates in a rhythmic motion much like the heart and lungs. It is argued that this vital force resides initially in the cerebro-spinal
fluid and all other bodily systems, tissue and cellular functioning is organised and resonates around this ordering principle.

As previously stated in the literature review, even within the osteopathic profession there is much debate about if OCF actually exists, and for those who do practice OCF, there is debate about its origins and applications (Liem, 2004). Although the participants may hold different beliefs about the principles of OCF, they all described their osteopathic beliefs and skills evolving and changing as they became more experienced. The osteopaths identified that while they initially learnt how to examine and treat babies utilising identification of specific anatomical lesions, they were now more likely to examine and treat the whole body rather than a specific lesion. They spoke of their osteopathic work as a ‘journey’ that has been modified and become more ‘whole’ as they become more experienced.

As with any occupation, constant immersion in a particular area will increase knowledge, experience and skill. Higgs and Jones (2000) state that continual fine tuning and adjustment of a huge and constantly changing and expanding personal database is a key component to success as a clinical physician. Brooks (2000) argues that a successful practitioner of OCF must learn the detailed anatomy of the PRM, including cranial sutural designs, the dura mater and its relationship to the bony, neural, and vascular structures with which it is associated; and in addition the pathway of the cranial nerves.

The osteopaths identified that while they initially learnt how to examine and treat babies utilising identification of specific anatomical lesions, they were now more likely to examine and treat the whole body rather than a specific lesion. A successful outcome when treating babies was more probable when treating the whole. Some of the osteopaths referred to using a biodynamic model of osteopathy (BOCF) to assist in illustrating their treatment of the ‘whole’. This model of osteopathy is firmly grounded in the philosophy and practice of Still but Jealous (an osteopathic teacher and physician) labelled the method as a ‘biodynamic model’ of OCF and attracted both interest and controversy (that embryonic energy is continual throughout human life) within the osteopathic profession (Liem, 2004).
The osteopaths also had a belief that the innate forces that they were palpating and working in conjunction with were embryological in origin. When describing the forces that the participants palpated, Jealous (2001) characterised traditional osteopathy as a science based on anatomy and characterised BOCF as a science based on embryology.

Liem (2004) connects the embryo to the explanation of BOCF:

The embryo, as an archetype of perfect form, serves as a blueprint for our body’s ability to heal itself. The formative, resorbative, and regenerative fluid forces that organize embryological development are present throughout our life span, ready for our cooperation in harnessing their therapeutic potency. In other words the forces of embryogenesis become the forces of healing after birth (p. 656).

This idea, concept or belief, that the embryological forces that initiate cell division are a part of our therapeutic wellbeing for our entire lives may be believed or not. There is no gold standard, double-blinded quantitative test which currently proves what might be a fundamental concept in human or every “alive” specimen’s inner health.

Many concepts in our lifeworld do not fit into a quantitative model, however they are still experienced, lived, discussed and studied. It is only through learning, studying and experiencing treating with BOCF that someone may form a realistic ideal about this theory of guiding to health.
The Silent Conversation

The osteopaths describe a non-verbal conversation they believe they initiate when treating babies osteopathically. This conversation is expressed through their intention and their touch, a type of respect that was able to be acknowledged by the baby. For Harry, this non-verbal conversation is mediated by how he contacts the baby and also his appreciation of the baby’s own personal space. Jenny also held a respectful appreciation of a baby’s space when treating.

According to Lederman (2005), it is our intention associated with our touch that forms the ‘conversation’ between patient and osteopath. If the osteopath’s intentions for treating or diagnosing the baby were too strong or intrusive; the baby would become unsettled and usually cry. Through acknowledging their own intentions the osteopaths were able to calm the baby and modulate their diagnosis and treatment methods. This concept of working and treating with intention supports Woodall’s belief that intention is something over which we have conscious control. In very early intention based osteopathic studies, Woodall (1906) affirmed that “no one can get the best results while the mind is employed in thinking about something foreign to the matter in hand” (p.339). While Engel’s (2002) alternative belief is that we do not have conscious control over our intention, “It is not possible for an osteopath to put his hands on a subject and do nothing” (p.81).

Jonas and Chez (2004) describe intention as the “mindful determination by one or more participants through both intuitive and conscious action to improve the health of another person or oneself”. The significance and value of practitioner intention has been identified in nursing (Hoover-Kramer, 2002), CranioSacral Therapy© (Upledger & Vredevoogd, 1983), and OCF literature (Jealous, 1997, 2002; Still, 1899, 1908; Sutherland, 1967, 1990). There is very little OCF literature regarding intention of practitioners and its effects on the clinical outcome. Jealous (1997, 2002), Still (1899, 1908) and Sutherland (1967, 1990) acknowledge that the importance of the use of intention within the osteopathic profession arose from their clinical experience rather than quantitative scientific studies.
The participants described being able to ‘listen’ to the patient’s body, in order to diagnose, treat and establish when a successful treatment had transpired. The osteopaths also used a form of touch to communicate with their patient. Touch, as previously stated is described as the most important non-verbal behaviour that the health professional can employ (Williams, 1997). Ekerholt and Bergland (2006) described skin-to-skin contact “as a kind of body dialogue without linguistic references” (p. 140).

The mutual or bi-directional non-verbal dialogue that is created with a baby in an osteopathic setting is described by the participants as an essential technique. Mothers are usually very clear if their baby is in pain, as they very quickly learn what each different cry means. However, a mother cannot inform a practitioner about everything that the baby is experiencing. That is why Sarah also describes having to “trust her hands” to find a diagnosis. The patient in this situation cannot communicate verbally the information required for an accurate osteopathic diagnosis of their complaint; therefore a deeper form of communication is required.

At this stage in the development of osteopathic research, it would be hard to demonstrate the non verbal-conversation that is so vital in the treatment of babies with breastfeeding problems. However, osteopaths do work under a code of ethics that provides guidelines for practice. The next section of this chapter will discuss the protocol (or lack of protocol) that the osteopaths use when treating babies with breastfeeding problems.

**Protocol**

A protocol or medical guideline is a document constructed with the aim of guiding decisions and criteria regarding diagnosis, management, and treatment in specific areas of healthcare. Such documents have been in use during the entire history of medicine. However, in contrast to previous approaches, which were often based on tradition or authority, modern medical guidelines are based on an examination of current evidence within the paradigm of evidence-based medicine. Woolf, Grol, Hutchinson, Eccles & Grimshaw (1999) state that a protocol is a formal set of conventions governing the
format and control of interaction among communicating functional units. It is a rule, a guideline or document which guides how an activity should be performed.

The osteopaths in this study were asked if they had a protocol or a set of procedural steps that they performed specifically when treating a baby with a breastfeeding problems. Some of the participants identified lesions that they recognised as common in this particular situation. The osteopaths shared a common belief, that they were not aware of any set protocol when treating babies with breastfeeding problems.

Some of the osteopaths felt that if there were procedural steps employed to treat babies with breastfeeding problems, then the essence of osteopathy would be lost. The osteopathic treatment would not be successful because every baby they treat is different and responds differently to their treatment. Harry describes his belief that following a protocol for this particular problem could be likened to following an uneducated recipe: do step A, B, C and you may get a successful outcome, but it is unlikely.

The reason the mother has brought their baby to an osteopath is because they are having problems breastfeeding. However, the osteopaths are not specifically treating the breastfeeding problem; the osteopaths are treating a dysfunction, the result of which is a breastfeeding problem. The belief of treating the diagnosed dysfunction rather than the complaint interconnects with one of the fundamental principles of osteopathy; that osteopaths work in an unidirectional causative paradigm. Dysfunction in any area will impact all other areas of the body through membranous, myofascial, bony articular, neurologic and vascular interactions, and through the primary respiratory mechanism. Consequently, the osteopathic treatment of somatic dysfunction affects the complete body (Coppinger, 1998). Sergueff (2007) states that the object of osteopathic practice is to:

Identify and treat somatic dysfunction at the various levels of fluid, membranous, myofascial, ligamentous, intra- and interosseous dysfunctions, thereby enhancing the whole body capacity for repair and maintenance of health (p. 138).
Harris (1993) suggests that every healthcare practitioner will directly or tacitly adopt, develop or promote their protocol to meet their statutory obligations and develop consistent approaches to patient care. An effective protocol can be shown to benefit patients, staff and organisations. Conversely, failure to follow a protocol may put a patient or health practitioner at risk.

It is unlikely that the osteopaths consider their patient at risk every time they treat (particularly when many of the babies the osteopaths treat are referrals from other primary health care practitioners). Yet, the osteopaths are not aware of any protocol that they abide by in a treatment setting. The osteopaths did establish that they utilised a general protocol regarding case history, examination and that they employed OCF as the treatment modality to treat babies with breastfeeding problems.

It may be argued that although simplistic in nature the general protocol for case history, examination and the acknowledgement of a treatment modality is the protocol. However, it has been suggested that protocols need a set of conventions or guidelines that originate from evidenced based medicine and the osteopathic treatment of babies with breastfeeding problems does not yet have this evidence. Another notion is that the value of a protocol sometimes lies in excluding high risk conditions. It may well be that the osteopaths do perform a ‘triage’ type of protocol, screening for infections and possible profound dysfunction and in cases where a high risk condition is diagnosed, the baby would be sent immediately to the appropriate treatment provider.

It seems that resolution of this quandary will only change with time focused on how evidenced based medicine can be altered to research osteopathy, or how osteopathy can fit more and coalesce into an evidence based medicine model.
The Practitioner's Role

When the osteopaths were asked to define their role as an osteopathic health practitioner treating a baby who is having problems breastfeeding, they all observed their role quite differently. One osteopath held a belief that her role when treating babies with breastfeeding problems was as a support person, rather than an osteopath. She felt that her role was in part an osteopath treating the baby, but she also felt that in this circumstance she spent a great deal of her time educating and encouraging the mother.

Descriptive and correlational studies are inconsistent regarding a health care professional’s influence on breastfeeding initiation and duration (Dennis, 2002). Studies completed in the 1980’s found that health professionals were rarely perceived as a significant source of influence regarding breastfeeding success and duration (Dusdieker, Booth, Ekwo, & Seals, 1984; Labbok & Simon, 1988). However research in this particular area in the 1990’s concluded, that an education intervention in the early postpartum period has been shown to promote positive breastfeeding behaviours (Susin, Giugliani, Kummer, Maciel, Simon & Silveira, 1999).

David described his role as a ‘doctor’; he conveyed that he does not merely diagnose osteopathic problems. The diagnoses he identified when treating babies were not necessarily osteopathic lesions. He diagnosed complaints that medical practitioners or naturopaths would commonly diagnose such as yeast infections and gut intolerances. After the initial diagnoses David would then refer to what he considered the appropriate health practitioner for treatment. He acknowledged what many of the other participants also identified, that when a baby is having problems breastfeeding there is usually more than one contributing issue. He therefore felt that as a registered osteopath he was practising within his scope of practice.

A scope of practice is a legal definition of the activities that can be performed by certain health practitioners. The New Zealand osteopathic scope of practice was established in 2004 by the Osteopathic Council under the Health Practitioners
Competence Assurance Act (HPCAA), 2003, (Occupational Therapy Board of New Zealand, 2004). The osteopathic scope of practice is as follows:

Registered osteopaths are primary healthcare practitioners who facilitate healing through osteopathic assessment, clinical differential diagnosis and treatment of dysfunctions of the whole person. Osteopaths use various, recognised techniques to work with the body’s ability to heal itself, thereby promoting health and wellbeing. These osteopathic manipulative techniques are taught in the core curricula of accredited courses in osteopathy. The ultimate responsibility for recognition of practice lies with the Osteopathic Council (New Zealand Osteopathic Council, 2003).

In evaluating his approach to practice, it seems that David has not stepped outside of his osteopathic scope of practice. He has employed clinical differential diagnosis as a primary healthcare practitioner to treat dysfunction of the whole body. The ambiguous nature of this scope of practice is beneficial in allowing osteopaths freedom to practice as autonomous clinicians. “various, recognised techniques”, gives osteopaths extensive breadth in which to use their diverse diagnosis and treatment methods.

The health care practitioner has reasonably clear aims: alleviating suffering and the care and/or cure of the sick. Therefore the role of a health care practitioner, be it that of nurse or doctor, is accurately definable, but Scott (1995) suggests that occupation cannot be defined in terms of its ‘role’ alone as the skills and aims of a person are also interwoven within this entity. Downie (1971) quoted in Scott (1995) provides a useful description between the sociological and the philosophical notion of role:

From the point of view of sociology and kindred enquiries ‘role’ is a de facto concept and roles are patterns of expected behaviours with certain effects while from the point of view of social ethics and kindred enquires ‘roles’ is a dejure concept and roles are clusters of rights and duties (p. 323).

It should be noted that the person who has the role in the sociologist’s sense may be quite unaware that he has it, whereas in the sense of the social philosopher the person
who has the role must be aware that he has it. The role of a health practitioner such as a
doctor or nurse, in most countries is reasonably clearly defined and legislated for, in
terms of rights and duties. In order to practice competently there are certain clearly
identifiable skills which the nurse or doctor must have. If these skills are not possessed
by the practitioner then the practitioner may have his or her licences to practice either
withheld or withdrawn, by society, through the agency of the appropriate registry body
(World Organization of Family Doctors, 1991).

Scott (1995) states that:

This interactive relationship between person and role has particular
implications for the education of health care practitioners... the quality of
the practitioner's role enactment and moral sensitivity has a direct bearing
upon patient care (p.323).

Scott (1995) also claims that a beneficial way to view the connection between a person
and their role is to observe how the individual interacts with and is formed by their role
and in turn shapes and influences that role.

It seems that in New Zealand the legislation for defining the role of an osteopath may
not be clear to some practitioners, as one osteopath felt that his role changed from
primary health practitioner to a complementary health practitioner depending on the
patient’s situation. He felt that if the baby had been examined by a midwife, general
practitioner, or specialist obstetrician for the breastfeeding complaint then his role was
to examine and treat the baby osteopathically for the breastfeeding problem. If however
the baby had not been examined by one of the above health practitioners for the specific
breastfeeding problem he felt it was his responsibility to provide the necessary
complete paediatric physical examination to the infant. This osteopath held a belief that
sometimes he did not work within his scope of practice but described that if he could
not work in this manner, he was not being an osteopath.

A contrary view, is that under the Osteopathic Council of New Zealand code of Ethics
(2006), this osteopath must make the care of the patient his main concern. Provided that
the osteopath has gained informed consent from the mother and also assisted in the
mother’s understanding of the nature, purpose, benefits and limitations of osteopathy, by taking a thorough case history and then deciding upon the most suitable examination procedures, this osteopath has indeed worked within his scope of practice and complied with his obligation to provide a “duty of care” at all times.

This chapter has discussed the importance of trust that permeates between the osteopath and the mother throughout the experience of osteopathically treating a baby with breastfeeding problems. Through verbal and non-verbal communication the osteopaths are able to establish a positive therapeutic environment so that a successful treatment can transpire. Furthermore the osteopaths identified employing a non-verbal conversation with the baby during the treatment session that is expressed through their intention and touch. This non-verbal conversation was identified as a critical component of the therapeutic interaction.

The next chapter deals with the study’s strengths and limitations, area for further investigation and the implications for osteopathic practice of the study’s findings.
Chapter Seven:
Conclusions
**Strengths of the Study**

This study provides a rich exploration of the lived experience of osteopathically treating babies with breastfeeding problems. The exploration can be used by osteopaths and osteopathic educators to gain additional insights into the communication, treatment and management procedures that may be utilised for this particular infant complaint.

One strength of this study is that it investigates a phenomenon in osteopathic research that in the past has had little consideration. As previously mentioned, the treatment technique typically utilised by osteopaths when treating babies with breastfeeding problems; OCF, although still controversial has been investigated, and Fraval (1991, 1998) contributed quantitative research that investigates the effects of osteopathic treatment provided for babies who demonstrate sucking dysfunction. However the lived experience and the complex nature of osteopathically treating a baby with breastfeeding problems have not previously been studied.

An essential principle underlying qualitative research is that there is far more depth in human behaviour than what can be directly observed. Emphasis can be placed on studying and documenting subjective experience and the meaning humans place on certain events. As already described, phenomenological research sets out to examine the nature of the lived experience of a phenomenon. Thus it can be proposed that another strength of this study was the successful match between the aims and objectives (investigating a human experience) and the methodological research approach employed.

The experience of treating babies involves a third party (the mother); the participants included in their experience of treating babies with breastfeeding problems the importance of successful communication between themselves and the mother. These findings may potentially be helpful to a wide range of healthcare professionals, particularly those who must communicate their diagnostic and treatment methods to a third party. This study is also another contribution to a body of work (Viedma-Dodd, 2006 & Gibbons, 2008) developing around osteopaths treating baby and mother dyads.
**Limitations of the Study**

The development of this study entailed interviewing five participants about their experience of osteopathically treating babies with breastfeeding problems. The data was then analysed and amalgamated into a number of themes that appeared to best represent the participants’ reflective experience. The findings from this research cannot be generalised to other populations or to a greater population due to the small sample size and sampling methods (purposive and snowball sampling). Conversely the objective of this research was not to produce generalisable findings, rather to collect a rich in-depth understanding of the experience of osteopathically treating babies with breastfeeding problems.

Given the time constraints on the completion of this study a further limitation of this study was the necessary exclusion of certain methodological processes that have been recommended to further ensure methodological rigour. For example van Manen (1997) states that a process of continual reflectivity is appropriate to clarify and make explicit the structure of the meaning of the lived experience. In the analysis process of this study the data was analysed, put away for one week then reanalysed and reflected on once more. More time spent away from data and more time spent reflecting and analysing data may have elicited the phenomenon further.

The point at which sampling was ceased could also be a limitation to this study. Minichiello et al., (1999) states that the decision to stop sampling is related to the depth in which the phenomenon is to be understood. It is acknowledged that while there are consistencies across the interviews in this study it could be argued that complete theoretical saturation was not achieved. However the phenomenological approach of immersion in the data and the time constraints of this project, necessitated a manageable number of participants and a respectable amount of time spent reflecting on the data obtained.

Another perceived limitation of the study is that two of the participants themselves had experienced trouble breastfeeding. These participants would perceptibly include this life experience into their osteopathic experience of treating other babies with
breastfeeding problems. However, some may see this limitation as strength as the participants who had experienced breastfeeding problems also contextualised the lived world of an osteopath treating a baby with a breastfeeding problem.

**Directions for Future Research**

The intention of this study was to further the understanding of the experience of osteopathically treating a baby with breastfeeding problems. Only five voices were heard in this particular study therefore it is unlikely that this study accurately reflects the experience of the wider osteopathic practitioner population. A need to examine a greater population to explore this phenomenon more exhaustively is required to capture generalisable concepts of this particular experience.

A large sample quantitative study investigating the effectiveness of osteopathic treatment for babies with breastfeeding problems would also be beneficial. If shown to be a successful form of treatment for this particular complaint, osteopathy may gain a larger and more effective role in the community in general and when dealing with this particular paediatric problem.

This research, like many research projects unveiled more questions than it has answered. A theme that emerged in this study about the non-verbal conversation that the practitioner has with the child requires further investigation. Although as previously mentioned there is a small amount of literature regarding the effects of intention in the treatment session, are larger investigation into the “non-verbal” conversation that the osteopath has with the baby would gain useful insights into the experience of the treatment session.

An issue that was revealed by the participants in this study was the inconsistency between osteopathy and the New Zealand Osteopathic Code of Ethics that the practitioners work in conjunction with. This quandary may not need researching but the concern voiced by the participants illustrates that the code may not be appropriate for this particular treatment paradigm and should be addressed by the appropriate faction.
Another area that would be beneficial to investigate is the mother’s lived experience of seeking and participating in osteopathic treatment for her baby who is experiencing breastfeeding problems. Understanding the experience from the mothers’ point of view could only help the therapeutic relationship as the osteopaths in this study affirmed this relationship is vital to the success of the osteopathic treatment.

**Implications for Practice**

The themes that emerged from this study primarily have implications for the role of an osteopath as a primary health care practitioner.

Participants in this study held different beliefs about their role as an osteopath providing treatment for a baby who is experiencing breastfeeding problems. Some osteopaths felt that they provided a complementary role, imparting support and management to the mother. While others saw their role as a primary health care practitioner. The osteopaths also disclosed that sometimes they worked outside of what they thought was their scope of practice in order to provide the appropriate treatment and management for their patient. Osteopathy as a profession may need to examine and alter the scope so that osteopaths clearly understand their role as an osteopathic practitioner working in New Zealand.

Another discrepancy between the participants was their description of the treatment modality (OCF) that they explained to the mothers of the infant being treated. Some osteopaths admitted to not explaining the treatment at all while others went into vast detail. All of the osteopaths agreed that OCF can be a very unusual concept for a mother to grasp and it was therefore important that the mother felt informed and content with the treatment process.

Informed consent now permeates all aspects of health care and patients expect to be well informed. The OCF curricula of both osteopathic continued professional development and tertiary training in osteopathy should be reviewed so that osteopaths
can be amply educated in the appropriate communicative methods utilised for this particular treatment paradigm.

In this study the osteopaths recognised communication as the nucleus of a successful clinical outcome. The osteopaths reported that “getting mum on board” was fundamental in the treatment process. The uniqueness of the communication demands for treating a mother and her baby needs to be acknowledged by the osteopathic profession so that these communication skills can be identified as highly significant and developed in tertiary training. Further research into the interaction between the mother and the osteopath as recommended above, would help to ensure communications training was effective and appropriate.

The osteopaths also expressed the importance of the non-verbal conversation that they retain with a baby when providing osteopathic treatment. They describe communicating this conversation through their intention and touch. This research suggests that more emphasis needs to be placed on the role of intention and touch within osteopathy and manual therapy realms. Teachers and educators may need to consider educating students of the effects of intention and different types of touch, the communicative power of intention and touch, and also the experience of intention and touch for patients.

The osteopaths identified that when working with babies who are having problems breastfeeding there is usually more than one aetiology involved. Part of the osteopaths’ role is to provide support and education about other treatment modalities in order for the problem to be resolved. Osteopathy as a profession may need to collaborate with other treatment providers to establish a clinical pathway that supports mothers and babies when there is a breastfeeding difficulty.
Chapter Seven: Conclusions

**Concluding Statement**

The study of the osteopaths lived experience of treating babies with breastfeeding problems revealed that the actual physical osteopathic treatment was only a very small amount of the lived experience. Due to the importance of the mother’s trust and its influences on the baby and the treatment outcome, a large amount of energy is expended educating, providing support and establishing a trusting relationship with the mother. The osteopaths identified that effective communication forms the basis of this unique patient-mother-practitioner triad relationship and profoundly dictates patient/caregiver satisfaction and other health outcomes.

While no set treatment procedures or protocols were identified for this particular patient complaint, the study did reveal the importance the osteopaths place on the non-verbal conversation they have with babies. The study also identified the osteopaths’ belief that there is already in each person a blueprint for health and the practitioner does not fix the problem, rather they are a guide that helps another being regain their own health.

This study aimed to explicate the osteopaths experience of treating a baby with breastfeeding problems. It appears that from listening to the osteopaths tell their story they are not merely enabling an infant to successfully breastfeed. The osteopaths have actually done something more profound, they have supported and helped a family unit.
References


Occupational Therapy Board of New Zealand (2004). Health Practitioners Competence


Appendices
Appendix A – Ethical Approval

Lydia Carey
72 Vermont Street
Ponsonby
Auckland

17 June 2008

Dear Lydia,

Your file number for this application: 2008-857

Title: An investigation into the osteopathic diagnosis and treatment of neonates with breastfeeding problems

Your application for ethics approval has been reviewed by the Unitec Research Ethics Committee (UREC) and has been approved for the following period:

Start date: 17 June 2008
Finish date: 1 December 2009

Please note that:
1. the above dates must be referred to on the information AND consent forms given to all participants
2. you must inform UREC, in advance, of any ethically-relevant deviation in the project. This may require additional approval.

This letter has been copied to the Principal Supervisor for Unitec student research projects.

You may now commence your research according to the protocols approved by UREC. We wish you every success with your project.

Yours sincerely,

[Signature]

Deborah Rolland
Deputy Chair, UREC

cc: Andrew Stewart
Cynthia Almeida
Appendix B – Information Sheet for Participants

An investigation into the osteopathic diagnosis and treatment of neonates with breastfeeding problems

The researcher
I am Lydia Carey, a Masters of osteopathy student at Unitec Auckland. Part of the requirement of my Masters is to complete a research project. My supervisors for the project will be Sue Gasquoine and Associate Professor Clive Standen.

The study
You are invited to take part in this study to investigate the osteopathic diagnosis and treatment of neonates with breastfeeding problems. My intention is to contribute to a knowledge base that will:

- Better inform effective osteopathic treatment of neonates with breastfeeding problems.
- Promote diagnosis and treatment designs and guidelines that are focused on the needs of neonates and their mothers.
- Establish criteria for future research into osteopathic interventions for neonates with breastfeeding problems.

I would like to interview practising osteopaths who specialise in the care of babies/neonates and give them the opportunity to tell ‘their story’ of their experiences in diagnosing and treating neonates with breastfeeding problems. The completed project will contribute to an emerging body of literature and may be considered for journal publication.

Involvement from Participants
I would like to conduct an in-depth interview, individually with each participant, at a location of your choice. The location could be your practice, home or the Unitec Osteopathic Clinic. It is intended the location should be relaxed and private facilitating undisturbed communication. The interviews will be unstructured and take at the most 90 minutes to complete. You are able to decline to answer any questions during the interview. These interviews will be recorded and then transcribed verbatim. You will have the opportunity to read your transcript so you can consent to its accuracy. If you wish to withdraw any or all or your data you will need to contact the researcher within 14 days from receiving the transcript.

Confidentiality
You will select a pseudonym for your interview and this pseudonym will ensure your anonymity at all times. All consent forms and transcripts will be handled and stored safely at all times. All data will be stored on a password-controlled computer.
Any concerns

If you have any further questions or concerns please feel free to contact me directly on 0276642132 or email to lyd154@hotmail.com

If you would like to contact my principal supervisor directly you can on 09-815-4321 ext 5104 or email to sgasquioine@unitec.ac.nz

Thank you for reading the information sheet. Please keep it for your own records.

This study has been approved by the Unitec Research Ethics Committee from 25 June 2008 to 1 December 2009. If you have any complaints or reservations about the ethical conduct of this research, you may contact the Committee through the UREC Secretariat (Ph: 09 815 4321 ext.7254). Any issues you raise will be treated in confidence and investigated fully, and you will be informed of the outcome.
Appendix C – Inclusion Criteria

Criteria for selection of sample

Inclusion Criteria

1. Osteopaths who are experienced (have practised as a fulltime osteopath for at least five years) in treating neonates with breastfeeding problems and for whom neonates are a significant proportion of their caseload.

2. Osteopaths who are fluent in English.
Appendix D – Sample Interview Guide

Sample Interview Questions

Osteopath
Tell me about treating babies with breastfeeding problems.
Tell me how mothers present their baby’s complaint.
What do you think mothers of these babies are expecting when they bring their infant for treatment?
On what do you base your treatments?
What do you see as the needs for babies with breastfeeding problems?
Are you treating the baby or the mother, or both?
Do you ask about support networks?
Appendix E – Consent Form

Consent Form

An investigation into the osteopathic diagnosis and treatment of neonates with breastfeeding problems

This research project is required as part fulfilment for the Masters of Osteopathy undertaken at Unitec New Zealand, 2007.

The researcher is Lydia Carey (post graduate student). Sue Gasquoine and Associate Professor Clive Standen from the School of Health Science at Unitec are supervising the project.

Name:…………………………………………

I have read the Information Sheet for this study and have had the details of the study explained to me. My questions about the study have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I agree to provide information to the researcher on the understanding that it is confidential. I can decline to answer any particular questions in the study. I also understand that I will receive a written copy of my interview transcribed verbatim. The purpose of this is so I can confirm the authenticity of the data and its transcription. If required I can make the necessary changes or withdraw any or all of my data. However this must be done within 14 days of receiving the transcript.

I have been given a copy of the Information Sheet and this Consent Form to keep.

I freely consent to participating in this study.

Participant Signature: ……………………… Date: ………………………

Name:…………………………………………

Address:………………………………………

Phone:…………………………………………

Project Researcher: ……………………… Date: ………………………

This study has been approved by the Unitec Research Ethics Committee from 25 June 2008 to 1 December 2009. If you have any complaints or reservations about the ethical conduct of this research, you may contact the Committee through the UREC Secretariat (Ph: 09 815 4321 ext.7254). Any issues you raise will be treated in confidence and investigated fully, and you will be informed of the outcome.