

**An exploration of the experience of  
parents in the osteopathic  
treatment of their infants.**

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# Abstract

**Aim.** The aim of this phenomenological study was to describe the experience of parents seeking and participating in the osteopathic treatment of their infants.

**Background.** Although there is some literature in the treatment of infants' from a mother's perspective, there is very little literature which combines both parents' perspectives.

**Methods.** Parents of infants aged between 6 months and two years who had sought osteopathic treatment for their infant participated. Data was collected by in-depth interviews conducted in the family homes and workplaces of the participants. These interviews consisted of five interviews where three involved both parents and two involved individual parents. The resultant data were analyzed using van Manen's (1997) hermeneutical phenomenological approach.

**Results.** Three phenomenological themes emerged from this study. From uncertainty and anxiousness, parents determined that **something is not quite right** and this influenced them to **seek osteopathy**. Parents found osteopathy through friends and family and their own previous experiences with osteopathy. Trust and communication within the triangular relationship between infants', parents' and osteopaths was most important in the positive outcomes of treatment. **The Future** requires a perception change from parents with regard to the scope of osteopathy.

## **Conclusions.**

When presented with a situation of uncertainty, parents work through different stages of enquiry as how to best resolve their infant's complaints. Osteopaths need to adapt their communication within this triangular relationship in order to build trusting therapeutic relationships. Community awareness and education in the osteopathic treatment of infants is paramount to ensure our infants' future health.

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# Key to Transcripts

Participant quotes are *italicized* referenced with the participant's pseudonym and transcript line number (ln). Pseudonyms have also been used for infants and osteopaths names have been replaced with "*the osteopath*". The interviewee's intonation has sometimes been highlighted for clarity by underlining the words involved.

Symbols used are as follows;

...	Omission of dialogue
...//...	A large break in the quoted dialogue
[ <i>Text</i> ]	Text is added or altered for clarification
F -	Father speaking
M -	Mother speaking
I -	Interviewer speaking

# **Chapter One**

## **Introduction**

## **Introduction**

Chapter One introduces the research topic: An exploration of the experience of parents in the osteopathic treatment of their infants. My personal background is outlined including the experiences that brought about the choice of research topic. A brief outline is given of the research project undertaken, the rationale behind the study and the methodology used to gather and analyze the data. This chapter concludes with an overview of the chapters to follow.

## **Personal Background**

Ezzy (2002) suggests the essence of qualitative research is a discovery of the voice of the other, or the story of the unknown, and bringing these unheard voices and unknown stories into dialogue with pre-existing knowledge in order to build new understandings and new theory.

I was first introduced to osteopathy as an adult after injuring my back while running. The osteopathic treatment I received influenced me to become a student of osteopathy. Through my experiences with osteopathy I then introduced it to my children. My interest in this project was prompted after the birth of my grandson. I had the great privilege of being present at his birth, which was considered a natural birth, where no drugs were used and there were no complications. Several months after his birth, my daughter noticed that my grandson preferred to feed from one breast more than the other. He also had a sticky eye which was not responding to treatments of saline solution and breast milk. I suggested to my daughter that we take him to see an osteopath who specialized in cranial treatment. I was intrigued by the method of treatment my grandson received, something I had previously

never witnessed. After three treatments my grandson's eye had cleared, he was feeding well on both breasts and sleeping through the night.

This experience was further enhanced in witnessing a similar outcome with both a friend's infant daughter and with my second grandchild.

### **Outline of the Study**

This project is a qualitative exploration of the experience of parents seeking and participating in osteopathic treatment for their infants. In this study the parents are the infant's voice. Parents are making the decisions regarding future treatment of their infant's and their future health.

This study builds on two earlier unpublished osteopathic studies into infant health by Viedma-Dodd (2006) and Gibbons (2008) where the experience of mothers and osteopaths in the treatment of unsettled, fussy or irritable (UFI) infants was explored. Viedma-Dodd found that although some mothers found osteopathic treatment for their unsettled, fussy or irritable infants helpful, they were unsure whether their infants' symptoms had improved. This was continued in Gibbons (2008) study which demonstrated the pervasive detrimental effect that caring for an unsettled, fussy or irritable infant has on the mother and her family and that osteopaths need to ensure they are being heard by being clear about what their role is in treating these infants. Viedma-Dodd (2006) recommended including the father's experience in future studies to identify whether the search to understand and care for their infant is a common theme for both mothers and fathers. Gibbons (2008) suggested that it would be useful to investigate mothers and osteopaths interacting within a therapeutic relationship.

The project explored the perspectives of mothers and fathers on their experiences, processes and outcomes when seeking osteopathic treatment for their infants. In today's changing social and political environment, the roles of men and women are constantly being redefined to adapt to the new requirements of everyday life. There is numerous literature on the mothers role and how mothers influence their children, however there is a paucity of literature on the fathers role and how fathers influence their children. Over the last 30 years, fathers' roles in caring for their children have been expanded by rapid and profound socioeconomic changes and by society's evolving perceptions and expectations of the fathers' roles (Coleman, Garfield, & Committee on Psychosocial Aspects of Child and Family Health, 2004). As a consequence, there appears to be an increase in the number of researchers turning their attention to the roles of both mothers and fathers.

## **Rationale**

As will be established in Chapter Two, research in osteopathy in the treatment of infants, is sparse. Limited literature is evident in publication with regard to the effectiveness of osteopathy and the experience of parents' in the osteopathic treatment of their infant's. There is only anecdotal evidence related to the success of osteopathic treatment where practitioners advertise they can help infants.

## Methodology

The focus of this study was to elicit the lived human world of both parents' in seeking osteopathic treatment for their infant's. To effectively reveal this experience, a qualitative methodology was chosen through which the phenomenon could be explored within context. In the same way the parents sought to understand their infant's unexplained condition the researcher sought to understand the process parents experienced in their journey to using osteopathy in the treatment of their infant's by using hermeneutic phenomenology as a qualitative approach to data collection and analysis.

To ensure a methodological fit within the tradition of phenomenology the study used in-depth interviews of data generation and thematic analysis. Descriptions of hermeneutical 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 and Chapter Four.

Thematic analysis was conducted from the interviews of eight parents. Three of these interviews included both parents. Analysis of the data collected from these interviews revealed themes that described how mothers and fathers recognized that *something is not quite right* with their infant, the process they went through to seek help and how they came to find osteopathy. The study also examined the differences in the mothers and fathers journey.

## **Summary of Chapters**

Chapter One has introduced the dissertation, including the background to the study and an outline of the study. The literature review in Chapter Two discusses findings of recent research relevant to the experience of parents' seeking treatment for their infant's condition and how they found osteopathy.

Chapter Three describes the phenomenological method used to collect and analyze the data and Chapter Four describes how this method was implemented. Chapter Five introduces the themes revealed in the data analysis and then discusses the themes with regard to the literature. Chapter Six reviews the limitations of the project, its implications for the practice of osteopathy for children and potential future research that may stem from this study.

## **Summary**

This chapter has provided a brief overview of the research question and my background. Furthermore it introduces an overview, the rationale and methodology behind the project. It concludes with a summary of the chapters to come. The following chapter will review the current research literature.

**Chapter Two**  
**Literature Review**

## **Introduction**

This chapter is a review of key topics discussed in recent literature that background the experience of parents' seeking and participating in osteopathic treatment of their infant's. Literature was sought from osteopathic texts and Unitec Library's online research databases PubMed, Sage and Science Direct. The topics to be reviewed here and latter discussed, in Chapter Five, with reference to the themes that emerged from this project's data analysis are first time parents, the role of parents when an infant has a health problem, seeking alternative therapies, osteopathic treatment, osteopathic treatment of infants, positional plagiocephaly, communication and trust in a therapeutic relationship.

### **First time parents**

It is widely recognized that a couple's first pregnancy and the arrival of a first child represents a major life transition (Belsky, Ward, & Rovine, 1986). The transition to parenthood involves commitment to bear and raise a child, significant physical, psychological and sociological changes associated with pregnancy and delivery, and the real and symbolic changes that accompany the addition of a small, relatively helpless and extremely demanding new member to the family unit (Belsky, Ward, & Rovine, 1986; Deave, Johnson, & Ingram, 2008; Wilkins, 2006). There are also the real changes that undoubtedly occur in day to day living and require adjustment. From everyone's perspective, be they mother, father, husband, wife or infant, the process of adding a new family member represents an event of some magnitude (Deave, Johnson, & Ingram, 2008; McCourt, 2006; Wilkins, 2006). This transitional situation can cause stress in the family and each person has

to use adjustment strategies to allow space for the new arrival. A qualitative study conducted by Deave et al. (2008) in the United Kingdom, researched the transition to parenthood, asking 24 first-time mothers and their partner's about how they could be better supported particularly in relation to the transition to parenthood and parenting skills. Several common themes emerged from both the antenatal and postnatal data, including support mechanisms, information and antenatal education, breastfeeding, practical baby-care and relationship changes. Knowledge about the transition to parenthood was poor. Women generally felt well supported, especially by female relatives and, for those who attended them, postnatal groups. This was in contrast to the men who often only had health professionals and work colleagues to turn to. The men felt very involved with their partner's pregnancy but excluded from antenatal appointments, antenatal classes and by the literature that was available. Several studies and policy documents have highlighted the lack of parents preparation for parenthood and indicate that there is a need for an improvement in parents preparation for parenthood (Deave & Johnson, 2008; Deave, Johnson, & Ingram, 2008; Wilkins, 2006).

### **The role of parents when infants have health problems**

In 2007, Pelchat, Lefebvre and Levert undertook a review of current literature in order to produce a profile of the experience of fathers and mothers of a child with health problems. This research was multidisciplinary and all study designs were included, with a majority of studies reviewed being quantitative. The review covered a broad spectrum of health problems in children, some present at birth and others developing later. Although the scope of the criteria chosen restricted the analysis of issues specific to each health problem, developmental stage of the child and cultural context, all

studies confirmed that the arrival and presence of a child with a health problem has multiple consequences in all spheres of family life. The studies were identified in a search of databases and additional research using reference lists in the texts identified in the databases. Two themes were identified: the impact of the child's problem and the coping strategies used by the parents.

The parents are plunged into an emotional maelstrom and often feel their dream of a 'perfect child' has been shattered. Yet they have to carry on and redefine their roles in every sphere of familial and extra familial life to reflect the additional care that the health problem entails. Pelchat et al. (2007) concluded that as parents of a child with a health problem, fathers and mothers display both differences and similarities. Further qualitative research that supports all the actors from an interdisciplinary perspective is required in order to open up new avenues of research.

There are no osteopathic studies researching the roles of parents when infants have health problems. One medical based phenomenological study conducted by Tomiak et al. (2007) in Ontario described the lived experience of parents of a child with Duchene muscular dystrophy (DMD) as highly dependent on the respective roles of the primary and secondary caregivers. Semi-structured interviews were conducted with 11 parents of children with DMD. Mothers and fathers were interviewed separately, with five couples both mother and father being interviewed and for one couple only the mother consented to be interviewed.

The primary caregiver role is usually assumed by the mother with the father usually providing a supportive role. This study showed that care giving tasks were not equally shared between partners, but were divided, primarily on the basis of role. Traditional stereotypes appeared to be regenerated, with

the mother providing daily care and the father overseeing the overall function of the family unit.

Pelchat et al's. (2007) review also revealed many factors that play a part in the differences observed between fathers and mothers of a child with a health problem. Fathers and mothers endure similar levels, but different types of stress. Mothers tend to deal with their stress by expressing emotions, thus demonstrating how important expressive support is to mothers. Fathers use more cognitive problem-solving strategies in adjusting to stress. According to one study, men prefer this type of solution for being more efficient, because the results are visible and immediately apparent. However, not all studies agreed, some show that men are no more likely than women to use coping strategies based on solving concrete problems. Behavioral strategies, particularly in searching for information seemed to be the area in which fathers and mothers were most alike. Many authors in this review showed that adequate information enables parents to adjust positively to the diagnosis, whereas lack of information generates additional stress.

Social support was another resource which many authors reported as being important in promoting the parents' adjustment to their life with the child. Mothers make more use of the help provided by friends and relatives, while fathers seem to be less inclined to ask for help. The woman's support system stems from the family and private relational sphere and promotes the expressing of emotions, unlike that of a man which stems from the public domain and is not inclined towards the demonstration of feelings (Pelchat et al. 2007).

When infants become ill, the processes parents undertake to seek and engage a health professional were explored by Ertmann, Soderstrom, and Reventlow (2005). They concluded that when parents found the situation of trying to cope with their ill children more demanding than they could handle, they

would call their physician for advice. This was mainly when they felt overtaxed, afraid or inadequately prepared to care for their ill child. Parents in this study expected the physician to take their observations of their child's symptoms seriously, to believe and use this information in their considerations, and to understand their motivation for visiting.

In instances where the medical profession cannot provide answers, parents seek alternative therapies. In her study of fussy, unsettled and irritable infants, Viedma-Dodd (2006), found that mothers seek help from alternative practitioners when they have exhausted all other options. This was further reiterated in Gibbons (2008) study, where the decision to explore alternative therapy was a gradual process which emerged after exhausting the mother's familiar knowledge and her subsequent research into alternative approaches.

### **Seeking Alternative Therapies**

In 1998, Astin conducted a written survey examining the use of alternative health care, health status, values, and attitudes toward conventional medicine. 1035 people were randomly selected for a mail survey, with a 69% response rate. The survey concluded that along with being more educated and reporting poorer health status, the majority of alternative medicine users appear to be doing so not so much as a result of being dissatisfied with conventional medicine but largely because they find these health care alternatives to be more congruent with their own values, beliefs, and philosophical orientations toward health and life.

Poynton, Dowell, Dew and Egan (2006) in a New Zealand nationwide survey aimed to provide an overview of general practitioners attitudes toward and uses of complementary and alternative medicine (CAM). Opinion amongst

respondents was evenly divided, with acupuncture, chiropractic and osteopathy perceived as conventional medicine. Thirteen therapies specifically mentioned in the questionnaire were selected after looking at previous literature and the National Center for Complementary and Alternative Medicine website. Traditional Maori and traditional Pacific Island medicine were included due to their cultural relevance to New Zealand society, however vitamins and minerals were excluded from the therapies. This study also provided important insight into the effect that the culture of evidence-based medicine is having on general practitioners attitudes toward CAM. A considerable proportion of respondents cited lack of scientific evidence of benefit or efficacy as a reason that these therapies should not be offered by general practitioners. This may have contributed to the lower number of GPs administering CAM therapies compared to earlier New Zealand studies (Poynton et al. 2006).

A study regarding the prevalence of complementary and alternative medicine (CAM) by Wilson, Dowson and Mangin (2007) in Christchurch, New Zealand, found that CAM was predominantly used for the prevention and treatment of acute symptoms. There were combined factors of high use, low disclosure to medical practitioners and self-teaching in obtaining information regarding CAM, principally asking friends for advice. Children whose parents used CAM were more likely to be using CAM for their children.

A more recent 2010 study by Ben-Ayre et al conducted in the United States explored parents attitudes toward complementary and alternative medicine (CAM) used for their children and its impact on parent-doctor and doctor-CAM practitioner communication. Parents perceived physician-CAM practitioner communication as highly important and instrumental in

promoting their children's health and safety. The gradual transition of CAM use from an alternative and complementary context to a more integrated concept in pediatric care is becoming a pivotal theme because both health care providers and consumers acknowledge the need for effective communication in the triad of parents, physicians and CAM practitioners. However, in the United States osteopathic medicine is a branch of the medical profession. The difference in the way CAM is used in New Zealand and the United States may be due to the fact that osteopathic physicians in the United States, known as DOs are licensed to practice medicine and surgery compared to New Zealand where osteopathy is considered a complementary medicine and is not a part of the medical profession.

### **Osteopathic Treatment**

Osteopathy uses three core principles, the body is a unit, structure governs function and the body has its own inherent ability for health. Andrew Taylor Still considered by many to be the 'founder' of osteopathy, focused on developing a system of medical care that would promote the body's innate ability to heal itself (Becker, 1997; Still, 1908).

An osteopathic practitioner will look for somatic dysfunction. Somatic dysfunction is defined as being impaired or altered function of related components of the somatic (body framework) system: skeletal, arthrodiagonal, and myofascial structures, and related vascular, lymphatic and neural elements (Seffinger et al., 2003).

The rationale for osteopathic treatment is based on these findings and aims to aid the body's return to health. The human body requires a balance between energy expenditure and energy supply to maintain homeostasis. Efficient operation of internal body systems conserves energy that can be used to

adapt to external stressors such as nutritional deficiencies, trauma, infection, nociceptive stimulation and others (Carreiro, 2009a).

### **Osteopathy in the treatment of infants**

Most of the published studies explored for this literature review examined plagiocephaly, specifically the risks associated with and prevalence of plagiocephaly. While this study is not about plagiocephaly, the literature found that osteopathic treatment of infants is dominated by the plagiocephaly 'debate'. The risk associated with the dominance of this literature means that other conditions that may benefit from osteopathy including colic, acute otitis media and cerebral palsy were overshadowed.

One may think that infants should have no structural stresses or strains in their bodies because they are so young however the reality is sometimes different. Birth is one of the most stressful events of our lives. Infants are subjected to enormous forces, while they turn and twist descending through the bony pelvis and it is common for infants to suffer a great deal of compression and trauma to the skull while being born (Frymann, 1996). An overlapping of the sutures and deformation of the cranial bones (molding) can occur in response to the forces acting on the cranium during birth and the asymmetries that occur in response to the intrauterine pressures applied to the emerging cranium may also leave an impression. After delivery, the mechanical forces and movements associated with breathing, crying and suckling expand the cranium and correct the sutural overlap. In some cases the normal forces of life are unable to resolve these strains, and a baby may present with irritability, problems suckling, abnormal posturing, delayed postural patterning or a myriad of other vague clinical symptoms (Carreiro, 2009b). Carreiro's (2003) osteopathic study of 1250 infants conducted in

France, found that 85% had some degree of abnormality of the skull (cranial) bones after birth, irrespective of whether the birth was a normal one or not.

Osteopathic practices commonly advertise that they help resolve many infancy and childhood problems such as birth trauma, colic/reflux, poor feeding patterns, recurring middle ear infections and asthma (see Appendix G – Osteopathic Advertisement). The literature available for review regarding the role of osteopathy in pediatric healthcare exists mainly in the form of teaching texts and osteopathic texts. There is limited literature surrounding the efficacy of osteopathic treatment with regard to these conditions. The following reviewed literature suggests efficacy but no conclusive evidence that osteopathic treatment is effective.

In 2006, Hayden and Mullinger published a preliminary assessment investigating the effectiveness of cranial osteopathic treatment for infantile colic. This was a randomized control study of 28 infants which concluded that the net result of cranial osteopathic treatment from the parent's perception was a more relaxed infant who cries significantly less, sleeps significantly longer and needs less comforting and placating. However in 2008 a letter was published to the American Osteopathic Association, suggesting that there was a problem with the design of the study due to the age of the infants. The infants in the study were eligible for osteopathic manipulation if they were no older than 12 weeks, and they were treated for 4 weeks, implying that some of them were 16 weeks of age at the completion of the treatment period. In the normal course of events with or without treatment, infantile colic usually resolves spontaneously by 12 weeks of age. Thus, the improvements in infantile colic symptoms observed by Hayden and Mullinger could not be attributed to osteopathic manipulation with certainty (Friedman, 2008).

Two New Zealand unpublished dissertations have been written on fussy, unsettled and irritable infants. Viedma-Dodd (2006) concentrated on identifying and describing factors which mothers associate with their infant's fussiness, unsettledness or irritability. Gibbons (2008) followed on with the experience of mothers seeking and participating in osteopathic treatment for their unsettled, fussy or irritable infant as well as the experience of osteopaths treating these infants where only one mother did not experience success with osteopathic treatment for her infant.

Mills, Henley, Barnes, Carreiro and Degenhardt (2003) studied the effects of osteopathic manipulative treatment as an adjuvant therapy to routine paediatric care in children with recurrent acute otitis media (AOM). Fifty-seven patients 6 months to 6 years old with 3 episodes of AOM in the previous 6 months, or 4 in the previous year, who were not already surgical candidates were placed randomly into 2 groups: one receiving routine paediatric care, the other receiving routine care plus osteopathic manipulative treatment. Both groups received an equal number of study encounters to monitor behavior and obtain tympanograms. Clinical status was monitored with review of paediatric records. The paediatrician was blinded to the patient group and study outcomes, and the osteopathic physician was blinded to the patient clinical course. The results suggested a potential benefit of osteopathic manipulative treatment.

Complementary and alternative medicines are widely used in the treatment of children with cerebral palsy (Duncan et al., 2008; Patrick, Roberts, & Cole, 2001; Wyatt et al., 2011). Duncan et al's. (2008) pilot study on the use of osteopathy in the cranial field found a series of treatments using osteopathy in the cranial field, myofascial release, or both improved motor function in

children with moderate to severe spastic cerebral palsy, however the study size, the design and the treatment protocols used in this study leave a question around the integrity of the project.

### **Positional Plagiocephaly**

Deformational plagiocephaly and nonsynostotic plagiocephaly are terms used for people with a deformation of the skull that is not due to bone fusion (synostosis), such as craniosynostoses, and characterized by an asymmetric skull and face. It is observed with increased frequency in infants after the adoption of supine sleeping recommendations to prevent sudden infant death syndrome (SIDS). There is significant controversy in the diagnosis and management of deformational plagiocephaly (Hutchison, Stewart, & Mitchell, 2010).

In a New Zealand prospective cohort study conducted by Hutchinson, Hutchinson, Thompson and Mitchell (2004), two hundred infants were assessed on the prevalence and natural history of nonsynostotic plagiocephaly in the first two years of life. This study concluded that the prevalence increased up to 4 months but diminished as infants grew older. This was followed up in 2010 with a longitudinal cohort study which compared 161 eligible children of the previous study at the age of 3 and 4 years. The head shape measurements, parental concern about head shape and any developmental delays in infancy were compared. The study concluded that 61% of head shape measurements reverted to the normal range, with 4% remaining severe at follow-up. Initially 85% of parents reported being very concerned about their infants head shape, this decreased to 13% at follow up. The percentage of children with developmental delay decreased from 41% initially to 11% at follow-up. The study explained that no child had orthotic helmet therapy, therefore the results are useful in

determining the natural history of positional head deformities after positioning advice and physiotherapy have been provided (Hutchinson et al. 2010).

The Oxford dictionary's definition of the 'natural history' used in medical terms, means 'the usual course of development of a disease or condition, especially in the absence of treatment' ("Natural History", 2011). The children in this study received both advice on positioning techniques and physiotherapy treatment. The study failed to describe the techniques for repositioning or physiotherapy and if the children showed any immediate improvement after these therapies.

In 2006, Philippi et al's randomized therapeutic trial of 32 infants' found that osteopathic treatment in the first months of life improves the degree of asymmetry in infants with postural asymmetry. Blinding the intervention and using a standardised measuring scale asserted the objectivity of these results. However the high variability of inter and intraindividual maturation and self-regulating processes precluded evaluating the extent of spontaneous improvement. Sergueef, Nelson and Glonek (2006) suggested that thorough neonatal osteopathic examination by osteopathy in the cranial field (OCF) can identify individuals predisposed to develop plagiocephaly in their review of six hundred and forty-nine children seen in an osteopathic practice in Lyon, France. A limitation of this review is that all children reviewed were from the same osteopathic practice and the osteopaths who found the physical findings and performed the osteopathic treatment were not identified. In 2011, Lessard, Gagnon and Trottier's clinical standardisation project of twelve infants, also found that osteopathic treatment does improve cranial asymmetries in infants younger than 6.5 months and determined the feasibility of conducting a randomized clinical trial investigating the impact of osteopathic intervention for infants with nonsynostotic plagiocephaly.

The most cited risk factors of positional plagiocephaly were reported in a review of eighteen studies between 1985 and 2007 carried out by Bialocerkowski, Vladusic and Wei Ng (2008). These risk factors included: male sex, firstborn child, difficult delivery, supine sleeping position, multiple birth, prematurity and torticollis or other imbalance of neck muscle function. In the 2009 first large case-control study of 2764 infants conducted in the United States, consistent with previous findings, plagiocephaly risk was positively associated with male sex, being a multiple birth, primiparity and older maternal age. New evidence was also reported that birth injuries and a wide range of congenital anomalies are associated with plagiocephaly risk (McKinney, Cunningham, Holt, Leroux, & Starr, 2009).

Another 2010 case-control study of neurodevelopment in deformational plagiocephaly by Speltz et al used the Bayley Scales of Infant Development administered to 235 case subjects and 237 demographically similar control participants to assess the neurodevelopment of infants with and without deformational plagiocephaly at an average age of six months. The cognitive and language scale differences were clinically modest, however the motor scale differences showed gross motor skills were reduced in the case subject group. Several hypotheses that might account for this association included a direct effect of deformational plagiocephaly in which skull asymmetry affects brain development directly and the reverse of this situation, in which deformational plagiocephaly is a consequence of early neuro-developmental delays. Unfortunately the data generated could not distinguish these possibilities.

As previously discussed there is significant controversy in the diagnosis and management of deformational plagiocephaly. Hutchinson et al. (2010)

confirms that some feel that the disorder is purely cosmetic, that the disorder is clinically unimportant and that there are no negative neurologic consequences, but others have suggested that if not treated early, the deformity may persist and that there may also be associated developmental difficulties. The one major study (Hutchinson et al. 2010) which assessed the natural history of nonsynostotic plagiocephaly used physiotherapy as an early intervention and there were inconsistencies in some studies with regard to sample sizes, methodologies and treatment protocols.

### **Communication and trust in the therapeutic relationship**

Current literature emphasizes the difficulties in the effective delivery of health care which can arise from problems in communication between patient and provider. Improvements in provider-patient communication can have beneficial effects on health outcomes.

Patients trust in their general practitioner is recognized as an essential feature of a therapeutic relationship and is related to increased patient satisfaction and adherence to treatment. Patient trust can be conceptualized as having two interrelated elements; interpersonal trust (trust in a particular general practitioner) and social trust (generalized trust in the healthcare system, the medical profession and/or the patients practice as a whole) (Pearson & Raeke, 2000).

The manner in which a doctor communicates information to a patient is as important as the information being communicated. Patients who understand their doctors are more likely to acknowledge health problems, understand their treatment options, modify their behavior accordingly, and follow their medication schedules (Travali, Ruchinskas, & D'Alonzo, 2005). In a 2003 cross-sectional questionnaire survey conducted by Tarrant, Stokes and Baker (2003) in the United Kingdom, 1369 patients responded to a questionnaire on

factors associated with patients' trust in their general practitioner. 76% reported high levels of trust in their general practitioner, with communication, interpersonal care and knowledge of the patient strongly associated with trust in a patient's general practitioner.

Communication plays a key role in determining trust relationships. The practitioner's ability to listen, demonstrate concern and a certain amount of humility contributes to the development of the trusting relationship. The ability to communicate well, openly and demonstrate respect, allows the patient to judge motivations and identify shared values and provides a means to judge the physicians competence (Goold, 2002).

Giddens (1990), states that "Trust, in short, is a form of faith" (p. 27), in which the confidence vested in probable outcomes expresses a commitment to something rather than just a cognitive understanding. Trust has a cohesive property which binds a socially complex and individuated social world together. At the same time, trust on the individual level is the basis for a personal sense of security in an environment in which one must rely on the integrity of strangers.

Searches using the key words 'therapeutic', 'osteopathy', 'infants', 'communication', 'trust', 'parents' and the date limiter of 2000 to 2011 identified only one study on patient physician (Travaline et al. 2005). The therapeutic relationship between osteopath and patient requires a high level of trust and confidence. This is even more important for parents who are placing their infant in the osteopath's hands. Parents base their decisions on the information received from an osteopath. Due to the age of infants, parents in effect are the infants voice.

In the public health sector there is a drive toward research for evidence-based practice and objective quantitative research in order to demonstrate clinical effects of treatments. However this type of research is isolated from practical experience in the field and research findings are not necessarily transferable to clinical settings. With the sparse amount of literature on the experiences of both mothers and fathers who seek osteopathic treatment for their infants, there is a need in research of a qualitative nature, to inform osteopaths of the differences in the parents' lived experience. This would add to the evidence informing osteopathic practice that by understanding and managing the differences parents experience with an infant who has a health problem, positive therapeutic relationships can be built between the parents, infants and the osteopaths.

### **Summary**

This chapter has reviewed the literature related to the experiences of parents seeking and participating in osteopathic treatment of their infants and identified gaps in the literature. The gaps recognized in this literature support the aims and objectives of this study.

The following chapter discusses the methodology on which this study was based and describes how the study was implemented.

## **Chapter Three**

### **Methodology**

In this chapter an overview of qualitative research will be given. The rationale for the choice of hermeneutic phenomenology as the research method for this study and its philosophical underpinnings will be discussed. An overview of van Manen's (1997) framework for hermeneutic phenomenological research is then described, along with the methods of analysis. Finally the question of rigor and credibility of qualitative research will be addressed.

## **Methodology**

### **Qualitative Research**

Qualitative research is a broad term to describe research that is focused on the human experience and represents a different philosophical view towards reality from the positivist or scientific approach. The methods employed in qualitative research are used to study human behavior and the complex variations of human behavior in context. There is a focus on human experience and it is possible to develop a rich description and deep understanding of the phenomena under investigation (Schneider, Elliott, LoBiondo-Wood, & Haber, 2003). There has been an upsurge in the use of qualitative research methodologies including ethnography, grounded theory and hermeneutic phenomenology (Denzin & Lincoln, 2003). The advantage of using a qualitative approach is that the phenomenon may be studied holistically and contextually. Osteopathic philosophy of looking at the body as a whole and beyond the patient's presenting complaint, fits with the qualitative approach to research. Osteopaths place great emphasis on the person as a whole and the many factors which contribute to a person's health. Morse and Field (1996) say that qualitative research is a holistic approach to research that does not reduce participants to functioning parts. Thus a holistic research paradigm is an appropriate choice to explore the

phenomenon of a parental perspective of osteopathy in the treatment of their infants.

### **Phenomenology**

Phenomenology has its origins in the thinking of the German philosopher Husserl, who introduced the concept of the life-world or lived experience (Koch, 1995). According to van Manen (1997), phenomenology is an exploration of the 'essence of lived experience' of a phenomenon. The meaning or essence of a phenomenon is something everyone does constantly in everyday life. Its emphasis is on the world as lived by a person, not the world or reality as something separate from the person (Lavery, 2003). The phenomenological researcher seeks a deeper and fuller meaning of the participants' experience of a particular phenomenon and offers a descriptive, reflective, interpretive and engaged mode of enquiry (van Manen, 1997).

### **Hermeneutic-phenomenological method**

Hermeneutics is a branch of phenomenology guided by the work of Husserl, Heidegger and Gadamer (Lavery, 2003). Hermeneutics means the art or science of the interpretation of literature. Hermeneutic-phenomenology's primary objective is the direct investigation and description of phenomena as experienced in life by using the practice of phenomenological reflection and writing to understand the form of life (van Manen, 1997). It is to give voice to human experience, just as it is (Koch, 1995). Lavery (2003), states that Heidegger was concerned with Dasein – "the situated meaning of a human in the world" (p. 7). He believed consciousness is not separate from the world and thereby we have the formation of a historically lived experience.

Gadamer emphasizes the importance of understanding through the interpretation of tradition. Tradition is a framework of practices, concepts,

hypotheses, prejudices and prejudgments which accompany humans to situations and condition the process of understanding. Therefore because of our background, our situatedness in the world, we are unable to step out of the pre-understandings (Koch, 1995). Examining our prejudices reflectively, allows us the openness of newness. This fusion of understanding forms the basis of the hermeneutic circle (Koch, 1995). This circle clarifies the relation between the interpreter and what he or she seeks to understand. In contrast to the phenomenological method of bracketing, where the researcher is asked to suspend judgment regarding the general or naive philosophical belief in the existence of the external world, and thus examine phenomena as they are originally given to consciousness. The hermeneutical approach asks the researcher to give considerable thought to their own experience and how this relates to the issues being researched. The results in many constructions or multiple realities, including the researcher's construction (van Manen, 1997).

Van Manen suggests an approach to research in relation to interpretive or hermeneutic phenomenology, in which the researcher acknowledges his or her previous experience, knowledge and beliefs, and how these may influence the researcher in all phases of data collection, analysis and interpretation. Furthermore, van Manen suggests a six step methodical structure (1997, p 30) for hermeneutic phenomenological research. These six steps are outlined below and provide a framework for the research method as a whole. The way in which this framework was implemented into the project is discussed in the chapter that follows.

The six steps outlined by van Manen (1997) were selected to provide a framework for this research as they allow flexibility in:

1. *'Turning to a phenomenon which interests us and commits us to the world'* in essence involves formulating a research question.

2. *'Investigating experience as we live it rather than as we conceptualize it'* is concerned with the methods employed to investigate the lived experience in question, for example, in-depth interviews for data collection.

3. *'Reflecting on the themes'* the emphasis is on the analysis process, by reflecting on the themes identified from the interviews and endeavouring to capture the essential meaning or essence of the lived experience in question.

4. *'Describing the phenomenon in the art of writing and rewriting'* is another important part of the research process, particularly the analytic phase. Phenomenology is "always a bringing to speech of something" (van Manen, 1997, p. 32). The intention is to make visible the feelings, thoughts and attitudes of the participants.

5. *'Maintaining a strong and oriented relation to the phenomenon'* the research strives to remain focused on the research question at hand. To establish a strong relation with a certain question, phenomenon, or notion, the researcher cannot afford to adopt an attitude of so-called scientific disinterestedness (van Manen 1997, p.33).

6. *'Balancing the research context'* by considering the parts and the whole, the researcher is asked to constantly measure the overall design of the study, against the significance that the parts must play in the total textual structure (van Manen 1997, p. 33). While these steps are a sequential set of procedures, frequently the researcher will be concurrently engaged in these processes and will occasionally be required to look back, reflect and re examine. They will be looking at the parts that make up the whole phenomenon.

### **Data Generation**

This sub section of the Methodology chapter describes the theory behind the methods chosen for and the approaches taken toward generating the study's data. The subsequent Method section will describe the way in which the methods were implemented.

### **Sampling**

In qualitative research individuals are selected to participate in the research based on their first hand experience of the phenomenon of interest. Unlike quantitative research, there is no need to randomly select individuals, because manipulation, control and generalization of findings are not the intentions of the study (Streubert & Carpenter, 1999). Purposeful sampling method, also called theoretical sampling, is a non-probability method which involves the conscious selection of subjects to be included in the study. The participants are chosen and included in the research project if they have experienced the phenomenon. The concern of the researcher is to develop a rich description of the phenomenon (Streubert & Carpenter, 1999).

## **Data Collection**

In hermeneutic phenomenological human science, one purpose of the interview is to be used as a means of exploring and gathering experiential narrative material that may serve as a resource for developing a richer and deeper understanding of a human phenomenon (van Manen, 1997). Taped conversations are often easier than writing as a way of collecting accounts. Sometimes it is necessary to ask questions, however patience and silence may be a more tactful way of prompting the other to gather recollections and proceed with a story. As we interview others about their experience it is imperative to stay close to the experience as lived (van Manen, 1997).

## **Thematic Analysis**

This study employed van Manen's approach toward thematic analysis. Van Manen, (1997, p 79) defines the analysis of the phenomenon as "trying to determine what the themes are, the experiential structures that make up the experience". Themes are stars that make up the universe of meaning we live through. By light of these themes we can navigate and explore such universes.

In order to attribute meaning to the data, van Manen (1997) suggests three methods for isolating thematic statements. These methods are the detailed reading approach, the selective or highlighting approach and the holistic reading approach. In the detailed reading approach, van Manen (1997) proposes that the researcher looks at each sentence or group of sentences while asking, 'What does this sentence, or sentence cluster, reveal about the phenomenon?'(p. 93). The selective or highlighting approach asks which statement is most revealing about the phenomenon in question. In the third

approach the holistic reading, van Manen suggests looking at the text as a whole and asking which notable phrase captures the fundamental meaning of the text. These themes are then used as a framework around which to create a text, which aims to capture the essential meanings of the phenomenon that have become evident within the data.

Van Manen (1997) suggests four existential life-world themes as guides for the reflective research process:

- 'lived space (spatiality)' is the way we experience the affairs of our day to day existence; in addition it helps us uncover more fundamental meaning dimensions of lived life.
- 'lived body (corporeality)' is the way in our physical or bodily presence we both reveal and conceal at the same time something about ourselves.
- 'lived time (temporality)' is our temporal way of being in the world. The temporal dimensions of past, present and future constitute the horizons of a person's temporal landscape.
- 'lived human relation (relationality or communality)' is the lived relation we maintain with others in the interpersonal space that we share with them.

These four fundamental existentials can always be used to ask about any experience. They are productive categories for the process of phenomenological question posing, reflecting and writing.

Van Manen (1997) also suggests for the purpose of clarity that we make the distinction between incidental themes and essential themes. Essential themes comprise of aspects of meaning contributing to a phenomenon that without these themes the phenomenon would not be. To determine such the researcher can pose the question that if they removed this theme from the phenomenon would it retain its fundamental meaning? The aim of phenomenological research is to uncover the themes that give a phenomenon its uniqueness, some themes that emerge may not be exclusive to the phenomenon but shared with others.

### **Rigour**

Rigour is the way in which the researcher demonstrates integrity and competence (Tobin & Begley, 2004). According to Koch (1994) one way of ensuring rigor within qualitative research is the demonstration of the researchers understanding of alternative research approaches and how the choice of each may affect the research process. In the case of hermeneutic phenomenology, the multiple stages of interpretation that allow patterns to emerge, the discussion of how interpretations arise from the data, and the interpretive process itself are seen as critical (Koch, 1995).

Van Manen (1997) believes a researcher can be influenced during the processes of data collection and analysis. A journal can be kept to record the actual processes and a researcher's reflective practice detailing thoughts and feelings experienced. Researchers can gain insight for discerning patterns of the work in progress and for reflecting on previous reflections.

Another way of strengthening the trustworthiness, according to Koch (1994), is by the researcher establishing an audit trail describing and justifying all the steps undertaken in the research process. Documentation of such procedures as the recruitment of participants, the interview process and the development of themes, add to the trustworthiness of the research.

This chapter, Methodology, has outlined the theoretical basis for using hermeneutical phenomenology to focus on the experience of parents' seeking treatment for their infants'. The techniques used to promote the credibility and dependability of the study included an outline of the projects data collection strategies and van Manen's (1997) thematic analysis. The following Chapter – The Research Method reviews the manner in which these strategies were implemented in this study.

# **Chapter Four**

## **The Research Method**

This chapter gives an overview of the implementation of the project. It describes the ethical considerations, participant selection, participant recruitment, participant characteristics, data collection and the development of themes. It also explains how the study addressed issues of rigor and integrity.

## **The Research Method**

### **Ethics Issues**

Ethical approval for this research project was obtained from the Unitec Research Ethics Committee on the 25th February, 2010 for the period between December 22<sup>nd</sup>, 2009 to December 21<sup>st</sup>, 2010 (see Appendix A – Ethics Approval). Ethical issues of privacy, autonomy and safety were identified as relevant and addressed as follows.

Participant involvement was voluntary thereby supporting the principle of autonomy (Streubert & Carpenter, 1999). Volunteers were given an information sheet – Appendix B as outlined in the next section by participating osteopathic clinics which outlined the purpose of the project, its method and who was conducting it. Contact details of the researcher and supervisors were provided. It also contained an explanation of the procedure for any complaints regarding the conduct of the research. A consent form – Appendix C was given to each participant. Informed consent means that participants have adequate information regarding the research; are capable of comprehending the information and have the power of free choice, enabling them to consent voluntarily to participate in the research or decline participation (Streubert & Carpenter, 1999). This consent form explained that the research would be confidential, that the data collected would remain

anonymous and that the participant could withdraw from the study any time up to two weeks after the transcript of the interview was sent to them. A contact phone number was included on the consent form for participants who had further questions or concerns regarding the project. This consent form was signed by the participant prior to the commencement of the interview.

To preserve the participants' anonymity all participants, infants, locations and other names were allocated pseudonyms by the researcher and referred to with a pseudonym in all printed data. Information linking the participant to the pseudonym exists in only one document. This document, with printed contact details and participant data is kept in a secure location accessible only to the researcher.

As the information sought from the participants was of a personal nature, there was the possible risk of participant distress, in recalling an unpleasant event, for example. In an effort to ensure that the participants were not put at risk of emotional harm, they were assured that they could cease the interview at any time. Through my education towards becoming an osteopath I am skilled in observing patient responses and therefore competent to respond to any distress that may be exhibited by the participant. During the data collection no such situation occurred.

### **Participant Recruitment**

A study conducted by Gasquoine (1996), concluded that the experience of mothers and fathers is sufficiently different to warrant separate investigation. Gibbons (2008) chose to interview mothers only in his exploration of the

experience of mothers and osteopaths in the treatment of unsettled, fussy or irritable (UFI) infants, as did Viedma-Dodd (2006) in her exploration of infant health from the viewpoint of mothers. In an effort to determine a parental perspective in the osteopathic treatment of infants, both mothers and fathers were recruited in this study. Parents who had experienced osteopathy in the treatment of their infants and their infants were between 6 months and 2 years at the time of treatment were included in this study.

Recruitment of these participants was sought through advertisements in Auckland osteopathic clinics, where the osteopaths were known to treat infants. Recruitment of parents involved a combination of advertising and word-of-mouth. With the permission of the osteopaths printed advertisements were placed in several osteopathic clinics (see Appendix D – Advertisement). Parents responded either directly to the researcher or through the osteopath. Those people who were recruited by the osteopath were then provided with an information sheet and permission for their phone number to be given to the researcher was sought. The researcher contacted each respondent by telephone, having a short discussion with each respondent to assess their eligibility, explaining the project, interviews and to answer any of their immediate questions.

Using snowball sampling, five sets of parents were initially sought. The five interviews conducted included three sets of parents, one mother and one father, a total of 4 mothers and 4 fathers.

An adequate sample is important in all types of research. In phenomenological research it is usual to use small numbers, as the goal is to achieve an understanding of the lived experience rather than to produce generalised findings. Boyd (2001) regards two to 10 participants or research subjects as sufficient to reach saturation and Creswell (1998, pp. 65 & 113)

recommends “long interviews with up to 10 people” for a phenomenological study. The sample size of eight participants was appropriate for a phenomenological study using in-depth interviews as a data collection method. The richness of data obtained from this sample allowed commonalities across participants to be revealed from which emergent themes could be extracted.

### **Criteria for Selection**

The following criteria were used to assess each participant’s eligibility.

#### *Inclusion Criteria*

- The parents had experienced osteopathy in the treatment of their infant.
- The infant was between the ages of six months and two years of age at the time of treatment.
- The parents were willing to communicate their experience.

#### *Exclusion Criteria*

- Parents of an infant with a chronic illness. Although all experiences are of value to researchers, this project was aimed at investigating lesser complaints.
- Parents of the infants that did not speak English as their primary language, as the project involved the ability of the parents to articulate their experience in the form of an in-depth interview.

## **Participant Characteristics**

### *Demographics*

All parents were Pakeha New Zealanders ranging from 20 to 40 years of age and first time parents. The infants were aged between 6 months and 2 years of age at the time of treatment. Four of the five infants were males and had varying degrees of altered skull shape, flattening (plagiocephaly) and preferences to turn their heads to one side only. The only female infant suffered from reflux and also had a preference to turn her head to one side only.

### *Participant Summaries*

#### *Peter, Mary and baby David*

David is Peter and Mary's first child. Mary's natural labour and delivery was 7 hours. David suffered trauma where his heart rate went down after Mary's waters were broken by the midwife. Peter and Mary noticed that David's head was flattening on one side and he preferred to turn his head to one side only. David was approximately 3 to 4 months of age. After seeking answers from their GP and Plunket, with no resolutions, Peter and Mary chose to seek the opinion of an osteopath. They both knew about osteopaths but only Mary had experienced treatment herself. Peter had seen a chiropractor for many years.

### *Anthony and baby son*

Anthony's son was his first child. He was a large baby (4.5 kilograms) and after 12 hours of labour, he was born by caesarian section. At 2-3 months of age Anthony noticed that his son preferred to turn his head to one side and his head was noticeably starting to flatten on one side. Anthony had experienced osteopathic treatment for five years and after discussions with both his wife and osteopath, decided to take his son for an assessment and treatment.

### *Stewart, Bronwyn and baby Campbell*

Campbell was Stewart and Bronwyn's first child. After 12 hours of labour, he was delivered with the assistance of Ventouse. Consequently he had a cone shaped head at birth. Stewart and Bronwyn were advised by the nursing staff to take Campbell to be checked out. So after several weeks, they chose to take him to see Stewart's osteopath, with whom he had a 15 year relationship. After two treatments it appeared to have resolved itself. However at 3 to 4 months of age, they noticed that Campbell's head was flopping to one side. Once again Stewart and Bronwyn chose to have Campbell treated by the osteopath.

### *Alison and baby Jacob*

Jacob was born naturally, after a 9 hour labour. Jacob was a very settled baby for the first few weeks, then he appeared to become unsettled and fussy feeding on one side of the breast, with a gluey eye. After trying different remedies, Alison chose to take Jacob to see an osteopath. A first time mother, Alison, had not experienced osteopathy before and did not really know what

they did. After several discussions with her mother and friends, Alison chose a cranial osteopath who was highly recommended by her mother.

### *Lisa, Terry and baby Caitlin*

Caitlin was Lisa and Terry's first child. Lisa's labour and birth was a total of 24 hours. Caitlin was posterior presentation and after 8 hours, Lisa was given Pethidine<sup>1</sup> and an epidural, which appeared to slow the labour down. At this time Syntocinon<sup>2</sup> was administered to assist the labour. Caitlin became distressed and Lisa was prepped for a caesarian section, but Lisa had a very quick vaginal birth. Caitlin had very bad reflux at birth and was placed on medication by the GP. At four weeks of age, Lisa and Terry noticed that Caitlin preferred to feed on one side and fuss on the other. Terry and Lisa had a long term relationship with their osteopath and discussed their concerns with the osteopath. At this time they decided to take Caitlin in for treatment.

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<sup>1</sup> Pethidine is an analgesic often used for pain relief during labour.

<sup>2</sup> Syntocinon or oxytocin is indicated for the initiation or improvement of uterine contractions.

## **Data Collection**

Data collection in this study consisted of in-depth interviews with participants. In hermeneutic phenomenological human science the interview is used as a vehicle to develop a conversation with a partner (interviewee) about the meaning of an experience (van Manen, 1990). The environment for the interviews to take place plays a crucial part in the participants' willingness to relax and discuss their experience, therefore the participants chose the location and time. Four of the five interviews were conducted in the participants own homes and one father chose his place of work, for convenience. Three interviews included both mother and father present, where infants were all sleeping. One interview was with the mother and settled infant present and the final interview was with father only present. The average length of time for each interview was 45 minutes.

The interviews were of a conversational nature, where open ended questions were used to guide the participants' responses and allow them to express their experiences and opinions. At times participants were encouraged to elaborate on their responses, in order to expand or clarify their experiences.

The interviews were audio taped using a digital voice recorder. Notes were taken during and immediately following the conducted interviews, to reflect on the actual experience. A professional transcriber was employed to transcribe each interview and a confidentiality agreement was signed by the transcriber prior to the data being sent for transcription (Appendix E – Confidentiality Agreement).

Once the interviews were transcribed, both the digital voice files and the transcribed interviews were transferred to a password protected personal computer. The consent forms and transcripts of the interviews were stored

separately in a secure location. A copy of the transcript was emailed to each participant to ensure an accurate representation of their interview process, with additional questions asked by the researcher to further clarify data where required. All participants responded with no changes required.

### **Data Analysis and Interpretation**

Each interview was played and replayed and each transcribed interview read and re-read in order to gain an intimate sense of the data. At the same time the researcher's reflective notes were made. During this process, significant pieces of data were extracted and studied to reveal a sense of their meaning.

The analysis and interpretation followed van Manen's six research activities as described in the previous chapter.

*Turning to the nature of the lived experience* was developed from the researcher's personal experience in osteopathy in the treatment of infants. As discussed in Chapter One under 'personal background', the research question was developed from my personal experience, as a student of osteopathy observing the osteopathic treatment of my grandchildren and also my friend's child. It was also influenced by two unpublished dissertations on the mother's experience of fussy, unsettled and irritable infants which also suggested that there was further scope for research in exploring a father's perspective. The research question became 'What is a parent's perspective on osteopathy in the treatment of their infants?' Throughout the research process and to ensure the methods continued to contribute to the answer, this question was continually referred back to.

*Investigating experience as we live it* was investigated through in-depth interviews, tape-recorded and transcribed. These interviews allowed the mothers and fathers to relive the experience and the researcher to understand the parents' experience of seeking and participating in the osteopathic treatment of their infants.

#### ***Reflecting on the essential themes which characterise the phenomenon***

In order to reflect on the essential themes, the themes and sub themes needed to be revealed in the data. During the interview process several themes became evident and with further reflection during and immediately after the interview, this assisted in influencing the direction of the following interviews. The interviews were transcribed verbatim and then analysed for common themes through reading and re-reading the transcripts whilst listening to the recorded interviews. Themes and sub themes were developed by statements, words and phrases found moving through the transcripts. A table was formed from these initial findings. See Appendix -F

#### ***Describing the phenomena in the art of writing and rewriting***

This in depth writing could not be accomplished in one straightforward session. The process of writing, rewriting, rethinking, reflecting and recognizing continued throughout the research process. As ideas emerged from the data, constant questioning and reflection of the emerging themes allowed a deeper understanding of the lived experience.

#### ***Maintaining a strong and oriented relation to the phenomenon***

During the process of reading, re-reading the transcripts and listening to the interviews, it was often easy to become immersed in the stories of the

participants and become distracted from the original research question. Reminding oneself of the research question and referring back to my journal of reflections assisted me in focusing once again on the research question.

### *Balancing the research context by considering the parts and the whole*

This developed throughout the research process. Through the process of the interview, the transcription, the listening to tapes and the reading and re-reading of transcripts, the whole phenomenon emerged.

### **Isolating Themes**

In Chapter Three, Thematic Analysis the three methods van Manen (1997) maintains can isolated themes were briefly outlined.

The initial method chosen was the detailed reading approach. In this method, van Manen (1997, p93) proposes that the researcher looks at each sentence or group of sentences while asking “What does this sentence, or sentence cluster, reveal about the phenomenon”? Reading and re-reading the transcripts, identifying words, phrases and sentences that formed concepts was the first method of analysis.

The selective or highlighting approach was used in the second stage of analysis and in asking which statements or phrases were most revealing about the phenomenon in question. These statements were then highlighted in *italics* in the text.

The third method of isolating thematic statements used the holistic reading approach. This method involved looking at the text as a whole and asking which notable phrase captures the fundamental meaning of the text. Certain experiential themes emerged with common recurring phrases and single statement captured.

### **Maintaining Rigour**

Van Manen (1997) believes a researcher can be influenced during the processes of data collection and analysis. Maintaining rigour is being able to articulate how the researcher's knowledge and experiences have influenced the research process. Prior to any data collection, the researcher herself was interviewed, to ascertain any previous knowledge, experiences and beliefs that were held by the researcher.

To confirm the accuracy of data collection, once interviews were transcribed, all transcripts were returned to the participants. This process allowed for further clarification and confirmed the participants meaning and understanding of the phenomenon, ensuring methodological rigour. All participants responded via email, with no changes required.

A journal with recorded decision making procedures was kept, with questions on the meaning of the data and reflection on my own assumptions. This was regularly referred to throughout the research project, in order the maintain focus on the research question.

As previously outlined, phenomenology has as its goal, the exploration of the nature of a lived experience of a phenomenon. This method proved to be appropriate in order to illuminate the lived experience of osteopathy in the treatment by infants. By following a research methodology that is faithful to

the research goal and providing a clear audit trail of the research process, the study has established credibility and rigor. A documented audit trail was completed of the recruitment of participants, the interview process, the allocation of pseudonyms and the development of themes.

This chapter has outlined how the project was implemented in accordance with the theory presented in Chapter Three – The Method. It described the development of the themes introduced in the next chapter.

**Chapter Five**  
**Interpretation and Discussion**

This chapter presents the data and the central themes that emerged using the data analysis and interpretation process outlined in the previous chapter. An introduction to the themes that emerged from analysis includes a discussion of the interpretations. The themes are then revealed, supported with excerpts, quotes and phrases from the data. These will be further discussed with relation to literature, their relevance to osteopathy and the links between the themes.

## **Introduction**

Parents experiences' of finding a healthcare practitioner who could help them with their infant's condition were explored in this study. The study looked at how parents came to use osteopathy as a therapy for their infant, how they experienced the osteopathic treatment their infant received and the outcomes of this treatment. In narrative form, the parents described their experiences' including the history of their infant's condition and they also related how they felt about the process of seeking osteopathy and their experience through the treatment and resolution of their infant's condition.

Infants in previous studies by Viedma-Dodd (2006) and Gibbons (2008) which explored the experience of mothers and osteopaths in the treatment of unsettled, fussy or irritable (UFI) infants, presented with relentless crying and constant pain, causing parents to be distressed, stressed and uncertain. The infants in this research did not appear to be in pain and their crying was not excessive. As well as all being first children, four of the five infants were males and had varying degrees of altered skull shape, flattening (described in Chapter Two – Literature Review as deformational plagiocephaly) and

preferences to turn their heads to one side only. The only female infant suffered from reflux, spilling with wind which caused pain and also a preference to turn her head to one side only.

The temporal nature of the themes emerged as being underlined by the uncertainty as *'something is not quite right'*, to seeking osteopathy and the future osteopathic treatment of the infants.

While discussing the history of their infant's condition, parents spoke of noticing changes in the shape and movement of their infant's heads. This was not a sudden realization that a change had occurred but a gradual realization over time until that moment when they realized that *something is not quite right*. They questioned whether the changes were normal or not and were anxious as to the possible underlying conditions which may be causing these changes. With this came *uncertainty about the unknown*. It was from this *unknown* that the parents experimented with different possible solutions.

Parents at this point sought information from friends, family, Plunket nurses, and doctors. In some instances, parents used their previous experience to seek information. The parents whose infant's were experiencing changes in skull shape and preferences for turning their head to one side, tried sleep repositioning techniques for their infants and changing breastfeeding positions. The parents of the only female infant in the study tried Losec<sup>3</sup> and Gaviscon<sup>4</sup> prescribed by their doctor for their daughters reflux and spilling. Due to the unsuccessful attempts using recommended alternatives to help their infants, parents were prompted at this stage to *seek osteopathy* for solutions to their infant's conditions.

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<sup>3</sup> Losec is a proton pump inhibitor or acid blocker used in infants with reflux.

<sup>4</sup> Gaviscon is designed to alleviate the pain and discomfort of reflux

*Factors that influenced parents to seek osteopathy* were either previous experience with osteopathy or recommendation from family and friends who used osteopathy. Differences in the process mothers and fathers took to use osteopathy became evident and there were some barriers that needed to be overcome to access osteopathy due to the parents' different experiences and their understanding on the scope of osteopathy.

With these barriers overcome, parents arrived at osteopathy with very little knowledge on osteopathic treatment of infants. Parents described the treatment process their infants went through. They reported on their expectations, their understanding of the treatment and identified the importance of *trust in and communication with* the osteopath and how this related to the outcome and the future use of osteopathy.

The osteopathic treatments that all the infants received were reported as being successful and the relief in finding a solution by the parents was evident. Many of the parents had already shown a commitment to osteopathy for their own treatment; however some appeared to be cautious in their future commitment to osteopathy in the treatment of their infant's. Other parents were disappointed in the lack of information given by Plunket nurses and doctors with regard to osteopathic treatment. Several parents described osteopathy as being '*fringe*', on the edge of orthodox medicine, not often recommended by western medicine and isolated to specific groups in society.

## **Theme One - Something is not quite right**

At a point in time all of the parents participating in this study came to a decision that they required further help with their infant's presenting complaint. All participants were first time parents experiencing the unknown. The decision to seek further assistance had come after observing their infant's and coming to the realization that '*something is not quite right*'.

Parents have a duty to provide a standard of reasonable care whilst caring for their children. This term duty carries a meaning not only of a common law obligation but a moral obligation to provide the necessities of (Burgess, 2008). When parents suspect '*something is not quite right*', they use a combination of behavioral and symptomatic clues to assess any deviation from what was normal for a particular infant. The parents in this study were generally confident about recognizing that '*something was not quite right*'. However there was uncertainty about deciding what was normal and if a problem was significant or serious. Two reasons for this uncertainty were present in the data (i) the parents were all first time parents with no experience with these conditions, and (ii) the infants were not in constant pain and did not appear to be unhappy, hence it was unknown how serious the condition may have been.

As previously discussed in the literature review, becoming a parent for the first time represents an event of some magnitude (Belsky, Ward, & Rovine, 1986). This transition to parenthood is stressful as both parents adapt to their new roles. The additional stress of an infant with a health problem has multiple consequences in all spheres of family life (Pelchat, Lefebvre, & Levert, 2007) . Whilst both parents expressed their uncertainty and anxiety

over the infant's condition, there were differences in the way their observations and feelings were expressed.

Van Manen's (1997) lifeworld existential 'corporeality' is the way in our physical or bodily presence we both reveal and conceal at the same time something about ourselves. The parent's corporeality was represented through the anxiety and uncertainty over their infant's condition and the internal processing of that experience.

Lisa described her feelings of uncertainty when her daughter would fuss on one side while breastfeeding. She was unsure the fussiness was caused through something she was doing or if there was a problem. Lisa's daughter also suffered from reflux which caused her pain at times, causing further uncertainty.

*....After her feed she'd either scream when she burped or she would power chuck everywhere and she's been a spewy baby ever since. It was just more around I think not frustration but why she was fussing. I couldn't understand if it was something I was doing wrong with the breastfeeding. I'd gone so many times with just thinking it was something obviously that I was doing wrong but knowing at the end it wasn't.  
(Lisa, In 296)*

The fathers in this research project, made clear concise statements throughout the interviews. The tone and words they used were interpreted as showing confidence and assertiveness in knowing there was something not quite right. In contrast, the tone in which the mothers portrayed their experiences appeared to be vague, tentative and unsure. This uncertainty reflected in their voices and they expressed being unsure if their infant's problem was

related to something they were doing or if there were other underlying problems.

The fathers portrayed a certainty that the information they were revealing was correct and accurate. Their view of the time line was different from the mothers and the information appeared to be more detailed. Fathers had the ability to stand back and observe the scene of mother and baby, whether breastfeeding or cuddling. They had an unobstructed view and a detachment from the mother and baby. There was a strong sense of responsibility and protection from all the fathers interviewed, that it is their role to ensure they found the answers to their infant's conditions. They were no less anxious than the mothers but their focus was not so much on the immediate needs of the infant as was the mothers but more on seeking the answers to their questions. The fathers wanted to understand what was happening. Why has my infant's head changed shape? What does this mean? How will it affect my infant long term?

Anthony described noticing his son only wanting to turn his head to one side, sleep on one side and a flattening of his son's skull started to appear. Anthony's uncertainty was not so much about the flattening but the thought that this might not be an optimal shape for his son's head. Although his son was quite forthright in his needs, he did not think that his son was in any pain.

*.... Noticing that there was a definite side preference and he wouldn't sleep on his back. He would always turn his head to the right [text] and obviously that was starting to flatten. .... I think I was less bothered about the flat side but just the preference to always go to one side from my knowledge [text] was probably not optimal [text]. He was always quite a forthright baby and always has been. I don't think necessarily that he was or is in pain. [text] He didn't appear to be. (Anthony, Ln 84)*

In contrast, all mothers in this study reflected uncertainty in their voices during the interview process. They appeared to be vague on the details of their experiences. Entering the new world of motherhood meant that established routines, in which they were confidently competent, were thrown into confusion as they learnt new skills for example breastfeeding and developed alternative ways of organizing their lives. They were beginners with little or no experience of the circumstances facing them. Although not verbally expressed, their tone indicated a disappointment, possibly a feeling of inadequacy in the situation they found themselves in. The lived world that mothers expected was disrupted by the infants. In Wilkins (2006) qualitative study exploring the support needs of first-time mothers on their journey towards intuitive parenting, it was found that the reality of motherhood was very different from what they had anticipated, and came as quite a shock to all, compounding their feelings of inadequacy. With this new responsibility comes the uncertainty of not knowing. Everything is new to both parents however mothers are not only adjusting to a new baby who requires all of their time but also with the changes occurring in their own bodies after the birth of a child. With the corporeal nature of these changes occurring, there is also a term used by some pregnant or postpartum women where they describe themselves as having "baby brain". This term refers to mothers having difficulty recalling information or impaired memory (DeAngelis, 2008). This may explain why some mothers appeared vague in the interview process, with regard to details around the birth of their infants and also the time line of when they first noticed that something was not quite right. If a baby is a little unsettled or fussy feeding on one side, a mother may feel anxious or confused by her lack of experience. This may further explain the perception of uncertainty the mothers portrayed.

Often a parent's first clue to their child being ill is excessive crying and possible indications of pain in a generally unsettled infant. However the

infants in this study did not cry excessively nor did they show signs of pain, so there appeared to be far more uncertainty about deciding what was wrong and if a problem was significant or serious.

The parents endeavored to seek control by engaging different individual adjustment strategies which parallel a systemic review of the literature designed to produce a profile of the experience of fathers and mothers of a child with a health problem. Mothers dealt with their stress by expressing their emotions with their support system, family and friends, thus demonstrating how important expressive support is to mothers in their private relational sphere. Fathers however used more cognitive problem-solving strategies, seeking information from professionals in the public domain (Pelchat, Lefebvre, & Levert, 2007).

## Theme Two - Seeking Osteopathy

During the process of seeking osteopathy, parents went through experimental stages and processes which were different for mothers and fathers.

The first step for mothers was to consult their midwives and Plunket nurses, often trying different techniques such as repositioning techniques and/or tummy time to prevent further flattening of their infant's skull. The next port of call was their general practitioner where the majority of parents reported disappointment in the lack of information or advice given.

*...the basic advice was put the head to the left or the right, but when the baby is tossing its head around you can't go and wake the child to turn its head to one side. Other than put the head to one side or the other that was it. No one picked up on the fact that his neck was tight and it was on quite an angle except for a girlfriend of mine who is a nurse noticed it when she came over. So no, a bit disappointed in medical practitioners for that. (Mary, Ln 255)*

*The Plunket nurses came around and checked him every so many weeks or months or whatever it was. It was kind of like they came in, watch, do their checks, tick the boxes and move on. It's not an educational visit in any way at all I don't think. (Bronwyn, Ln 399)*

*I used my GP. They all saw that David's head was flat. I asked each one of them about it and not one of them recommended an osteopath, and that really actually annoyed me because I knew they were out there but being tired and a new mother I didn't actually carry it out on my own. [text] I think both GP's and Plunket should be aware of it. (Mary, Ln 204)*

Their next step was to discuss alternatives with friends and family.

*.... through a recommendation from other people [text] and through my mum who had heard that this particular osteopath was one of the best.... (Alison, Ln 51.)*

*Friends, reading, magazine, all of those kinds of things. [text] there's not that much information around about it, but I have had friends that have had to use it before. (Mary, Ln 21)*

In comparison, the fathers' processes were different in that they generally used experience to seek professional help. Three of the four fathers interviewed in this research had previous treatment with osteopaths. None had any knowledge on the scope of osteopathy with infants. Two of the three fathers with previous experience asked their osteopath about their infant while having treatment themselves. These discussions with their osteopaths resulted in the parents taking their infant's to see the osteopath.

*Really it was actually due to the fact that I've been going to an osteopath myself. Obviously I've been going to my osteopath now for probably four or five years and know him quite well. So when I noticed that my son had an issue where he was consistently only turning one side and sleeping on one side and starting to get a flat head, [text] I spoke to my osteopath in a session that I had and sort of asked him whether he did and what he did and he talked with me around what he did. (Anthony, Ln 15)*

*When we'd gone in and seen our osteopath we were just casually talking to him about it and he mentioned to us to check her out. (Terry, Ln 12)*

With the need to have their questions answered and the uncertainty experienced by both parents, this prompted them to seek further information on their infant's condition so they could decide if their infant's required treatment.

Compared with previous studies by Gibbons (2008) and Viedma-Dodd (2006) all of the parents had either previous treatment with osteopaths or their partner's had had previous treatment with osteopaths. Thus there was not a necessity to investigate osteopathy due to their previous exposure to osteopathy. The decision to explore osteopathy as a potential solution to their infant's conditions was a gradual process that emerged after exhausting the parent's familiar knowledge, interacting with family and friends and subsequent discussions with osteopaths. The infants arrived at osteopathy through two routes: referral by family or friends and their parent's previous experience with osteopathy.

The data revealed several types of trust which influenced the parents in their choice of osteopathy and the success of the osteopathic experience. The confidence in friends and family and their osteopath, fostered their personal social trust of osteopathy. Social trust is trust in collective institutions, influenced broadly by the media and by general social confidence in particular institutions (Pearson & Raeke, 2000).

Several fathers had regular osteopathic treatment themselves and had built a trusting relationship with their osteopath, who they felt they could trust to advise them on their infant's condition. They had built up an experiential interpersonal trust which develops with the knowledge of the one trusted over time (Goold, 2002). Interpersonal trust is trust built through repeated interactions through which expectations about a person's trustworthy

behavior can be tested over time (Pearson & Raeke, 2000). However for one father there was a barrier to overcome prior to having his infant treated. Anthony's wife needed some convincing that it was safe to take their son to see the osteopath. She had a different view on manual therapy.

*My wife isn't quite so keen. So there were obviously some conversations around sort of getting her to feel comfortable. She'd been to some sessions where she'd seen stuff with me, so she felt she trusted the osteopath but it was kind of where we talked about what do we do and things like that. So once she had decided that yes she thought that the movement and everything was worth talking to the osteopath about we thought we'd just take him in. We both went in. (Anthony, Ln 104).*

Based on her observations and conversations with both her husband and the osteopath, his wife concluded that it was safe to take her infant to see an osteopath and she consented to their son being treated.

Some participants had also been referred to an osteopath by close friends or family, people they trusted were recommending their osteopath.

*... to be honest I wouldn't have even thought of taking Campbell to an osteopath or anyone if it wasn't for my brother who took their little girl. (Stewart, Ln 31)*

The interpersonal trust Anthony's wife had in her husband and Stewart had with his brother prompted them to take the next step to seeking osteopathy. Trust in terms of attending the initial appointment was framed by anecdote, advice from family and friends, specifically his brother who trusted the osteopath.

In trusting an osteopath to treat their infants, the parents entered a patient-practitioner relationship with the osteopath on behalf of the child. They were the infant's voice in this triangular relationship. Parents arrived at the appointment, according to their own reports, with no idea of what type of osteopathic treatment the osteopath would use. There was a lack of understanding from parents on the techniques used to treat their infants. However all parents reported being satisfied in the information they received from the osteopath and the explanations they received during the treatment process of their infants.

*Yes and from what I remember it was yeah, just very gently trying to sort of ease the plates in the head around cause they hadn't fused and the rest of that sort of stuff [text]. The osteopath has always been very good at that sort of stuff in explaining what he's doing. I suppose once again it's a lot to do with trust and it's a lot to do with if you've seen somebody and you know them for a long time then would you put your baby in their arms and with the osteopath I was very comfortable that that was the case. (Anthony, Ln 126)*

Several parents' reported how trust in the osteopath influenced the depth of information they required in order to feel comfortable having the osteopath treat their infant. The experiential trust that had developed over time with their previous experience with the osteopath meant that they were happy to relinquish the necessity to fully understand the process or treatment of their infants. This is demonstrated with Terry who had built up a long term trusting relationship with his osteopath. He explained that

*... There is quite a big trust factor in the relationship. So we left him to do what he was doing and didn't ask too many questions and that's simply just because we've been going to see him for so long and I've referred a number of people to him and everyone had great things to say about him. (Terry, Ln 46)*

Terry's faith and trust in his osteopath was so strong that he was prepared to allow the osteopath to work without too many questions. He had used ideas and understandings which he was familiar with during his treatment sessions to understand the unfamiliar treatment of his infant and it was the process of seeking meaning which seemed central to this trust.

It would appear that some parents were placing their trust in a very different treatment format than they had ever experienced. Although Alison's husband had previous osteopathic treatment, she had no prior experience with osteopathy. She felt very comfortable and trusting in the first meeting with her osteopath. She communicated her experience of the treatment process

*She was really down to earth, it was very easy, and because I had Jacob with me, I was able to feed him if he needed to be fed and I felt very relaxed and not sort of under any pressure or anything. (Alison, Ln 64)*

The communication between the parents and the osteopath was significant in the ongoing relationship and further treatment sessions for their infants. Communicating openly demonstrates respect and allows the patient to judge the motivation of the practitioner (Goold, 2002).

The development of a positive therapeutic relationship between the parents, the infants and the osteopaths appeared to be dependent on the honesty, integrity and professionalism of the osteopath. This appeared to cement trust and faith in the osteopath and his ability to help their infants. Several parents related to what they had experienced in their own treatment. Knowing that

they had successful and positive outcomes, they were prepared to allow the osteopath to treat their infant's.

*...because of our relationship we were actually totally comfortable with whatever he was doing. Like we'd known whenever he's worked on us how much better we've felt afterwards as a result..... So knowing that he can fix whatever problems I had I felt totally comfortable with what he was doing. I had no issue, no worries about him. When he said something about can I have a look at her, definitely, go. (Terry, Ln 145)*

*I trust him and well if he said something I would just let him do it. I wouldn't question oh why are you doing it, why are you doing this cause generally most of the time he gets quarter of the way through what he's doing and he'd tell you all about it anyway. So as he's working on you he's telling you exactly what he's doing, what he's trying to loosen up and how this is happening and it was exactly the same with Campbell. When he was working on Campbell he was telling us all the different scenarios, things that can happen due to this, this or this and everything to look for and work on. (Stewart, Ln 519)*

### Theme Three - The Future

With all the infants responding to the osteopathic treatment, there appeared to be a sense of relief to see the changes in their infants, further endorsing the continued relationship between the osteopaths, parents and infants.

For one father, Peter, who although he had exposure to osteopathy and chiropractors for himself, was surprised that his son's condition could be treated by an osteopath. Peter had never contemplated an osteopath being able to help with his son's condition;

*I didn't think it was a manipulative, a thing that could be manipulated you know, the cranium. Apparently there are four plates or so that move..... I didn't actually think that it could be done. I thought the cranium was one whole complete piece but obviously its not. It obviously fuses at a later stage. (Peter, Ln 168).*

Alison expressed her understanding of the treatment of her son;

*... I see it basically as a way of treating people holistically. So you are treating every sort of part of them, not just physically you're treating them. Yeah, it sort of brings in everything. It's physical, it's emotional, it's spiritual, it's everything. It's all the parts of the body coming together to heal. Not just, yeah, not particularly concentrating on one certain area. It's the whole body and how it interacts with each other and different parts of your body how they affect other parts. It's here in the entire body rather than just a specific problem. (Alison, Ln 89).*

There were differences in the way Peter and Alison portrayed their understanding of osteopathy. Peter's description was based on a mechanical, functional view, compared to Alison who looked at osteopathy from a holistic viewpoint.

Although all parents spoke positively about osteopathy in the treatment of their infants, several parents reported osteopathy as isolated, fringe and not very well known. My understanding of the term fringe in this context is that the modality is seen as being on the boundary of or periphery of acceptance in complementary therapies.

When asked “Is osteopathy ever recommended or talked about and what is your perception”;

*My perception is no. My perception is it's still seen by a lot of people as fringe.  
(Anthony, Ln 161)*

*It's strange that they still seem to be fringe. Where they are not really fringe. (Peter,  
Ln 225)*

There appeared to be more discussion with regards to osteopathy in coffee groups or with friends and family than from midwives, Plunket or the medical profession.

*... like you go through antenatal classes or midwives or whatever else and no one from a medical or a I don't know, government funded educational point of view ever points you in the direction of an osteopath, but like if you've got kids and you establish common ground, you know, they're doing this in the evening and I'm struggling with this and we've having a problem, oh we did this and saw an osteopath and oh it's so much better, and then you see them three weeks later and oh yeah, I've been to an osteopath and they're fine now. Just like that, yeah, education.  
(Terry, Ln 401).*

*A few people in my coffee group, coffee group, two or three were quite interested or wanted to use, but then I think the antenatal class recommended it. (Bronwyn, Ln 389)*

All of the participants said that they would recommend osteopathy in the future and use it for their children and any other children they had. Several of the fathers were committed to osteopathy and often recommended it to friends, family and colleagues however it was evident that there were differences in when they might seek osteopathy in the future for their infants.

Anthony would base his decision on whether to seek osteopathic treatment for his infant again, depending on the type of condition the child presented with.

*...Depending on what the issue was and everything like that whether it would be seek initially or seek secondary and things like that. It's always a case of reviewing at the time what the problem is and whether you would go straight to them or whether you would go straight to somebody else. (Anthony, Ln 252)*

Stewart said that he would take his son for anything as he had nothing to lose;

*But due to that sort of education of you know, what we've done. It made me realise that there's a lot of benefits for young ones as well and when you see what can be, you know like just all the little things that you would never think about. The spilling, hiccupping or we can't get him to eat or he's cranky and tired and all that sort of stuff. If I had a chance to fix that I would not think twice about going to see him. I've got nothing to lose. (Stewart, Ln 377)*

When asked what might prompt him to take his daughter back to see an osteopath, Terry revealed;

*I don't know actually to tell you the truth. Yeah, if I notice that she might have had a, well now that she communicates she could probably tell us that she's got a sore back or something. So probably something along those lines I would. If I'd seen her, if she's walking with a limp or something like that I'd take her. If she's getting too many headaches or things like that I'd definitely take her along and get her seen too.*

*(Terry Ln 372)*

Parents would assess their infant's conditions in future and determine the type of therapy they wanted for their infants. Osteopathy would be included in this if the parents determined that the condition was in their opinion in the scope of osteopathic treatment.

The hesitancy of several parents' to commit to when they would use osteopathy in the treatment of their infants could be due to one of two reasons. The parents' view of osteopathy as being on the fringe and not as acceptable as the medical profession in the treatment of their infants or that they do not understand the scope of osteopathy in the treatment of infants. Considering that all parents reported positive outcomes in the treatment of their infants and cost was not reported as a consideration, the later appears to be more plausible, that parents do not understand the scope of osteopathy in the treatment of infants. As discussed by several participants education about osteopathy and knowledge of the scope of osteopathy are limited. Very few midwives, medical practitioners or Plunket nurses recommended osteopathy to the parents participating in this study. Osteopathy was only sought after parents had exhausted many other avenues.

## **Further Discussion**

### **Birth Trauma and Positional Plagiocephaly**

It is well documented in literature that a relationship exists between birth trauma and positional plagiocephaly as discussed in Chapter Two – Literature Review. With the adoption of supine sleeping between the late 1980's and the early 1990's to prevent sudden infant death syndrome (SIDS) or now referred to as sudden unexpected death in infancy (SUDI) (Ministry of Health, 2011), there has been an increase in the prevalence of infants presenting with altered skull shape or positional plagiocephaly.

All infants in this research project received osteopathic treatment for varying degrees of positional plagiocephaly. Although the parents observed the head shape changes in their infant's, they did not know what it was or what it was caused by. This not knowing, increased their anxiety and stress, in an already volatile environment where the responsibility of being first time parents was taxing for both parents. There are various sources of information from the internet with regard to positional plagiocephaly, with information on how parents can reduce the flattening of the skull. One example is the Paediatric Society of New Zealand Inc's website which suggests that if you find that your baby favors a particular head or neck position, it may be because they have a tight neck muscle on one side, preventing them from turning their head which may require physiotherapy (Paediatric Society of New Zealand Inc : Kidshealth, 2011). Parents in this research were advised to use re-positioning techniques by their general practitioners and Plunket, with no success.

The ongoing debate on whether or not positional plagiocephaly resolves itself through natural history and whether there are any long term effects, leaves

the medical profession and parents with no clear guidelines to follow on how to resolve their infants altered skull shape.

Bialocerkowski et al's. (2008) review synthesized current research evidence on the prevalence, risk factors, and natural history of positional plagiocephaly. It demonstrated a point prevalence of plagiocephaly as high as 22.1% at 7 weeks of age, decreasing to as low as 3.3% at two years without treatment. This indicates that plagiocephaly of the infants in these studies may have resolved through natural history and without treatment. To date the research shows that some infants do appear to have developmental delays but these infants catch up in development at 3 to 4 years of age (Hutchinson et al. 2010). The studies that do show evidence of osteopathic treatment being effective in the treatment of positional plagiocephaly are being questioned with the debate that natural history may have resolved these cases without treatment.

The risk factors are evident, with this study showing that four of the five infants had experienced birth trauma, with one caesarian delivery, one Ventouse delivery and two deliveries where the infants became distressed. They were all first born children, four males and one female with varying degrees of altered skull shape. The findings in this study supports the research, where evidence suggests that possible risk factors that increase the risk of positional plagiocephaly include assisted delivery, first born children, male sex, cumulative exposure to the supine position and neck problems (Bialocerkowski et al. 2008).

However, the question still remains, do parents have their infants treated for this condition or do they allow natural history to take its course without treatment? Currently there are no clear answers.

## **Conclusion**

This chapter has discussed the three central themes which emerged from the data *something is not quite right, seeking osteopathy and the future*.

The parents journey began with the realization that *'something was not quite right'*. The sense of the unknown that was expressed throughout the experience in *seeking osteopathy* was countered by the trust, communication and rapport built with their osteopaths and the positive outcomes for their infants. *The future*, still held a sense of unknown as to how they as parents may use osteopathy again in the treatment of their infant's.

The conclusions drawn from this phenomenological study, the limitations of this project and recommendations are discussed in Chapter Six – Conclusions.

# **Chapter Six**

## **Conclusions**

This chapter will evaluate the overall research process including the strengths and limitations of the study. Topics for future study that have arisen from undertaking this project are proposed. Finally, the implications of the findings from this study are discussed with relevance to the osteopathic profession.

### **Strengths of this Study**

A rich description of the lived experience of parents seeking and participating in osteopathic treatment for their infants has emerged from this study. It can be used by medical professionals to contribute to understanding the journey taken by parents as they seek alternative treatment for their infants and the frustrations parents experience due to the lack of information available to them regarding alternative treatments.

This study builds on two small osteopathic studies on infant health by Viedma-Dodd (2006) and Gibbons (2008). A father's perspective is added of seeking and participating in osteopathic treatment for their infants and some of the ways in which this differs from a mother's perspective.

Research on parenting has focused predominantly on motherhood, however recently an increase in research is being conducted on fatherhood. The transition to fatherhood consists of many life changes including the new commitment and responsibility of having a child, balancing work and home life, time and routines and the changing relationship towards their partner (St John, Cameron, & McVeigh, 2005). In 2008, an explorative study of twenty first-time father's experiences during the early infancy of their children,

found that fathers suggested they performed childcare to the same extent as the mother when both parents were at home (Fagerskiold, 2008).

As one of two parents, fathers are important in their child's growth, development, emotional health and cognitive development. The father's perspective is valuable and understanding father's experiences during the early infancy of their children may bring about increased support from all health professionals.

Although first time parents were not sought for this study, all participants were first time parents which reduced the number of variables and increased the strength of the discussion. All participants experienced the uncertainty of being first time parents and the unknown. As primary healthcare practitioners, osteopaths need to understand the stresses placed on first time parents and the additional pressure placed on them when an infant has a health problem. The ability to empathise, communicate and alleviate the parents concerns is paramount in the future relationship between parents and their healthcare practitioners.

While this study is not about positional plagiocephaly, with the increased prevalence of positional plagiocephaly since supine sleeping for infants was introduced in 1994, it was not surprising that infants in this study presented with positional plagiocephaly. All infants in this study presented with varying degrees of altered skull shape and/or preferences to turn their heads to one side only. The findings of this study correlate with research where evidence suggests that possible risk factors that increase the risk of positional plagiocephaly (altered skull shape) include assisted delivery, first born children, male sex, cumulative exposure to the supine position and neck problems. This study further supports the research by Bialocerkowski et al. (2008) with regard to risk factors.

## **Limitations of this Study**

During the interview process, a phenomenological researcher seeks a deep and full meaning of the participants' experience of a particular phenomenon. During the interview process with parents, three of the five interviews conducted had both mother and father present. Although the data from these interviews were rich in the description of their experiences, on reflection, the true experience of these parents' may have not been revealed due to the sensitivity of some topics. In addition it was also observed that during these three interviews, two sessions were dominated by the father and his perspective of the phenomenon. Although the mothers appeared to agree with the father's perspective, separate interviews may have given both mothers and fathers the opportunity to discuss their experiences without possible censorship of the discussion.

Hermeneutic phenomenology was the method of choice for this study. The nature of phenomenological research dictates that the number of participants is small, due to the time intensive nature of interviewing and transcription. As a result the findings of this study are for a small population of parents. In addition all eight participants in this research were New Zealand 'Caucasians' and different cultural groups may have revealed contrasting experiences. Therefore findings cannot be generalized to other populations. A larger population may have allowed other themes to emerge.

## **Future Research**

Although this study explored the perceptions of both mothers and fathers experiences in seeking and participating in osteopathic treatment for their infants, it also revealed that the majority of infants in this study were suffering from varying degrees of positional plagiocephaly. There are numerous studies on positional plagiocephaly both in New Zealand and overseas, where opinions vary on the increased prevalence of positional plagiocephaly, the effectiveness of osteopathic treatment for this condition and its long term effects. Further research on the current prevalence of positional plagiocephaly and how effective osteopathy is in the treatment of positional plagiocephaly could help to clarify the differences in opinion. Current literature shows a significant increase in plagiocephaly up until four months of age. Research introducing osteopathic examination and treatment of neonates may determine whether it is effective in reducing the increased prevalence of plagiocephaly.

All participants in this study were first time parents, experiencing the transition to parenthood and the life changes that this brings to both mother and father. Further research recruiting parents who had used osteopathy for their first, second and perhaps third children may reveal differences in the way parents experience osteopathy in the treatment of their infants and whether their initial perceptions were still relevant.

There were positive outcomes for all five infants and osteopathic treatment was seen by parents' as being effective in the treatment of their infant's. Further research recruiting a wider range of parents who have used osteopathy in the treatment of their infants is required to identify the types of conditions that New Zealand infants present with to osteopaths and how successful these treatments are. This type of research would be valuable for

the community, increasing their understanding of the scope of osteopathy and how important it is for their infant's future health.

### **Implications for Practice**

This study revealed the importance of trust and communication in a therapeutic relationship and how this can promote excellent patient-practitioner relationships.

Trust for all parents in this study was the catalyst that prompted parents to *seek osteopathy*. Whether this was the trust associated with the opinions of family and friends or the trust built over time with their own osteopaths, the parents motivation to seek help was based on the osteopaths reputation as a respected expert in their field. Parents expected the osteopath to be somebody that could give them advice and furthermore that the osteopath would respect and value their information on their infants condition. The parents trust in their osteopath served to reinforce the functioning of the therapeutic relationship as a health partnership.

The unknown world of parenthood and the additional stress of having an infant with an unexplained condition were reflected in the way in which the mothers and fathers communicated their experiences. The mothers expression of their experience was more emotional than the fathers whose portrayal was one of certainty. Although the fathers were no less anxious than the mothers, their focus was on finding the answers to their infant's condition.

Osteopaths are reminded that communication is the key to their future with parents and infants and there is a difference in the communication needs of mothers and fathers. Mothers have a need to express their experiences and

emotions. Osteopaths can reassure mothers by communicating with empathy, understanding and honesty, helping mothers to understand their infant's condition. Fathers have a need to know the facts. They want the information on what it is, how it will affect his infant and how the osteopath can help. Fathers concerns can be alleviated through clear factual communication.

Trust and communication are inter-related. Understanding and using adaptive communication with parents' can assist osteopaths in building long term parent-practitioner relationships.

## Concluding Statement

Becoming a parent, especially a first-time parent is a life changing event and with the additional stress of observing their infants with a health problem can be overwhelming. Parents do not know what is happening, whether the condition is serious or not and if they should seek treatment. However they do know that *something is not quite right*. The journey to seek help can be fraught with disappointment and frustration due to the varying opinions of health professionals and the lack of information available on alternative therapies. Parents will often *seek osteopathy* after exhausting most other avenues.

This study demonstrates the need for all health practitioners to become more aware of the differences mothers and fathers experience when confronted with an infant with a health problem. Osteopaths can be further informed of the need to adapt their communication skills between mothers and fathers and that building trust and communication within the triangular relationship between infants, parents and osteopaths is most important in positive treatment outcomes.

Community awareness and education in the scope of osteopathic treatment for infants is paramount to *the future* of osteopathy in the treatment of infants and for our infant's future health.

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## **Appendices**

## Appendix A – Ethics Approval



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Mt Albert campus: Carrington Rd, Mt Albert, Auckland, New Zealand  
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Karen Gardner  
37A Kelvin Road  
Remuera  
Auckland

25 February 2010

Dear Karen

Your file number for this application: 2009-1028

**Title: Exploring the use of osteopathy in the treatment of infants**

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: 22 December 2009

Finish date: 21 December 2010

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.

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

Yours sincerely

A handwritten signature in blue ink, appearing to read 'Lyndon Walker'.

 Lyndon Walker  
Deputy Chair, UREC

cc: Elizabeth Niven  
Cynthia Almeida

## Appendix B – Information Sheet – Parents



### Exploring the use of osteopathy in the treatment of infants

#### Invitation to this project

You are invited to participate in this project which is a study exploring the use of osteopathy in the treatment of infant(s).

I am interested in researching this topic from a parents' perspective as they act as a voice for children and are ultimately responsible for their infant's health and well being.

#### The Researcher

The research is being undertaken by **Karen Gardner**, a Masters of Osteopathy student from the Unitec Institute of Technology. Te Whare Wananga o Wairaka Faculty of Social and Health Science.

The project is being supervised by Dr Elizabeth Niven and Sue Gasquoine of Unitec.

#### Taking part in the project

This project will investigate your experience as a parent in relation to the use of osteopathy in the treatment of your infant. An in-depth interview will be conducted by me (Karen) which will be taped and notes prepared from the verbal discussion and is expected to take approximately one hour and a half. The interview will take place at an agreed location and time of your choice. A copy of the transcript will be posted to you as soon as possible after the interview and you are able to comment on the transcript.

You may withdraw from the research process and remove your data at any time up to 2 weeks after the transcript is sent to you. It is planned that the interviews will take place between February and May 2010.

#### Confidentiality

All information provided in the interview will be confidential. Your name, or any other information that could identify you, will not be disclosed in any publication resulting from the study, nor will such information be available to any other participant in the study. All our notes, data and the consent forms will be kept securely for 5 years from 2010.

#### Consent

I will ask all participants to complete a consent form prior to conducting the interview.

#### Contacting me

Please contact me, Karen Gardner, if you would like to discuss participating or if you have any questions or concerns. I can be contacted at ph: (09)524 7993 or (021) 732815, email: [kfels@slingshot.co.nz](mailto:kfels@slingshot.co.nz).

Alternatively you are welcome to contact my principal supervisor, Dr Elizabeth Niven at Unitec on (09) 815 4321 ext 8320.

#### Thank you

#### UREC Registration Number: 1028

*This study has been approved by the UNITEC Research Ethics Committee from November 2009 to November 2010. If you have any complaints or reservations about the ethical conduct of this research, you may contact the Committee through The UREC Secretary (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 – Consent Form



### Consent Form

#### Exploring the use of osteopathy in the treatment of infants.

This research project will investigate the use of osteopathy in the treatment of infants. The research is being undertaken by Karen Gardner a Masters of Osteopathy student from Unitec Institute of Technology/ Te Whare Wananga o Wairaka Faculty of Social and Health Science. The project is being supervised by Dr Elizabeth Niven of Unitec.

I have seen the Information Sheet dated \_\_\_\_\_ for individuals taking part in the exploratory project on the effectiveness of osteopathy in the treatment of infants. I have had the opportunity to ask questions and have them answered.

**I understand that participating in the research is my choice and that I may withdraw at any time prior to and during the interview and at any time up to two weeks after the transcript is sent to me.**

I understand that everything I say is confidential and none of the information I give will identify me. I also understand that all data will also be saved in electronic form on the personal computers of the researcher and supervisors. Computers are password protected. Hard copies of the data will be stored in locked cabinets in the supervisor's and/or the researcher's home office.

**I understand that my discussion with the researcher during the interview will be taped and notes prepared from the verbal discussion.**

**I am aware that I may contact the researcher, Karen Gardner by phone on (09) 5247993 or (021) 732815 or via email at [kfels@slingshot.co.nz](mailto:kfels@slingshot.co.nz) if I have any queries about the project.**

**I have had time to consider everything and I give my consent to be a part of this project.**

*Participant Signature* \_\_\_\_\_ *Date:* \_\_\_\_\_ 2009

*Project explained by* \_\_\_\_\_ *Date:* \_\_\_\_\_ 2009

**If you have any concerns about the conduct of this project or any other issue please contact the researcher's supervisor Dr Elizabeth Niven at Unitec, (09) 815-4321 ext 8320.**

**UREC Registration Number: 1028**

*This study has been approved by the UNITEC Research Ethics Committee from November 2009 to November 2010. If you have any complaints or reservations about the ethical conduct of this research, you may contact the Committee through The UREC Secretary (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.*

Please retain a copy of this consent form for your records.

## Seeking parents to participate in a study about infant health.



**We are conducting research on the use of osteopathy in the treatment of infants.**

- **Has your infant had osteopathic treatment?**
- **Was your infant between the ages of six months and two years of age at the time of treatment?**
- **Did the treatment take place within the past six months?**
- **Would you like to share your experience of your infant's osteopathic treatment?**



**If you are interested in participating please contact the researcher:  
Karen Gardner  
Ph: 09 524 7993 or 021 732815  
Email: [kfels@slingshot.co.nz](mailto:kfels@slingshot.co.nz)**

**The research is in the form of an interview. All aspects of the research are *confidential* and *anonymous*.**

**Appendix E – Confidentiality Agreement**



**Transcribers Confidentiality Agreement**

**Exploring the use of osteopathy in the treatment of infants**

I ..... (Full Name - printed)

agree to transcribe the recordings provided to me.

I agree to keep confidential all the information provided to me.

I will not make any copies of the transcripts or keep any record of them, other than those required for the project.

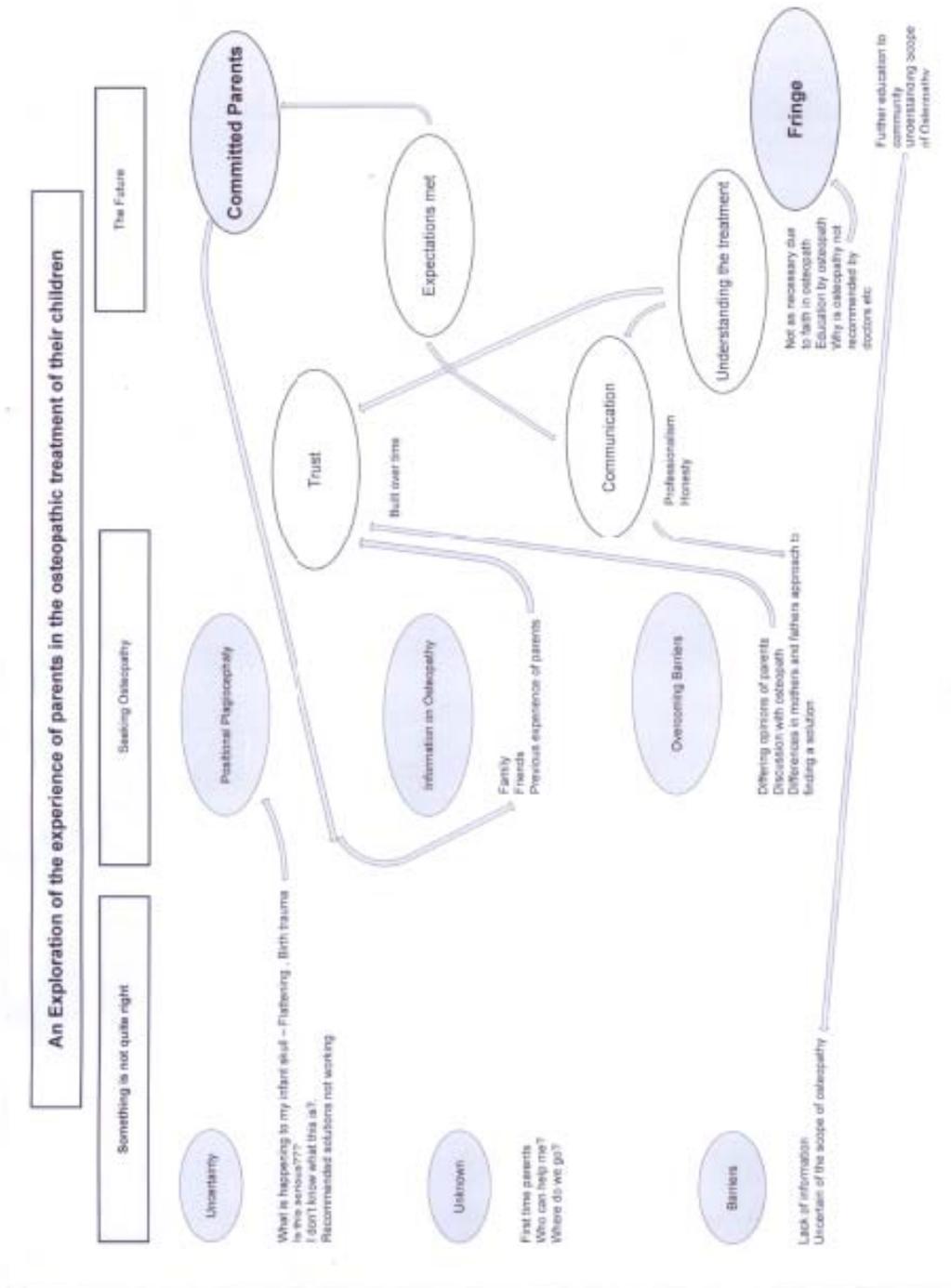
**Signature:**

.....

**Date:**

.....

# Appendix F – Diagram of Themes



## Appendix G – Osteopathic Advertisement



### **Osteopathy for Babies & Children**

Here at Kingsland Osteopaths, we take great pleasure in helping and treating children. We enjoy providing a child-friendly clinic with wide doorways for buggy mobility, plenty of toys and reception staff at the ready to help out.

### **Osteopathy helps resolve many infancy & childhood issues**

#### ***Birth Trauma***

A newborn's cranium compresses as a normal part of the birth process. Difficult deliveries, as well as normal deliveries can affect the expansion of these bones. Gentle cranial osteopathy for babies can often resolve this situation in a few treatments.

#### ***Colic/reflux***

Babies with colic usually have recurrent milk regurgitation and a prolonged period of distressed crying that worsens in the evening. Our osteopathic training allows us to check and treat any parts of the baby that may be contributing to the colic symptoms.

These include irritation of the nerve that helps control the stomach, which may be strained as it passes through the top of the neck - an area that undergoes considerable torsion during the birthing process. The upper back and ribs can also be restricted, which creates extra pressure on the babies stomach and makes babies stomach feel artificially full.

### ***Feeding difficulties***

Sometimes babies have difficulty feeding; feeding can take a long time and is often associated with difficulties winding. Baby's neck, face and throat muscles can sometimes be stretched or strained during the birthing process, and may result in discomfort for the baby. These muscles may get tired earlier than they should, resulting in feeding difficulties.

### ***Crying irritable baby***

Some babies are fractious, and parents have great difficulty settling their child. These babies often prefer to be carried. An osteopath can check if the baby has any areas of discomfort, either in the back of the neck and head or through the upper back. If these areas are under strain, each time baby is placed on their back to sleep, they will often become distressed.

### ***Recurrent ear infections***

The ear canal in a young child is very short and can therefore be easily infected. Many children suffer ear infections more than once, which can be distressing to both the child and their family, and may then require further medical intervention such as grommets. Osteopathy for children aims to ensure that any residual birth strains in the cranium or neck are not impeding drainage from the ears. Osteopathic treatments can be used alongside normal medical treatment such as antibiotics.

### ***Asthma***

Many New Zealand children suffer from asthma, and whilst osteopathy is not a cure, it can help in the reduction and management of symptoms.

Children with asthma often change their breathing pattern to cope with the stresses of asthma episodes. This can result in over use of certain respiratory muscles and structures, which may eventually restrict the breathing further. Osteopathic management of asthma is a good adjunct to medical treatment.

### ***Headaches***

Children's headaches can start occurring at the ages of 7-8, along with growing pains, vulnerability to sprains, and other aches and pains. The pressure of bony joints of the skull as they fully form at this age can aggravate the problem. Kingsland Osteopaths work with your child to relieve and help eliminate this new found pain.