Do You Hear Me?
The Caregivers Experience of Osteopathy for their Child’s Otitis Media

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Abstract

Aims: It is not commonly known that osteopathy can be beneficial for children with otitis media (OM). The research aims of this study are twofold. Firstly, to explore the parents’ experience of having their child treated for otitis media by an osteopath. Secondly, to stimulate the discussion regarding adjunct treatments for otitis media.

Design: A qualitative study using interpretive description. Recruitment was via advertising material in osteopathic and allied health clinics in the greater Auckland region as well by as word of mouth. Data were collected via semi-structured audio-recorded interviews, analysed thematically and themes evolved through the process of interpretative description.

Findings: Irrespective of the outcome of the osteopathic treatment for otitis media, all participants continue to use osteopathy as a treatment option for themselves and their families. Three themes were identified, (1) first line treatment paths, (2) the emotional impact of parenting a child with otitis media (3) osteopathy for otitis media. An overarching theme ‘Do you hear me’ refers to the interpretation of the ever-present subtext of caring for a child with OM.

Conclusions: Osteopathy offers a non-invasive, drug-free treatment approach for children with otitis media. Research suggests osteopathy could have a place in providing adjunct treatment to standard biomedical care for otitis media. Regardless of the chosen treatment, positive shared decision making between care giver and health professional plays a significant role in the outcome of a child’s illness narrative.

Keywords: Otitis media, osteopathy, parenting, shared decision making
Preface
This research explored the caregiver experience of osteopathy for a child with otitis media of six participants in Auckland, New Zealand. The thesis is comprised of three main parts. Part one is presented in two chapters. Chapter one is a literature review that orientates the reader to the presentation of otitis media, contemporary treatments of otitis media, the role of parenting an ill child and osteopathic treatment for otitis media. Chapter two reviews the methodology used for this thesis and addresses the research methods.

Part two is the manuscript prepared for submission to Elsevier journal, Contemporary therapies in medicine. Part three is the appendices, containing ethics approval, participant and marketing information and examples of working with the data though out the research process.
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It takes a village to study osteopathy.
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Part One Chapter One
Introducing the research

The preface orientates the reader to the structure of this thesis. This introduction provides the reasoning behind the research topic and acquaints the reader to the core topics of the research, osteopathy and otitis media.

Introduction
Otitis media is often cited as the commonest reason for a child to see their doctor and in New Zealand there are high rates of OM with disproportionate numbers in Māori and Pacific Island communities (Bowie, Pearson, Campbell, & Barnett, 2014). With the documentation of a worldwide increase in antibiotic resistance (World Health Organisation, 2014) and OM being identified as the primary presentation of prescribed antibiotics in children (Vergison et al., 2010), the need for an adjunct or alternative treatment option for OM is apparent. Osteopathy can offer an adjunct therapy to contemporary biomedical care for the treatment of OM.

To date there are a number of studies exploring the experience of parenting an ill child and a small number of studies regarding the osteopathic treatment of OM. However, no study has been identified that investigates the parental experience of osteopathic treatment for their child with OM. This thesis explores the experience of six parents who sought treatment options for their child’s OM either as an adjunct to biomedical care or as an alternative option when the standard approach had not been successful. Interpreting the data has led to the conclusion that a paradigm shift from contemporary biomedical care that incorporates adjunct or alternative therapy such as osteopathy for the treatment of OM should be considered. Regardless of the treatment approach, shared decision making between health professional and parent is paramount to the success of the child’s illness narrative.

Osteopathy, foundations and principles
Osteopathy is a form of manual therapy pioneered by Andrew Taylor Still in the late 1800’s in Kirksville, United States. The roots of Still’s osteopathy are based on a belief that structure and function of the body are inherently interrelated and this belief has been interpreted and evolved into osteopathic principles that are adhered to today (Paulus, 2013; Stark, 2013). The evolution of osteopathy has seen the practice adopted by manual therapists globally.
Osteopathy in its country of origin is currently practised by clinicians who train as medical doctors, incorporating osteopathic philosophy into their general practice. Training facilities in Europe, Australia and New Zealand adhere more to the traditional interpretation of osteopathy, graduating osteopathic practitioners who seek to master the art of manual therapy (Chila & American Osteopathic Association, 2010).

The Osteopathic Council of New Zealand (Osteopathic Council of New Zealand, n.d-b) endorses the following philosophy and principles of osteopathic treatment. Implicit in these philosophies is the belief that osteopathic intervention has a positive influence on the presentation of the patient.

- The body is a unit.
- Structure and function are reciprocally interrelated.
- The body possesses self-regulatory mechanisms.
- The body has the inherent capacity to defend itself and repair itself.
- When normal adaptability is disrupted, or when environmental changes overcome the body's capacity for self-maintenance, disease may ensue.
- Movement of body fluids is essential to the maintenance of health.
- The nerves play a crucial part in controlling the fluids of the body.
- There are somatic components to disease that are not only manifestations of disease but also are factors that contribute to maintenance of the diseased state.

Within the scope of practice of an osteopath in New Zealand, the OCNZ currently has seven specialised scopes of practice (Osteopathic Council of New Zealand, n.d-b). A proposed vocational scope of practice in child and adolescent health is currently before the OCNZ that may see the instatement of an eighth scope of practice. The addition of a paediatric scope of practice will allow prospective patients and referring healthcare professionals to identify osteopaths who have specific interest and training in treating the paediatric population (Osteopathic Council of New Zealand, n.d-b).

Otitis media is one of the most common presentations for a child over one and under five years seen by an osteopath (Stone, 2015). While there is not one particular treatment protocol that can be assigned to the treatment of OM, the inclusion of a treatment pathway for the treatment OM (Appendix A) to guide osteopaths is included in a report on the capabilities of paediatric osteopaths in New Zealand.
Otitis Media

Otitis media, colloquially known as glue ear, is a general term referring to inflammation of the middle ear and covering a spectrum of diseases that usually occur in a continuum (Curry, Mathews, Daniel Iii, Johnson, & Mansfield, 2002). There are several presentations of otitis media, three of which will be the focus of this literature review; acute otitis media (AOM), otitis media with effusion (OME), and chronic otitis media (COM). Acute otitis media is defined by the presence of fluid in the middle ear combined with signs of acute illness, fever, irritability, otalgia, otorrhoea, and a rash (Lieberthal et al., 2013). Otitis media with effusion occurs when the presence of fluid is not accompanied by signs of any other infections or signs of hearing loss (Daniel et al., 2013). Chronic otitis media involves a variety of signs, symptoms, and physical findings, including tympanic membrane perforation and chronic otorrhoea, that usually result from long-term damage to the middle ear by infection and inflammation (Tsilis, Vlastarakos, Chalkiadakis, Kotzampasakis, & Nikolopoulos, 2013).

The term otitis media will be used in this thesis as an overarching term for the multiple forms in which OM can present and is diagnosed; a brief outline of the commonest presentations (AOM, OME, COM) in the reviewed literature aims to orientate the reader to each particular diagnosis. Participants of this study had their child diagnosed with ‘glue ear’ by a general practitioner. Using a general term such as ‘glue ear’ suggests subtleties within each different presentation of OM.
Part One Chapter Two
Literature review

The aim of this literature review is threefold. Firstly, the reader will be orientated to different OM presentations, pathogenesis, and epidemiology, and introduced to an overview of the contemporary biomedical approach to treatment for OM. Secondly, literature pertaining to parenting an ill child with a focus on OM will be explored. Finally, an overview of osteopathy and the documented success of osteopathic treatment as an option for treatment of OM is presented. The final argument identifies osteopathy as a manual therapy with a small collection of evidence based research that has the potential to benefit a wider audience than it currently services.

Outline of different otitis media presentations

Acute otitis media

Viral upper respiratory tract infections often precede or coincide with episodes of AOM. Viral infections are now thought to play a fundamental role in AOM progression (Nokso-Koivisto, Marom, & Chonmaitree, 2015; Qureishi, Lee, Belfield, Birchall, & Daniel, 2014). It is thought that viral infection of the nasopharynx creates an environment that promotes bacterial colonization, adhesion to cells, and invasion of the middle ear. Bacteria common in upper respiratory tract infections are the same as those found in AOM effusion. Streptococcus pneumoniae, Haemophilus influenzae, Moraxella catarrhalis, Staphylococcus aureus, and Streptococcus pyogenes bacterial strains are thought to enter the middle ear cleft via the eustachian tube (Nokso-Koivisto et al., 2015; Qureishi et al., 2014). There is a variable incidence in the detection of these bacteria from effusions in AOM. Streptococcus pneumoniae and Haemophilus influenzae are the most commonly detected. Similar bacteria have also been cultured from fluid in OME (Qureishi et al., 2014).

Common pathogens associated with ear infections are also frequently observed as harmless residents of the upper respiratory tract forming, along with harmless bacteria, viruses, and fungi, an intricate ecological network. Changes occurring within these networks, or microbiomes, can be associated with ear infections (Wolk, 2016).

Upper respiratory tract infections can trigger a cascade of events that leads to mucosal congestion in the eustachian tube and nasopharynx preventing normal eustachian tube function. Nasopharyngeal pathogens can be drawn into the middle ear if mucosal congestion is sustained. The presence of these pathogens then stimulates inflammation and pus collection
within the middle ear, resulting in clinical symptoms of AOM. During this inflammatory period, the middle ear ossicles are less mobile and may be subject to resorption, an event which predisposes the child to permanent conductive hearing loss (Qureishi et al., 2014).

**Otitis media with effusion**

OME is a chronic inflammatory condition involving an inflammatory reaction with increased production of mucus. Increased mucous production overwhelms normal clearance of the middle ear, resulting in the accumulation of a thick mucous by-product, creating middle ear effusion. OME may occur as a consequence of slow resolution of an episode of AOM (Qureishi et al., 2014).

**Chronic otitis media**

COM can be divided into 2 main categories, active, when the ear demonstrates active inflammation, and purulent discharge, and inactive, when there is no otorrhoea, although this may happen at any time. There is a high correlation between COM and permanent perforation of the tympanic membrane. The inflammation associated with COM may not only affect the mucosa of the middle ear but also the ossicular chain; damage to the ossicular chain can have serious consequences on a child’s hearing. COM can be a sequel to AOM and OME (Tsilis et al., 2013).

**Pathogenesis of otitis media**

Multifactorial influences need to be considered in each presentation of OM. Eustachian tube dysfunction, environment and genetics can play contributing roles to the incidence of AOM, OME and COM (Daly et al., 2010; Lieberthal et al., 2013; Qureishi et al., 2014; Rovers, Schilder, Zielhuis, & Rosenfeld, 2004; Tsilis et al., 2013).

**Eustachian tube dysfunction**

The anatomy of the cranium involves a gradual process in its maturation from the embryological stage of development. Included in this anatomy are the Eustachian tubes which remain short, horizontal and prone to dysfunction until around the age of six or seven years, which is often the age of natural resolution of OM (Qureishi et al., 2014; Rovers et al., 2004).

**Environment**

Early child care education centres and overcrowded living conditions can contribute to a higher incidence of OM due to the increased chance of contracting upper respiratory tract infections (Bowie et al., 2014). Passive tobacco smoke inhalation is also related to increased
risk of OM (Daly et al., 2010; Rovers et al., 2004). Breastfeeding and the immunological benefits it provides can be associated with lowered incidence of OM (Daly et al., 2010).

**Genetics**
OM is a complex disease involving multiple genetic and environmental factors (Daly et al., 2010; Qureishi et al., 2014; Rovers et al., 2004). Large numbers of genes may be involved in complex diseases or traits, making these genes difficult to detect. OM varies in severity of symptoms, age of onset, recurrence and chronicity, which further adds to the difficulty of defining an appropriate phenotype and consequently to selecting the optimal population to study to retrieve genetic information. (Daly et al., 2010; Qureishi et al., 2014).

**Natural history of Otitis Media**
“Rational management of otitis media begins with a firm understanding of the natural history of untreated disease” (Rosenfeld & Kay, 2003, p. 1645). Both AOM and OME have favourable rates of spontaneous resolution (Daly et al., 2010; Rosenfeld & Kay, 2003). A child’s immune response and clearance of secretions through a patulous\(^1\) eustachian tube can be attributed to the spontaneous resolution of AOM. Persistent inflammation and mucosal oedema in middle ear effusion often hinders the complete clearance of middle ear effusion. Recurrent AOM resolution is more gradual and most likely a combination of immune maturation and eustachian tube growth. OME most likely owes its resolution to the maturation of the eustachian tube which encourages drainage and absorption of fluid combined with a gradual decrease local inflammatory response (Rosenfeld & Kay, 2003).

**Epidemiology**
Otitis media is universally cited as being the commonest reason for doctors’ visits, antibiotic prescription and surgery for children under the age of five years (Vergison et al., 2010). Epidemiological research shows continued high prevalence of OM especially in indigenous populations. This research is representative of a cross section of different countries and populations (Daly et al., 2010). Nevertheless it is reported that some countries show a declining trend in OM incidence (Daly et al., 2010).

The exact incidence of OM in New Zealand is not known (Gribben, Salkeld, Hoare, & Jones, 2012). An annual average of 7,157 children were hospitalised with OM in New Zealand between 2004 and 2008 (Bowie et al., 2014). Between 1 November 2008 and 31 October

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\(^1\) Refers to a physical disorder where by the eustachian tube stays intermittently open, when it is normally closed. A patulous eustachian tube causes the patient to experience autophony, the hearing of self-generated sounds
2009, data from 19 out of 21 New Zealand District Health Boards identifies 6261 consultations for AOM. Of these, 5225 related to new episodes of AOM (Gribben et al., 2012). Bowie et al (2014) report a higher number of OM hospitalisations of Māori populations than other New Zealand ethnicities. These authors assert this disparity in representation of Māori is associated with more overcrowded living and lower socioeconomic areas, than those of other ethnicities. McCallum, Craig, Whittaker, and Baxter (2014) also report high incidence of OM in Māori and Pacific Island children, and note inequalities in tympanostomy tube insertion between European children with higher rate of insertion under the age of four years, than their Māori and Pacific Island counterparts. Future research into these disparities is warranted.

Status quo biomedical treatment for otitis media

This section aims to orientate the reader to the current thinking of the biomedical community. Guidelines for biomedical treatment of OM have evolved. Antibiotics, over the last half century, have been first line of treatment and are still commonly prescribed. The evolution of watchful waiting as part of a treatment plan has been introduced as has the process of vaccination. Despite increasing antibiotic resistance, and the introduction of watchful waiting, antibiotics remain front line treatment for OM.

Acute otitis media

Standard medical treatment for AOM involves a three-tiered approach. Watchful waiting, antibiotics, and, in the event that recurrent episodes of AOM do not resolve, tympanostomy tubes are surgically inserted and adenoïdectomy is also sometimes performed. This is the treatment regime outlined by the Clinical Practice Guides issued by the American Academy of Paediatrics and American Academy of Family Physicians, The Diagnosis and Management of Acute Otitis Media (Lieberthal et al., 2013). While New Zealand does not have a national guideline for the treatment of OM the same pattern of treatment is recommended. In the absence of guidelines Salkeld (2012) published an article in the journal New Zealand Doctor that charts important aspects of clinical practice when treating OM and which correlates with the guidelines established by Lieberthal et al. (2013).

Watchful waiting, born out of the observation of the natural history of OM, involves a 72-hour period of observation of a child with AOM. If symptoms fail to resolve over this time period antibiotics are prescribed (Rosenfeld, 2001). Watchful waiting is sometimes neglected as an option for ‘treatment’ as clinicians often presume parents want antibiotics (Broides et al., 2016). Of 600 parents in Broides et al. (2016) study across four different primary care
settings in Israel, only 32% were willing to fully or partially accept the watchful waiting approach, with an increase in acceptance in parents with a higher education and in those who received prior explanations about this approach. Amongst physicians, Broides et al. (2016) claim that 38% reported that they never or almost never used the watchful waiting approach in children with AOM older than two years, that 39% of physicians used this approach rarely, that 17% used it often and that 6% used this approach most of the time. Therefore, there is an obvious need for significant changes in knowledge and attitude toward the watchful waiting approach in parents and physicians alike.

Symptomatic and/or analgesic relief is administered during the three-day watchful waiting period if necessary. Symptomatic relief can include warm compresses and decongestant nasal sprays (Levi, Brody, McKee-Cole, Pribitkin, & O’Reilly, 2013). The reason for waiting to prescribe antibiotics is to observe the natural resolution of AOM, reduce the use of antibiotics and in turn reduce antibiotic resistance (Rosenfeld, 2001).

Antibiotics are overly prescribed and often unsuccessful for the treatment of AOM (Venekamp, Sanders, Glasziou, Del Mar, & Rovers, 2013; Venekamp, Sanders, Glasziou, Del Mar, & Rovers, 2015). A systematic review of randomised controlled trials comparing antimicrobial drugs with placebo (13 trials with a total of 3401 children aged between 2 months and 15 years), and immediate antibiotic treatment with expectant observation, including delayed antibiotic prescribing (5 trials with a total of 1149 children), in children with AOM, reveals little utility in prescription of antibiotics for AOM in children over the age of two years (Venekamp et al., 2015).

In the United States AOM is the number one reason for the prescription of antibiotics with an estimated 15 million prescriptions written a year (Spiro et al., 2006). Antibiotic prescription for AOM has been associated with a near doubling of the risk of problems commonly associated with antibiotics (Del Mar, Glasziou, & Hayem, 1997; Venekamp et al., 2015) with as many as 1 in 14 children having some adverse effect such as rashes, vomiting and diarrhoea (Venekamp et al., 2015).

Over prescription of antibiotics raises the concern of increasing antibiotic resistance (World Health Organisation, 2014). The World Health Organisation (WHO) conducted a report into antibiotic resistance in April 2014. The outcome of the report was the following statement “Antibiotic resistance—when bacteria change so antibiotics no longer work in people who need them to treat infections—is now a major threat to public health.” (World Health Organisation, 2014).
Side-effects of antibiotics also play a role in the decision to prescribe.

Tympanostomy tubes, colloquially known as grommets, can be inserted into the ear of a child with recurrent AOM which is diagnosed by the occurrence of three or more new episodes of AOM in a six-month period (Lieberthal et al., 2013; Rovers et al., 2004). The purpose of the tympanostomy tube is to allow the eustachian tube to drain. The tube is implanted in the tympanic membrane allowing air to pass into the middle ear. Tympanic tubes generally fall out of the ear as the ear drum grows, usually after four to six months (Adil & Carr, 2014). Despite being a common operation, there is limited evidence for the effectiveness of tympanostomy tubes (Lous, Ryborg, & Thomsen, 2011).

Adding to surgical options for intervention of OM is adenoidectomy. Adenoidectomy is carried out either on its own or in conjunction with tympanostomy tube insertion. It is hypothesised that anatomical folds of the adenoids house pathogens associated with OM due to their close proximity to the eustachian tubes. Lieberthal et al. (2013) recommend that adenoidectomy alone should not be used for the prevention of AOM, however, some benefit may be observed when performed in conjunction with tympanostomy tube insertion.

**Otitis media with effusion**

OME is the most common cause of hearing loss in children (Robb & Williamson, 2012). OME treatment is preceded by a three-month watchful waiting period (Daniel et al., 2013; Robb & Williamson, 2012). The resolution of OME can be expected in 3 months in 63% of cases and 12 months in 88% of cases, as cited by Daniel et al. (2013). Failing resolution in a three month period and depending on hearing tests, children with bilateral OME are recommended tympanostomy tubes insertion (Robb & Williamson, 2012). This is occurs because speech development is more of a concern than temporary hearing loss (Robb & Williamson, 2012).

The United Kingdom National Institute of Clinical Excellence (NICE) guidelines for surgical intervention for OME recommends the three month watchful waiting period (Daniel et al., 2013). During this three-month period the child’s hearing is monitored for severity of hearing loss affecting speech development and behaviour. Daniel et al. (2013) retrospectively reviewed case notes of 319 children from 5 different hospitals, analysing practice in accordance with NICE guidelines in children having their first tympanostomy tube insertion. The review indicates that 87% of children have tympanostomy tubes inserted in accordance
with NICE guidelines. This figure includes exceptional cases as well, such as those with speech problems and frequent infection which may lie outside the three-month observational period. Therefore, only 32.2% of cases in the review fit with the core criteria set out by the guideline of audiograms three months apart. Daniel et al. (2013) argue that this suggests individualisation by clinicians of the protocol.

NICE guidelines do not include recommendations for adenoidectomy surgery. However, Boonacker et al. (2014) completed an individual patient data meta-analysis reviewing randomised controlled trials in children up to 12 years of age diagnosed with recurrent AOM and/or persistent OME in which adenoidectomy, with or without tympanostomy tubes, was compared with non-surgical treatment or tympanostomy alone. The meta-analysis found that adenoidectomy is most beneficial in children with persistent otitis media with effusion aged four years or younger. The authors note that consideration must be given to the balance between benefits and harms (Boonacker et al., 2014).

Chronic otitis media
The aim of treatment for COM is to achieve symptomatic relief, reduce otorrhoea, and if possible restore hearing (Tsilis et al., 2013). To achieve these outcomes, the goal of creating a dry ear of the child is paramount. Quinolones in the form of ear drops without steroids and if necessary antibiotic ear drops are administered in preference to oral antibiotics (Tsilis et al., 2013). If symptoms persist or complications such as cholesteatoma arise, then surgical options are discussed. These options range from the insertion of tympanostomy tubes to clearing the middle ear to the removal of abnormal skin growth (Tsilis et al., 2013).

Vaccine
Measuring vaccine effectiveness for OM is complicated due to the multifactorial pathogen profile, multifactorial risk factors, variability of diagnosis and the vast spectrum of OM (Best et al., 2016). A Cochrane review of 11 randomised controlled trials indicates modest benefits of the pneumococcal vaccine PCV7 on healthy infants with a low risk of AOM. Administering PCV7 in high risk infants appears to have no benefit in preventing further episodes of AOM (Fortanier et al., 2014). Research of a New Zealand cohort by Best et al. (2016), of middle ear effusion following the introduction of the ten valent pneumococcal vaccine (PHiD-CV10) conducted in two phases, adds to the findings of the Cochrane review by Fortanier et al (2014). The two-phase approach tests samples of middle ear effusion from children vaccinated with PCV7 in 2011 (n = 325 otitis prone children) and middle ear effusion from children vaccinated with PHiD-CV10 in 2014 (n = 319 otitis prone children)
and concludes that the introduction of PHiD-CV10 has no effect of the microbiology of children with middle ear effusion who received tympanostomy tubes in New Zealand (Best et al., 2016).

While Best et al. (2016) found no significant impact of either PCV7 or PHiD-CV10 vaccine in children with middle ear effusion, they acknowledge a study in a children’s hospital in Iceland that has reported a reduction in AOM cases with the introduction of PHiD-CV10. This study indicates the potential of vaccines to have an impact on the incidence of OM. Continued research and developments of vaccines may lead to a solution that targets the multifactorial pathogen profile of OM.

Otitis media is a common but complex childhood illness. The multifactorial pathogen profile and complex multifactorial risk factors make OM a difficult illness to treat. Treatment of OM in the biomedical setting is successful for a proportion of OM suffers. However, these treatments, antibiotics and tympanostomy tubes being the mainstay, are not without complication or side effects. Continued research and development of treatment options, including vaccine, may in time see a reversal in the current trends of OM.

**Parenting a child with otitis media**

There is not a large pool of research into parenting a child with OM. The majority of the research available is quantitative. There is utility in information such as number of days missed from work due to caring for a child with OM which highlights the financial and social burden of OM. However, lack of qualitative research that explores the lived experience of parenting a child with OM does little to acknowledge the emotional impact this chronic illness has on child, caregiver and family as a unit. This section will discuss both quantitative and qualitative research on parenting a child with OM.

**Qualitative Research**

Two qualitative studies have been sourced. Kendall & Ingils (1993), both registered nurses, explored the experience of parenting a child with glue ear in the context of a New Zealand setting. Wuest & Stern (1990) both nursing academics, used a grounded theory approach to investigate the impact of relationships with a health care provider for children with OME. Using a phenomenological approach Kendall and Ingils (1993) interviewed 10 randomly chosen families whose child had been diagnosed with glue ear by an Ear, Nose and Throat specialist in New Zealand. Five clusters of themes emerged from the data collected by way of individual interviews with parents of each family; Characteristics, Guilt/Blame/Confidence,
Knowledge and Understanding, Support/Coping, Caring. Discussion of these themes is focused largely around the experience of interacting with health professionals, with the key point identified, “a caring attitude by any health professional involved was noted and valued by parents” (Kendall & Inglis, 1993, p. 32). One hypothesis introduced, but not explored in the research is the fact OM is not necessarily considered a chronic illness as it does not pose life threatening consequences. However, OM does impact on the child and the family who care for the child and accommodate the symptoms of OM. The conclusion of this study indicates the need for shared decision making between parents and healthcare professionals. The concept of shared decision making will be introduced in the next section. This study is limited by its lack of explanation of the phenomenological theory and expansion of ideas regarding the five clusters of themes, while its strengths lie in the fact that it appears to be the only study of its kind that is set in a New Zealand context, making it a valuable resource in the context of the New Zealand health care system.

Parenting a child with otitis media as a chronic illness can influence the lives of the family unit and creates a long standing relationship with the family’s chosen health care provider (Nuutila & Salanterä, 2006). A grounded theory study by Wuest and Stern (1990) examines the relationships of caregivers of children with OME and healthcare professionals within the setting of the Canadian health service. Thirty individuals, representing 12 families, were interviewed about their experience of OME. Learning to manage was the core theme that emerged from the data analysis process. Influencing how a family ‘learns to manage’ are three variables: their relationship with the health care system, effects of the disease process on the child, and the degree of disruption on family life. Arguing a similar conclusion to that provided by Kendall and Inglis (1993), the relationship between the family and the health care provider, has a profound effect on the management of disease (Wuest & Stern, 1990). This conclusion further indicates the necessity for comprehensive shared decision making. Strengths of this study include the comprehensive discussion of each of the three variables that contribute the theme of learning to manage when dealing with a child in the health care system who is being treated for OME. A limitation of this study is the absence of explanation as to who the 30 individuals representing 12 families are. The reader is left unsure whose voice is being represented.

The necessity for shared decision making is highlighted in both these qualitative studies. Empowering parents through shared decision making could reduce uncertainty around
treatment and disease outcomes which could have a positive effect on the emotional impact of parenting a child with OM.

Quantitative research

Quality of life surveys of caregivers of children with OM have added to the body of research regarding parenting a child with OM (Barber, Ille, Vergison, & Coates, 2014; Dubé, De Wals, & Ouakki, 2010; Greenberg et al., 2003; Heidemann et al., 2014; Holl et al., 2015). Collectively these quantitative studies recognise the impact OM has on the family unit expressly focusing on caregiver quality of life, and in some cases the child.

Barber et al. (2014) conducted online surveys in populations across 12 countries. Two populations were surveyed, an AOM experienced group (n = 1438) and a non AOM experienced group (n = 1429). The objective of the research was to investigate parental attitudes and awareness of AOM and its associated burden. Dubé et al. (2010) undertook 502 telephone questionnaires in the Canadian provinces. Of respondents, 32% had a child with at least one episode of AOM in the last 12 months and the severity of the disease and its consequences on quality of life of both child and caregiver were investigated. Greenberg et al. (2003) interviewed parents of children with AOM regarding the week preceding the AOM diagnosis and every 3 days henceforth for an additional 21 days. The interview included information on loss of workdays, use of health care services and impact on the patient’s (n = 150) and family’s quality of life. A control group (n = 51) were interviewed in an identical manner. While the number of patients in this study is stated, it is not clear how many parents participated. Heidemann et al. (2014) employed the disease-specific Caregiver Impact Questionnaire to assess caregiver quality of life in relation to child otitis media. Caregivers were enrolled from private Ear-Nose-Throat clinics in southern Denmark (n = 435). This study speaks more to the efficacy of the questionnaire than the information collected from it. Finally, Holl et al. (2015) utilised an AOM-specific parental quality of life questionnaire across 5 European countries including 73 medical practices where a large participant base of parents of 852 children filled out the questionnaire.

High participant numbers and inclusion of different demographics from a geographical perspective, adds strength to these studies. Key findings of these research projects includes the increase in days off work for the caregiver to care for their child, lack of sleep of both caregiver and child, disruption of day-to-day routine of the household and emotional stress as
primary markers that impact on the quality of life of a caregiver of a child with OM. The severity of the impact on activities of daily living and the emotional toll of OM are directly related to the severity of the OM presentation (Brouwer et al., 2005; Holl et al., 2015). Furthermore, the impact of OM has ramifications not only for the family unit but also places a burden on the resources of the public health care service and the work force. The social burden of OM needs to be considered in terms of the toll on the health system and work force, with parents having to take days off work to care for their ill child (Mahadevan et al., 2012). Barber et al. (2014) acknowledge this social burden.

The major drawback of this body of quantitative research is that while it identifies reduced quality of life for a caregiver associated with having a child with OM, it fails to explore what exactly this means for caregivers. It addresses only part of the experience due to the limitations of the tools used to conduct the studies.

**Parenting an ill child**

Caring for an ill child is an emotionally charged and challenging time in a parent’s life. To best serve the child in a health care setting, health professionals need to understand and action the understanding, of the needs of the parent who is making the decision regarding their child’s care.

**Acknowledging the parent’s needs**

Individual parents will have individual needs that need to be taken into consideration during the consultation process regarding their child’s illness. Recent research asserts the idea that “Medical decisions are a prime example of complex decisions that confront individuals in our society” (Ritchie, Chorney, & Hong, 2016, p. 116). These authors hypothesize that “parents who were experiencing decisional conflict may have had more negative emotional experiences during the surgical consultation, and also have lower self-reports of their own autonomy, sense of relatedness, and competence (Ritchie et al., 2016, p. 115)”.

The identification of these three factors, autonomy, relatedness and competence, provides a health care practitioner a starting platform for acknowledging parental needs during their child’s illness journey.

In a qualitative study, Jackson et al. (2008) engaged ten participants from South Yorkshire, United Kingdom, in three focus groups and one in-depth interview. They deduct that sharing knowledge from health professionals to parents will encourage the child and family to participate in the process of decision making and treatment. A key theme to emerge from this
research is the practitioner/family relationship. The authors go on to note “The relationship between the parent/child and the professional has a significant psychosocial impact on the experience of care and information delivery. Parents emphasized the importance of developing a good rapport and communication with professionals.” (R. Jackson et al., 2008, p. 34). The study concludes with a set of implications for practice, and personalisation of interaction with health professionals embodies these key implications for practice. One-to-one consultations, continuity of liaison person, good communication channels, consideration of impact of psychosocial experience of the parent and specialist nursing support are the imperative aspects to be considered in the keys for implications for practice. The data collected in this research are representative of a 90% female participant set. It is not known whether this number represented accurately the primary caregivers in the population studied.

A systematic review of 149 studies across various child health decisions, settings and study designs was conducted by the School of Healthcare at the University of Leeds by C. Jackson, Cheater & Reid (2008). The objective of the research was “to identify the decision support needs of parents attempting to make an informed health decision on behalf of a child” (Jackson, Cheater, & Reid, 2008, p. 232). From the process of thematic analysis of the 149 studies, three overarching themes emerged with eight descriptive categories that reflect a caregivers perspective on their decision making and support needs: “(1) need for information (including suggestions about the content, delivery, source, timing); (2) talking to others (including concerns about pressure from others); and (3) feeling a sense of control over the process that could be influenced by emotionally charged decisions, the consultation process, and structural or service barriers” (C. Jackson et al., 2008, p. 232). The authors suggest the three over-arching themes identified are often inadequately addressed by health service providers, citing similar recent systematic reviews arriving at similar conclusions. Adding to the validity of C. Jackson et al. (2008) study is the global representation of research from which they draw.

The conclusions of both the studies reviewed here highlight the hypothesis arrived at by Ritchie et al. (2016): parents need positive shared decision making experience to feel a sense of autonomy, relatedness, and competence in relation to their child’s illness.

**Shared Decision Making**

Shared decision making is a key element in the consultation for a child with OM. Decisions have to be made by a caregiver regarding repeated antibiotic use and potential surgery for a child within the framework of a biomedical health care setting. Having established the
importance of shared decision making between caregivers of an ill child and healthcare professionals, the literature reviewed here seeks to understand what that might mean.

The WHO considers “autonomy with respect to a person’s participation in choices about their own health” (Kerssens, Groenewegen, Sixma, Boerma, & van der Eijk, 2004) as an important aspect of an individual’s health care. “Participation in choices” suggests a collaborative approach, and this can be seen to be applied to the following characteristics that shape the basis of a framework for shared decision-making “(1) that at least two participants—physician and patient be involved; (2) that both parties share information; (3) that both parties take steps to build a consensus about the preferred treatment; and (4) that an agreement is reached on the treatment to implement” (Charles, Gafni, & Whelan, 1997, p. 681). An updated review of the Charles et al. (1997) model of shared decision making, concludes the original framework of core characteristics of shared decision making are still applicable. However, the decisions faced by patients are not limited to simple treatment decisions. The role of a primary health care provider may also include encouraging the patient to seek out medical or technical information (Murray, Charles, & Gafni, 2006).

Expanding on the concept put forth by Murray et al. (2006), that health professionals should encourage active participation in their health care are key learnings from Cabral, Horwood, Hay and Lucas (2014). These authors suggest clinicians take a more biopsychosocial view of caregiver communications to avoid misunderstandings about the caregivers’ expectation. Conducting a systematic review of 13 qualitative research papers, Carbral et al. (2014) summarise the need for improved clinician communication, when parents are faced with a decision regarding antibiotic prescription. Parents who are communicating concern, the need for information and an attempt to understand their child’s presentation, can often be misinterpreted by a clinician as requesting antibiotics for a child who has an acute illness.

Decisional conflict, often accompanied by emotional distress and the possibility of delayed decision making, is experienced amongst parents who need to make a decision regarding surgical intervention in their child’s condition. Chorney et al. (2015) hypothesise that the process of shared decision making can reduce the incidence of decisional conflict. Sixty-five caregivers, whose children were enrolled for elective otolaryngological procedures, completed the Shared Decision Making Questionnaire and the Decisional Conflict Scale. On the decisional conflict scale a 16-item measure assessing parent uncertainty regarding a decision, 16.9% of participants scored highly. The decisional conflict scale rates 0.94 on the Cronbach’s alpha, indicating excellent reliability of the method. Parents who felt more involved
in the decision making process regarding their child’s surgery reported lower levels of decisional conflict (Chorney et al., 2015).

Furthermore, investigation by a group of researchers from the Chorney et al. (2015) study identifies a lack of connection between observed behaviours and perceptions of shared decision making between parents and clinicians. Hong et al. (2016) video-recorded otolaryngological consultations of 126 participants whose children were candidates for tympanostomy tube insertion or adenoid removal. Prior to recording, caregivers completed Shared Decision Making Questionnaire Patient Version, and surgeons completed the clinician equivalent. Results from the questionnaires revealed caregiver and surgeon were positively correlated. However, from their observations of video footage, Hong et al. (2016) recommend clinicians should not always assume that high levels of interaction with a parent correlates with the parent experiencing successful shared decision making.

The research reviewed in this section confirms the importance of shared decision making between a health professional and caregiver pertaining to treatment of a child. The practice of shared decision making could reduce decisional conflict and stress associated with caring for an ill child, reiterating the necessity of positive shared decision making experience so the caregiver can feel a sense of autonomy, relatedness, and competence in relation to their child’s illness Ritchie et al. (2016).

**Information seeking**

In this age of easily accessible information parents have ready access to a plethora of literature surrounding their child’s medical condition. Neill et al. (2015), observes that caregivers’ information seeking is dominated by the Internet. Data collected from 27 parents, using focus groups, were analysed using the compare and contrast analysis technique by a research group from the University of Northampton, United Kingdom. The study was comprised predominately of mothers (n = 24) and included participants of several ethnicities. Risk of information overload of often inconsistent information can increase anxiety in relation to a child’s health status. A combination of the consumption of time involved and the absence of clearly identifiable reliable resources, can further add to the anxiety increase.

Regarding the use of Internet for their child’s illness, Pehora et al. (2015) surveyed 146 parents who had children undergoing surgery in a tertiary care facility in Toronto, Canada. The researchers aim was to gather “…information on current patterns of Internet use by parents searching for information on their child’s health, types of devices used to access
information, perceived reliability of websites and cross-corraboration of information, and future uses of the internet for child’s health information” (Pehora et al., 2015, p. n.p). Data from their study shows 80% of participants used public search engines to retrieve information regarding their child’s illness. Of these 80%, only 24% perceived the information from public search engines as safe and reliable. Almost half of the participants reported cross-checking the information found on the Internet with their health care professional. To conclude their research, the authors reiterate the need for health care professionals to advise of safe, reliable sources for Internet based research. Caregivers who did not speak English were excluded from this study. Further investigation in how different cultures interact with the internet would give a more balanced view of this issue.

Information based on research is constantly changing regarding medical conditions, therefore, there are risks in relying only on the internet as a resource for the most current advice on a medical condition. The flood of information easily found on the Internet could lead to confusion and frustration in parents who are already distressed (Balgowan, Greer, & D'Auria, 2016).

**Emotional impact of parenting an ill child**

The primary responsibility for health care management of a child usually rests with the caregiver and, as a result, the caregiver can find themselves experiencing increased stress directly related to caring for their ill child (Morawska, Calam, & Fraser, 2015). Previously identified in the literature, is the co-relation between the severity of the child’s illness and its direct relation to the severity of increased caregiver stress (Brouwer et al., 2005; Morawska et al., 2015).

A meta-analysis by Coffey (2006) sourced 11 studies and examined the phenomena of parenting a child with a chronic illness from the parents’ point of view. Seven themes emerged as a result of synthesising data from the 11 qualitative studies. Several of these themes elucidate the emotional experience of parenting a child with a chronic illness: living worried, staying in the struggle, carrying the burden and survival as a family. Rich data extracted from the studies builds the foundations of these themes that examine the feelings of guilt, anxiety, frustration and stress related to parenting an ill child. The studies reviewed by Coffey (2006) included both mother and father as part of the inclusion criteria. As previously observed, there is a dominance of female participants in some of the studies reviewed. Considering the point of view of both mother and father provides a more comprehensive parental point of view.
Cousino and Hazen (2013) corroborate the findings of Coffey (2006). Their meta-analysis of 13 studies and qualitative analysis of 96 studies finds “caregivers of children with chronic illness reported significantly greater general parenting stress than caregivers of healthy children” (Cousino & Hazen, 2013, p. 809). Employing a mixed methods approach to a substantial number of studies, Cousino and Hazen (2013) offer a comprehensive analysis of literature corresponding to the stress of parenting a chronically ill child.

This section of the literature review has focused on largely negative elements of caring for an ill child. While parenting a child with a chronic illness can result in increased stress and emotional strain on the parenting role, it is important to acknowledge some parents are able to add meaning to their lives through parenting their ill child (Kepreotes, Keatinge, & Stone, 2010).
Osteopathy and otitis media

Osteopathic Research

There is a paucity of literature referring to Osteopathic treatment of OM. Three studies were sourced that involve the treatment of AOM using osteopathic techniques. The most recent of these was published in the Journal of the American Osteopathic Association in June 2014. The study was designed to evaluate the efficacy of an osteopathic manipulative protocol on middle ear effusion following an episode of AOM (Steele, Carreiro, Haug, Conte, & Ridpath, 2014). The processes used by Steele et al. (2014) to execute their study are well thought out and implemented. Using a control group that received only standard medical care (n = 24) and a group who received standard medical care plus manual osteopathic treatment (n = 26) the researchers’ objective was to measure the efficacy of osteopathic manual treatment protocol on middle ear effusion following an episode of AOM. Analysis of the ear exhibiting middle ear suffusion was carried out by tympanogram analysis (testing rate of vibration of tympanic membrane at different pressures) and acoustic reflectometer (testing the ability of the tympanic membrane to reflect sound) after each osteopathic treatment. Overall, results demonstrated that children who were treated with the protocol of osteopathic manual therapy established for this study, showed significant improvement in the rate of resolution of middle ear effusion compared with children who received standard medical care alone. Future research with larger participant numbers and inclusion of a sham group would strengthen these results.

Comparatively the other two studies of osteopathic treatment of AOM are less comprehensive than that of Steele et al. (2014). One has very small participant numbers (n = 8) (Degenhardt & Kuchera, 2006). This study is a pilot, and small sample sizes can be acceptable in this instance, however, descriptions of methodology are lacking as is a control group. The second osteopathic study (Mills, Henley, Barnes, Carreiro, & Degenhardt, 2003), while having significantly higher participant numbers than previous studies (n = 57), lacks a full rounded report in that it does not provide treatment explanations. However, these two studies provide a platform from which Steele et al. (2014) can set their work.

All three osteopathic studies arrive at similar conclusions; osteopathic treatment can be beneficial for patients suffering from recurrent OM. The limited body of quality evidence to support the use of osteopathic treatment for the benefit of OM is recognised by chiropractic researchers Pohlman and Holton-Brown (2012). These authors suggest more rigorous
research is needed to inform both practitioners and patients of a clear picture of osteopathy (and chiropractic) treatment for OM.

**Osteopathic Treatment**

Osteopathy recognises the body as a unit and interprets an interrelatedness of function and structure of the body. Combining an understanding of the science grounding osteopathy, with skilled application of osteopathic technique, the osteopathic practitioner intends to facilitate the body’s natural healing process. Osteopathic treatment for children with OM is aimed at facilitating optimal functioning of the structural anatomy (cranial base and eustachian tube), improvement of middle ear drainage by increasing venous circulation and lymphatic drainage, reduction of compression of the neuropathies that may affect functioning of the oropharynx and upper gastrointestinal system, as well as acknowledging external stresses and environments that may be contributing to the presentation (Chila & American Osteopathic Association, 2010).

Literature explaining the physiology behind osteopathic techniques and the associated efficacy of these techniques osteopaths find beneficial in treating OM is scarce. The treatment protocol established by Steele et al. (2014) provides a brief outline of how to perform each of the ten techniques but does not extend into the research field of the specific benefits or efficacy of these techniques. Discussion of one particular technique, the Galbreath technique for draining the eustachian tube in OM is discussed by Pratt-Harrington (2000). While the discussion of the technique offers a comprehensive guide to executing it, consideration regarding the pathological process that the patient undergoes as a result of performing the Galbreath technique is lacking.

**Complementary and alternative medicine**

Osteopathy is one of a number of healthcare modalities to offer treatment for OM. Others include traditional Chinese medicine, naturopathy and homeopathy. Levi et al. (2013) review research into some complementary and alternative medicine (CAM), including osteopathy, for the treatment of OM. While the authors of this research do not dismiss CAM as a possible adjunct or alternative care for OM, they reiterate the importance of consulting a physician when making treatment decisions for full guidance on the risks and benefits of any treatment option.
Summary

This literature review outlines contemporary biomedical treatments for otitis media, the parental experience of caring for an ill child with a focus on OM, and the osteopathic research regarding treatment of child with OM. An abundance of research is available for the first two sections that examine the status quo treatment of OM in a biomedical setting and parenting an ill child. However, insufficient research is available regarding osteopathy and OM to give a definitive endorsement of its benefits and efficacy.

There is evidence to suggest a paradigm shift in how treatment for OM is approached. Increasing antibiotic resistance and the reluctance to follow guidelines that could reduce antibiotic prescription for OM. Tympanostomy tubes, successful for some patients, fail to offer reprieve for all OM patients and adds the stress of surgery, in many cases repeated, to the child’s illness narrative. Osteopathy can offer an alternative or adjunct approach to biomedical treatment of OM.

Shared decision making dominates the interaction between caregiver and health professional. The importance of successful shared decision making, that can aid in diffusing decisional conflict and reduce the stress of parenting an ill child, is paramount to ensuring the best possible outcome for the child.
Part One Chapter Three
Methodology and Methods

Methodology
This chapter examines both the methodology and the methods employed to research the phenomenon of the caregivers lived experience of having a child with OM treated with osteopathy.

Qualitative research
Qualitative research has been chosen for this research as it seeks to explore lived experiences and social phenomena. Research indicates there is only a small body of qualitative research in the experience of parenting a child with OM, and none regarding the treatment of osteopathy for a child with OM. Qualitative research in the osteopathic field adds a depth to research that is perhaps untouched by quantitative research, making both research approaches necessary to assist the profession by creating an understanding of “the multidimensional and complex nature of osteopathy” (Thomson, Petty, Ramage, & Moore, 2011, p. 124). Exploring the qualitative nature of the lived experience of the phenomenon of osteopathy for OM will add to the body of osteopathic research already conducted concerning the efficacy of osteopathy for OM. The nature of this explorative research lends itself self to a qualitative research model. It gives the researcher the ability to explore the experience of the caregiver of a child with OM and their experience of osteopathic treatment for OM.

There are different methodologies within the qualitative research framework. Grounded theory, ethnography, discourse analysis, hermeneutic phenomenology, and interpretive description are amongst the methodologies that were considered at the beginning of this research design. Grounded theory is the study of social processes. While there are social processes discussed within the data, they are not the focus of this research. Ethnography explores cultural influences, social organization and local perspectives. The current study interviewed people from the central Auckland area, but this has no bearing on the outcome of the research as children experiencing OM are located in all geographical regions of New Zealand. Discourse analysis emphasizes the importance of language and communication (Thomson, Petty, & Moore, 2014) and was therefore not appropriate for this research. Hermeneutic phenomenological approach considers the lived experience (Van Manen, 1990).
Lived experience seeks to explain first-hand experiences of an individual or group of people who have had similar experiences. Van Manen (1990) borrows from Dilthey (1985) that lived experience in its “most basic form involves our immediate, pre-reflective consciousness of life: a reflexive or self-given awareness which is, as awareness, unaware of itself” (Van Manen, 1990, p. 35). While lived experience was considered, its focus is not on clinical relevance, which is important for a health professional.

**Interpretative description**

The aim of interpretive description, a relatively new qualitative methodology, is to generate knowledge relevant for the clinical context of applied health disciplines (Hunt, 2009). Developed by Thorne, Kirkham, and MacDonald-Emes (1997), interpretive description fills the void in nursing research with a qualitative method that focuses on developing knowledge that will inform clinical practice (Hunt, 2009). Borrowing from “…aspects of grounded theory, naturalistic inquiry, and ethnography, drawing on values associated with phenomenological approaches inherent in the methods of data collection” (Thorne, Kirkham, & O'Flynn-Magee, 2004, p. 6) sets the design basis of interpretative description.

Thorne et al. (2004) suggest the product of an interpretive description research project should have a sense of practical application. It is hoped a clinician would utilise the findings which “…provide a backdrop for assessment, planning and interventional strategies... Thus, the intended products of interpretive description would constitute not a new truth, but a sort of ‘tentative truth claim’ about what is common within a clinical phenomenon” (Thorne et al., 2004, p. 7). ‘What is common within a clinical phenomenon’ is the key to extracting an understanding from a study that is beneficial not only to the osteopathic profession but ideally across the health care sector as it is often the multidisciplinary approach that will most benefit a patient.

Ensuring an evaluation criteria is in place to address the issue of rigor is essential in enhancing the credibility of an interpretative description study (Thorne et al., 2004). This research underwent an extensive evaluation criterion, following Thorne’s (2008) processes which are addressed in the methods section of this chapter. Theoretical scaffolding according to Thorne (2008) is the initial set up of an interpretive description study involving two key components. Firstly, the literature review, that orientates the researcher deep within the knowledge base of their research. Secondly, the researcher needs to understand the ‘positioning of self’ in the research. The positioning of self in the data Thorne (2008) refers to as ‘theoretical baggage’, acknowledging initial preconceptions and bias that may influence
the data. Theoretical baggage for this research is addressed in the ‘contextual awareness’ section of the methods section.

“Interpretive description offers the qualitative health researcher an opportunity to work outside of the disciplinary confines of the more traditional methodological approaches and create a design logic that is consistent with the aims of an investigation of clinical health and illness phenomena” (Thorne et al., 2004, p. 18). This makes the interpretive description research model the most appropriate for researching the phenomena of experiencing osteopathy for a child with OM. The participants of this thesis bring a narrative that is rich with experience for the researcher to respect and interpret. It is hoped the interpretation of the data collected holds true to the narratives of the participants and that this research will have some clinical utility for not only the osteopathic profession, but the wider health care community. The endeavour of upholding the values of the methodology of interpretive description in this thesis is examined in the ‘addressing rigor in qualitative research’ section, further on in the chapter.

**Methods**

**Participants and participant recruitment**

Six caregivers, all mothers of children aged 3 months to 11 years, who had previously or currently experienced OM, who received osteopathic treatment for their symptoms were recruited for this lived experience research. The six participants were recruited via word of mouth and recruitment posters (Appendix B) placed in osteopathic and allied health clinics in the greater Auckland area.

**Inclusion and exclusion criteria**

**Inclusion Criteria:**

The child must have had an episode of otitis media in the last 36 months of which one mode of treatment was osteopathic treatment. A minimum of two osteopathic treatments must have been completed as this number of treatments is the suggested minimum number by credible professionals in the osteopathic field.

The caregiver must have attended the osteopathic treatments with the child concerned.

**Exclusion Criteria:**

A caregiver who had not been present during osteopathic treatment would have been excluded in order to ensure the data gathered would be first-hand knowledge and experience of the osteopathic treatment process.
**Ethics**

Ethical approval for this research was applied for through the institutional Research Ethics Committee. Ethical principles that were to be observed include; privacy (anonymity); self-determination (informed consent); safety (respect of their story); truth (presenting their narrative correctly); prevention of harm (final product written to avoid identification). Ethics were approved for this study on 2/9/15 to be undertaken between 2/9/15 and 2/9/16. Approval number 2015-1054 (Appendix C).

**Participant Protection**

Potential participants received an information sheet outlining the study upon showing interest in participating (Appendix D). Informed consent was sought from each participant at the commencement of each interview (Appendix E, Ea, Eb).

All material pertaining to data collection process including audio recordings of interviews, transcripts, and email communication have been stored in a password protected computer. Hard copy documents have been kept separately and held in locked filing cabinets. Consent forms are held in a locked filing cabinet at the institution. All documentation will be kept for five years following completion of the study in accordance with the regulations of the Unitec Institute of Technology, after which time they will be destroyed.

**Data collection**

Six participants were interviewed using a semi-structured interview process to allow each participant’s unique narrative to emerge throughout the process. An interview guide was supplied to participants (Appendix F). To explore the phenomena of lived experience, interviews were the most appropriate platform, allowing the researcher a data base of a subjective nature specific to the lived experience of experiencing osteopathy for a child’s OM (Thorne, 2008).

Interviews between the researcher and the participant were audio recorded at a location of the participant’s choice allowing the process to be as convenient as possible for the participant (Tracy, 2012). During semi-structured interviews participants retold their experience of parenting a child with OM, with a focus on osteopathic treatment. Semi-structured interviews “stimulates discussion” (Tracy, 2012, p. 139) which allows the participant’s narrative to emerge without the restriction of specific questioning. Interviews reached a natural conclusion once the participant felt they had expressed all they needed to.
The interviews ranged from 25 minutes to 50 minutes and were transcribed by an independent transcription service. During the transcription process the data were protected by the scribe.com confidentiality agreement (Appendix J).

**Data analysis**

**Thematic analysis**

The process of thematic analysis was employed as one of the methods of addressing the data. “Thematic analysis is a method for identifying, analysing, and reporting patterns (themes) within data. It minimally organises and describes your data set in (rich) detail” (Braun & Clarke, 2006, p. 6). Thematic analysis is considered a “foundational method for qualitative analysis” (Braun & Clarke, 2006, p. 4), deeming it an appropriate analytical method for the novice researcher.

The process of thematic analysis begins when the researcher notices patterns and points of interest in the data, which may start as early as the data collection phase (Braun & Clarke, 2006). Thorne et al (2004) warn that while the interpretive research data collection and analysis processes interact and inform in an iterative manner, the researcher should be sceptical of “immediately apparent” themes.

Thematic analysis can be executed under either an inductive or theoretical framework and an inductive process was chosen for this research. An inductive approach involves the “process of coding the data without trying to fit it into a pre-existing coding frame, or the researcher’s analytic preconceptions” (Braun & Clarke, 2006, p. 12); making the analysis data driven and the themes that emerge strongly linked to the data, as suggested by Braun and Clarke (2006). Inductive thematic analysis resonates within the framework of interpretative description research methodology. “Using inductive analytic approaches characteristic of interpretive description, researchers seek understandings of clinical phenomena that illuminate their characteristics, patterns, and structure in some theoretically useful manner” (Thorne et al., 2004, p. 6).

**Analytic Process**

Immediately after each of the six interviews a reflective audio recording was made regarding thoughts on the interview process, how improvements could be made for future interviews and noting any specific points of interest that stood out. Within a week of each interview taking place, the audio recording was listened to and initial thoughts and ideas were recorded in a reflective journal. Writing is an integral part of analysis and therefore should begin in the early phase and continue throughout the analysis process, argue Braun and Clarke (2006). By
repeated immersion in the data at an early stage, the researcher is able to begin synthesizing, theorizing and re-contextualizing the data (Morse, 1994). When all interviews were complete, all audio recordings were sent to transcription service. While transcribing was taking place the audio recordings were listened to again and the process of mind mapping and the process of pattern recognition began (Boyatzis, 1998) (Appendix G). Literature around the topic was not engaged with during this period as inductive analysis is enriched by refraining from engaging with literature in the early stages of analysis (Braun & Clarke, 2006).

Once transcripts were returned they were individually anonymised and returned to each participant. During the anonymising of transcripts mind maps and reflective journals were reviewed and evolved as a deeper understanding of the data began to emerge. This was the beginning of the process of forming codes. Each participant had a two-week period to make any changes to their transcript and withdraw from the study.

Five codes were established to identify common threads that ran through each set of data (Appendix H). Each code was assigned a colour and the anonymised transcripts were compiled into one document for ease of working across one rather than five documents (Braun & Clarke, 2006). Once the initial coding was complete, each code was extracted from the transcript into a standalone document. A process of mind mapping and reflexive conversations with supervisors and peers ensued, referencing the data in the code sets. Initial themes emerged from this process.

**Interpreting the data**

Moving past the initially generated themes proved a challenging task, although the analytic process stayed true to the epistemology of the interpretative description methodology. By asking the question of the data “what is happening here?” and “what am I learning about this?” (Thorne, Kirkham, & MacDonald-Emes, 1997, p. 174), revisiting the audio recorded interviews and original transcripts, and aided by reflective journaling, a deeper comprehension of the data began to form. This iterative process of returning to the original data source enabled patterns and themes within the data to be ordered into a narrative where the researcher was able to make sense of key ideas and review their meaning from a different stance (Thorne et al., 2004). The iterative process keeps the researcher close to the data, ensuring a constant engagement with the participants’ experiences and confirming the emerging ideas maintain true to the data.
As a parallel process to iterative actions unfolding, the original literature that was the basis for the research was reviewed. Reading Steele et al.’s (2014) quantitative study reinvigorated the research process and provided the motivation to add depth to this under-researched area with a lived experience study that provides clinical utility (Thorne, 2008). Themes were re-engaged with and gradually produced a rich understanding of the lived experience of osteopathy and OM, strongly reflecting the caregivers’ experience.

This process was also guided by the supervision of experts in the field of interpretive description. Supervisors provided a platform that challenged the researcher to seek a depth within the data to produce themes rich with clinical relevance.

**Addressing rigor in qualitative research**

“Rigor, in qualitative terms, and reliability/validity, in quantitative terms, are ways to establish trust or confidence in the findings or results of a research study” (Thomas & Magilvy, 2011, p. 151). To maintain the integrity of qualitative research, it is essential the researcher employs methods throughout the research journey that ensure the trustworthiness of the findings for their particular project, rather than having rigor assessed by external examiners (Morse, Barrett, Mayan, Olson, & Spiers, 2002). Lincoln and Guba (1985) were the first to address the concept of rigor in qualitative research with their model of trustworthiness of qualitative research (Thomas & Magilvy, 2011); Credibility, transferability, dependability and confirmability form the basis of the trustworthiness model. Thorne (2008) further develops the concept of rigour to resonate within the frame work of the qualitative research methodology of interpretative description. Thorne’s (2008) evaluation criteria for rigor were consulted during this research project.

**Epistemological integrity**

All qualitative research should demonstrate “epistemological integrity in the sense that there is a defensible line of reasoning from the assumptions made about the nature of knowledge through to the methodological rules by which decisions about the research process are explained” (Thorne, 2008, pp. 223-224). A clear and logical connection between the question posed by this research, and the application of the methodology has been demonstrated. The connections are present in the data collection, the management of the data, the processes of reflection and the findings.
Representative credibility
Throughout this research project, findings from the data were shared with supervisors and peers creating a platform of reflection from a triangulation of data sources. This process enables the researcher move past a “single angle of vision” (Thorne, 2008, p. 224) and goes beyond superficial involvement with the data, adding to the credibility of the research. The input of people who have had same or similar experiences allows parallels of experience to measure findings against, confirming ideas.

Analytic logic
An inductive thematic analysis informed the analysis process of data for this research which is discussed in the previous section. Further, to confirm the process of analysis, Thorne (2008) recommends the generation of an audit trail. Examples of the mind mapping (Appendix G) and coding (Appendix H) as well as an example of initial theme development (Appendix I) part of theme development have been included as part of an audit trail.

Interpretive authority
Patients of osteopathy have their own views and experiences surrounding osteopathy, osteopaths and the individual treatments they receive (Thomson et al., 2011). In order to ensure the clinical relevance that will best inform osteopathic [and other] practitioners, this interpretative description research project took serious heed of an analytic process that involved deep immersion within the data. Undertaking this process in order to maintain the integrity of the data renders this novice researcher with an element of interpretive authority.

Moral Defensibility
The time of the participants of this thesis was freely given and their narratives were interpreted with the clear purpose of deriving some form of clinical utility from their experience. Great care was taken to ensure participants narratives are shared with sensitivity and have clear benefit to them and those who experience similar narratives with children with OM. The data also supports the moral defensibility of this research. The participants were clear that having a child with OM had a major impact on the family. When antibiotics and grommets failed to resolve the problem, osteopathy was worth exploring, and for most made a difference to their child’s presentation of OM in some way or another.

Disciplinary Relevance
There is a direct link between the relevance of this research and its relevance to the osteopathic profession. Paediatric osteopathy in New Zealand is considering a potential change, in the form of a specialised scope as discussed in the literature review. OM is a
common childhood illness and those who suffer from it could benefit from osteopathic treatment. This research also highlights how as a profession, improvement could be made with communication between the osteopath and parent which could be applicable to all parents, not just those whose child has OM.

Pragmatic obligation
Thorne (2008) suggests that to honour the concept pragmatic obligation, the proposed research must intend to do no harm. The themes that have emerged from this data are purely theoretical. The purpose of this research is to stimulate a conversation whereby the treatment of OM by the osteopathic profession could become a more accessible adjunct therapy. The researcher respects the need for biomedical intervention as a first line response to OM.

Contextual awareness
In order for this research to have sound clinical relevance, previous biases needed to be addressed. Coming from a background that is embedded in osteopathic values and belief, it was evident that some initial bias was present in the early stages of this research. There was also an expectation that participants would have had negative experiences with the public health care sector. However, by implementing a comprehensive inductive thematic analytic process from the beginning of the data analysis process, it was possible to move past the ‘theoretical baggage’ and engage with the data from a more neutral standpoint (Thorne, 2008). This is reflected in the themes and discussion that have emerged from the data.

Probable truth
With all research, there is the question of absolute truth. As researchers in the qualitative field we must accept our research as probable truth, as best and truest representation of the data our skills were able to interpret (Thorne, 2008).

Withdrawal from study
Participants were given the option to withdraw from the study, as outlined in the information document (Appendix C) each participant received on enquiry of the study. Each participant was reminded at the beginning of their voice recorded interview they could withdraw from that point on, up to two weeks after receiving a copy of their transcript to review at their discretion.

Summary
Chapter three of this thesis has outlined the qualitative methodology and methods employed for the process of undertaking this research. An argument has been provided for the use of the
chosen methodology, interpretative description, with a description of consideration taken in regards to rigour and ethical standards and implications.
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Do You Hear Me?
The Caregivers Experience of Osteopathy for their Child’s Otitis Media

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‘Do You Hear Me?’
The Caregivers Experience of Osteopathy for their Child’s Otitis Media

Abstract

Aims: It is not commonly known that osteopathy can be beneficial for children with otitis media (OM). The research aims of this study are twofold. Firstly, to explore the parents experience of having their child treated for otitis media by an osteopath. Secondly, to stimulate the discussion regarding adjunct treatments for otitis media.

Design: This is a qualitative study using interpretive description as the chosen methodology. Participants were recruited via advertising material in osteopathic and allied health clinics in the greater Auckland region as well as word of mouth. Data were collected in semi-structured audio recorded interviews, analysed thematically and themes evolved through the process of interpretative description.

Findings: Irrespective of the outcome of the osteopathic treatment for otitis media, all participants continue to use osteopathy as a treatment option for themselves and their families. Three themes were identified, (1) first line treatment paths, (2) the emotional impact of parenting a child with otitis media (3) Osteopathy for otitis media. An overarching theme ‘Do you hear me?’ refers to the interpretation of the subtext of caring for a child with OM.

Conclusions: Osteopathy offers a non-invasive, drug free treatment approach for children with otitis media. Research suggests osteopathy could have a place in providing adjunct treatment to standard biomedical care for otitis media. Regardless of the chosen treatment, positive shared decision making between caregiver and health professional plays a significant role in the outcome of a child’s illness narrative.

Keywords: Otitis media, osteopathy, parenting, shared decision making
**Introduction**

Otitis media (OM), colloquially known as glue ear, is a general term referring to inflammation of the middle ear that covers a spectrum of diseases usually occurring in a continuum (Curry et al., 2002). Otitis media is commonly stated as the primary reason for antibiotic prescription in children and as one of the commonest childhood illnesses, with one in three children having at least one episode in their first year (Bowie et al., 2014).

There are several presentations of otitis media. The three most common being: acute otitis media (AOM), otitis media with effusion (OME), and chronic otitis media (COM). Acute otitis media is defined by the presence of fluid in the middle ear combined with signs of acute illness, fever, irritability, otalgia, otorrhoea, and a rash (Lieberthal et al., 2013). OME occurs when the presence of fluid is not accompanied by signs of any other infections and can be accompanied by possible signs of hearing loss (Daniel et al., 2013). COM involves a variety of signs, symptoms, and physical findings that usually result from long-term damage to the middle ear, including tympanic membrane perforation, and the changes caused by infection and inflammation (Tsilis et al., 2013).

In New Zealand OM is most commonly diagnosed in Māori and Pacific Island children where the numbers of children diagnosed in these ethnic groups is disproportionately higher than in other ethnic groups in New Zealand (Salkeld, 2012). Overcrowded living situations may contribute to this rate of diagnosis (Bowie et al., 2014). Multifactorial influences need to be considered in each presentation of OM. Eustachian tube dysfunction, environment and genetics can play contributing roles to the incidence of AOM, OME and COM (Daly et al., 2010; Qureishi et al., 2014; Rovers et al., 2004; Tsilis et al., 2013).

The current biomedical treatment for OM involves a process of watchful waiting, prescription antibiotics, and tympanostomy tubes should the presentation not be resolved as outlined by the clinical practice guidelines (Rosenfeld et al., 2016). Success of each of these treatments is variable, and it is possible that an adjunct therapy could be beneficial in supporting the biomedical approach. Osteopathy is a therapy that has identified results in offering an non-invasive adjunct therapy for children with OM (Steele et al., 2014).

Osteopathy is a form of manual therapy pioneered by Andrew Taylor Still in the late 1800’s in Kirksville, America. Although it may have once been described as an arcane art, osteopathy is now established as a manual therapy with an emerging body of evidence based practice. Osteopathic practitioners in New Zealand are primary health care providers,
registered by a regulatory body, The Osteopathic Council of New Zealand. Core principles and philosophies of osteopathy include regarding the body as a unit with the onus on structure and function being interrelated as well as the concept that the body possesses self-regulatory mechanisms and has the inherent capacity to defend and repair itself (Osteopathic Council of New Zealand, n.d-b).

Regardless of the treatment administered to a child with OM, the importance of shared decision making between caregiver and health professional cannot be underestimated. Caregivers need positive shared decision making experience to feel a sense of autonomy, relatedness, and competence in relation to their child’s illness (Ritchie et al., 2016). Decisional conflict and the subsequent stress associated with parenting an ill child can be reduced with the experience of positive shared decision making (Chorney et al., 2015; Ritchie et al., 2016).

Design
Interpretive description, a qualitative research methodology, has the specific focus of ensuring the clinical relevance of the research aims (Thorne et al., 1997). This makes the interpretive description research model the most appropriate for researching the phenomenon of experiencing osteopathy for a child with OM.

Recruitment and participants
Six caregivers of children who have had or currently experienced OM, and who had first-hand knowledge of osteopathic treatment for their child’s symptoms, were recruited for this research. The six participants were recruited via word of mouth and recruitment posters (Appendix B) placed in osteopathic and allied health clinics in the greater Auckland area.

Participant Inclusion Criteria:
The child had to have had an episode of otitis media in the last 36 months in which one mode of treatment was osteopathic treatment. A minimum of two osteopathic treatments had to have been completed as this number of treatments is the suggested minimum number by credible professionals in the osteopathic field. The caregiver had to have attended the osteopathic treatments with the child concerned.

Participant Exclusion Criteria:
A caregiver who had not been present during osteopathic treatment would have been excluded to ensure the data gathered would be only of first-hand knowledge and experience of the osteopathic treatment process.
Data collection and analysis

Six participants were interviewed via a semi-structured interview process to allow each participant’s unique narrative to emerge throughout the process. Interviews were the most appropriate platform to explore the phenomena of participant experience, allowing the researcher a data base of a subjective nature specific to the actual experience of osteopathy for their child with OM (Thorne, 2008).

Data were analysed using an inductive thematic analysis approach (Braun & Clarke, 2006), a process that fits with the interpretive description framework (Thorne et al., 2004). The analytic process involved immersion in the data allowing for the development of codes. Codes were interpreted using a reflective process in conjunction with peer and supervisor feedback to generate themes that have some clinical utility.

Ethical consideration

Ethics approval for this research was gained through the Institutional Ethics committee. Ethical principles observed include; privacy (anonymity); self-determination (informed consent); safety (respect of their story); truth (presenting participant narrative correctly); prevention of harm (final product written to avoid identification).

Findings

While some participants whose children had repeated antibiotic treatment and (or) repeated surgery for tympanostomy tube insertion, osteopathy was described as a panacea in remedying OM. Nevertheless, osteopathy was not successful in the reduction of symptoms for all participants. However, osteopathy provided a temporary reprieve from the stress in parenting a child with OM, as all participants reported their children responded to treatment with a sense of calm and quiet. Improvements with shared decision making and patient education could have enhanced the experience of osteopathy for these participants. An overarching theme ‘Do you hear me?’ refers to the interpretation of the subtext from the six participant interviews in this study.

Do you hear me? Despite feelings of satisfaction with standard care in the public (or private) health care sector, the data indicates a subtext suggesting participants were experiencing building frustration with repeated episodes of unresolved OM remaining which was seemingly untreated. Answers as to why this was happening and/or alternative treatment suggestions were not offered by practitioners of standard medical care, leading participants to potentially question their autonomy in the health practitioner relationship regarding their
child’s illness. Another example is feeling unsure about the diagnosis of glue ear. It was not until their doctor showed them an image of an ear did they begin to understand what glue ear meant, until this point the participants’ understanding of their child’s illness was compromised. Competence in their own parenting ability was also questioned by participants in regard to whether or not they were doing enough for their children. The subtext in this situation alludes to some enclaves of society not ‘hearing’ the difficulty associated with caring for a child with OM.

Table one: Themes and sub themes

**Overarching theme: Do you hear me?**

**Theme 1: First line treatment paths**

Sub theme: Treat me once, treat me twice

Sub theme: What next?

**Theme 2: The emotional impact of otitis media**

Sub theme: The emotional roller coaster

Sub theme: If I had a crystal ball

Sub theme: A sigh of relief

**Theme 3: Osteopathy for glue ear**

Sub theme: Remembering osteopathy

Sub theme: It takes two

Sub theme: Peace at last

**Theme 1: First line treatment paths**

The collective voice of the participants indicates a level of satisfaction with which their child’s OM was treated in the public health care sector. There is a common path that each participant took with the doctor being the first port of call to investigate their child’s ear ache and to receive the diagnosis of ‘glue ear’. From here, participants “went down different paths”, but have narratives that describe similar experiences. A choice of private health care was taken by one participant [P4] and another decided on no antibiotics and went straight to an osteopath for treatment [P2]. The remaining participants journeyed through the public
health care system, making decisions about their child’s care with the best information available, before arriving at osteopathy as a treatment option.

Participant 1 was a key informant of this research. Their narrative offers a rich insight to the experience of parenting a child with OM including the experience of osteopathy. Participant 1’s narrative is particularly strong in theme 1 and 2.

Treat me once, treat me twice
Caregivers generally felt supported by the public health care system. However, when the treatments their children were receiving were repeatedly unsuccessful there were limited options provided by allopathic practitioners. This left parents feeling frustrated, with “what now?” questions. The health care system was unable to provide answers, leaving the daunting task of try to find solutions elsewhere.

[P1] Well actually, I guess I am saying it blinkered, but it was like, this is the field of options and we always got good referrals to (children’s outpatient service) in a timely manner and we were seen at (children’s outpatient service), and they were great. But again I felt that the options were limited. It was, "Let's try grommets, let's try grommets." And yeah, after time number three of "Let's not try grommets, what other options are there?"

The first line of treatment offered to parents for their child’s glue ear was antibiotics. Five out of the six participants chose antibiotic use as the initial primary line of care for their child and the other participant [P2] chose not to use antibiotics and moved straight to osteopathy as the primary line of care for their child. The participants reported repeated prescriptions of antibiotics for the remaining five children provided only intermittent reprieve from the symptoms of OM.

[P5] Those three initial ear infections within the 18 months, he was on antibiotics. I think it probably helped with, I suppose, the pain and everything initially, but not to the root of the problem.

For those who chose the antibiotic route, four out of the five of their children went on to have grommets. Of the children who had grommets, only one child’s OM successfully resolved. The remaining three children had at least two set of grommets and their parents described a lack of confidence in the process.
So of course after a couple of rounds of that (antibiotics) grommets were suggested, and in total [child name] had three sets of grommets before it became apparent that that just wasn't effective.

**What next?**

In a bid to find solutions for their child’s glue ear, when biomedical treatments failed to work, five out of the six participants explored alternative methods. These ranged from an onion poultice on the child’s ear, to ear wax candling to draw out the “glue”. Homeopathic and naturopathic advice was also sought and used in combination with both biomedical and osteopathic treatment. When parents spoke of seeking other options of health care it was evident this required a concerted effort and time allocated to this task.

[P3] relays their experience with a homeopath:

*Four little pills, and I had to give them two and then wait two weeks later, then the other two. I wasn't allowed to touch them with my hand or anything, I had to get them out of the package with a spoon, and put them straight on their tongues. ... But it wasn't like I had three months of no ear infections on the back of all this effort.*

It is apparent from the data that participants invested large amounts of time and energy into whichever treatment option they were exploring at the time.

**Theme two: The emotional impact of otitis media**

*The emotional roller coaster*

Parenting a sick child is often accompanied by frustrations and stress. Nuances of guilt and exhaustion accompany participant reports of frustration and stress. These emotions weave their way through each participant’s narrative, highlighting the intensity of parenting a child with OM. Repeated episodes of glue ear, with short time frames in between each episode, did not give the parents sufficient time to regroup from the ‘emotional roller coaster’, of caring for their sick child.

[P3] Yeah, particularly [child name], because his ears have been so bad. And then I feel bad, he'll have one for five days, and he might have 10 days of no ear infection, and he has another one for five days. And I'm like, "Well, how often do I not send him to day care? How far do I go?" And he's a really happy kid, they've got these ear infections and stuff just like pouring out his ears, but he still wants to play and do things .... And sometimes I feel like this mad woman rushing around trying to do things for them, because of these ear infections.
It is clear from the data that participants directed these feelings at themselves as parents, not at their children.

**A future of uncertainty**

Part of the process of parenting a child with glue ear is the concern for the child’s on-going health. Compromised hearing can be a direct result of OM. One participant [P1], reports their child as having some minor hearing damage, but it was also a concern for all participants during the initial days of their child’s illness.

\[P6\] ... those first years of being a baby to a toddler where we would think, "Oh my God, we're gonna have a deaf child...

Social implications of living with OM that encumbered the child with physical symptoms was also a concern. Sending a child to school or into social situations knowing there is the potential for the child to be rejected by their peers added another layer of stress for parents, as Participant describes when their child has symptomatic otorrhoea. The instinctive action of a parent to protect their child has been hindered by the presence of glue ear.

\[P1\] Kids will be just like, "Ugh, the yucky kid." And it was difficult for her 'cause she's quite a sociable kid as well. And so she didn't always understand the rejection and, so we just kept persevering (with treatment).

**Beyond glue ear, relief that it’s in the past**

Otitis media was such a part of the lives of the families whose children experienced it in that was hard for them to see past it. Their later narratives are pragmatic accounts of an illness journey that is left in the past. The reflective aspect of retelling their story allowed participants to relay an essence of the magnitude of impact glue ear had on their child and family.

\[P1\] I thank our lucky stars. Actually... Given that it's been a couple of years now, I don’t even think of it all the time anymore, so that's a really good thing. It's far from being on my daily radar. As a result, my daughter's and my relationship is a lot better, than it was, I think. As I said, I've lost that worry that when she's 15, 16, 17, 18, and for her adult life she's not going to be dealing with something that was really, pretty bloody gross actually.

Something that had such a large impact at the time gets absorbed into the family narrative as life continues with new challenges and new narrative.
Theme three: Osteopathy for glue ear

*Remembering osteopathy*

All the participants in this study had, at some point, experienced osteopathic treatment themselves. The data reveal that having had a positive experience with osteopathic treatment was what eventually led participants to seek osteopathy as a treatment option for their child.

*[P1]* And then all of a sudden I thought, "Oh. I used the osteopath for all sorts of things. Why don't we take [name] to the osteo, try and see if it's possible to have her ear looked at?"

Expectations of what osteopathy could do for glue ear were varied, based on each participant’s previous experience of osteopathy.

*[P5]* I probably was a believer that it would fix it, and I thought that, yeah, if I get these in enough before we go to the specialist at the hospital, she'd go, "Oh! There's no need for a grommet." So yeah, I did. I had all my faith in this, and look, if it didn't work, at the same time I wasn't heartbroken by it.

The lasting impression for all participants was that osteopathy was largely a positive experience regardless of the outcome for the child in relation to their OM.

*It takes two*

While some participants are happy with the explanation that there was a “shift” or “tightness” being released during the osteopathic treatment, it appeared some participants experienced lack of explanation regarding their child’s treatment and management plan. This led to some confusion and uncertainty about the osteopathic treatment process for some participants.

The quote below identifies the importance of shared and informed decision making, when creating a management plan. Participant 3 was not confident enough to question the management plan being made by their osteopath, so they “did as I was told”, relinquishing their autonomy in their child’s health care.

*[P3]* And I don't know why they've done it in three week blocks. Yeah, but I didn't ask though either, I just did as I was told. And then after the three weeks I'm like, "Do you want to see him next week?" And he's like, "No, no we do that in three weeks."
It emerged from the data that an osteopath must not assume the parent has an understanding of OM. Participant 2 experienced some confusion regarding their child’s diagnosis and indicates that people have individual learning needs.

Like my doctor yesterday got the chart out and showed me a picture of the ear.
And it was much... Seeing it was like, "Oh, yeah. That's better." I know what's going on now, rather than someone just explaining it to me.

Peace at last
It was generally felt by participants that osteopathic treatment had a profoundly calming effect on their child. Children responded to osteopathic treatment by relaxing and allowing the gentle treatment to unfold. As participants observed their child’s relief over the period of the osteopathic treatment, their own relief became evident. They experienced hope for reducing their child’s distress and coincidentally their own.

[P4] remembers the first time they took their child to the osteopath for treatment of OM:

He was so grizzly the day I took him [to the osteopath] ... And I got him out of there, and laid him, and I thought, "Oh, he is never gonna lay still for this guy." So I got his favourite blanket.... He was about three or four months or five months old... And I laid him on the little bed and then [osteopath name] just put his hands on him and [child name] ... And that was just it. He instantly stopped. I'll never forget it, he instantly stopped. And he just relaxed over about a period of a few minutes. He just relaxed. God, it was amazing. Amazing. It was amazing.

The positive impact of the experience of osteopathic treatment for the participants and their children, temporary or otherwise, had a profound effect of generating some ‘peace at last’.

Discussion
This research was centred on the parents’ experience of osteopathy for OM. What emerged from the data was the journey of a child’s illness narrative which at some point included osteopathic treatment for OM. Findings showed that participants embarked on similar journeys with their child’s treatment path. Participants’ first step was taking their child to their doctor. Once a diagnosis was established, all but one participant administered the antibiotics prescribed to their children. Thus began the individual experience of each participant with recurrent episodes of ‘glue ear’ involving repeat antibiotic prescriptions,
repeat surgical insertion of ‘grommets’, and attempts with alternative treatments ranging from ear candling to homeopathy. Osteopathy was used as an alternative to standard medical care by one participant and as an adjunct therapy or last resort by the remaining five participants.

Best practice clinical guidelines for the treatment of OM involve a process of watchful waiting, antibiotic prescription (if the child is less than 2 years old antibiotics are prescribed without period of watchful waiting), and if required, surgical insertion of tympanostomy tubes (Qureishi et al., 2014; Rosenfeld et al., 2016; Salkeld, 2012). Despite increasing antibiotic resistance (World Health Organisation, 2014), ineffectiveness of antibiotic use for OM and antibiotic side effects (Venekamp et al., 2015), and guidelines that recommend watchful waiting (Rosenfeld et al., 2016; Salkeld, 2012), antibiotics appear to remain the first line of treatment for OM. It can be argued that this is due a perception of clinicians individualising care or attempting to meet parental expectations (Daniel et al., 2013).

Tympanostomy tubes are commonly inserted (Daniel et al., 2013), sometimes in combination with adenoidectomy (Boonacker et al., 2014), with varying degrees of success and a lack of research that suggests their effectiveness (Lous et al., 2011). There is research to suggest short term improvement of quality of life upon insertion of tympanostomy tubes (Cheng & Elden, 2014). Vaccines are being introduced into vaccination profiles, however there is currently insufficient research to establish effectiveness in the reduction of OM episodes (Best et al., 2016).

When standard biomedical care treatment approaches are successful in eradicating OM, alternatives need not be sought. All participants of this research sought alternative treatment for their child’s OM. Osteopathy as an adjunct therapy to standard medical care has shown to reduce symptoms of OM (Degenhardt & Kuchera, 2006; Mills et al., 2003; Steele et al., 2014). Thus osteopathy could potentially reduce the impact of the effects of OM on the child, including, compromised speech development and loss of hearing (Robb & Williamson, 2012). Alternative care for OM is not largely supported by members of the biomedical community and there is research that refutes the benefits of osteopathic and other manual therapy for OM (Pohlman & Holton-Brown, 2012).

Lack of shared decision making between caregivers and health professionals (biomedical and osteopath) increased anxiety and stress in participants of this research. These findings are consistent with researchers in the field of paediatric medicine (Coffey, 2006; Ritchie et al., 2016). It is apparent from the data that participants were engaged in various levels of shared decision making related to both treatment and management plans by the osteopaths treating
their children. Succinct explanations were not always given regarding either the treatment the child was receiving, or reasoning around the child’s management plan. This created an increased anxiety in some participants, which could have been easily avoided. It is clear in cases where the osteopath was highly communicative with a participant there was an absence of anxiety or confusion surrounding their child’s osteopathic treatment. The osteopathic profession follows an informative and inclusive model in regards to patient treatment and management plans (Osteopathic Council of New Zealand, n.d-a); The Health and Disability Commission also outlines shared decision making as a patient right (Ministry of Health, 2014). The importance of shared decision making was highlighted repeatedly throughout the data.

Regardless of some participants reporting either confusion or anxiety regarding their child’s osteopathic treatment, an overall satisfaction with the treatment their child received was conveyed. Caregivers largely attributed this to the reaction of each child during the treatment process. Osteopathy appeared to have a profound effect, relaxing and calming an often restless child during treatment. These effects were, in some cases long lasting, giving the parent a reprieve from the behaviour of a child who had otherwise been in some form of distress from the symptoms of OM. All participants continue to use osteopathy as a treatment option for their children, even those who had no success with OM treatment.

The overarching theme ‘do you hear me?’ refers to the subtext in the findings. Participants felt the impact of OM on them and their child was not being heard by health practitioners. It is common when caring for a child with OM for the caregiver to have days off work, increasing parenting stress, anxiety and fatigue (Barber et al., 2014; Coffey, 2006). However, it is evident the emotional impact of caring for a child with OM is not being incorporated in consideration to the biosocial aspect of a consultation between health care professionals and parents. It is not until the needs of the caregiver are being acknowledged and met that they will feel heard in regards to healthcare of their child.

Limitations
The previously unexplored research question combined with the paucity of research supporting osteopathy as a successful adjunct treatment option for OM, be it adjunct or otherwise offers a limitation for the scope of the researcher. Other paediatric presentations that are commonly treated by osteopathy have not been considered as part of this research. Failure to do so results in a narrow osteopathic perspective.
Small self-selected participant numbers representing a homogenous demographic also adds limitations to this research. While Thorne (2008) and Tracy (2012) suggest small participant numbers are sufficient for an interpretative description study, the findings of this study may have limitations for other demographic groups. For example, accessibility and affordability of osteopathic treatment has not been considered as part of this thesis.

As noted in the literature review, mothers are the predominant participants in research regarding their child’s glue ear. A cross section that includes male caregivers could enhance the value of the research.

**Future research**

Research into the practical application and success of osteopathic treatment for children in New Zealand who experience OM, could identify if there is a need for incorporating osteopathy into standard biomedical care for OM. In conjunction, it would be necessary to assess the willingness of the biomedical community to utilise the skill set of osteopaths as a possible adjunct or alternative treatment for OM.

Also, research with a focus on shared decision making as part of the experience of treatment for OM in a New Zealand setting, may bring about a deeper understanding of the needs of caregivers for health professionals who treat this common childhood presentation.

**Conclusion**

A paradigm shift from the biomedical community in regards to the treatment of OM is required. Current standard care treatment approaches do not provide satisfactory resolution for all OM sufferers. Repeated antibiotic prescription and unnecessary repeated surgery expose a child to potentially unnecessary physiological stressors. The data collected for this research reveals that it is not well known that osteopathy can be utilised to treat OM. Increased awareness of osteopathy as an adjunct therapy to standard care, and employment of the osteopathic skill set for OM could play a vital role in reducing the impact of this illness on the child and family.

Additional data that emerged from this research is the emotional strain experienced by the caregiver during their child’s journey with OM. Osteopathy provided participants and their child a temporary respite from some of the symptoms of OM, therefore easing the emotional strain. For some participants’ osteopathy was the panacea for their child’s OM, when standard medical care was unable to provide a solution.
Improvements in the practice of shared decision making, by all health care providers, could instil a sense of autonomy, relatedness and competence in caregivers of ill children. In doing so, parents would face less decisional conflict and feel more confident in the choices made concerning their child’s health care. This would enable caregivers to be part of their children’s illness narrative without maintaining the question of health professionals ‘do you hear me?’
References


World Health Organisation. (2014). WHO’s first global report on antibiotic resistance reveals serious, worldwide threat to public health *New WHO report provides the most comprehensive picture of antibiotic resistance to date, with data from 114 countries* (pp. no page).
Part three
Appendices
Appendix A

Figure 3: Glue ear pathway
Appendix B

SEEKING PARENTS TO PARTICIPATE IN A STUDY ON OSTEOPATHY AND GLUE EAR.

To express an interest and receive information on eligibility criteria, please contact lead researcher:

Jane McCulloch
021 640 141
.glueearstudy@gmail.com

Approval for this study was granted by Unitec’s research ethics committee on 2/9/15 to be undertaken between 2/9/15 and 2/9/16. Approval number 2015-1054.
Appendix C

Jane McCulloch
12 Notely Street
Westmere
Auckland 1022

24.9.15

Dear Jane,
Your file number for this application: 2015-1054
Title: Retrospective experience of osteopathy for Otitis Media.

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: 2.9.15
Finish date: 2.9.16

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,

[Signature]

Sara Donaghey
Deputy Chair, UREC

cc: Elizabeth Niven
Cynthia Almeida
Appendix D

Information for participant

Synopsis of project

In New Zealand we experience a high number of glue ear cases. There is limited research available regarding how families, in particular parents, feel about they have been treated by the health care system and more specifically osteopaths, during their child’s journey with glue ear. This research project invites parents and guardians to participate in an interview to enable the researcher to explore, in particular the interaction between osteopath, parent and child.

What we are doing

We are conducting interviews with six participants. The data from these interviews will be analysed to create a concise report of what you experienced during your child’s osteopathy treatments. The information from this research will inform osteopaths and potentially other primary health care practitioners of the needs of parents and children during treatment for glue ear.

What it will mean for you

A one-hour interview will take place either in your home or in clinic 41, the student osteopathy clinic on the Mt Albert campus of Unitec. The interview will be sent to an online transcription service, scribie.com and you will receive a copy of the transcript.

The researcher will provide morning or afternoon tea as a thank you for giving up your time to participate in this research project.

If you agree to participate, you will be asked to sign a consent form. This does not stop you from changing your mind if you wish to withdraw from the project. However, because of our schedule, any withdrawals must be done within two weeks of receiving your transcript.

Your name and information that may identify you will be kept completely confidential. Data collected from interviews will be transcribed by online transcription service scribie.com. Scribie.com takes the following steps to ensure confidentiality of your interview:
There is a split up the file into smaller parts and distribute it to our transcribers. That way they only have access to parts of the file. Nobody but our employees and contractors have access to the full audio file.

Freelance transcribers are bound by our terms to keep the content of the audio confidential. Once the transcript is completed, they cannot retain the audio file or the transcript.

Industry standard 256-bit SSL encryption is used on our website so that all communication between servers and browsers is encrypted.

All information collected from you will be stored on a password protected file and only the researcher and my supervisors will have access to this information.

The research will be published in the form of a thesis available in the Unitec library including the online library. There is potential for this research to be published in osteopathic and nursing journals.

Please contact me if you need more information about the project. At any time if you have any concerns about the research project you can contact my supervisor:

My lead supervisor is Elizabeth Niven, phone 021 654 935 or email eniven@unitec.ac.nz

UREC REGISTRATION NUMBER: 2015-1054

This study has been approved by the UNITEC Research Ethics Committee from 2/9/15 to 2/9/16. 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 8551). Any issues you raise will be treated in confidence and investigated fully, and you will be informed of the outcome.
Appendix Ea

Participant Consent Form

Research Project Title: Retrospective experience of osteopathy for otitis media.

I have had the research project explained to me and I have read and understand the information sheet given to me.

I understand that I don't have to be part of this research project should I choose not to participate and may withdraw up to two weeks after receiving the transcript of my interview.

I understand that everything I say is confidential and none of the information I give will identify me and that the only persons who will know what I have said will be the researchers and their supervisor. I also understand that all the information that I give will be stored securely at Unitec for a period of 10 years.

I understand that my discussion with the researcher will be recorded and transcribed.

I understand that I can see the finished research document.

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

Participant Name: ………………………………………………………………………

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

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

UREC REGISTRATION NUMBER: 2015-1054

This study has been approved by the UNITEC Research Ethics Committee from (2/9/15) to (2/9/16). 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 8551). Any issues you raise will be treated in confidence and investigated fully, and you will be informed of the outcome.
Appendix Eb

Pro-Forma Consent Form – Adults

To:

From:

Date:

Re:

I have been given and have understood an explanation of this research project for the Masters of Osteopathy. I have had an opportunity to ask questions and have had them answered. I understand that neither my name nor the name of my organisation will be used in any public reports, and that I may withdraw myself or any information I have provided for this project without penalty of any sort.

I agree to take part in this project.

Signed:

Name:

Date:

UREC REGISTRATION NUMBER: 2015-1054

This study has been approved by the UNITEC Research Ethics Committee from 2/9/15 to (2/9/16). 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 8551). Any issues you raise will be treated in confidence and investigated fully, and you will be informed of the outcome.
Appendix F

Interview Guide

During this one hour interview we will endeavour to cover the topics listed in this interview guide. If at any time you wish to retract something you have said, please let the interviewer know. The time on the recording device will be noted and the comments will be excluded from the data analysis. As part of this process, the interviewer may also take written notes to highlight areas of particular interest.

1. Tell me about your child’s journey with glue ear.
   - Tell me about a time when it was particularly bad.
   - What (if any) impact did this have on your family’s activities of daily living

2. At what stage of your child’s glue ear did you decide to seek osteopathic treatment?
   - Why did you choose osteopathy as an alternate and/or adjunct therapy for your child’s glue ear?
   - Other than osteopathy what other treatments have you tried (non biomedical)?
   - What is your understanding of what the osteopath did?
   - What were/are your expectations of osteopathy for your child’s glue ear?
   - How does/did your child respond to osteopathic treatment?

To conclude we will discuss any questions or queries you may have regarding the interview. Please feel free to contact the researcher at any point if any questions or concerns arise in the days following the interview. A transcript will be posted to you once it has been completed by on line scribing service scribie.com.

Your participation in this research is greatly appreciated.

Contact details.

Lead researcher: Jane McCulloch: phone 021 640 141: email glueearstudy@gmail.com
Appendix Ga
Appendix H
Coding Key

Antibiotics and grommets
Frustration and Stress
Trust
Alternative treatments
Osteopathy

15:37 S2: Okay. Was there anything that the osteopath could've done differently, do you feel, during your treatment?

15:50 S1: We were really happy. It just made such a difference. I think firstly, I really trusted the osteopath. I really trusted the type of treatment, and because we could see results and it was all being explained to us, it was great. My only wish was that every other kid who had ailments had the same opportunity really. And just knowing that Maori kids in particular really struggle with so many things... Because the glue ear they struggle with. Those who have it really bad struggle with social participation, with learning, and things like that, and they can just have such a cumulative effect on life.

16:34 S2: Absolutely. Have you recommended other people to go, that [16:38] _____?

16:38 S1: Yeah, I have actually. Yeah. My cousin's baby, who's not a baby anymore, he's about four now, he had colic rather than glue ear, and so I suggested... And they were really open to it, and they were really happy with what results came of that as well.

16:57 S2: Oh, that's great. You know, we've just whizzed through this. [chuckle] I'd expected it to take an hour, but because you're so open and just good at talking, I haven't had to prompt you for many things. Is there anything that you want to add about your experience with anything non-osteopathic or osteopathic and the glue ear?

17:29 S1: Yeah. I guess one of the frustrations I had, and it's not the fault of the medical profession per se, but I felt like there weren't many options outlined to us. It was just simply, "We'll try this antibiotic and we'll try that antibiotic." And I totally respect that that's the toolkit that they have. And I don't know why it took me so long to think of osteopathy, as I said, but all I can think is that there'll be hundreds and thousands of other families out there who... It doesn't come to them either. Maybe they've never even heard of osteopathy or other treatments, and so I felt that there wasn't a great deal of encouragement. Well, not encouragement, it was just not even on the table. It wasn't even... I'm not...
Appendix I

To understand the experience a parent has with the treatment of their child for glue ear by an osteopath, we must first understand the journey they have taken to arrive at their osteopathic appointment. There is a chronological order of events that unfolds in the data. In order to respect the illness narrative of the child, in this case told by the parent, guides us not only in the individual treatment needs of the child, but also of those of the parent. By doing so, we stay true to the philosophy of osteopathy that aims to treat the patient in a holistic manor.

The data collected in research clearly identifies two overarching themes. Firstly, the experience of parenting a child with glue ear. This theme describes the similar journeys of the six participants prior to their child having osteopathic treatment. The second theme, parent’s experience of osteopathy for glue ear, explores the experience of both the child and parent (as told by the parent).

Parenting a child with glue ear

The collective voice of the participants leads toward five sub themes under the umbrella of parenting a child with glue ear. Experience of public health care, experience with antibiotics, experience with grommets, stress and frustration, and alternative treatment options.

1: Experience of public health care.

Parents generally felt supported by the public health care system. However when the treatments their children were receiving were repeatedly unsuccessful there was a short fall in options, leaving parents despairing with “what now” questions.

[P1] “Well actually, I guess I am saying it blinkered, but it was like, this is the field of options and we always got good referrals to Starship in a timely manner and we were seen at Starship, and they were great. But again I felt that the options were limited. It was, "Let's try grommets, let's try grommets." And yeah, after time number three of "Let's not try grommets, what other options are there?"
2: Experience with antibiotics

Five out of the six participants chose standard practice antibiotic use as the initial primary line of care for their child; the other participant chose not to use antibiotics and move straight to osteopathy as the primary line of care for their child.

[P2] And that they could prescribe antibiotics, but there is a good chance that they won't work. So yeah, just... I'm still breastfeeding, so keep breastfeeding. I decided to take her [to an osteopath] when she first got the ear thing. 'Cause I thought that could help just loosen her up.

Repeated prescriptions of antibiotics for the remaining five participants provided only intermittent reprieve from the symptoms of glue ear. To the point where more than one participant was told that continuing along the route of antibiotics was a fruitless endeavour.

[P1] “They'd give us antibiotics and it would clear up and always took a long time to clear. It was like we had three weeks’ worth of oozing and then we'd have one week clear and then it'd be back again.”

[P6] “Yeah, so we had her on antibiotics for quite a long time, and then it got to this point where the GP said, "Look, I've been looking at new research and it says that basically antibiotics do nothing. You've got just as much likelihood to have it clear up on its own without it."

For those who chose the antibiotic route, four out of the five went on to have grommets; the other participant (P X) chose not to have grommets and to cease antibiotics and seek osteopathic treatment for their child.

3: Experience with grommets

Of the children who had grommets, only one had success in remedying the child’s glue ear. The remaining three participants had at least two set of grommets and described a lack of confidence in the process.
“No, I'm not completely confident with grommets, having had [child name] just had his second set”

“So of course after of couple of rounds of that (antibiotics) grommets were suggested, and in total [child name] had three sets of grommets before it became apparent that that just wasn't effective.”

4 : Alternative care

In a bid to find solutions for their child’s glue ear, five out of the six participants explored alternative methods. From onion poultice on the child’s ear, to ear wax candling to draw out the “glue”. Homeopathic and naturopathic advice was sought and used in combination with both allostatic and osteopathic treatment. When parents spoke of seeking other options of health care a tone of desperation was eminent.

“Four little pills, and I had to give them two and then wait two weeks later, then the other two. I wasn't allowed to touch them with my hand or anything, I had to get them out of the package with a spoon, and put them straight on their tongues. So I would give her feedback on any... It was mainly [child #2 name], for his ears, on any changes that I may have noticed since I had been to see her, and what repeat ear infections he'd had, and she would adjust this formula dosage. But it wasn't like I had three months of no ear infections on the back of all this effort.”

5 : Frustration and stress

Parenting a sick child is fraught with frustrations and stress.

“A little bit frustrated, but more frustrated with myself that I had let it get to this point, you could say.”

With this frustration and stress comes the feeling of guilt. Even when parents have invested copious amounts of time and energy to ensure their child’s health needs
have been met, there is an unsure feeling questioning whether they have done enough.

[P3] “Yeah, particularly [child #2 name], because his ears have been so bad. And then I feel bad, he’ll have one for five days, and he might have 10 days of no ear infection, and he has another one for five days. And I’m like, "Well, how often do I not send him to daycare? How far do I go?" And he’s a really happy kid, they’ve got these ear infections and stuff just like pouring out his ears, but he still wants to play and do things. [P3] And sometimes I feel like this mad woman rushing around trying to do things for them, because of these ear infections.”

Stress is placed on the day to day running of the household when a sick child is part of the family. Coordinating a family and organising the logistics of meeting a sick child’s needs places a strain on the family unit.

[P4] “Because he was so sick, and yeah, it did actually. And luckily [name of husband], when he was in the [name of work place] he was working shift work, so often when I was at work he was at home with the kids, or when they got older they went to daycare two mornings a week and he would pick them up in the afternoons. And he was often at the doctor’s, often at the A&E, getting the antibiotics or getting something.”

Parents experience of osteopathy for their child’s glue ear

1: Previous experience of osteopathy

All the parents in this study had themselves, at some point, had osteopathic treatment for various different presentations. This is important as it identifies the audience that osteopathy is reaching and the fact there is work to be done in the community to heighten the awareness of osteopathy for glue ear.

[P1] “And then all of a sudden I thought, "Oh. I used the osteopath for all sorts of things. Why don’t we take [child name] to the osteo, try and see if it’s possible to have her ear looked at?" So, we went to our local osteopath”
2: Child’s reaction to osteopathy

Most of the children responded to treatment in a manner that made the job of the osteopath easy.

[P4] “He was so grisly the day I took him to... I still have that memory. He was in the car seat, the ones which used to carry out, those pod ones. And I got him out of there, and laid him, and I thought, "Oh, he is never gonna lay still for this guy." So I got his favourite blanket, and sit him up. He was about three or four months or five months old. Somewhere in between that time. And I laid him on the little bed and then [osteopath name] just put his hands on him and [child name] just went... And that was just it. He instantly stopped. I'll never forget it, he instantly stopped. And he just relaxed over about a period of a few minutes. He just relaxed. God, it was amazing. Amazing. It was amazing.”

However, it is important to note that this is not always the way and a child will quite often dictate the tone of the treatment

[P2] “She doesn’t like it when she does the head part. But when she’s doing her back or any of that she's just sitting on my lap and she’s fine
And I’m lucky because I’m still breastfeeding. So when she gets a bit nippy with her, I just feed her.”

3: Explanation of osteopathic treatment

While some are happy with the explanation that there is a “shift” or “tightness” being released during the osteopathic treatment, it remains imperative that that parent is constantly being informed about the stages of the treatment. Assuming the parent is fully versed on the pathogenesis of glue ear or what the management plan can leave the parent feeling less in control of their child’s health care.
“Maybe just better explaining would be good. Good explanation. Like my doctor yesterday got the chart out and showed me a picture of the ear. And it was much... Seeing it was like, "Oh, yeah. That's better." I know what's going on now, rather than someone just explaining it to me.”

“And I don't know why they've done it in three week blocks. Yeah, but I didn't ask though either, I just did as I was told. And then after the three weeks I'm like, "Do you want to see him next week?" And he's like, "No, no we do that in three weeks." And, "We'll see you next time."

“Yeah, that's completely it, and just to use basic words. He's a lovely guy, and amazing with the kids and stuff, with [child #2 name] he was amazing, I just couldn’t follow his explanations at all.”

4: Expectation of osteopathy for child with glue ear

“I probably was a believer that it would fix it, and I thought that, yeah, if I get these in enough before we go to the specialist at the hospital, she'd go, "Oh! There's no need for a grommet." So yeah, I did. I had all my faith in this, and look, if it didn't work, at the same time I wasn't heartbroken by it.”

“That was a really good experience for us actually. I went in there very naively and quite desperate and [osteopath name] said try the osteopathy. I probably thought, initially to be honest, I never thought, "Oh what is that going to do"? So when it happened and when it was a relief, it was such a cool thing in our lives. So it was great, it was a really positive experience.”

“No. Just from my own experience with the osteo, I had an expectation that there would be some type of hands-on assessments and diagnosis of what was going on, as well as the explanation that mainly myself at that stage gave. [chuckle] And [child name] saying, giving some information as to what she thought and felt and how it affected her. And then, from the diagnosis, the subsequent treatment and
manipulation and that... And it was all really straightforward, and we had it explained to us at each stage how it was going...”

5: Parent’s impression of osteopathy treatment for their child

[P1] “We were really happy. It just made such a difference. I think firstly, I really trusted the osteopath, I really trusted the type of treatment, and because we could see results and it was all being explained to us, it was great. My only wish was that every other kid who had ailments had the same opportunity really.”

[P4] “Yeah. I really felt like the two services complimented each other in a way. I really do. And as often when he went to what's his name, or when he went there, and he got the gunk out, and then we did a treatment here, and it helped make the gunk also flow a bit more. Because it used to flow through the grommets itself but when it got obviously thicker, mucus-y or whatever, it would then build up and that's when he'd feel the pressure. And then when he went there, he often relieve that pressure. And then we wouldn't have to go there (ENT) so often. So I just think for us, really both things for [child name] complimented each other.”

[P6] “It doesn't even cross my mind anymore, that's how far we've left it behind. But I really do attribute it to having the osteopathy.”
Confidentiality Letter

To Whom It May Concern

I Rajiv Poddar, on behalf of Scribie.com, agree to treat in absolute confidence all information that we become aware of in the course of transcribing the interviews or other material connected with the files which we receive for transcription. We agree to respect the privacy of the individuals mentioned in the interviews that we are transcribing. We will not pass on in any form information regarding those interviews to any person or institution. On completion of transcription we will not retain or copy any information involving the above project.

We are aware that we can be held legally liable for any breach of this confidentiality agreement, and for any harm incurred by individuals if we disclose identifiable information contained in the audiotapes and/or files to which we will have access.

Signature: ................................................................. Date: .................................................................

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Full title of thesis/dissertation/research project ('the work'):
Do you hear me? The caregivers experience of osteopathy for their child's orthopaedic media

Principal Supervisor: Dr Elizabeth Niven  Associate Supervisor: Sue Gasquoine

Associate Supervisor: Sue Gasquoine

Practice Pathway: Osteopathy

Degree: Masters of Osteopathy

Year of presentation: 2017

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Signature of author: [Signature]

Date: 9/7/17
Declaration

Name of candidate: Jane McCulloch

This Thesis/Dissertation/Research Project entitled Do You Hear Me? The Caregiver Experience of Osteopathy for their Child’s Otitis Media is submitted in partial fulfilment for the requirements for the Unitec degree of Masters of Osteopathy

Candidate’s declaration

I confirm that:

- This Thesis/Dissertation/Research Project represents my own work;
- Research for this work has been conducted in accordance with the Unitec Research Ethics Committee Policy and Procedures, and has fulfilled any requirements set for this project by the Unitec Research Ethics Committee.

Research Ethics Committee Approval Number: 2015-1054

Candidate Signature: Jane McCulloch Date: 9th February 2017

Student number:1402200