

PROMOTING OPTIMAL BREASTFEEDING THROUGH THE OSTEOPATHIC
THERAPEUTIC CYCLE

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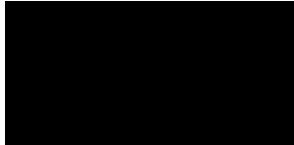
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DOCTOR OF PHILOSOPHY DECLARATION

I, Denise Cornall, declare that the PhD thesis entitled, "Promoting optimal breastfeeding through the osteopathic therapeutic cycle", contains no material that has been submitted previously, in whole or in part, for the award of any other academic degree or diploma. Except where otherwise indicated, this thesis is my own work.

Signature

A solid black rectangular box used to redact the signature of the author.

Date

12/02/2015

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Finally, I dedicate this thesis to all those who are committed to improving the healthcare of mothers and babies and thereby ensuring the wellbeing of future generations.

ABSTRACT

The purpose of the study is to identify osteopaths' therapeutic approaches in the situation of assisting mother and baby dyads with breastfeeding difficulties. More specifically, it seeks to explicate the processes involved when paediatric osteopaths apply osteopathic holistic principles and manual therapy for the baby to promote breastfeeding. This qualitative study involves observations of osteopaths treating babies with breastfeeding difficulties, in their clinics throughout metropolitan Melbourne. Information is gathered from clinical observations and in-depth audio-recorded interviews with the osteopaths and mothers involved in the treatment sessions. The study uses Corbin and Strauss's (2008) grounded theory methodological approach to inform the methods of concurrent data collection and analysis. This methodology provides the analytical tools for exploring the interactive processes that take place during the osteopathic treatment session, and with increasing levels of abstraction, to ultimately generate a theoretical framework of paediatric osteopathic practice in the situation of treating mother-baby dyads with breastfeeding difficulties.

The study's key conceptual findings comprise the core problem, the core category and its four related categories, and three contextual determinants. The core problem, *Struggling to breastfeed satisfactorily*, is a clinical problem faced by osteopaths, which represents a trajectory of mother-baby dyads experiences of trying to overcome breastfeeding difficulties and other related perinatal challenges. The core category, *Promoting optimal breastfeeding through the osteopathic therapeutic cycle*, arises in response to the core problem, and accounts for a structured, yet creative and individualised approach to treating the baby with manual therapy and assisting the mother to achieve *optimal breastfeeding*. This end goal is conceptualised as the best form of breastfeeding on the basis that it is effective, personally fulfilling, and meets the health needs of the dyad. It is achieved through a progressive transitional cyclic process that is underpinned by four interlinking categories, *Connecting*, *Assimilating*, *Rebalancing*, and *Empowering*. Contextual determinants are the broader sets of conditions that impact upon osteopath-dyad interactions and thus help to shape the core problem and categories. They are identified as *Women's views and experiences*, *Osteopaths' professional identity*, and *Health care as a commodity*. Finally, when drawn together into an explanatory schema with the core process as the central organising theme, these findings are used to generate a substantive theory. Overall, *Promoting optimal breastfeeding through the osteopathic therapeutic cycle*, shifts paediatric osteopathy toward a broad and reflective biopsychosocial practice approach that follows a transitional wellness orientation.

KEY TO TRANSCRIPTS

Categories	All category and subcategories names are highlighted using <i>italics</i> .
Direct Quotations	Direct quotations from the literature are presented in regular font style.
Exemplars	Italics are used when presenting quotations from participants' interviews.
I	Interviewer
M	Mother Participant
O	Osteopath Participant
Pseudonyms	All names used to refer to study participants; osteopaths, mothers, babies, and family members, including names that appear in exemplars, are pseudonyms.
O 05/10	Prefix O = osteopath participant 05 = interview number 10 = page number in interview transcript
M 10/05	Prefix M = mother participant 10 = interview number 05 = page number in interview transcript
[Square brackets]	Researcher's comments, added to provide clarity or explanation
...	Words omitted from a single sentence
....	Words omitted from two or more consecutive sentences
Gender	Where the gender of participants is not made clear by the context, female pronouns are used. This decision was made to maintain literary consistency throughout the thesis and to show respect for the research topic of breastfeeding; a fundamentally feminine issue.

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LIST OF PUBLICATIONS AND AWARDS

Cornall, D. (2011). A review of the breastfeeding literature relevant to osteopathic practice. *International Journal of Osteopathic Medicine*, 14, 61-66.

2011 Victoria University Faculty of Health, Engineering and Science, Postgraduate Research Conference; July 20th, 2011. Winner: Judge's Choice Award, 3-Minute Thesis Competition.

2011 Victoria University Faculty of Health, Engineering and Science, Postgraduate Research Conference; July 20th, 2011. Winner: Afternoon Platform Presentation.

PART A: INTRODUCTION TO THE STUDY

CHAPTER ONE

INTRODUCTION TO THE STUDY

1.1 INTRODUCTION

This thesis presents a study into how paediatric osteopaths respond to mothers and babies who attend their clinics for assistance with breastfeeding difficulties. The babies, as the patients, are brought to the osteopaths, mainly on the premise that physical strains in their bodies might be contributing to the breastfeeding problems. On this basis, osteopaths evaluate the situation and provide support services in various ways; the most obvious service being manual therapy treatment. Manual techniques are applied to the baby's body to improve function, which in this case, is expressed by more effective breastfeeding behaviours and general well-being. This chapter presents an overview of the study, commencing with an outline of the research problem. The research question and aims of the study are then stated. Key terms are defined, followed by discussion pertaining to the significance of the research topic or the impetus for undertaking such a study. Finally, the overall structure of the thesis is presented.

1.2 BACKGROUND TO THE STUDY

Breastfeeding, as a topic of conversation, invariably invokes a range of opinions and feelings. As a community member and in my roles as health professional and mother, I have been struck by the intensity and emotion that lies behind individuals' views of breastfeeding; many of whom are mothers or personally close to mothers who have had profound, often confronting, infant feeding experiences. In the process of preparing for, and becoming a mother, women often receive mixed messages about breastfeeding. Currently, breastfeeding is promoted as a natural human behaviour that is the optimal way to feed a baby for a number of well documented health reasons. Despite this pervasive view, it is apparent that the ideology does not necessarily match the reality of infant feeding practices and experiences for many contemporary women. This contention is supported by statistics that show that, despite the growing recognition of individual and public health benefits of breastfeeding, Australian breastfeeding rates¹ have remained static over the past decade (Tawia, 2010) and although 96% of women initiate breastfeeding, only 2% exclusively breastfeed their babies to six months (Commonwealth of Australia, 2011) in accordance with World Health Organisation (2014a) recommendations. Some women who choose to breastfeed their babies find it difficult to do so satisfactorily and report considerable difficulty in finding, accessing, and

¹ See Chapter 2.3 for an account of Australian breastfeeding rates.

implementing helpful breastfeeding support strategies. For this reason and general awareness regarding the value of prophylactic health measures, there has been much interest in studying appropriate interventions to promote and support breastfeeding.

Breastfeeding strategies are more likely to be successful when based on an understanding of the complex biological and socially determined processes that are involved. The human experience of breastfeeding has a complicated history because it has been closely associated with changing cultural and social attitudes, particularly concerning women, their bodies, and what it means to be a mother (Carter, 1995; Green, 2010; Liss & Erchull, 2012; Mercer, 2010), and a mother within a contemporary Australian context (Maher, 2010). Some authors contend that societal views as a whole need to undergo substantial change for breastfeeding to become accepted as the 'normal' way to feed a baby (Australian Breastfeeding Association, 2014b; Battersby, 2000; McNiel, Labbok, & Abrahams, 2010)². Others, such as health professionals, consider the breastfeeding problem from a more pragmatic and individualised approach, which recognises that breastfeeding success involves a special mother-baby partnership that incorporates natural biological processes and interactive learnt behaviours. Generally, it is thought that a normal term baby knows instinctively how to breastfeed and studies to promote breastfeeding have investigated interventions to support, primarily, the mother (Renfrew, McCormack, Wade, Quinn, & Dowswell, 2012). Support, typically consists of instruction and assistance with positioning the babies and practising breastfeeding skills³. Very few studies, however, have considered the breastfeeding problem from the perspective of the baby's ability to perform effective breastfeeding or sucking behaviours. In some cases, health professionals, such as osteopaths, recommend interventions to address more specifically, the baby's physical breastfeeding actions.

Osteopaths have a particular interest in, and understanding of, the body; its unity, self-regulation and the interrelationship between its structure (anatomy) and function (physiology). On this basis, they apply manual techniques to normalise body movements and tensions and to promote wellbeing (Greenman, 2003; Parsons and Marcer, 2006)⁴. These principles are relevant to treating a baby, who, in order to breastfeed effectively must coordinate suck, swallow, and breathing actions (Carreiro, 2003). The idea for this study grew from personal clinical experiences with breastfeeding mothers and babies, and reflection on several years of clinical experience treating irritable but otherwise healthy

² Part of the Australian Breastfeeding Association's mission statement is to educate and influence society to acknowledge breastfeeding as the normal standard for infant feeding (Australian Breastfeeding Association, 2014b).

³ See Chapter 2.8 for a full account of studies that have investigated interventions to promote breastfeeding.

⁴ Osteopathy is defined on p.6 and its principles and practices are developed more fully in chapter 6.2.2.

babies with some success. It seems logical to me as an osteopath, to evaluate and treat babies who demonstrate symptomatic behaviours that could indicate some form of physical discomfort or dysfunction, which in turn, might interfere with their breastfeeding proficiency.

Through discussion with colleagues and professional experiences of interacting with, and trying to assist, new mothers and babies, it is evident that many complex biological, psychological, cultural, and socially mediated processes are involved. While this could be said of any patient-practitioner interaction, the special circumstances of dealing with a mother and baby, who have particular needs, both as individuals and as a single biological unit, and the contemporary Australian breastfeeding culture are all factors that add to the complexity of issues that an osteopath must take into account when responding to mothers and babies with breastfeeding difficulties. Furthermore, osteopaths are aware that some mothers, who are considering osteopathy for their baby, might feel unsure about it because many view osteopathy as unorthodox compared to traditional medicine⁵. In general, osteopaths, as manual therapists, are perceived to work by manipulating the body and questions might arise concerning whether this treatment modality is deemed to be appropriate, or even safe, for young babies. Although osteopathy has a long history of paediatric clinical practice⁶, the idea that osteopaths treat babies regularly with manual therapy comes as a surprise to many, including practitioners from other health disciplines.

While the theoretical literature emphasises the crucial role that manual therapy plays in osteopathic treatment of babies with breastfeeding difficulties (Carreiro, 2003, 2009), it is not the only form of therapeutic activity. Some of the basic elements of treatment, for example, comprise having time to spend one-on-one with mother and baby within a comforting environment and with the experience of therapeutic touch. Osteopathy has traditionally focused on the body framework, grounded in biomechanics and biomedical sciences. Such knowledge forms the basis of treatment models and the rationale for manual therapy. At the same time, osteopaths claim to follow holistic humanistic principles but scant attention has been paid to discovering more about psychological, social and interpersonal factors that play a part in how osteopaths respond to their patients and influence treatment outcomes. Exploring some of the other, more tacit, less well defined aspects of osteopathic treatment is another important research interest because this component of clinical practice has been largely overlooked.

⁵ A general lack of knowledge concerning who osteopaths are and what they do has been reported in the literature (Cameron, 1998; Qureshi & Kusienski, 2010).

⁶ Since its beginnings in 1874, with the establishment of the American School of Osteopathy by its founder Dr A.T. Still, osteopathy has included treatment of people of all ages including babies and children (Still, 2010).

The background provided thus far highlights my research interest in exploring *all* the processes involved when a mother brings her baby to a paediatric osteopath for treatment. This broad area of enquiry is sharpened by framing it within the context of breastfeeding difficulties. Promotion of breastfeeding is an important health issue and one that paediatric osteopaths address in their clinical practice. Furthermore, my professional interest in this area is heightened by the paucity of research concerning paediatric osteopathic practice and manual therapy intervention, in general, to support effective breastfeeding. Discovering how a grounded theory methodological framework has been successfully used by researchers from other health disciplines, such as nursing, to gain insight into their clinical work, I felt that this research approach could provide a fresh perspective and means to explore paediatric osteopathic practice and, at the same time, shed light on women's experiences with breastfeeding difficulties. Within this background, the research question and aims of the study are now defined.

1.3 RESEARCH QUESTION

How do paediatric osteopaths promote effective breastfeeding in mother and baby dyads with breastfeeding difficulties?

1.4 RESEARCH AIMS

The study has three aims:

- To explore mothers' experiences of encountering and dealing with breastfeeding difficulties.
- To explain how paediatric osteopaths adopt a holistic approach and use manual therapy for the baby to promote effective breastfeeding.
- To generate a substantive theory of paediatric osteopathy in the situation of responding to mother-baby dyads with breastfeeding difficulties.

1.5 OPERATIONAL DEFINITIONS

In the thesis, a number of terms are used that are now defined. Given the specific reference to 'paediatric osteopaths' in the study's aims, an overview of paediatric osteopathic practice is presented to provide a context for explaining what is meant by the term, 'paediatric osteopaths'. Then follows a definition of other operational terms used throughout the study.

Paediatric osteopathic clinical practice means that, unlike conventional medicine, where paediatrics is regulated as a specialised area of clinical practice, paediatrics remains part of general osteopathic practice. Before defining what is meant by paediatric osteopaths, an overview of osteopathy, as a contemporary health discipline, is presented. There is no standardised definition of osteopathy but for the purpose of this study, according to Mosby's Medical Dictionary, **Osteopathy** is,

A form of health care that emphasises diseases arising in the musculoskeletal system and also affecting other systems by extension. There is an underlying belief that all of the body's systems work together, and disturbances in one system may affect function elsewhere in the body. Osteopaths practise osteopathic manipulation, a full-body system of hands-on techniques to alleviate and restore function, and promote health and wellbeing (Harris, Nagy, & Vardaxix, 2006 p.1253).

In Australia, osteopaths are primary healthcare practitioners in that they are trained to recognise conditions that require medical referral (Australian Osteopathic Association, 2014). Osteopathy is considered to be complementary to medicine. It is one of a group of ten complementary health professions, three of which are manual therapy disciplines⁷, which are regulated by the Australian Health Practitioner Regulation Agency (AHPRA)⁸. However, the perception of what are complementary and alternative health professions and therapies is subject to change, individual interpretation, and cultural context. For the purpose of this study, the following definitions are used.

Complementary health professions refer to disciplines that provide various forms of therapy that are viewed, in the main, as working alongside and in cooperation with conventional medicine.

Alternative health professions are disciplines considered to be mutually exclusive from conventional medicine (Oxford University Press, 2010). An example is Homeopathy, which is based on an alternative biomedical system (Xue, Zhang, Lin, & Story, 2006).

Complementary and Alternative Medicine (CAM) is a term, commonly used in the literature, to encompass a range of health disciplines and therapies that consumers use,

⁷ Three manual therapy health professions that are regulated by the Australian Health Practitioner Regulation Agency are osteopathy, chiropractic, and physiotherapy.

⁸ The Australian Health Practitioner Regulation Agency's (AHPRA) operations are governed by the Health Practitioner Regulation National Law Act, 2009 (Australian Health Professionals Regulation Agency, 2010). The National Osteopathy Board of Australia, which regulates the osteopathic profession, operates within the structure of AHPRA and began full operation on 1 July, 2010.

instead of, and in conjunction with, conventional medicine. In Australia, a national population based study, identified osteopathy as one of 17 CAM therapies (Xue et al., 2006).

Manual therapy is characterised by hands-on techniques whereby the practitioner feels the patient's body and applies manually guided forces to normalise body structures. Although many common techniques are perceived to be used by different manual therapy health professions, each discipline operates independently, drawing upon their own principles and techniques. According to the definition of osteopathy⁹, osteopaths practise "osteopathic manipulation"; an expression that is used synonymously with the terms, osteopathic treatment or osteopathic manual therapy.

Osteopathic manual therapy or treatment "uses techniques such as stretching and massage for general treatment of the soft tissues (muscles, tendons and ligaments) along with mobilisation of specific joints and soft tissues" (Australian Osteopathic Association, 2014).

Paediatric osteopaths apply the general principles and practices of osteopathy to babies and young children. However, anecdotal evidence and some preliminary research (Bhat, Goosens, Pitcher, Oberhofer, & Unal, 2010) indicate that clinical practice with this group of patients, and in particular babies, requires special skills. For example, treatment techniques must be adapted to suit a baby's immature and changing physiology and ability to communicate and cooperate. In addition, family circumstance and the mother's wellbeing need to be taken into consideration because the two individuals are so closely intertwined. Although osteopathic treatment of babies is well documented in the theoretical literature (Carreiro, 2003; Frymann, 1976; Moeckel & Mitha, 2008; Sergueef, 2007; Turner, 1994), not all osteopaths treat babies, preferring to refer them to colleagues who are known to have special interest and expertise in this field. Therefore, there exists an informal professional recognition of paediatric osteopaths as those who have the training, experience, and competence required for treating babies and by extension, for providing appropriate support for their mothers.

Patient is the individual who seeks and receives osteopathic treatment. In a health care context, such individuals are known as clients, consumers, or patients. In this study, the more traditional term, **patient**, is used because it reflects the common language used by osteopaths.

⁹ See p.6.

Mother and baby dyad refers to the mother and baby as a partnership, which operates as a single biological entity. The term, dyad, is used throughout the thesis, where appropriate, to reflect this concept.

Breastfeeding is nurturing the baby directly at the breast (Thorley, 2011)¹⁰.

Breast milk feeding is feeding expressed milk to a baby, usually by bottle.

Effective breastfeeding is the successful transfer of milk from the breast to the baby. It is defined also as “a state in which a mother-infant dyad/family exhibits adequate proficiency and satisfaction with the breastfeeding process” (Harris et al., 2006 p.245).

1.6 SIGNIFICANCE OF THE STUDY

There is a need for a study that investigates osteopathic treatment of babies with breastfeeding difficulties. Such a study is relevant to both lay and professional audiences concerned with osteopathic professional practice and breastfeeding trends. No such study has been undertaken before and it is anticipated that knowledge gained would ultimately improve paediatric osteopathic clinical practice and the delivery of quality health care for mothers and babies.

A significant need in the breastfeeding literature was identified regarding the timing, delivery and nature of effective interventions to promote breastfeeding, particularly after discharge from hospital when breastfeeding rates rapidly decline (Renfrew, McCormick, Wade, & Dowswell, 2012). Paediatric osteopaths contend that manual therapy for the baby is one such intervention that may assist at this time and they currently treat babies on this basis (Moeckel & Mitha, 2008; Carreiro 2009). This is an area of clinical practice, however, where little supportive research has been undertaken. Although few in number, studies that investigate manual therapy as a strategy to assist with breastfeeding difficulties¹¹ provide a common rationale for treatment based on an understanding of the biomechanics of a baby's effective feeding actions. Positive breastfeeding outcomes following manual therapy have been reported; however little is known about the processes involved and these conclusions require further investigation. This study aims to redress some of these gaps in the breastfeeding and paediatric osteopathic practice knowledge base by specifically addressing the following three areas: mothers' experiences of breastfeeding difficulties, insight into the influences and processes involved when

¹⁰ For clarity, breastfeeding has been defined because, although its general meaning is well known, as a term, it can be interpreted subjectively according to how it is practised. For example, whether breastfeeding is being established or maintained and to what extent it is used in conjunction with artificial feeding methods.

¹¹ See chapter 2.9.1.

paediatric osteopaths assist mother and baby dyads with breastfeeding difficulties, and developing a substantive theory of paediatric osteopathic practice.

In order to provide women with appropriate breastfeeding assistance, it is important to evaluate breastfeeding women's views. This project seeks insight into a group of women's experiences of being in the situation of wanting to breastfeed yet finding it difficult to do so. Mothers' perspectives on breastfeeding difficulties and osteopathic treatment for their babies add depth to paediatric osteopaths' understanding of their needs. Such knowledge is an important step toward guiding the provision of more meaningful professional health care for breastfeeding women. The study seeks also to identify how paediatric osteopaths promote effective breastfeeding. Definitions of osteopathy and osteopathic manual therapy, drawn from the professional literature¹², emphasise treatment of physical dysfunctions by applying manual techniques to the baby's body. While it is important to make these physical processes explicit, it is also important to uncover broader therapeutic processes and contextual influences, which impact on treatment experiences. Other processes include, for example, interpersonal relationships, and emotional and practical breastfeeding support. Ultimately it is anticipated that this knowledge will assist osteopaths to deliver effective care to assist mothers and babies in their breastfeeding efforts and lead to improved understanding of paediatric osteopathic practice. By understanding the detail of what paediatric osteopaths do, other health professionals are better placed to refer for osteopathic treatment, where appropriate, and find ways to work cooperatively toward achieving better outcomes for breastfeeding mothers and babies.

The methodological framework of this study not only provides the means to explore osteopaths' therapeutic approaches, but to develop a substantive theory that explains osteopathic paediatric practice in the situation of treating mother and baby dyads with breastfeeding difficulties. Such a substantive theory is useful to the profession because it provides a framework to guide practice and that can be potentially applied and tested within other clinical situations. A qualitative study, undertaken with the aim of broadening and deepening understanding of the therapeutic processes involved in osteopathic paediatric practice would provide a new and valuable research perspective.

1.7 STRUCTURE OF THE THESIS

The thesis consists of fourteen chapters and is divided into two parts. The first, Part A, has four chapters that set out the general background and conduct of the study. The second, Part B, presents the results of the study, which are organised into ten chapters.

¹² See section 1.5 and also chapter 6.2 *Osteopaths' professional identity*.

In this first chapter, an introduction and impetus for the study has been provided and the research question and aims identified. In Chapter Two, a review of the breastfeeding literature relevant to the study is undertaken. Chapter Three presents the study's methodology and rationale behind selection of a qualitative approach using Corbin and Strauss's (2008) version of grounded theory. Chapter Four presents the methods used to conduct the study. Chapter Five presents an overview of the study's findings including socio-demographic information about participants and a concise summary of the final theory. Such an overview provides a framework to explain how key findings are organised before they are explicated in more detail throughout the remaining chapters. Chapter Six presents the study's contextual determinants; *Women's views and experiences*, *Osteopaths' professional identity*, and *Health care as a commodity*, which represent the overarching factors that influence participants' experiences and interactions. In Chapter Seven, the study's core problem, *Struggling to breastfeed satisfactorily*, is explicated and its two key contributing factors, *Facing uncertainty* and *Experiencing distress* are presented. The next four chapters, Eight to Eleven, identify and explicate the study's four categories, respectively; *Connecting*, *Assimilating*, *Rebalancing*, and *Empowering*. Each category represents a key conceptual process that rests upon particular strategies and sub-strategies, which osteopaths use in response to the core problem. Chapter Twelve presents, in detail, the study's core category or process: *Promoting optimal breastfeeding through the osteopathic therapeutic cycle*, and its three transitional themes; *Creating the therapeutic space*, *Facilitating positive change*, and *Integrating*. In this chapter, study findings are integrated as a whole to generate the resultant substantive theory. Chapter Thirteen follows with discussion of the theory, its four categories, and how key findings relate to the literature and address the original study aims. Discussion then takes place around the distinctive features of paediatric osteopathic practice, which are compared, where relevant, to those from general osteopathic practice and other health professions. Finally, in Chapter Fourteen, the study's strengths and limitations are presented and the implications for future research are made. The thesis finishes with a final concluding statement.

CHAPTER TWO

BREASTFEEDING

2.1 INTRODUCTION

Breastfeeding has been the subject of extensive research, and in this chapter, I review the breastfeeding literature relevant to this study. My aim is to gain a broad view of breastfeeding to become sensitised to a range of issues and possibilities and at the same time, create a background in which to situate the study and the research question. Breastfeeding issues pertaining to circumstances in Australia and other similar developed countries are thus investigated and more emphasis is placed on breastfeeding practices and outcomes in the postpartum period when mothers leave hospital. This is the time when breastfeeding rates typically decline and mothers, who are finding breastfeeding difficult but wish to continue, are most likely to seek professional assistance, such as osteopathy.

The review starts by considering breastfeeding recommendations, rates and practices followed by a summary of the elements that contribute to effective breastfeeding; its advantages and related influences. This leads to an overview of studies that investigate breastfeeding difficulties, and interventions to promote effective breastfeeding, and support breastfeeding in general. Studies concerned with manual therapy intervention and more specifically osteopathic treatment for babies with breastfeeding difficulties are presented in more detail. Where relevant, gaps in the evidence base relevant to this thesis are identified.

2.2 BREASTFEEDING RECOMMENDATIONS

Advancing technology and social change, in the early part of the twentieth century, saw a rapid decline in breastfeeding and increased acceptance, and use of, infant formula and bottle-feeding (Brodribb, 2004; Carter, 1995; Smith & Tully, 2001; Thomson, 1989). Growing concern over decreasing breastfeeding rates in the 1970s¹³ stimulated a renewed interest in strategies to support breastfeeding, and a rise in breastfeeding related research. As a consequence of research findings, particularly concerning the health advantages of breastfeeding, a number of international resolutions to support breastfeeding were developed¹⁴ (United Nations Children's Fund, 2013; World Health Organisation, 2014b). The World Health Organisation (WHO) (2014a) for example,

¹³ The decline in breastfeeding became most pronounced during the 1950's and 1960's (Carter, 1995) and reached its lowest ebb in the early 1970s (Brodribb, 2012).

¹⁴ For a comprehensive chronological summary of international and WHO and UNICEF global initiatives to promote breastfeeding from the 1970s to 2012, refer to Brodribb (2012, pp. 484-6).

currently recommends exclusive breastfeeding for the first six months, with the introduction of complementary foods and continued breastfeeding up to two years of age or beyond. The WHO recommendation for exclusive breastfeeding up to six months is the widely accepted benchmark for target breastfeeding rates found throughout the literature.

In Australia, the Commonwealth government has taken a number of steps to support breastfeeding (Commonwealth Department of Health and Aged Care, 2000; Commonwealth of Australia, 2009; National Health and Medical Research Council, 2003). A more recent government initiative is the endorsement in 2009 of the *Australian National Breastfeeding Strategy 2010-2015* (Commonwealth of Australia, 2009). Its objective is to increase national breastfeeding rates and practices to align with the WHO recommendation outlined above. Following the release of *'The Best Start'* report (Parliament of the Commonwealth of Australia, 2008); a report based on a parliamentary inquiry into how the government could improve the health of the Australian population through support for breastfeeding, a *'Support Breastfeeding Mums Initiative'* was launched. As a part of this initiative, Australia's first 24-hour, seven days a week, toll-free helpline for breastfeeding mothers commenced on March 20, 2009, in Melbourne (Australian Breastfeeding Association Media Release, 2009), which continues today. The helpline is run by the Australian Breastfeeding Association (ABA) supported by funding from the Commonwealth Government. The ABA has become known as a leading source of breastfeeding information and support, in Australia¹⁵.

The Australian College of Midwives (2011) supports and supervises two significant interlinked WHO global initiatives to promote breastfeeding; the Baby Friendly Health Initiative (BFHI)¹⁶ and the *'Ten Steps to Successful Breastfeeding'* (United Nations Children's Fund, 2014). The BFHI was first launched by the WHO and United Nations Children's Fund (UNICEF) in 1991, to improve hospital and health care systems by encouraging policy change to protect, promote and support breastfeeding (World Health Organisation, 2014c). The *'Ten Steps'*, which were developed by the WHO (2007) after a critical review of the available evidence, summarise the maternity practices necessary to support breastfeeding and form the foundation of the BFHI. In Australia, February, 2014, 77 health services are accredited as 'baby friendly' under this initiative (Australian College of Midwives, 2014).

¹⁵ The ABA has become one of the largest voluntary organisations in Australia. First established in 1964, the ABA's vision is for breastfeeding and human milk to become the norm for infant feeding (Australian Breastfeeding Association, 2014a).

¹⁶ The BFHI, previously known as the Baby Friendly Hospital Initiative, provides a package of tools and materials to facilitate implementation of improved maternity and health facilities that promote breastfeeding.

2.3 BREASTFEEDING RATES

A national standardised system for monitoring breastfeeding has yet to be established in Australia (Tawia, 2010). A lack of consistency concerning definitions of breastfeeding rates, duration and practices has been reported (Brodribb, 2012), which has hampered the collection of high quality data on breastfeeding rates¹⁷. In particular, there has been a general lack of breastfeeding data beyond six weeks post-partum (Martin, Gunnell, & Davey Smith, 2005; Walsh, Pincombe, & Stamp, 2006) and on the percentage of infants that were exclusively breastfed to three and six months (Forde & Miller, 2010; Tawia, 2010). While differences in data collected and analysed across Australian states has been reported, consistent trends in breastfeeding rates are, however, evident. One trend, for example, is that while the majority of new mothers initiate breastfeeding; by six months, breastfeeding rates have steadily declined. Breastfeeding duration and exclusivity remain below Australian government and WHO recommendations. Results from studies that provide more detailed statistical analyses of breastfeeding rates follow.

More up-to-date information on breastfeeding rates in Australia is available from the 2010 Australian National Infant Feeding Survey conducted between November 2010 and January 2011 (Commonwealth of Australia, 2011). While a high initiation rate of 96% for any breastfeeding is reported, this rate declines to 60% at six months. Rates for exclusive breastfeeding drop to 61% at one month and to 2% at six months. Although there is a higher rate of breastfeeding initiation, overall, breastfeeding rates have not significantly improved when compared to data from earlier infant feeding surveys, and rates of exclusive breastfeeding at six months have declined. For example, analysis of the 2001 National Health Survey by Amir and Donath (2005) found that 64% of infants were receiving breast milk at three months, 49% at six months, and 25% at one year. The Australian Institute of Health and Welfare's (2007) review of the '2004-5 National Health Survey' identified that 88% of infants had been breastfed to some extent, which reflected the high rate of initiation of breastfeeding. Similar proportions were reported in 1995 and 2001. However, despite these high initiation rates, only 50% of infants were fully breastfed at three months of age or less; and 25% were fully breastfed at six months¹⁸. Internationally, similar breastfeeding rates have been found in the United States of America (USA) (Ruowei, Darling, Maurice, Barker, & Gummer-Strawn, 2005) and United

¹⁷ "Towards a National System for Monitoring Breastfeeding in Australia: Recommendations for population indicators, definitions and next steps" was published in 2001 by the Australian Food and Nutrition Monitoring Group, so that research data could be comparable between studies and over time (Brodribb, 2004 p.477).

¹⁸ Fully breastfed refers to infants who receive only breast milk on a regular basis (Australian Institute of Health and Welfare, 2007, p. 3).

Kingdom (UK) (Hunt, 2006), reporting slightly lower initiation rates (75%), which drop to less than 25% of exclusively breastfed infants at six months of age.

Although there has been a substantial rise in breastfeeding rates since the 1970's (Brodribb, 2012), another more recent trend is that Australian breastfeeding rates are remaining static over an extended period of time (Amir & Donath, 2008; Tawia, 2010) and continue to fall far short of the WHO recommendation, particularly with regard to duration of exclusive breastfeeding. The National Health and Medical Research Council (2003) dietary guidelines propose that an initiation rate of 90%, with 80% of mothers continuing to breastfeed at six months is a realistic goal. As this goal is clearly not being met, it would seem that current strategies to sustain breastfeeding are insufficient or not meeting breastfeeding women's needs.

2.4 BREASTFEEDING PRACTICES

In Australian maternity hospitals, women are usually discharged at day three after an uncomplicated birth of a normal baby. In Victoria, reviews of the mother and baby by the maternal child health nurse (MCHN) are recommended at two, four, and eight weeks, followed by reviews at four, six to eight, and twelve months (Victorian Government Department of Education and early Childhood Development, 2013). Professional support throughout this period consists mainly of breastfeeding education and practical advice, which is provided primarily by midwives, lactation consultants, and MCHNs depending on the timing of support offered and the protocols of the maternity hospital or local healthcare facility. Once the baby is born, professional breastfeeding support usually begins with individual one-on-one assistance with the first breastfeeds in the early postpartum hospital period. Following discharge from hospital, the MCHN takes responsibility for continued health care. Domiciliary visits are routinely provided only up to a week after discharge and thereafter, consultations take place at the health centre at infrequent intervals; a situation that is purported to result in limited or inadequate breastfeeding support for some dyads (James, 2004). The MCHN might offer breastfeeding support or refer mothers and babies to specialised breastfeeding support services, private lactation consultants, or in some cases, recommend the services of other health providers, such as an osteopath.

In more recent years, some maternity hospitals, such as the Royal Women's Hospital Melbourne (2014) provide Breastfeeding Support Units for mothers with complex breastfeeding issues. However, some studies report that referral to such services can be uncoordinated, under resourced, not available free of charge (James, 2004; Zareai, O'Brien, & Fallon, 2007), and particularly slow to develop in rural areas (Pettingill, 2000).

As lactation can take one month to become established, and many women wean within the first three months, a number of studies concur that strong commitment is needed by the health sector to provide timely, consistent, and effective support services to mothers and babies to maintain breastfeeding (Forde & Miller, 2010; Renfrew et al., 2012; Riordan, Gill-Hopple, & Angeron, 2005).

2.5 EFFECTIVE BREASTFEEDING

Breastfeeding success is a complex concept because its meaning can be interpreted and experienced in individual ways. For breastfeeding women, success is linked to effective practice and a sense of achievement, which implies an emotive element. Ultimately, effective breastfeeding tends to be determined by evidence of a healthy growing baby and satisfied mother and family. Breastfeeding success has been associated with a number of variables and psychosocial influences that have been identified throughout the literature (Mulder, 2006; Riordan & Auerbach, 1993). Factors that are linked to breastfeeding success include the mother's early breastfeeding intentions and motivation (Scott, Landers, Hughes, & Binns, 2001), family and partner's views, sexual factors (Carter, 1995; Thomson, 1989), the mother's education, socio-economic status, level of social support, and experience throughout the pregnancy, birth and the postnatal period (Dettwyler, 2004; Scott et al., 2001; Thomson, 1989; Thompson, Kildea, Barclay, & Kruske, 2011). The infant's personality and feeding style has also been implicated in effective breastfeeding behaviours (Glass & Wolf, 1994; Katsumi, Koichiro, & Madoka, 2004). An accurate knowledge of the biological processes of lactation is preliminary to understanding effective breastfeeding. These processes can be broadly considered in terms of the mother's lactation capacity and the baby's breastfeeding behaviours.

2.5.1 Maternal effective breastfeeding characteristics

The majority of mothers and healthy term babies have a physiological capacity to breastfeed successfully (Brodribb, 2012; Smith & Tully, 2001). Breast changes and initiation of milk secretion involve complex hormonal and nervous pathways that can be influenced by emotions. The mother must also learn positioning skills to enable her baby to establish and maintain an effective attachment to the breast. Breast milk is made available to the sucking baby by excretion of the mother's milk ducts, known as the let-down reflex. Continued lactation relies on the sucking of the baby, which stimulates neurological responses which in turn, lead to hormonal releases, and milk ejection. Breastfeeding thus involves a unique mother-baby supply-demand balance (Brodribb, 2012; Thorley, 2011).

Experiencing some problems particularly in the early weeks of breastfeeding is common and establishing a successful mother-baby breastfeeding relationship has been strongly linked to the mother's motivation and access to appropriate support (Binns & Scott, 2002; Scott et al., 2001). Some studies have focused on mothers' breastfeeding experiences where success was expressed in terms of maternal enjoyment and infant satisfaction (Leff, Gagne, & Jefferis, 1994; Mozingo, Davis, Droppleman, & Merideth, 2000). In these studies, women saw breastfeeding as more than a means of feeding a baby; it "symbolised nurturing and caring and the embodiment of the maternal role attainment" (Mozingo et al., 2000 p.125). Mothers' attitudes to breastfeeding were found to influence their emotional state, which, in turn, influences their breastfeeding capabilities and expectations. Social and cultural attitudes, which also influence maternal breastfeeding decisions and behaviours, are discussed later in the chapter¹⁹.

2.5.2 The baby's effective breastfeeding characteristics

The normal term newborn is born with instinctive feeding responses, which become integrated into learned behaviour, by practice at the breast. The mechanics of how the baby removes milk from the breast has been investigated by numerous studies using different technologies. They include detailed observation of the processes involved (Woolridge, 1986), real time ultrasound of intra-oral events (Bu'Lock, Woolridge, & Baun, 1990), a video camera attached to an artificial nipple to take pictures inside the mouths of babies who are usually breastfed, feeding from a bottle (Eishima, 1991; Tamura, Horikawa, & Yoshida, 1996), measuring changes in intra-oral sucking pressures (Ramsay & Hartmann, 2005; Sakalidis, McClellan, Hepworth, Kent, Lai, Hartmann, & Geddes, 2012), and recording electromyographic muscle activity of breastfeeding muscles (Tamura et al., 1996). Overall, findings from these studies have increased understanding of how the baby coordinates latch, suck, swallow and breathing actions for effective breastfeeding. Such information is of particular interest to osteopaths because it can form part of the rationale for manual therapy treatment.

A baby's mature nutritive sucking pattern involves coordination between many muscles of the tongue, mouth, pharynx, and neck²⁰. To successfully latch onto the breast, the baby must open the mouth wide to acquire a good mouthful of breast tissue and the bottom lip turns out on the breast to create a seal. The tongue, which moves forward as the jaw opens, consists of intrinsic muscles concerned with changing the tongue shape, and

¹⁹ See section 2.5.

²⁰ Neck muscles of the sub-mental triangle, which is the anterior cervical region between the jaw and hyoid bone are particularly active during breastfeeding (Moore & Dalley, 2006).

extrinsic muscles which attach to the jaw, skull, and hyoid²¹ bones (Carreiro, 2003). Tongue movements are described as both wave and piston-like (Brodrribb, 2012; Tamura et al., 1996; Woolridge, 1986). The tongue moves rapidly away from the back of the palate to generate a negative pressure, which, accompanied by lowering of the jaw, draws the nipple and milk contents into the mouth for the start of a new suck cycle (Ramsay & Hartmann, 2005; Woolridge, 1986). Milk excretion from the breast ducts also assists in delivery of milk into the back of the baby's mouth (Ramsay & Hartmann, 2005), which initiates swallowing. Swallowing similarly involves coordinated action of the tongue²², soft palate, oropharynx, and cervical musculature (Carreiro, 2003). Overall, the baby's sucking pattern consists of a series of bursts or group of sequential sucks interspersed with pauses, swallows, and breaths in a highly organised fashion. Swallowing consistently interrupts breathing, so the suck to swallow ratio, which varies for each baby, will influence respiration (Glass & Wolf, 1994; Ramsay & Hartmann, 2005). Anatomical and physiological knowledge forms the basis for analysis of some breastfeeding difficulties, known as suck dysfunctions that are considered later in the chapter²³.

2.5.3 Measuring effective breastfeeding

From a public health perspective, breastfeeding success is defined according to breastfeeding rates of initiation, exclusivity, and duration. From the health professional's view-point, successful breastfeeding is reflected by signs and measures of effective breastfeeding practice, adequate infant growth and development, and maternal and baby health. Numerous studies have attempted to develop tools to determine and measure effective breastfeeding for the purposes of identifying breastfeeding dyads 'at risk', analysing breastfeeding behaviours, and evaluating the effectiveness of interventions (Creedy et al., 2003; Dennis, 2003; Riordan, Bibb, Miller, & Rawlins, 2001).

Moran, Dinwoodie, Bramwell and Dykes (2000) undertook a critical analysis of six tools that claimed to measure breastfeeding interaction but found little agreement amongst them on how to measure a successful breastfeed. However, the baby's latch, suck, swallow, and breathing actions were consistently noted as key determinants of effective breastfeeding; a finding well supported by others (Brodrribb, 2012; Mulder, 2006; Riordan & Auerbach, 1993; Jan Riordan et al., 2005). In recognition of the need to develop an accurate, reliable and easy to use breastfeeding assessment tool, Riordan, Gill-Hopple and Angeron (2005), undertook a study to determine which breastfeeding indicators were

²¹ The hyoid is a small bone situated in the front of the neck, which has important muscle attachments that are involved in feeding and swallowing.

²² Tongue reflexes are controlled by cranial nerves: trigeminal, glossopharyngeal, vagus and hypoglossal nerves.

²³ See section 2.7.1.1.

associated with actual milk intake by observing and recording breastfeeding behaviours, and weighing infants before and after each breastfeed. They found that observed infant rooting and swallowing during the first four postpartum days, and audible swallowing, after this time, provided the best estimate of milk consumption.

Another approach to measuring breastfeeding has been undertaken by focusing on the concept of self-efficacy, namely the ability to perform a specified task. Self-efficacy has been studied within the framework of social cognitive theory (Bandura, 1977), and then applied to breastfeeding situations (Dennis & Faux, 1999). This approach has been used to develop a measure, the Breastfeeding Self-efficacy Scale (BSES), to assess maternal breastfeeding confidence and, where appropriate, instigate self-efficacy strategies (Creedy et al., 2003; Dennis, 2003; Dennis & Faux, 1999). Such strategies are directed toward assisting a mother to master the technical aspects of breastfeeding, offering encouraging feedback, and improving her physical and mental status (Dennis & Sword, 2007).

2.6 ADVANTAGES OF BREASTFEEDING

The advantages of breastfeeding for babies, mothers, families, and communities are well established and include health, social, psychological, economic, and environmental benefits. Breastfeeding contributes to improved infant health and lowered infant mortality (Commonwealth of Australia, 2009; National Health and Medical Research Council, 2003). The nutritional and immunological content of human milk constantly adapts to the baby's needs (Dettwyler, 2004) and its direct benefits for infant nutrition, growth, immunity, and development have been well addressed in the literature (American Academy of Pediatrics, 2005; Blincoe, 2005; Riordan & Auerbach, 1993; United Nations Children's Fund, 2013). More recently, the evidence has reached a critical threshold for breastfeeding to be accepted as a public health recommendation to reduce the risk of Sudden Infant Death Syndrome (Young, Watson, Ellis, & Raven, 2012).

2.6.1 Long-term health benefits

A growing area of enquiry concerns the preventative, long-term, health benefits of breastfeeding for baby and mother. Individual studies, systematic reviews and meta-analyses of the literature, have drawn similar conclusions; that the incidence of particular diseases is reduced in the infant, child or adult who is, and was, breastfed (Ip, Chung, Raman, Trikalinos, & Layu, 2009). Diseases include gastrointestinal infection (Drane, 1997; Gribble, 2011; Kramer & Kakuma, 2009), obesity (Moore, 2001; Oddy, Scott, Graham, & Binns, 2006; Smith & Harvey, 2010), hypertension (Martin et al., 2005),

lymphoma, leukaemia (Moore, 2001), sudden infant death syndrome (Young et al., 2012), diabetes (types 1 and 2), Hodgkin's disease, hypercholesterolemia and asthma (American Academy of Pediatrics, 2005; Van Rossum, Buchner, & Hoekstra, 2006). Maternal protective effects of breastfeeding were found for pre-menopausal breast and ovarian cancer (American Academy of Pediatrics, 2005; Blincoe, 2005). The evidence suggests also that for the breastfed baby, the longer duration of breastfeeding, the lower the incidence of several conditions; otitis media, gastrointestinal and respiratory infections, eczema, asthma, Crohn's disease, leukaemia and obesity (Van Rossum et al., 2006).

The psychological benefits of breastfeeding are also significant. They relate to improved mother and baby bonding and reduced maternal reactions to stress. These effects were found to be associated with close mother-baby skin-to-skin contact and hormonal responses (Brodribb, 2012; O'Brien, 2006). The breastfeeding mother's physiological state has been compared to that of a person with an overall lowered neuroendocrine and cardiovascular response to stress (Blincoe, 2005; Mezzacappa, 2004; Nissen, Gustavsson, Windstrom, & Uvnas-Moberg, 1998), which is important when considering the adjustment required to the maternal role (Carolan, 2005; Mercer, 2010). Others have considered the economic benefits of breastfeeding; primarily as a result of lowered incidence of certain diseases (Drane, 1997), and improved maternal and infant health outcomes (Smith & Harvey, 2010), leading also to decreased parental absenteeism from work (Abdulwadud & Simpson, 2006; Commonwealth Department of Health and Aged Care, 2000). For example, Drane's (1997) study involved an economic analysis of the impact of breastfeeding prevalence on the potential financial savings to the Australian health system. A considerable reduction of health care costs was estimated if the prevalence of exclusive breastfeeding at three months was increased from 60% to 80%.

2.7 CONCERNS WITH BREASTFEEDING

From a health perspective, once the benefits of breastfeeding are weighed against the risks of not receiving human milk, only a few rare medically based contraindications to breastfeeding have been reported (American Academy of Pediatrics, 2005). A review of the literature by Kramer and Kakuma (2009) on the optimal duration of exclusive breastfeeding in developing and developed countries supports the WHO recommendation of exclusive breastfeeding for the first six months. Although breastfeeding is promoted as the healthiest ways to feed a baby, many women continue to use artificial feeding methods and this suggests that, for some, breastfeeding may be difficult or undesirable.

A variety of obstacles to initiation and continuance of breastfeeding have been identified, which can contribute to women's infant feeding decisions and practices²⁴. At some point, some of these obstacles might be perceived as disadvantages. Hunt (2006) points out that with fewer than 25% of mothers in the U.K. exclusively breastfeeding to six months, (as is similar to the situation in Australia); breastfeeding is no longer the norm, and it can be difficult for individuals to go against social norms. Within the women's liberation movement, two differing views on breastfeeding have been presented. One view considers that women need to be given every available support to fulfil their biological role of breastfeeding their babies, while another view expresses the idea that the responsibility of infant feeding should be shared. This can be achieved, in part, through bottle feeding (Carter, 1995; Thomson, 1989). Another commonly expressed view is that breastfeeding difficulties arise largely from social rather than individual reasons (Renfrew, Fisher, & Arms, 1990) and that a lack of supportive breastfeeding policies can impact negatively on breastfeeding (Thomas, 2006).

Common impediments to breastfeeding, reported in the literature, include feelings of embarrassment and adverse reactions to breastfeeding in public (Lavender, McFadden, & Baker, 2006); portrayal of the breast as a sexual object (Carter, 1995; Hunt, 2006; Thomson, 1989); and the challenge of combining return to work and breastfeeding in a non-supportive workplace environment (Brodribb, 2012; Visness & Kennedy, 1997). These issues are not limited to recent times; infant feeding practices such as wet nursing²⁵ have a long history of being shaped by different beliefs and social contexts and are associated with the wider debate about women's choices and changing roles (Carter, 1995).

2.7.1 Breastfeeding difficulties

Although promoted as 'natural', breastfeeding can be challenging. One view-point is that women in developed countries often have less contact with babies or opportunity to learn from watching other women breastfeed (Brodribb, 2004). Studies that explored women's breastfeeding views and experiences in Australia (Binns & Scott, 2002) and the United Kingdom (Graffy & Taylor, 2005) report similar findings; that women expected to have difficulties and felt under prepared for the demands of breastfeeding. Other studies found that many of the breastfeeding problems encountered by new mothers, particularly in the early stages, were manageable, and resolved when the mother was determined to deal

²⁴ The challenges of breastfeeding are discussed in detail in section 2.7.1.

²⁵ Wet nursing is the practice of breastfeeding a baby by a woman who is not the baby's mother. It was common practice in the 18th century, one which declined with social change and the introduction and acceptance of formula and bottle feeding (Golden, 1996).

with them and could access appropriate support (Australian Breastfeeding Association, 2005; Lewallen et al., 2006; National Institute for Health and Clinical Excellence, 2005; Renfrew et al., 2012).

Breastfeeding difficulties can focus on the mother or baby, but in reality they are so closely inter-related that it is somewhat artificial to separate them. Babies with breastfeeding difficulties are typically described as 'fussy' or unsettled (Biedermann, 2004a; James, 2004) and a crying baby creates considerable stress for a mother and family which, in turn, further exacerbates the breastfeeding problems. A baby's unsettled behaviour is most commonly interpreted as hunger-related. The baby may continue to gain weight at a satisfactory rate, or fail to thrive²⁶. If a breastfed baby's weight does not increase in line with recommended guidelines, a diagnosis of insufficient milk supply (IMS) is often made, and supplementation of feeding with infant formula is usually recommended. However, a diagnosis of IMS should only be made by a health professional after a thorough review of the dyad's health status, breastfeeding positioning skills and the baby's feeding behaviours because supplementary feeds with infant formula have been shown to be associated with early cessation of breastfeeding (James, 2004). Often, mothers will self-diagnose, interpreting their baby's unsettled behaviour as related to inadequate quantity and quality of breast milk (Binns & Scott, 2002). Mothers' concerns about milk supply were found to be the most common reason given for stopping breastfeeding earlier than intended (Dykes & Williams, 1999; Graffy & Taylor, 2005; James, 2004; Katsumi et al., 2004; Thomson, 1989). Concerns with IMS were found to be related to women's self-confidence in their physiological capabilities, particularly as it was not possible to precisely measure the baby's milk intake. It can be difficult to determine the underlying cause of IMS, which may be physiologically induced, linked to incorrect feeding practices, and is also heavily influenced by socio-cultural factors (Dykes & Williams, 1999).

Another cause of unsatisfactory breastfeeding has been postulated by osteopaths (Carreiro, 2003; Centres, Morrelli, Vallard-Hix, & Seffinger, 2003; King, 1998; Lay, 1997; Magoun, 1976; S. Turner, 1994), chiropractors (Davies, 2000; J. Miller, Miller, Sulesund, & Yevtushenko, 2009; Vallone, 2004), and a medical physician (Biedermann, 2005). It relates to the potential consequences of unresolved injuries sustained by the baby during birth²⁷. The general consensus is that the irritable behaviour of a healthy but unhappy

²⁶ 'Failure to thrive' is a term used to describe an infant who demonstrates some degree of growth failure. It is commonly defined by a weight gain below the tenth percentile for age specific weight gain guidelines (Lawrence & Lawrence, 1999).

²⁷ Birth trauma can be associated with a long and difficult labour, birthing practices, and the effects of forceps intervention and vacuum extraction on the newborn cranium and upper cervical spine. Many of the

term baby might be due to pain²⁸ or physical dysfunction that constrains the baby's breastfeeding actions (Carreiro, 2003). This view has been supported by some lactation consultants who have recognised that a small proportion of babies do not respond to the usual management strategies. These babies have become generally known as having 'suck problems' (Heselev, 2003; Noble & Bovey, 2001; Palmer, 2002). Suck problems might mean a disorganised suck, characterised by the infant's inability to coordinate suck, swallow and breathe actions, or a dysfunctional suck, characterised by abnormal orofacial muscle tone (Noble & Bovey, 2001).

2.7.1.1 Suck problems

Suck problems are thought to be related to abnormal biomechanical and anatomical relationships, whereby discomfort or restricted mobility of one structure interferes with another and ultimately leads to dysfunction. For example, the baby's head and body position influences hyoid placement²⁹, which, in turn, enables the tongue to move forward and the jaw open. Opening of the jaw is important for the baby to latch effectively onto the breast. Insufficient breast tissue in the mouth can traumatise the nipple, and obstruct milk flow (Brodribb, 2012). It is postulated that abnormal muscular tensions in the neck, jaw, or tongue could result in fatigue and a weakened or poorly controlled sucking pattern (Carreiro, 2003; Magoun, 1976). When breastfeeding, a baby must also breathe sufficiently well to maintain respiratory needs. A baby's respiration relies on coordinated action of respiratory and trunk muscles³⁰ to stabilise the compliant rib cage. During times of increased respiratory demand, breathing rate, rather than volume or depth, increases; this can readily lead to muscle fatigue (Carreiro, 2003; Centres et al., 2003). Two case studies involving breastfeeding infants with suck problems, one with failure to thrive (Norton, 1992), and another who exhibited coughing and choking behaviour during feeding (Glass & Wolf, 1994), were managed successfully by modifying feeding positions to enhance correct anatomical relationships and feeding behaviours, and spacing breaks during breastfeeding to allow the baby's breathing needs to be met.

Some babies with breastfeeding difficulties appear to feed more proficiently from a bottle than the breast. There is general agreement that feeding actions will be affected by the

conclusions drawn from the osteopathic literature that link birth trauma to symptoms arising from disturbance of the baby's musculoskeletal system are based on clinical experiences and anecdotal evidence and cannot be substantiated; however, this body of theoretical knowledge has stimulated much professional thought and debate.

²⁸ It is difficult to interpret why babies show signs of distress as their responses to pain are similar to distress from fear and other non-painful conditions (Choonara, 1999; Mathew & Mathew, 2003).

²⁹ In newborns, the hyoid is a small immature bone that lies within the arch of the mandible, suspended from the base of the skull by ligaments and muscles above the superficial muscles of the throat. There are also muscle attachments between the hyoid and shoulder girdle (Carreiro, 2003).

³⁰ Muscles of respiration are the diaphragm and intercostals, which rely also on the scalenes (neck), quadratus lumborum (twelfth rib to pelvis) and thoraco-abdominal muscles (Carreiro, 2003).

method of feeding: breast or bottle (Sakalidis et al., 2012; Tamura et al., 1996) but the differences remain poorly understood. Generally, it is thought that bottle feeding involves a relatively constant milk flow rate, whereas breastfeeding involves highly variable milk flow rates, thereby requiring a more adaptive suck and swallow response from the baby. For this reason, feeding a baby expressed breast milk from a bottle has been traditionally used as a temporary measure for a baby's immature or weak suck problem (Thorley, 2011)³¹.

2.7.1.2 Maternal problems

Maternal breastfeeding difficulties are identified as sore nipples, breast engorgement, mastitis, and IMS (Duffy, Percival, & Kernshaw, 1997; Righard & Alade, 1992; Smith & Tully, 2001; Thorley, 2005), and tend to be associated with the baby's suck dysfunction and incorrect positioning. These factors can impact negatively on the lactation cycle in a number of ways. Maternal discomfort or pain can inhibit lactation and alter milk composition and secretion (Duffy et al., 1997; Thorley, 2005). Ongoing clinical problems, the ready availability and marketing of infant formula (Dykes & Williams, 1999; Smith & Tully, 2001; Thomas, 2006), lack of breastfeeding management skills and support (Lewallen et al., 2006) and return to work (Abdulwadud & Simpson, 2006; Lewallen et al., 2006; Visness & Kennedy, 1997), are all reasons given for early cessation of breastfeeding.

While uncommon, an unsatisfactory breastfeeding experience can have significant negative psychological consequences. Women have expressed powerful and mixed emotions relating to breastfeeding difficulties, such as relief versus guilt, shame, grief, and a general sense of failure (Dykes & Williams, 1999; Leff et al., 1994; Mozingo et al., 2000; Nelson, 2003). For some women, these feelings took a long time to resolve (Mc Guire, 2007; Mozingo et al., 2000). Women in these studies, typically stopped breastfeeding on their own initiative, often due to several factors in a chain of events; a scenario that emphasises the need for early identification and support for problems as they arise.

2.8 INTERVENTIONS TO PROMOTE BREASTFEEDING

Due to the complexity of issues involved, a multi-layered approach to promote breastfeeding is recommended (Demirtas, 2012; Hunt, 2006; Lavender et al., 2006; Smith & Tully, 2001). The infrastructure provided by governments, health agencies and health professionals is viewed as a key starting point for assisting women who want to

³¹ A new and growing trend of normalising breast milk feeding with a bottle has been reported in the literature, which has raised concerns about the disadvantages of this practice compared to direct breastfeeding (Tawia, 2010; Thorley, 2011).

breastfeed (Thomas, 2006). In Australia, breastfeeding education and support services are provided primarily by maternity hospitals, whose evidence-informed policies and practices underpin a range of breastfeeding support strategies. The Baby Friendly Health Initiative (BFHI) discussed earlier, is one such example. However, successful promotion of breastfeeding through the BFHI relies not only on the development of policies but also on their effective implementation. An Australian-based study found variable levels of compliance with the *'ten steps to successful breastfeeding'* in BFHI accredited hospitals (Marten, Dratva, & Ackerman-Lieblich, 2005). One recommendation of the study relates to adequate levels of training for all staff in the skills necessary to implement the hospital's breastfeeding policies. This view is supported by other studies that have consistently reported maternal frustration and dissatisfaction with professional breastfeeding advice that is perceived to be too complex or inconsistent (Craig & Dietsch, 2010; Graffy & Taylor, 2005; McInnes & Chambers, 2008; Mazingo et al., 2000; Smith & Tully, 2001). Numerous interventions for increasing initiation and duration of breastfeeding have been investigated in the literature and thus, where possible, relevant systematic reviews are presented to reflect general trends. Overall, such reviews have identified that both peer and professional support are important for breastfeeding success (Schmied, Beake, Sheehan, McCourt, & Dykes, 2011; McInnes & Chambers, 2008; Renfrew et al. 2012). As breastfeeding strategies differ in their focus; for convenience, they are considered according to the three different time frames, in which they are typically provided: antenatal, hospital postnatal and later postnatal when mothers and babies return home.

2.8.1 Antenatal interventions

Antenatal education classes are routinely offered by maternity hospitals to prepare future parents for the new experiences of birth and early parenting. Typically, they comprise structured education programmes in a group workshop format, combining information with practical demonstrations and interactive activities. Education on breastfeeding is included with the intention of providing information to assist parents in making informed choices and to have realistic expectations. In more recent times, two main discourses around breastfeeding education have arisen: breastfeeding as natural; and breastfeeding as a technical skill that needs to be learnt (Craig & Dietsch, 2010; Locke, 2009; Thompson, Kildea, Barclay, & Kruske, 2011). It is contended that, in modern times, women have limited opportunities to acquire traditional breastfeeding knowledge through role modelling from other mothers and social networks. They thus need to learn correct positioning and infant attachment skills from perceived experts³². However, Thompson et al. (2011) argue,

³² In Australia, breastfeeding education is provided primarily by midwives and lactation consultants, whose educator roles are considered in section 2.8.2.

that an overtly technical approach to breastfeeding can potentially interfere with more innate breastfeeding behaviours. Locke (2009) proposes, however, that breastfeeding as natural, and breastfeeding as learnt, are not necessarily competing discourses but operate concurrently within contemporary breastfeeding education programmes.

Mixed results have been reported among various clinical trials that have investigated different antenatal breastfeeding educational programmes to increase breastfeeding rates. For example, Duffy et al. (1997) found that a practical 'hands on' antenatal group session (using dolls) improved breastfeeding outcomes and rates at six weeks after birth. However, educational sessions for women during the mid-pregnancy period in an Australian study (Forster et al., 2004) and in a Canadian study (Kluka, 2004), showed no effect on breastfeeding rates compared with standard care. A systematic review of the literature, however, including 11 trials conducted in America, concluded that, in general, educational programmes, which took place before the first breastfeed were effective at increasing breastfeeding initiation rates³³ (Dyson, McCormack, & Renfrew, 2006). Another systematic review reports similar findings but found also that combined individual and group educational programmes were more effective than individual or group sessions alone in increasing breastfeeding rates (Haroon, Das, Salam, Imdad, & Bhutta, 2013). Other reviews similarly report positive associations between individualised education sessions and positive breastfeeding outcomes (Dyson et al. 2006; Pannu, Giglia, Binns, Scott, & Oddy, 2011).

2.8.2 Interventions during the hospital postnatal period

In Australia, during the early hospital based postnatal period, midwives assist the mother to initiate breastfeeding. In an uncomplicated delivery, the first hour of life, which involves heightened mother and baby physiological responses, has been identified as an opportune time for the initiation of breastfeeding³⁴. Early skin-to-skin contact has been implicated in this process and a systematic review of the literature concluded that babies were more likely to be breastfed, and for longer if they were exposed to skin-to-skin contact within 24 hours of birth (Moore, Anderson, Bergman, & Dowswell, 2012). Based upon an accurate understanding of the physiology of lactation, step seven of the "ten steps" advocates that new mothers and babies should remain together at all times. This practice is supported by an Australian study that found, by measuring the volume, frequency and fat content of breast milk in a cohort of 71 exclusively breastfeeding mother and baby dyads over a 24-hour period, a wide range of breastfeeding behaviours, milk

³³ Investigation of interventions to increase duration, rather than initiation, of breastfeeding rates has focused more on strategies delivered in the postnatal period. See section 2.8.3.

³⁴ Refer to the "ten steps to successful breastfeeding" in section 2.2.

production and content (Kent et al., 2006). These results support the view that each mother-baby dyad has a unique, symbiotic breastfeeding relationship and infants should be fed on demand, day and night, rather than conform to an average (Kent, 2007). Strict hospital feeding regimes not aligned to the infant's needs, in association with early introduction of formula have been implicated in undermining breastfeeding initiation (World Health Organisation, 2007). It has been suggested that poor compliance with step seven may be a reflection of past hospital practices or social views that have been resistant to change (Walsh et al., 2006).

Midwives have assumed the role of teacher to new mothers (Fletcher & Harris, 2000; James, 2004; McInnes & Chambers, 2008) and some studies have considered how the midwife's approach to this role can affect breastfeeding outcomes. Findings from a metasynthesis of qualitative research to examine women's perceptions and experiences of breastfeeding support emphasise the importance of a trusting relationship, conceptualised as "an authentic presence", between a mother and her care giver (Schmied et al. 2011, p.51). Thompson et al. (2011) undertook an extensive review of the literature from 1970 to 2010, including some texts from 1940 to 1960, to explore changing midwifery practices around breastfeeding. They conclude that increasing professionalisation of breastfeeding has occurred in line with increasing medicalisation of normal labour and birth, and midwifery practice; however this change has not led to an increase in sustained breastfeeding for Australian women over the past two decades (p.100). They question the negative impact of unnecessary birth interventions on breastfeeding and the emphasis on teaching 'correct' technical breastfeeding skills and advocate for a paradigm shift toward greater emphasis on respecting the innate breastfeeding capacities of women and babies. This idea reflects a trend of shifting breastfeeding interventions toward an individualised needs-based breastfeeding self-efficacy perspective. This trend can be tracked through earlier studies that have implemented new strategies such as the "*hands-off technique*" whereby new mothers were encouraged to position and attach their babies to breastfeed without this being done for them at the Royal Women's Hospital, Melbourne (Fletcher & Harris, 2000) and in maternity hospitals throughout the United Kingdom (Inch, Law, & Wallace, 2003). Other more recent literature review studies similarly emphasise the value of interventions that promote women's sense of breastfeeding self-efficacy, and that are also tailored to individual needs (Demirtas, 2012; Meedy, Fahy, & Kable, 2010).

2.8.3 Postnatal interventions

Once discharged from hospital, interventions to support breastfeeding consist of peer and social support strategies, and specialised professional support provided as part of services attached to maternal health facilities, and by private practitioners. The Australian Breastfeeding Association (ABA), discussed previously³⁵, is generally recognised as a valuable breastfeeding support service that provides breastfeeding women with advice from trained voluntary counsellors and coordinates local social network groups for families (Australian Breastfeeding Association, 2014a). Peer support has been found to be successful in promoting breastfeeding (Dennis, Hodnett, Gallop, & Chalmers, 2002), particularly for young mothers and disadvantaged groups (Bowen, 2005). Findings from a 12-month longitudinal study conducted in 2 Australian maternity hospitals suggests that the most effective methods for increasing breastfeeding initiation and duration consist of more personalised and interactive interventions that are provided over an extended time; from antenatal, early postnatal, to 'at home' periods (Pannu et al., 2011). Overall, international systematic reviews of the literature (National Institute for Health and Clinical Excellence, 2005; Renfrew et al. 2012) report that lay and professional support in the postnatal period, individually, and combined, significantly extended the duration of breastfeeding. Professional support was provided primarily by lactation consultants, both within the hospital, home based, face-to-face and by telephone. Some lactation consultants have recognised that a small group of babies with 'suck problems', who did not respond to the usual strategies, require specialist therapeutic intervention. One such intervention recommended specifically for suck problems was cranio-sacral therapy (Noble & Bovey, 2001; Westcott, 2004). This treatment approach is considered the area of expertise of paediatric osteopaths, but is also used by other manual therapists³⁶.

2.9 MANUAL THERAPIES TO PROMOTE BREASTFEEDING

Knowledge of the neuromotor activity that underpins the baby's breastfeeding actions, the theoretical manual therapy literature (Moeckel & Mitha, 2008; Sergueef, 2007)³⁷, and anecdotal clinical evidence provides a clear rationale for the potential role of manual therapy to facilitate effective breastfeeding. However, only a small number of studies that explored this treatment approach were found, and many lacked critical supporting evidence. The findings from these studies, which involve manual therapies other than

³⁵ See section 2.2.

³⁶ Cranio-sacral therapy is a derivative version of Osteopathy in the Cranial Field (OCF); a treatment approach based on the original teachings of Dr Sutherland, osteopath (Magoun, 1976). Cranio-sacral therapy has been adopted and taught extensively outside the osteopathic profession, and is frequently referred to in the breastfeeding literature.

³⁷ For a more extensive list of the osteopathic theoretical literature see sections 2.7.1.1 *Suck problems* and 2.9.1.

osteopathy, are presented first, followed by those that use osteopathic treatment. Two of the more robust studies; clinical trials that investigated the use of chiropractic (Miller et al., 2009) and osteopathic (Fraval, 1998) treatment as interventions to promote effective breastfeeding, are presented in more detail.

Biedermann, an orthopaedic physician in Germany, conducted a number of observational clinically based studies, over a decade³⁸. He reports typical developmental patterns that occurred in irritable but otherwise healthy babies and proposed a model to explain these observations called '*kinematic imbalances due to suboccipital stress*' (KISS) (Biedermann, 2004a). Babies diagnosed with KISS were generally unsettled and had significant sleeping and feeding problems. It was postulated that dysfunction of the baby's upper cervical spine and muscular tension, potentially as a consequence of prolonged and difficult labour, had a negative influence on behaviour and development. It was contended that manual therapy was able to successfully alleviate many of these symptoms; however, supporting evidence for these conclusions was not provided.

Two case studies involving chiropractic treatment of babies with breastfeeding difficulties were reported in one paper (Hewitt, 1999). The cases involved two infants, aged eight-weeks and four-weeks, who were diagnosed with mechanical lesions of the cranium and spine that were corrected by chiropractic adjustment and cranio-sacral therapy. In both cases, improved breastfeeding outcomes were reported. A clinical trial conducted by Vallone (2004) involved chiropractic assessment and treatment of 25 infants with breastfeeding difficulties. One of the study's aims was to examine the variety of neuromotor causes for breastfeeding dysfunction. Each baby's prenatal and birth history and physical findings were tabulated in detail. The conceptual basis to explain how biomechanical and neuromuscular problems could interfere with successful feeding was discussed and '*craniocervical subluxation*'³⁹ was identified as one of the most important causative conditions. Treatment consisted of a variety of manual therapies, including cranio-sacral therapy, and an 80% post-treatment improvement in latch and ability to breastfeed was reported. Information to substantiate this outcome was, however, missing.

Miller et al. (2009) conducted a descriptive, clinical case series study of 114 infants, who were referred by a medical practitioner to a chiropractic clinic, with suboptimal breastfeeding. This diagnosis was made on the basis that the infant could not be fed exclusively at the breast. Infants underwent a biomechanical evaluation at the chiropractic

³⁸ Biedermann's work and that of other medical practitioners, who were members of the European Workgroup for Manual Medicine has been collated into a book (Biedermann, 2004b).

³⁹ 'Craniocervical subluxation' is a clinical term specific to chiropractic. It refers to a degree of mal-alignment of the joints between the base of the skull and the upper cervical spine.

clinic and clinical findings were documented and later discussed. Infants then received routine care plus a course of chiropractic manual therapy treatment. Outcome measures involved the mother's report on rating of improvement in breastfeeding (or not) on a 10-point numerical rating scale. After intervention, exclusive breastfeeding was reported for 89 infants (78%) within a 2-week time period. All mothers reported some improvement. The authors concluded that cooperative multidisciplinary care was valuable in supporting women who want to exclusively breastfeed their babies, and that chiropractic treatment might be useful adjuvant therapy for breastfeeding problems with a biomechanical component. A recommendation was made for future randomised controlled study designs to more accurately determine the role of manual therapy in promoting breastfeeding.

2.9.1 Osteopathic treatment

Literature specific to osteopathy and breastfeeding difficulties is sparse, although breastfeeding difficulties are implicated in the wider spectrum of physical strains and unsettled behaviour of the newborn due to birth trauma. Several studies were undertaken in America, between the 1960's to 1990's by osteopaths, Frymann (1998) and Upledger (1996), which investigated the relationship between birth trauma, physical strains in the newborn and osteopathic assessment and treatment in the cranial field. Frymann's clinical studies in paediatric osteopathy have been collated into a book (King, 1998). Taken within the context of the time, these early studies were exploratory and results were inconclusive, but suggestive of this being an important field for further study. Osteopathy in the Cranial Field (OCF)⁴⁰, known also as cranio-sacral therapy, is a particular approach, which applies osteopathic principles in a detailed way to the head as part of the body. It has a special focus on babies and children due to the potential deleterious effects of the birth process on the immature cranium, spine, and developing systems. The theoretical literature and anecdotal evidence supports the value of OCF as a treatment approach suited to the paediatric population (Lay, 1997; Magoun, 1976; Moeckel & Mitha, 2008).

Studies that involved osteopathic treatment for babies with breastfeeding difficulties consist of three case studies and one pilot clinical trial. The case studies share some common characteristics. They involve very young infants, aged twelve-hours (Rivera-Martinez, 2005), nine-days (Fraval, 1991), and eleven-days old (Palmer, 2005); a history of a difficult labour; and a baby who demonstrated a weak or dysfunctional suck that persisted after assistance from a lactation consultant. In all cases, OCF was the predominant treatment approach used by the osteopath and the initial findings of physical

⁴⁰ See Chapter 10.3 for further information on osteopathic manual techniques, based on the principles of OCF.

strains resolved after one or two treatments and the baby was able to breastfeed effectively. The babies had been referred to the osteopath by a lactation consultant and the successful outcome was attributed to the combined management skills and techniques of practitioners from both disciplines.

Fraival (1998) undertook a pilot clinical trial to investigate the use of measuring and comparing differences in the pre- and post-feed breast milk fat concentration of breastfeeding infants as a means of determining their sucking efficiency. The study involved twelve healthy term breastfed infants: an experimental group of six, referred by a lactation consultant with a dysfunctional suck, and a control group of six, who were feeding without difficulty. The experimental group received osteopathic treatment, with an OCF approach, over one month. The initial small difference in this group's individual pre-post-feed milk fat measures increased following a course of osteopathic treatment, to a level that was comparable with the 'normal' group. A significant relationship between osteopathic treatment and the changes in pre-post-feed milk fat concentrations was found. The author contended that results could be attributed to an improved infant sucking ability, and recommended that the study be extended to a larger cohort. This pilot study investigates a simple, non-invasive empirical measure of an infant's sucking ability; however the validity of the measure as a research tool and the treatment effects of osteopathic treatment require further on-going scrutiny.

In summary, studies that investigate manual therapy as a strategy to assist with breastfeeding difficulties present a common rationale for this treatment approach based on an appreciation of the biomechanical elements of breastfeeding. In general, positive breastfeeding outcomes following manual therapy for the baby were found; however experimental evidence for the efficacy of manual therapy is limited and these conclusions require further investigation. Research has been unable to establish the effects of specific interventions, such as manual therapy, for breastfeeding difficulties, for several reasons. This includes the lack of valid and reliable breastfeeding outcome measures, the complexity of other contributing factors such as psychosocial support, the involvement of other health practitioners, and the natural course of the condition. All studies did not address long-term follow up; an important issue considering concerns about the decline in duration of breastfeeding at six months.

2.10 CONCLUSION

The extensive breastfeeding literature highlights the many biological, social and cultural factors that influence women's infant feeding practices and decisions. Effective

breastfeeding is defined according to the baby's feeding characteristics of latch, suck, swallow and breathe, influenced by many other individual factors. While natural, breastfeeding difficulties are common. The literature emphasises the significant health related advantages of breastfeeding and the need for a multifaceted approach to promote breastfeeding. Such an approach involves government policies, hospital practices, and educational, social, practical, peer and professional support strategies. Research has indicated that lay and professional support has increased breastfeeding rates but more information is needed regarding the nature of effective interventions to promote breastfeeding, particularly after discharge from hospital when breastfeeding rates rapidly decline. Osteopathic manual treatment of the baby is one such intervention but the supporting evidence-base is weak. Osteopaths argue that the complex neuromotor activity that underpins the baby's breastfeeding actions and anecdotal evidence provides a rationale for the application of osteopathic manual therapy to the baby to facilitate effective breastfeeding, but further investigation is required. As health practitioners, osteopaths need also to consider individual, family, and social attitudes and cultural influences when developing strategies to assist breastfeeding mothers and babies. The literature, in general, calls upon a collective effort to promote a positive breastfeeding culture so that women feel encouraged and supported to initiate and sustain breastfeeding, according to individual circumstance.

CHAPTER THREE

METHODOLOGY

3.1 INTRODUCTION

In this chapter, the methodology of the study and its key philosophical underpinnings are presented. Strauss and Corbin (1998) define methodology broadly as “a way of thinking about and studying social reality” (p.101), whereas Crotty (1998, p.3) offers a somewhat more pragmatic approach by describing methodology as the strategy which lies behind the choice of methods, which are in turn, linked to the research goals. Common to both definitions is the idea that methodology concerns theoretical assumptions and practical considerations that underlie the aims and conduct of the study and the form of knowledge to be generated. The present study uses a grounded theory methodology informed by the theoretical framework of interpretivism and symbolic interactionism. The chapter commences with a discussion of why I chose a qualitative approach and a grounded theory methodology. Epistemological and ontological considerations and the study’s theoretical perspective of interpretivism and symbolic interactionism are presented. Grounded theory is then explained in detail, which includes my choice of Corbin and Strauss’s (2008) version of grounded theory, the level of theory generated, and the characteristics of the methods of this approach. Finally, a critique of the various forms of grounded theory is presented.

3.2 SELECTION OF A QUALITATIVE METHODOLOGY

The nature of the study’s aims, which centre on exploring the actions, thoughts, emotions, and interactive processes that occur between an osteopath and a mother and her baby with breastfeeding difficulties, pointed towards an inductive qualitative research approach. The features of this methodological approach are presented before explaining further the rationale for this choice.

Qualitative research has a long tradition of studying the personal meanings and behaviour of specific groups of individuals in their social settings. A form of knowledge is acquired on the assumption that ‘social reality’ is a product of social interaction as viewed from those involved (Burns, 2000, p.388). Truth is, however, subject to change according to the people, place, and time in which it is placed. Qualitative research is interested in gathering evidence that will reveal the qualities and complexities of life and human behaviour. People’s ideas and actions provide valued sources of information in order to explore the relative nature of human knowledge. A concise definition of qualitative methodology is somewhat difficult to find in the literature. Reasons given for this include qualitative

research's history of embracing numerous epistemologies, using a variety of methods and practices across different disciplines, areas and subjects (Denzin & Lincoln, 2003; Schwandt, 2000). Qualitative methodology tends to be defined according to its core characteristics; essentially, it involves a study of the behaviours, actions and experiences of people in an attempt to understand social processes (Hansen, 2006). As health care is premised on human interaction, often placed within complex situations, qualitative studies have increasingly played a significant role in health-related research (Morse & Field, 1995; Rice & Ezzy, 1999). Grounded theory, for example, is one qualitative methodology that provides the framework and methods for studying human interaction, within the everyday health-care context or clinical environment that these processes occur (Morse & Field, 1995).

In general, qualitative methodologies adopt an inductive research approach. An inductive approach aims to generate knowledge by exploring phenomena in their normal environment such that theoretical propositions arise from a ground-up perspective. Emphasis is placed on an investigatory process that starts from a specific instance and moves to a general pattern of combined instances and then grows to make more abstract statements about the phenomenon being investigated (Taylor, Kermode, & Roberts, 2006). Although the overall methodological approach is described as inductive because ideas are built around what happens in a prescribed situation, researchers use inductive and deductive thinking to develop concepts and hypotheses as the study progresses until a final theoretical construct is reached at the conclusion of the study.

An inductive qualitative methodology was determined to be the best approach to explore the research question, "How do paediatric osteopaths promote effective breastfeeding?" This question is framed in a way that emphasises the elements of process that take place in the paediatric osteopathic environment. It also concerns a specific group of people who interact with each other within a defined social context. The osteopathic clinic is a particular social setting or natural environment in which the phenomenon of interest; in this instance osteopathic treatment processes, occur. Osteopathic treatment is directed toward a mother and baby who are experiencing a problem with breastfeeding, which is a sensitive and multifactorial health and social issue. Osteopathic treatment is based upon a holistic and humanist philosophy. It involves not only specific procedures, treatment techniques and responses, but also an important practitioner-patient relationship and other significant, but less well defined influences. I wanted to capture the complexity of paediatric osteopathic practice and gain insight into the actions and experiences of participants. My aim was to uncover, rather than test, variables. An inductive qualitative

approach was best suited to studying the behaviour of individuals and the processes involved when osteopaths respond to mother and baby dyads with breastfeeding difficulties, in depth, openness, and detail.

3.2.1 Selection of grounded theory methodology

The next decision related to which qualitative methodology was best suited to this study. The emphasis on exploring human interaction and the processes and actions that osteopaths use in paediatric clinical practice pointed towards grounded theory. Grounded theory is one approach that is named for its ability to explore and uncover processes; to start from the ground, in this instance, the basic processes that occur within paediatric osteopathic clinical practice, and move conceptually upward in an inductive way. This approach provided me with a “sense of vision” (Strauss & Corbin, 1998, p.8) or where I wanted to go with the project. Limited research has been undertaken in this area and very few studies specific to osteopathy for babies with breastfeeding difficulties were found. I wanted to explore this area of osteopathic practice but more from the perspective of what happens in practice, in the everyday clinical setting, and the personal meanings that participants attach to their actions, in detail. Conceptual findings that arise from a grounded theory study are derived from data taken from the natural setting; data that is systematically gathered and analysed. Grounded theory identifies and relates factors in ways that can be used to explore complex human problems and to explain relatively unknown situations (Taylor et al., 2006). One of the strengths of grounded theory methodology is that it has proved to be particularly useful in studying substantive areas where little information is known (Morse & Field, 1995; Strauss & Corbin, 1998); as is the case with the present study.

As well as providing the researcher with a sense of vision, grounded theory methodology is known to be pragmatic. It provides the means for bringing the research vision to fruition by offering a systematic approach, guidelines, and techniques for gathering and analysing data and developing theoretical findings. Use of this methodology is well supported by examples of other grounded theory studies⁴¹, particularly in a health care context, and the ready availability of qualitative research texts that provide a background to the approach; its framework, tools and methods.

According to Charmaz (2003a), grounded theory is pragmatic because it offers “analytic explanations of actual problems and basic processes in the research setting” (p.511). Findings that are systematically derived from data in a substantive area of interest are

⁴¹ See examples of grounded theory studies in section 3.5.1.

generally deemed to have practical value because they describe and explain the phenomena under investigation (Bluff, 2005). Strauss and Corbin (1998) contend that grounded theory studies are likely to “offer insight, enhance understanding, and provide a meaningful guide to action” (p.12). This notion is generally supported by the health care literature, for example, where the overall consensus is that grounded theory research has proven to be helpful for informing clinical practice (Corbin, 2009; Rice & Ezzy, 1999; Stern, 1985, 2009; Taylor et al., 2006). A grounded theory is also generally recognised as pragmatic and durable because applicability, relevance, and modifiability are important criteria for ultimately evaluating the research findings (Glaser, 1992).

Theory development, which is a fundamental feature of grounded theory, was an important research goal for this study. While grounded theory methodology focuses on people’s actions and interactions, it also moves beyond detailed and rich description to conceptualisation. It involves discovering, developing and verifying theories of human behaviour (Morse & Field, 1995; Strauss & Corbin, 1998). One of the aims of the originators of grounded theory, Glaser and Strauss (1967), was to inspire researchers to pursue their research interests by generating their own theories and grounded theory gave them a specific method to do this. In the present study, I particularly wanted to undertake research that had a strong theoretical link to clinical practice and the idea of generating a substantive theory of paediatric osteopathic practice from its clinical basis (practice to theory) rather than the other way round, appealed to me.

My preferences and experiences, particularly as a health practitioner, also played a key role in the choice of a grounded theory methodology. I enjoy working with and learning about people and grounded theory focuses on finding the meaning behind interpersonal relationships and actions. While I am comfortable with some ambiguity, I also have a pragmatic view of life. I want to know more about paediatric osteopathy, an area of great interest to me, and I want to develop empirical knowledge that has relevance to clinical practice, academic, and non-academic audiences. As grounded theory methodology is rooted in interactionism and pragmatism, it seemed to fit with my various personal attributes and research goals. Coming from a western medical and scientific method educational and clinical background, its rigorous and structured nature appealed to me. Corbin and Strauss’s (2008) grounded theory offered a balance between a structured yet innovative approach by providing clear guidelines for methods of data collection and analysis but also valuing the flexibility and creativity of the research process. Methodological decisions were also made on the basis of epistemological influences and the theoretical underpinnings of the study; issues that are now discussed.

3.3 EPISTEMOLOGY AND ONTOLOGY

Consideration of the nature of *being* (ontology), and the nature of knowledge (epistemology), including how it is generated, is integral to the choice of each particular approach to research. From the beginning of a study, epistemology, ontology, and methodology must be aligned because these elements inform and are informed by each other. Examining the ideas and assumptions behind the search for knowledge, reality, and truth leads to greater clarity and sense of direction for the research project. This idea is summarised succinctly as “different ways of viewing the world shape different ways of researching the world” (Crotty, 1998, p.66). Ideas and understandings concerning the nature of knowledge, especially with regard to its methods and validation, are important to osteopaths and health professionals, who have a responsibility to their patients. They must continually reflect on what they know and do, and how trustworthy that knowledge and action is. Over time, a range of epistemologies have informed health care research, clinical practice and decision making. The philosophical stance for this project is informed by the epistemology of constructionism, the theoretical perspective of interpretivism, and more specifically, one of its branches, namely symbolic interactionism. These three elements, which are strongly linked to grounded theory methodology, are examined below after a consideration of some other comparative research epistemologies and approaches relevant to the delivery of health care.

Evidence based medicine is premised on the need for health professionals to use rigorous clinical evidence from systematic research as the basis for their clinical decision making. Historically, the dominant biomedical paradigm has developed as the scientific method, which is rooted in the epistemology of logical positivism and advocates the discovery of a true and accurate knowledge of the world (Crotty, 1998). Typically, studies underpinned by this paradigm take a reductionist approach using controlled research environments and in health care research, the randomised clinical trial is recognised as the gold standard of the scientific method. A poststructuralist perspective argues for the use of multiple paradigms for health related research (Cox Dzurec, 1989). While studies undertaken in the positivist tradition have added significantly to medical knowledge, they do not provide information about contextual factors such as relationships, communication and individual experiences. Qualitative research situated in alternative paradigms offer ways for expanding and potentially transforming the clinical research environment by studying it from a variety of perspectives. For example, seeking answers to questions about how to deliver health care in a way that is meaningful to patients and that will improve their quality of life. Some elements of this idea are encapsulated by Miller and Crabtree (2000) who

state, “There is much to be learned about how patients and clinicians actually implement ‘best evidence’” (p.213).

The view that there are multiple perspectives to consider when providing health care aligns with the epistemology of constructionism. This philosophical stance holds that knowledge or meaning is constructed by people as they engage with the world. It rejects the notion of discovering an objective truth, as meaning is not discovered but constructed (Crotty, 1998). Objectivity and subjectivity are brought together as individuals interact with the world and its objects, to create meaning. Individuals construct different meanings according to their own interpretations and experiences. Hence, the epistemology of constructionism links closely to the theoretical paradigm of interpretivism.

3.4 THEORETICAL PERSPECTIVE OF INTERPRETIVISM

Theoretical perspective is defined as “the conceptual underpinning of a research study” (Hansen, 2006, p.182). One such theoretical perspective is interpretivism, which attempts to understand and explain human behaviour and social attitudes by assuming that there are multiple interpretations of reality. Interpretivism “assumes emergent, multiple realities; indeterminacy; facts and values as linked; truth as provisional; and social life as processual” (Charmaz, 2006, p.126). The main intention of research that is situated within an interpretive theoretical perspective is to generate meaning. In order to make sense of a phenomenon of interest, this approach emphasises people’s practices and actions within the prescribed social context. A study that operates within this framework aims to understand how the individuals involved construct their own view of reality and act accordingly. In other words, in the circumstances of dealing with mothers and babies with breastfeeding difficulties, how a mother and baby dyad’s experiences and understandings of their breastfeeding circumstances have brought them to seek assistance from an osteopath; how the osteopath responds to them; and how the three individuals find purpose and meaning through their interaction. Such an interpretive view of events is closely aligned with the distinctive approach to the study of human behaviour called symbolic interactionism, which historically, has been firmly embedded in grounded theory methodology (Glaser & Strauss, 1967).

3.4.1 Symbolic interactionism

Symbolic interactionism is a theoretical perspective which proposes that people make sense of their experiences through symbolic actions, thoughts and processes (Rice & Ezzy, 1999). Interaction is symbolic because it is only possible through using symbolic tools, such as language and gestures, as a way of communicating and constructing

meaning in social contexts (Stern, 1994). Symbolic interactionism was first named by Herbert Blumer in 1937, who attributed George Herbert Mead, an American scholar in the Chicago school of sociology, as chiefly responsible for laying the foundations of this approach (Blumer, 1969). Blumer (1969) described symbolic interactionism as based on three fundamental premises:

The first premise is that human beings act toward things on the basis of the meanings that the things have for them...The second premise is that the meaning of such things is derived from, or arises out of, the social interaction that one has with one's fellows. The third premise is that these meanings are handled in, modified through, an interpretive process used by the person in dealing with the things he encounters (p.2).

Based on Blumer's premises above, symbolic interactionism assumes that people are active and reflective and that they construct their sense of self, society, and reality through interpretation and interaction. The individual's construction of self and the social world is dynamic and continually changed through interaction. Individuals' "meanings arise out of actions, and in turn influence actions" (Charmaz, 2006, p.189). Symbolic interactionism focuses on the dynamic relationships and processes involved between meaning and action, which are influenced by particular circumstances and broader societal structures (Denzin, 1992). For health care professionals, this perspective has particular relevance because their work is based on doing and the meaning that is attached to what they do, within a specified health context and according to the circumstances of the wider health care system.

The epistemological basis of symbolic interactionism provides a framework by which researchers can explore complex human behaviour, by observing and analysing individual behaviour at symbolic and interactional levels (Denzin, 1989). In this study, symbolic interactionism provides a way of thinking about and studying how osteopaths and mothers of young babies, sharing common circumstances, make sense of their experiences. This perspective emphasises how osteopaths and new mothers, interpret, define, and respond to their situation; in this instance encountering and overcoming breastfeeding difficulties. The processes involved are important because meaning is found in a particular communication or action; influenced by the way it has been interpreted, which will in turn, direct further thoughts and actions. For example, the osteopath's thoughts and actions are based on her professionally based and personal intentions as well as her interpretation of the mother's story, views and actions. The osteopath's actions make sense in terms of the system of meanings to which these actions belong, such as her educational background, osteopathic principles, clinical protocols and treatment techniques. The mother's actions

make sense in terms of a range of influences, such as her views and past experiences with osteopathic treatment, personal expectations of new mothering, and societal views on breastfeeding.

Researchers in the symbolic interactionist tradition are not only interested in participants' views but also the processes by which their viewpoints develop and influence or change their behaviour. Different people, based on past experiences and social backgrounds, can come to interpret a specific situation in divergent ways. In a health care context, for example, it can be useful to explore different perceptions of events because shared perspectives cannot be taken for granted. Symbolic interactionism is a theoretical perspective that underpins grounded theory methodology; it informs how information can be gathered, analysed, and used to generate theoretical explanations of human meaning and interaction within a specified context.

3.5 GROUNDED THEORY

Grounded theory was first developed by two sociologists, Barney Glaser and Anselm Strauss in the 1960's, who published their seminal book on the method: *The Discovery of Grounded Theory* (Glaser & Strauss, 1967). Seen within the historical research climate of that time, they developed a new philosophical approach and method with the aim of developing robust theory that "fit with reality" (Morse & Field, 1995 p.157) and was valuable to professional and lay audiences. Glaser and Strauss offered a process for researchers to generate theoretical propositions from collected data, placing a new emphasis on examining human behaviour in detail, within small-scale contexts (Minichello, Sullivan, Greenwood, & Axford, 2004).

Glaser and Strauss's original goals appear to have met researchers' needs, evidenced by the continued rise in popularity of grounded theory, particularly in health care research. There have, however, been shifts and changes in the original version of grounded theory. Glaser and Strauss moved in different directions, employing variations in interpreting and applying the research process. Over time, other researchers have similarly developed new and innovative approaches to conducting grounded theory research, which are generally seen as different versions of the original or classical grounded theory. Charmaz (2009) sees grounded theory as "an umbrella covering several different variants, emphases, and directions- and ways to think about data" (p. 128).

Overall, this shift has been viewed as a healthy and inevitable evolution of a relatively new methodological approach (Morse et al., 2009). It is important, however, from the beginning of a research project that the researcher clearly identifies which version of grounded

theory is to be used. Differences occur in some of the underlying theoretical assumptions that will, in turn, impact on methods of data collection and analysis. My preferred methodology for the present study is Corbin and Strauss's (2008) version of grounded theory. Reasons for this choice and a critique of the three main versions of grounded theory methodology; Glaser's (classical), Strauss and Corbin's, or Charmaz's constructivist approach, are outlined later in the chapter. Despite their differences, these versions share common features. In the main, their shared characteristics are substantive and differences relate more to degrees to which any characteristic is employed (McCann & Clark, 2003a). The elements of grounded theory as a general method are now explicated starting with a discussion of the type of theory generated from a grounded theory study.

3.5.1 Defining a grounded theory

The prime objective in a grounded theory study is theory generation or modification of an existing theory, derived from the data. Silverman (2000) defines theory as a "set of concepts used to define and/or explain some phenomenon" (p. 301). A similar view is held by Strauss and Corbin (1998) who define theory in terms of relationships between concepts, which are integrated to build an abstract framework, which can be used to explain phenomena. The meaning of theory differs from the notion of a theoretical perspective, which provides a broader view of theory and its epistemological underpinnings⁴². Theory is deemed to provide a more focused perspective and range than a conceptual model (McCann & Clark, 2003). Theories also have different properties and tend to be classified as either formal or substantive, according to their level of abstraction, scope, and generalisability.

Formal or grand theories are highly conceptual; they are more generalised and thus have broader applicability. An example is "structural role theory" which has been useful for developing knowledge about human behaviour and social life under a variety of conditions and across different disciplines, such as different organisations, the experience of illness and the delivery of health care (Hardy & Hardy, 1988). Historically, grounded theory was developed at a time when grand theories predominated and research was built around verifying existing theories. Grounded theory was developed with the intention of enabling researchers to discover theory systematically from data (Glaser & Strauss, 1967), in large scale and small scale situations. Substantive theories, often described as "middle range" theories are the more common type of theory generated from grounded theory studies (Morse, 2001). In a grounded theory study, the meaning of 'theory' relates directly to

⁴² Theoretical perspective is discussed in section 3.4.

findings and assumptions confined to the context of the study. They have limited insights into the real world because they concentrate on the micro (between people) aspect of action and interaction. However macro conditions, which are broader in scope and potential impact are also important as they form part of the analytic background (Strauss & Corbin, 1998). Substantive theories are popular and well suited to the field of health care. In this context, macro conditions could include family, hospital, and community influences; while micro conditions are confined to a specific group of people and setting. Each unique theory is constructed from data, and offers an explanatory scheme and some level of predictability that is useful for directing guidelines and procedures (Strauss & Corbin, 1998)⁴³. Examples include the physician-child-parent relationship in caring for the child with a disability (Garth, 2005), what osteopathic care means (Barnes, 2004), and how mental health nurses promote wellness in young adults with schizophrenia (McCann & Clark, 2005). The aim of the present study is to develop a substantive theory that defines the research problem, in this instance breastfeeding difficulty, and offers a theoretical explanation of how paediatric osteopaths respond to mother and baby dyads to promote effective breastfeeding.

3.5.2 Characteristics of a grounded theory study

One of the defining characteristics of grounded theory methodology is the cyclic nature of the research process. Grounded theory methodology provides the framework and tools for data collection and analysis, which occurs concurrently and thus, remains closely linked as the research progresses in successive stages. In this way, theory emerges in close relationship to data collection and analysis. Grounded theory is underpinned by the following seven key characteristics; theoretical sensitivity, theoretical sampling, constant comparative analysis, coding and categorising the data, theoretical memos and diagrams, use of the literature, and integration of the theory (McCann & Clark, 2003). A brief summary of their main elements follows and where variations occur as a result of the different versions of grounded theory, the differences are identified.

3.5.2.1 Theoretical sensitivity

Corbin and Strauss (2008) define sensitivity as “the ability to pick up on subtle nuances and cues in the data that infer or point to meaning” (p.19). Sensitivity is thus a quality of the researcher’s approach to the investigatory process. The researcher can demonstrate sensitivity in a number of ways; according to how she interacts with participants during interviews, the questions she asks, and how she responds to the data. Theoretical sensitivity is commonly referred to as a starting point of seeking some clarity or insight

⁴³ Predictability relates to transferability of a study’s findings, which is discussed in Chapter 4.7.3.

about the phenomenon of interest (Strauss & Corbin, 1998). It is a beginning point in the analytic process because it allows the researcher to move beyond a surface understanding and gain access to the meanings in the data at a deeper level. It also allows the data to speak for itself and not be driven by the researcher's assumptions or preconceived ideas.

Theoretical sensitivity tends to be discussed in terms of its contrasting relationship to objectivity. There is an ongoing debate within the literature concerning sensitivity versus objectivity, and how the researcher influences the research situation (Holloway & Wheeler, 1996). In order to gain rich data, the researcher becomes immersed in the research setting yet must maintain some analytic distance. Strauss and Corbin (1998) advocate for a balance between sensitivity and objectivity; a situation where the researcher is reflexive and aware of her own assumptions, in order to avoid bias, and be truly open to uncovering participants' perspectives and the new⁴⁴.

Theoretical sensitivity is a research skill that the researcher can develop by being aware of her assumptions concerning the area of interest and by adopting a mindset that is open to research participants' views and experiences. The literature, professional background, and personal experience can be sensitising sources if used in ways that give meaning to events without imposing extant ideas onto the data. Theoretical sensitivity continues to be developed as the research progresses through the use of the analytic tools of grounded theory, such as asking questions, making theoretical comparisons, theoretical sampling, and coding techniques. These tools stimulate the inductive process and further sensitise the researcher to discovering the relevant properties and dimensions of emerging categories and concepts (Strauss & Corbin, 1998).

3.5.2.2 Theoretical sampling

Theoretical sampling is "a method of data collection based on concepts/themes derived from data" (Corbin & Strauss, 2008, p.143). It differs from other purposive sampling techniques in that it pertains only to the ongoing development of concepts and theory. It is the process of obtaining selective data to refine, check and expand major categories (Charmaz, 2006). Initially the researcher collects data from a wide range and as analysis takes place and concepts arise, the emerging theory influences further decisions regarding participants and the nature of new data to be collected. Sampling is cumulative and no longer predetermined as at the start of the project. It builds upon previous data collection and analysis, and with time, becomes more specific. Sampling becomes based

⁴⁴ See Chapter 4.4 for discussion of the researcher's expectations and assumptions.

on the concepts that have emerged from data analysis and its purpose is to further develop these concepts in terms of their properties and dimensions (Strauss & Corbin, 1998), until no new properties emerge. This point is referred to as data saturation, that is, when no new information is forthcoming and the researcher determines that, for the purpose of the study, each category has been sufficiently well developed in terms of its properties and dimensions and under different conditions (Corbin & Strauss, 2008). Theoretical sampling provides direction for gathering more focused data in order to answer analytic questions, fill conceptual gaps, and help the researcher to fit the emerging theory with the data (Charmaz, 2006).

3.5.2.3 Constant comparative analysis

Constant comparative analysis is a basic procedure in grounded theory that continues throughout the analytic process in conjunction with other, more defined analytic tools, such as theoretical sampling and coding. Its purpose is to find similarities and differences in the data. Constant comparative analysis involves asking questions that will lead to greater theoretical understanding of the phenomenon of interest. Questions are also directed at identifying variations in patterns found in the data, through comparison of their properties and dimensions under different circumstances (Strauss & Corbin, 1998). Glaser's classical grounded theory approach favours constant comparison of event to event and event to emerging concept as a technique that enhances natural emergence of theory (Grbich, 2003). Doing constant comparative analysis is described as an art (Charmaz, 2006; Strauss & Corbin, 1998), as the researcher's creativity and line of questioning and use of comparison is what yields rich data and innovative analyses. This technique aims to stimulate thinking about the research question and the data in a variety of ways; by enhancing sensitivity, guiding the research direction and theoretical sampling, and by developing abstract concepts that ultimately generate theory.

3.5.2.4 Coding and categorising the data

Coding and categorising is the process of defining and making analytic interpretation of the data; it involves "abstracting, reducing, and relating" events, acts, and outcomes (Strauss & Corbin, 1998, p.66). Coding starts by breaking down or fracturing the data to open it up, uncover ideas, look for patterns, and develop concepts. It involves labelling segments of the data in a way that simultaneously summarises and accounts for each piece of data (Charmaz, 2006). All data are coded but initial codes tend to be modified or transformed as analysis progresses (Holloway & Wheeler, 1996). Codes with a similar meaning are linked and redefined as categories, which have a higher level of abstraction. Categories are defined as "concepts that stand for phenomenon" (Strauss & Corbin, 1998,

p.101). As the relationships between categories are further developed by coding techniques, sub-categories or “concepts that pertain to a category, giving it further clarification and specification” (Strauss & Corbin, 1998, p.101), are also developed. The researcher moves back and forth between the different coding techniques in response to the direction and flow of the research pathway. Three different levels of coding are identified by Strauss and Corbin (1998): open, axial, and selective coding. In classical and constructivist grounded theory, similar levels of coding are found but with some differences; the main one being the absence of axial coding.

Open coding is defined as “the analytic process through which concepts are identified and their properties and dimensions are discovered in data” (Strauss & Corbin, 1998, p.101). Open coding is used at the beginning of analysis to break down the data into discrete parts, in order to name and give meaning to it (Bluff, 2005; McCann & Clark, 2003). Microanalysis, which involves very careful examination of the raw data, such as line-by-line analysis, is used initially and at times when new events occur in the data. It is a tool to assist in conceptualising data and giving labels to patterns found within it. Microanalysis forces the researcher to focus on the data, without the undue influence of preconceived ideas. When codifying or assigning names to concepts, the researcher needs to think carefully about her choice of words to describe what takes place in the field of study. The purpose of labelling phenomenon is to make it recognisable and able to be grouped according to its particular property or attributes (Strauss & Corbin, 1998).

As codes arise, they can be labelled in two ways; in vivo codes and sociological constructs (McCann & Clark, 2003). The first, in-vivo codes, uses participants’ own words rather than those of the researcher. Various meanings can be attached to a word or phrase and exploring every possible meaning behind participants’ use of a particular word or phrase is an analytical strategy that avoids the problem of the researcher assigning their own interpretation (Corbin & Strauss, 2008). In-vivo codes tend to be found frequently in the data and often contain a sense of imagery, which closely reflects participants’ experiences (Holloway & Wheeler, 1996). Using in-vivo codes has the advantage of keeping the analysis close to the data and more accurately representing participants’ meanings. The second way of codifying data is to use the researcher’s words, which are based on a consideration of theoretical knowledge, expertise, and what appears in the data. Sociological constructs have the advantage of providing a more abstract scholarly perspective but can lack the more vivid imagery of in vivo codes. Strauss and Corbin (1998) view conceptual labelling as a creative research skill because it involves emphasising a phenomenon in terms of its link to the conditional background in

which it is located and on the basis that its name should evoke a sense of imagery that captures a particular action or quality.

Axial coding follows open coding. It is termed 'axial' because coding occurs around the axis of a category, as the nature of each category's properties and dimensions are defined and relationships between categories are further explored. As links between categories and subcategories are made, the data are "reassembled" (Strauss & Corbin, 1998, p.103) or put back together in a different form (Holloway & Wheeler, 1996), as a 'coherent whole' according to the emerging analysis (Charmaz, 2006, p.60), and as an important start to building theory. The process draws on the same tools of grounded theory analysis, such as asking questions and making comparisons, using inductive and deductive thinking (Bluff, 2005; McCann & Clark, 2003), which overall, requires a more focused and abstract approach than that needed for open coding.

One of the differences between Glaser and Strauss's original, and Strauss and Corbin's later, versions of grounded theory relate to the addition of axial coding and the specific technique of using a prescribed coding paradigm. Strauss and Corbin introduced these analytic devices intending to help the researcher pose relational questions about the data to enable it to be reconstituted in new ways. According to Glaser (1992), this approach was viewed as a distortion of the original ideas of grounded theory, which held that meaning was discovered within the data and allowed to emerge rather than be made to fit or forced into a predetermined structure (Bluff, 2005).

Selective coding is "the process of integrating and refining the theory" (Strauss & Corbin, 1998, p.143). Coding at this stage becomes more sophisticated as major categories, which contain developing theoretical ideas, are constructed. Selective codes represent recurrent themes and are more abstract, general, and "analytically incisive" than the initial codes that they subsume (Charmaz, 2003b, p.322). Selective coding involves the linking of all categories around a core, also described as the basic social-psychological process or "essence of the study" (Holloway & Wheeler, 1996, p.106). The aim is to discover the core or overriding category, to integrate it with other categories and validate the links between them. The processes used at this stage are theoretical coding, theoretical sorting and saturation, memos, and diagrams.

3.5.2.5 Theoretical memos and diagrams

Theoretical memos and diagrams are tools for conceptualising the data and the relationships between the codes and categories, and for ongoing theory development. Memos are "written records of analysis" (Corbin & Strauss, 2008, p.117). Essentially, they

consist of exploratory, creative, and spontaneous notes that reflect the researcher's interaction with the data at that point in time. They can range in their style, from free flowing ideas and questions to well-constructed analytic statements. Memos link coding of the data to the report writing process and Charmaz (2003b) describes them as "the crucial intermediate step that moves analysis forward" (p.322). Charmaz (2003b) identifies six ways that memo writing helps the researcher; to think about the data, stimulate ideas to check in further interviews, discover gaps in earlier interviews, treat qualitative codes as categories to analyse, clarify and define categories, and make explicit comparisons (p.323). In the current study, when writing memos, I found it helpful to include excerpts from participants' interviews or observations as the basis around which memos were written. In this way, memos maintain the link between data, the original analysis of the data, and report writing. Memo writing is a tool for taking codes apart analytically, before raising them conceptually to form categories and then to delineate categories in terms of their properties and relationships with each other. In this way, memos provide the foundation for the written drafts of segments of chapters of the thesis and the final written theoretical construct.

Diagrams are "visual devices that depict relationships between analytic concepts" (Corbin & Strauss, 2008, p.117). Diagrams arise from analysis and provide a visual representation of thought. They develop in complexity and clarity as the research progresses and with time, become more integrative. I found diagrams particularly useful for organising data, capturing the relationships between multiple concepts, and providing a broad overview of the study's findings. Diagrams force the researcher to work with and present their findings at once, in a systematic way; "in a manner that reduces the data to their essence" (Corbin & Strauss, 2008, p.125). Together, memos and diagrams work in different but complementary ways to enrich, bring to life, and make explicit the various meanings found in the data.

3.5.2.6 Literature

The place of the literature in grounded theory studies can be confusing. In classical grounded theory, Glaser and Strauss (1967) advocate delaying a review of the literature until after analysis is completed; a practice thought to encourage the researcher to articulate original ideas and not through the lens of known theoretical constructs. In principle, Glaser (1992) continues to adopt this stance but Strauss and Corbin have moved away from this original idea on the basis that it can be impractical and ambiguous. In general, grounded theorists recognise that the researcher already brings a professional

body of knowledge and disciplinary literature with her (Morse et al., 2009) and a review of the literature can be used as a methodological tool in different and specific ways.

A preliminary review of the literature serves a particular purpose. It justifies the need for the study, develops sensitising concepts, and creates a background to the study (McCann & Clark, 2003). A second literature review is used as an analytical resource. The most common concern about the use of literature is the potential for it to limit creativity and impose existing ideas onto the data. Most grounded theorists agree that it is how the researcher uses the literature in a grounded theory study that is important. Some of the advantages of using the literature, noted in previous discussions, relate to its ability to enhance theoretical sensitivity and theoretical sampling. It is contended that the researcher can look to the literature to relate extant theories to the developing theory without necessarily imposing ideas onto the analysis and theoretical findings (Stern, 1985). Charmaz (2006) contends that a thorough and critical review of the literature can lay the foundation for a scholarly discussion in a substantive area and strengthen the study's findings, which in turn, enhances its credibility. McCann and Clark (2003) summarise five key benefits of using the literature as enhancing theoretical sensitivity, providing a useful secondary source of data, giving rise to questions about the data, providing an important means of theoretical sampling, and offering an approach to validating the data. In summary, the literature can be used by the researcher in a number of ways as an analytical device to assist with exploring ideas, thinking about the data, evaluating the trustworthiness of findings, and ultimately enhancing conceptualisation.

3.5.2.7 Integration of theory

Integration is the last step of analysis, where all the research threads are pulled together to create a plausible explanatory framework (Corbin & Strauss, 2008). The categories, which are well developed in terms of their variations, are linked around a core category and the final theoretical construction is refined. Integration of theory is achieved by linking data collection and analysis along the way; a process that is continued until a theory with sufficient detail and abstraction is generated. At this stage of the analysis, the researcher might search for a negative case which often represents a variational extreme or exception that will provide a richer conceptual view of a phenomenon. In the present study, the data yielded a broad dimensional range, and while I did not search for a negative case, dimensional extremes were evident in some instances. For example, there were situations where breastfeeding and the baby's behaviour were deemed to be either significantly improved or worse after osteopathic treatment. This situation, particularly if the latter, had consequential effects for how the osteopath proceeded at the next visit.

Exploring the processes involved in dealing with this situation added depth to the analysis. Other strategies likely to be useful for integration include theoretical sampling, memos and diagrams, and selective sampling of the literature and data. These strategies continue to uncover properties of the main categories and deduce and check hypotheses. The emphasis shifts from exploring to summarising, checking and filling in logical gaps to assist with conceptualisation, fine tuning, and integration of the final theory.

3.6 CRITIQUE OF GROUNDED THEORY

The three main versions of grounded theory are examined as a prelude to explaining my choice of Corbin and Strauss's (2008) approach to grounded theory methodology for the present study. For the purposes of this discussion, the three versions are named after their originators; Glaser, Strauss and Corbin, and Charmaz, although the original or classical grounded theory was first developed by Glaser and Strauss (Glaser & Strauss, 1967). Glaser (1992), however, remained steadfast in his support of the original version, while Strauss, in association with Corbin, instituted some fundamental changes (Strauss & Corbin, 1990, 1998). Corbin (2008) then went on to write a revised text that reflects how she and her approach to Strauss and Corbin's (1998) methods might have changed over time or become '*modernised*' (Corbin, 2009, p.42) and aligned more with contemporary views of qualitative research. Charmaz (2003a, 2006) sought to retain the ideas intrinsic to grounded theory but provide a new framework for analysis. She argues that as the social world changes, so should "twenty first century methodological assumptions and approaches" (Charmaz, 2006, p.9).

The differences in grounded theory approaches can be traced back to their roots. Glaser came from a quantitative positivist research background and Strauss came from a pragmatist and social science field research tradition. Together, they created a new philosophical framework and strategy for qualitative analysis of everyday empirical data. According to Charmaz (2003a), Glaser retained his link with traditional positivism while Strauss and Corbin moved toward an objectivist position. She argued the case for taking the tools of grounded theory "from their positivist underpinnings to form a revised, more open-ended practice of grounded theory that stresses its emergent, constructivist elements" (p. 510). Constructivist grounded theory reflects its "pragmatic roots and relativist epistemology" (Charmaz, 2009, p.138). Keeping in mind that all versions of grounded theory share many common characteristics, it is useful for the researcher to consider how the different theoretical underpinnings impact on the conduct of the study. The main differences in approach concern identification of the research problem, the position of the researcher and her relationship with participants, and how the theory is

developed. These considerations and a preliminary outline of my views of each approach, their differences, and strengths are presented.

A Glaserian (Glaser, 1992; Glaser & Strauss, 1967) approach to grounded theory provides a strong conceptual focus for the undertaking the study but limited structure or practical advice. At the start, there is no literature review as the emphasis is on emergence of the problem area, from the data. The overarching premise is that the research guides the ongoing direction of the investigatory process and the researcher remains focused on, and open to, what is happening in the data. While the researcher is immersed in the delineated area of interest, she adopts an independent stance. Glaser places less emphasis on fragmenting the data in favour of making theoretical comparisons and theoretical coding to relate categories to each other. In this way, the emergent theory is derived from data and not tainted by or arrived at by the researcher's or other theoretical assumptions.

Strauss and Corbin (1990, 1998) offer a more structured approach to transforming research ideas into practice within a grounded theory framework. The research problem is identified by using a combination of experience, pragmatism, and the literature (Hunter, Murphy, Grealish, Casey, & Keady, 2011). The researcher is advised to take a balanced stance between objectivity and sensitivity. This stance is based upon the assumption that the researcher brings her experiences and perspectives to the research task. Through awareness and transparency, and by employing grounded theory tools and procedures in a systematic way, the researcher avoids imposing preconceived ideas on the data and ultimately, an abstract theory is developed. The advantage of this approach is that it offers practical guidance for neophyte researchers and those new to grounded theory in how to undertake data collection and analysis. It has, however, also been criticised as being too technical and rigid, although Strauss and Corbin emphasise that the procedures they offer are only tools to be used creatively and flexibly by the researcher (Allen, 2010).

Charmaz (2006) argues for a constructivist approach to grounded theory based on the idea of theory as a co-construction between the researcher and research participants that is situated in a specific time, place, and context. The research problem is identified by discipline-specific sensitising ideas. The researcher and research participants have an interactive relationship that values reciprocity and the researcher's background, assumptions, and views are made explicit. Theory is not discovered or emergent; it is constructed by an interpretive portrayal of participants' data; data that is also a construction based on participants' interpretation of their circumstances. The theory is thus grounded in the researcher's and participants' experiences. A fundamental

assumption is that “constructivists aim for interpretive understanding of the empirical phenomena in a theory that has credibility, originality, resonance, and usefulness, relative to its historical moment” (Charmaz, 2009, p. 139). I found Charmaz’s approach fresh and stimulating but felt uncertain about the extent to which the researcher becomes involved with research participants and in theory development. I considered this approach to be more suited to the experienced researcher.

3.6.1 Selection of the approach to grounded theory

From the beginning, two factors influenced the decision to use Corbin and Strauss’s (2008) approach to grounded theory. First, this approach reflected my preference for a shift towards a pragmatic constructivist epistemology. Corbin (2009) contends that the philosophical underpinnings of Strauss’s original (1990, 1998) method remain unchanged; ‘rooted in pragmatism and symbolic interactionism, with its emphasis on structure and process’ (p.37) but there has been a subtle shift or updating of the method in line with the present. It was important to me that the fundamental links with earlier versions were maintained, particularly concerning the relationship between objectivity and sensitivity (Strauss & Corbin, 1998, p.42). The idea of the researcher finding an individualised sense of balance between objectivity and sensitivity resonated with me on the basis of my experiences as a health practitioner. While interacting with patients, I have developed an awareness of my potential to influence them and the need for seeking and at the same time, valuing a balanced professional and individualised interpersonal relationship. While Glaser’s, and Strauss and Corbin’s forms of grounded theory have strong links to positivism and post positivism, the epistemological shift, influenced by postmodern ideas, of Corbin and Strauss’s (2008) approach was considered more appropriate than the critical realist ontology of classic grounded theory. Second, Strauss and Corbin offered a more structured approach to data collection and analysis. This was an important consideration for me as a novice researcher as this approach provided step-by-step guidelines and techniques to assist in gathering and constructing detailed and rich data (Charmaz, 2003a). Although this approach has been criticised by some as being overly prescriptive (Allen, 2010; Hunter et al., 2011), I felt that, at its core, Corbin and Strauss’s (2008) version also fostered considerable flexibility and innovative research.

As this was my first experience of undertaking a grounded theory study, my choice was theoretically based. As I moved further into data collection and analysis and used the techniques and procedures to explore the research problem, I became more aware of the fluid and dynamic nature of the analytic process. This stimulated my interest in the more contemporary discourse regarding how grounded theory has continued to evolve,

particularly in the postmodern era. Taylor (2006) notes that researchers can choose to be influenced by postmodern ideas but not constrained or directed by them (p.327). Some of the newer ideas regarding qualitative research include a re-evaluation of the nature of knowledge and truth, and what constitutes rigorous and quality research. Throughout the discussion of variant forms of grounded theory, there appears a common thread of valuing grounded theory as a creative and thinking process in which study participants, including the researcher, find meaning and respond to events according to a number of factors such as their experiences, time and place, and backgrounds. Stern (2009) for example, states

I see grounded theory as a creative process; if you really want to know what is going on, you have to feel it; you have to be affected by it; you have to let it move you. There is no place for objectivity in grounded theory (p.57).

Stern's comments challenge some of the basic tenets of classical grounded theory. The question of the researcher's role in the analysis has been much discussed. There appears to be a greater call for reflexivity; for researchers to reflect upon and make visible how they influence the research process, and, in turn, how it influences them. As a health practitioner, I agree with Corbin's practical stance as a nurse; that clinical practice requires a body of knowledge to guide action. Conceptualising data provides a language for professional discussion and developing knowledge-based practice and knowledge "may not mirror reality; but it does help us understand human response" (Corbin, 2009, p.40).

My final comment on grounded theory relates to the criticism that had been directed at some research that claims to be grounded theory but has not faithfully employed the methods or there was a muddling or lack of clarity between grounded theory and other interpretive methods (Stern, 1994). Charmaz (2009) suggests that inexperience or researchers' limited understanding of grounded theory methodology has "by default, contributed to making it a general method rather than a unitary one" (p128). For this reason, and as a novice researcher, I took care to adopt a systematic methodological approach within a particular theoretical perspective and make clear my use of a Corbin and Strauss (2008) grounded theory framework.

3.7 CONCLUSION

A systematic investigation of a research problem rests upon assumptions about forms of knowledge and ways of knowing. In this chapter, epistemological and ontological assumptions and choices regarding the study's methodological approach are articulated in order to make clear the principles, philosophy, strategies, and procedures that underpin

the research project. The rationale behind the researcher adopting a qualitative grounded theory methodology, informed by the theoretical perspective of interpretivism and symbolic interactionism for the present study, has been presented. This approach was deemed to best fulfil the study's aims of exploring, in detail, how osteopaths and mother and baby dyads with breastfeeding difficulties interpret and make sense of their circumstances and respond through actions, thoughts, and emotions. Corbin and Strauss's (2008) version of grounded theory was preferred due to its tendency toward a constructivist epistemological stance, and its ability to offer a creative, flexible approach combined with particularly clear methodological direction. This methodology was chosen also because it provides the means for meeting another important research goal; generating a substantive theory grounded in paediatric osteopathic practice. Such a theory that has a tight fit with data derived from paediatric osteopaths' and mother and baby dyads' experiences of dealing with problematic breastfeeding offers an explanatory framework that reflects an interpretation of reality that is likely to offer insight with the potential to inform health care practice.

CHAPTER FOUR

METHODS OF THE STUDY

4.1 INTRODUCTION

This chapter presents the methods of the study, which concern the collection, management, and analysis of data, which occurred concurrently over the course of the study. The chapter begins by presenting the context in which the study was conducted. Ethical considerations are discussed next as they impacted on all decisions about the study's methods. An account of how study participants were selected and recruited is then presented, followed by discussion of methods of data collection and analysis. Finally, issues of academic rigour are addressed.

4.2 CONTEXT OF THE STUDY

A feature of the grounded theory method is that the researcher becomes immersed in the culture and setting of the study in order to explore the research problem from participants' perspectives. This study was conducted within the context of paediatric osteopathic clinical practice. Osteopathy has a long tradition of incorporating paediatrics into general practice⁴⁵. However, anecdotal evidence and some preliminary research (Bhat et al., 2010) indicates that osteopathic practice with this group of patients, and in particular babies, requires special skills. For example, treatment techniques need to be adapted to suit a baby's body and ability to communicate and cooperate, and the osteopath also must address the mother's concerns because the two individuals' wellbeing is so closely intertwined.

4.2.1 The osteopathic clinic

The natural setting for the study was osteopath participants' clinics. Here, mothers arrived for treatment of their babies with breastfeeding difficulties according to scheduled appointments. Osteopath participants worked autonomously in private practice providing care on an individual basis. Their clinics were located throughout metropolitan Melbourne. Typically, the clinic premises were shared by a small group of osteopaths or allied health practitioners. Each osteopath worked in her own room and shared a common reception area, services, and facilities. Overall, the clinics presented a 'family-friendly' environment in that they provided a pleasant informal reception and treatment space that catered to mother and baby dyads' needs. Practitioner treatment rooms followed this trend and were distinctively organised and personalised, often with family photos on display. The room

⁴⁵ Osteopathic assessment and treatment of babies and children has taken place since its foundation in 1874 by Dr Still (Still, 1992).

reflected much in the way practitioners worked and presented themselves, professionally and personally, to their patients. A few worked as sole practitioners in clinics set up in their homes.

The waiting room in the clinic is where I first met the mother and baby face-to-face and began gathering information through informal interaction and general discussion. Observations of treatment sessions between dyads and the osteopath took place in individual treatment rooms, which also provided the setting in which most of the osteopaths were interviewed. Data concerning the clinical setting was gathered and written down as field notes.

4.3 ETHICAL CONSIDERATIONS

Research must be conducted within an accepted ethical framework that protects the rights of research participants, who, in a health-related research context are often practitioners and patients (Freegard, 2006). Historically, various codes of ethics have been developed in response to violation of human rights within a research context (Taylor et al., 2006). As a health practitioner and researcher, ethical considerations underpinned my thoughts and actions in implicit ways throughout the design, review, and conduct of the study. More specific ethical issues arose when making decisions about the methods used in a qualitative study and in particular, one that was to be conducted in a clinical setting. This study was conducted after gaining approval from the Victoria University Human Research Ethics Committee, which aligns with the National Health and Medical Research Council (NHMRC) of Australia's code of ethics. The NHMRC (2009) has developed guidelines on ethical conduct that applies to human research, to which this study subscribes. Drawing on these guidelines, ethical considerations are discussed according to the methods of the study, and within the context of three fundamental principles; beneficence, respect for human dignity, and justice.

4.3.1 Beneficence

The ethical principle of beneficence is conjoined with the principle of non-maleficence, which essentially means to pursue research that benefits humankind and does no harm. The significance or anticipated benefits of the study have been outlined previously⁴⁶. Harm, in this study, pertains to the potential for, and management of, the risk of harm to participants should adverse events occur. Research participants should not be penalised or harmed as a result of their participation, and strategies should be put into place to minimise such risks.

⁴⁶ See Chapter 1.6.

4.3.1.1 Minimising the risk of harm

The current study was deemed to have little risk to osteopath or mother and baby participants. There were no risks of physical harm. The only foreseeable risk was the possibility of participants experiencing minor psychological discomfort during an interview or while being observed. I was particularly sensitive to the emotional state of new mothers, who were recounting their experiences of breastfeeding difficulties; a situation that might cause some distress. An action plan was devised to deal promptly with this type of scenario. As an experienced health practitioner, I would offer initial emotional support. The interview would be stopped and the mother given ample time to settle and decide if she wanted to continue with the interview. If necessary, the mother could be referred to a psychologist⁴⁷, for appropriate counselling and referral, at no cost. No such adverse event occurred. Although, at times, participants' interviews contained some highly emotive episodes, mothers appeared to remain articulate and in control, while expressing a desire to continue with the interview. This finding supports some existing evidence that many research participants have found it helpful, on a personal level, to talk about their experiences (Reinharz & Chase, 2003). In general terms, the risk of psychological harm to participants was further minimised by the researcher acting towards them according to the principles of respect for human dignity and justice.

4.3.2 Respect for human dignity

This principle concerns research participants' autonomy or their right to make decisions and determine their own actions based on a clear understanding of the study; the potential risks, benefits, and expectations. It includes informed consent and the right to withdraw from participation in a study without penalty.

4.3.2.1 Informed consent

Informed consent concerns a person's voluntary agreement to take part (or not) in a study. The two components of informed consent are the nature of the information provided and how participants convey their consent. Information must be provided in a complete and comprehensible form and language. In general, providing information, in this study, was assisted by mother and osteopath participants' high levels of education, health literacy, and language skills. However, the ability to give consent concerns, not only cognition, but personal judgement and appreciation of the research situation. It is generally acknowledged that, in a health care context, patients are in a more vulnerable position due to the imbalance in their power relationships with health professionals

⁴⁷ A psychologist and academic staff member of Victoria University volunteered to assume this role, if necessary.

(Freegard, 2006; Holloway & Wheeler, 1996). For this reason, steps were taken to distance osteopath participants from directly recruiting mothers and babies for the study. In the event that the osteopath played a key role in recruitment, I sought the mother's reassurance that she was a willing participant. It became apparent, however, through discussion with osteopaths that their prime concern was the dyad's wellbeing rather than acting as an agent for the researcher. It was emphasised to the mother and osteopath that their involvement in the study was independent from their relationship with each other and the baby's treatment.

Written and verbal explanations about the study aims and methods were provided to participants. I found, however, that mother and osteopath participants, typically, preferred a verbal explanation to reading the detail of the study information form. Verbal discussion occurred most frequently, by telephone. Hence, I had a responsibility, to provide clear and complete information about the study with ample opportunity to seek and answer their questions. Individual verbal agreement and completion of consent forms confirmed participants' intention to take part in the study. Mutual consent from the osteopath and mother was required for observation of their treatment session. No form of coercion was used and it was reiterated at regular intervals throughout the conduct of the study, that participants were free to withdraw, at any time, without giving their reasons and withdrawal would not have any adverse effects. No participants withdrew from the study.

4.3.3 Justice

The principle of justice concerns participants' rights to be treated fairly and with courtesy and respect. In the current study, this means that procedures are followed to ensure strict confidentiality with recordkeeping, information given, and participants' identity.

4.3.3.1 Data storage, access and disposal

Audio recordings of observations and interviews were saved to discs and coded numerically. Discs, consent forms and all other written documents and data related to the study were stored in a locked cupboard; the key being held by the researcher. Transcripts of observations and interviews were labelled numerically and saved to a computer that was password protected and used solely by the researcher. Participants' names were removed and replaced by pseudonyms to ensure anonymity. All data will be kept for a minimum period of five years after any related publications according to the protocol of the Victoria University Human Research Ethics Committee's code of conduct for research. After this time, it will be destroyed. Participants were advised that only members of the research team and a transcript typist, had access to the data. The research team included

two supervisors, experienced researchers and academics, who were aware of their responsibilities in maintaining confidentiality. The identity of participants remained undisclosed and confidential to all, except the researcher.

4.3.3.2 Privacy, confidentiality and anonymity

The access arrangements set out above helped to ensure the confidentiality of information provided to the researcher. As participants' views and experiences could be directly relevant to the final thesis, pseudonyms were used at all times. Confidentiality is especially important for qualitative studies that explore individuals' thoughts and feelings, which might give rise to data of a sensitive nature. Participants' full name and contact details were available only to the researcher for the purpose of undertaking the observations and interviews. Pseudonyms were used throughout the transcripts, which were only made available to identified members of the research team for the purpose of undertaking data analysis according to grounded theory methods. No identifying details will be disclosed in any future published documents.

4. 4 ASSUMPTIONS AND EXPECTATIONS

Before commencing fieldwork, I had to give due consideration to my influence, as the researcher, on the methods of the study. Because the researcher becomes immersed in the data, there is an ongoing interplay between her and the research act (Strauss & Corbin, 1998, p.42). Strauss and Corbin deal with this problem by emphasising the need for the researcher to maintain a balance between an objective stance and developing sensitivity to the meanings in the data. There is, however, an ongoing debate within the literature concerning sensitivity versus objectivity, and how the researcher can influence the research situation (Burgess, 1993; Holloway & Wheeler, 1996). For example, being sensitive to the area of study can intensify examination and development of ideas, described by Charmaz (2006) as a starting place for gathering rich data (p.17). On the other hand, such sensitivity could be associated, unwittingly, with preconceived ideas that result in the researcher ignoring other aspects of the data and allowing a degree of bias; a situation described by Spradley (1980, p. 55) as 'selective inattention' that can be associated with years of familiarity with an area of study. A commonly held view is that the researcher becomes a "primary instrument" in the research process (Burgess, 1993, p.79; Corbin, 2009, p.31; Morse & Field, 1995, p.71). This view reflects contemporary post-modernist and feminist views (Karyn Cooper & White, 2012) whereby researchers do not separate who they are from the research and analysis that they do. Corbin (2009) states that each person using a grounded theory methodology "infuses the method with some aspect of the self and of the project" (p.37).

As the study progressed in alternating sequences of data collection and analysis, I found that, through the research experience, my initial understanding of the notion of balancing objectivity and sensitivity evolved. The issue concerning how the researcher influences, and is influenced by, the research project needs to be firstly acknowledged and articulated through self-awareness and reflexive action at a number of levels (Alvesson & Skoldberg, 2000). Although reflexivity is a widely used term in the qualitative research literature, it is a complex concept and difficult to define (Carolan, 2003). There appears to be a consensus, however, regarding two fundamental levels of reflexivity. The first involves an examination of the researcher's pre-conceived experiences, assumptions, and expectations about the research topic, and the second involves the importance of reflecting on the impact of these assumptions and expectations on the research participants, the data, and its analysis, throughout the conduct of the study.

Three broad factors influenced my assumptions regarding the research topic. The first concerned my professional background as an osteopath with many years of clinical experience. In the later years of practice, I had developed a special interest in paediatric osteopathy; an area of practice that I found satisfying and rewarding. I believed in the therapeutic benefits of manual therapy for mothers and babies but recognised the substantial influence of interpersonal and psychosocial processes that impacted on patients' experiences and treatment outcomes. The second influence was my academic experience which placed high value on critical appraisal, reflection, and balancing an evidence-informed, yet open and creative, approach to osteopathic undergraduate clinical education. The third factor was my own early mothering experiences, which despite the passage of time, remain a subtle but strong background influence.

Reflection is not undertaken just for the purpose of self-understanding; it is a useful research tool to gain insight into the phenomenon under investigation (Carolan, 2003) and a range of strategies can be used, at different stages of a project to enhance reflexivity (Malterud, 2001). In the first instance, one such strategy is making explicit and adhering to a particular theoretical perspective. In the present study, a grounded theory methodology provided a clear framework, strategies and tools for reflexive research practice. For example, when compiling field notes, writing theoretical memos, using theoretical sampling, and considering ethical dilemmas, the researcher's mind-set is one of critical thought and reflection. The strategy that I found most useful for reflexivity was discussion with colleagues and my research supervisors. I found my research supervisors' critical thinking and unfamiliarity with, or distance from, osteopathic clinical practice particularly helpful for articulating ideas about what was going on in the study setting, from a new

perspective. Reflexivity is embedded within the processes and activities of producing quality research, discussed later in the chapter. Where possible, I have attempted to demonstrate reflexivity by making clear my thoughts concerning decisions and actions regarding the methods used in the remainder of the chapter.

4.5 SELECTION AND RECRUITMENT OF PARTICIPANTS

Sampling and recruitment methods are presented separately for the two different participant groups; paediatric osteopaths, and mother and baby dyads with breastfeeding difficulties. Purposive sampling techniques were used initially, in order to locate the research question within its specified everyday environment. A broad range of participants and their experiences was found through the selection process, which took place over a period of twelve months, at which point it was determined that data saturation⁴⁸ had occurred. Thirteen episodes of fieldwork took place at twelve different clinic locations. Each episode involved observation of an osteopathic treatment session of the baby followed by interviews with the osteopath and mother involved. In total, 13 observations and 26 interviews were conducted; 13 with mothers and 13 with osteopaths. Interviews occurred within a short time frame (no longer than a week) after the observed treatment session. It was thought that this approach would assist in obtaining rich data from the interviews due to participants' familiarity with the researcher and recall of events that had taken place during the treatment session. As the study progressed, theoretical sampling was used during interviews to explore the dimensions of specific concepts that were deemed to be important to the developing theory. Details of decisions made specifically for the two participant groups, follows.

4.5.1 Osteopath participants

The only inclusion criterion for osteopath participants was that they were experienced in paediatric practice, which is the defined area of interest for the study. This decision was based on the circumstances of osteopathic practice as not all osteopaths assess and treat babies. There are limited opportunities for post graduate studies in this area, so expertise was defined by at least four years of osteopathic clinical practice and having a regular paediatric client base.

Potential participants were sent a letter of invitation to take part in the study, an information form (Appendix A), and a study information pamphlet (Appendix E). A follow-up phone-call was made to ascertain the osteopath's ongoing interest and to provide an opportunity for discussion. If the osteopath expressed an interest in participating in the

⁴⁸ Data saturation is discussed in Chapter 3.5.2.

study, a convenient time was made for the researcher to visit the clinic. I believed that personally meeting those involved was important to facilitate ease of entry into the research setting. It also provided the opportunity to deliver the necessary paperwork, which consisted of participant consent forms (Appendix C) and several study information pamphlets (Appendix E) that were to be used for recruitment of mother and baby participants. Return of the completed consent form confirmed the osteopath's intention to participate. In all cases, osteopaths handed the completed consent form to me at this initial visit.

4.5.2 Mother and baby participants

The inclusion criteria for mother participants were that they were experiencing breastfeeding difficulties and they had conversational English language skills. The inclusion criteria for babies were that they were normal, term (minimum 37 weeks gestation), otherwise healthy infants with breastfeeding difficulties. These criteria concern the health of the baby. As a baby's suck reflex is usually established by 37 weeks gestation (Carreiro, 2003) and premature babies might require specialised care to establish feeding, I reasoned that initially, the study should consider the everyday, uncomplicated or routine cases.

Pamphlets (Appendix E), which briefly outlined the nature of the study in plain language, were displayed in the reception area of the osteopath's clinic. In addition, the clinic receptionist personally offered a study information pamphlet to a potential mother and baby participant. The pamphlet invited interested mothers to contact the researcher directly or to notify the clinic receptionist of their interest. Following this latter option, the receptionist asked the mother's permission for her contact details to be provided to the researcher. Involvement of the receptionist removed the treating osteopath from direct recruitment of mother and baby participants. This strategy was considered important for emphasising to participants that osteopathic treatment remained independent from the research project.

I then telephoned the mother to explain the study's background, intentions and procedures in more detail. If the mother wished to become involved, arrangements were made for me to observe osteopathic treatment of her baby at the next convenient appointment and if sufficient time allowed, I posted information (Appendix B), and consent (Appendix D) forms to them. We met at the osteopath's clinic about ten minutes before the appointment time where the mother was provided with an information form and consent form, if she hadn't already received one. At this point, it was emphasised to the mother

that she was free to withdraw at any time, and that this would not affect her baby's treatment or her relationship with the osteopath in any way. Completion of the consent form confirmed her intention to participate in the study.

4.6 DATA COLLECTION METHODS

According to Charmaz (2006), data in a grounded theory study, can consist of a variety of material gathered in different ways that provides a means for learning about the research topic. However, data are most commonly generated by fieldwork that involves interviews and observations but there is much to consider in how each of these methods are best used to explore the research question. As this study sought to identify and explore the strategies used by osteopaths to promote breastfeeding, observations of the osteopathic treatment session and in-depth interviews with osteopaths and mothers were considered the most appropriate ways of collecting rich data. The use of observations and interviews with two different participant groups also provided differing perspectives, and helped to explore and verify the links between what is spoken about, and what is seen to take place in practice. The relationship between observations and interviews as a mixed methods approach to data collection is discussed later in the chapter.

4.6.1 Entering the field

While planning the research project, I needed to consider how to gain access to the osteopathic clinical setting and potential participants, and how the methods could be employed in as unobtrusive way as possible. Preparation for fieldwork focused on how to best enter the research setting, establish a relationship with participants, and develop data collection skills. A balance must be found between fitting into the setting, maintaining a low profile and remaining neutral to the different participant groups (Burgess, 1993; Kellehear, 1993; Morse & Field, 1995; Travers, 2006). For example, I was careful not to engage in any health professional type of activity or conversation with the osteopath in front of the mother, which could be seen as 'taking sides'. Deciding what to wear to the osteopath's clinic and the mother's home was subtly influenced by personal choices, a desire to put participants at ease, and an attempt to 'blend in' with the setting. Clear and concise communication with all people involved was a prime objective. Time invested, at the beginning, in telephoning and meeting participants was crucial for clarifying expectations, developing rapport and gaining access.

Telephone calls to osteopaths elicited mixed reactions. Several expressed interest in the project but had not yet thoroughly read the study information pamphlets, or having intended to read them, had put them aside, being distracted by the demands of a busy

practice. They seemed more comfortable to discuss the study with me personally, after which, they agreed to participate if a suitable mother and baby made an appointment to see them and who also genuinely wanted to take part. They were supportive of research that had implications for their clinical field but were also sensitive to their professional responsibilities to take care of the mother and baby as their patients. Once they were reassured about the study's ethical and procedural framework, most were willing to participate.

Telephone calls to mothers always began with a friendly greeting and an empathic question about whether they were in a position to chat, given the current demands of new mothering and family life. Most mothers responded positively and readily discussed the research project with me. In general, they were interested in my background, and I decided early on in the project to begin with a standardised introduction about my professional background with an emphasis on my commitment to research and understanding more fully about their views and experiences. I stated also that I was willing to answer their questions openly and honestly, and reiterated the voluntary and autonomous nature of their involvement in the study.

Before commencing data collection, I visited the clinics of interested osteopath participants. A personal visit demonstrated a form of reciprocity or regard for the osteopath's time and effort, and fulfilled a number of practical functions. I delivered the necessary paperwork, which also helped to ensure that study information brochures were put on display in practice waiting rooms. Visiting clinics provided an opportunity to personally meet with potential participants, even if only for a few minutes. This approach, in a group practice, was useful in one instance, where one enthusiastic osteopath's participation encouraged another to also take part. I recognised the integral role of the receptionist or practice manager, who often functioned as a 'gatekeeper', in the success of the study. Gatekeeper is a term used to describe an individual in an organisation in a position to grant or deny access for researchers (Burgess, 1993; Burns, 2000). Meeting face-to-face with the receptionist assisted with recruitment of suitable mother and baby participants, and with scheduling and rearranging appointment times to accommodate my needs.

4.6.2 Participant observation

Being a health practitioner, my observational skills were well developed in a clinical sense but they had to be honed in another way when used in a research context. My familiarity with osteopathic paediatric practice was helpful in that I felt at ease and shared a common

language with those who worked in this field. However, it was important that I took a step back each time I entered this setting in an attempt to gain a fresh view. I wanted to study the paediatric osteopath's clinical 'world' through an insider and outsider lens by firstly observing it and learning about it with an emphasis on the actions or processes that take place within it. These observed events or interactions between an osteopath, a mother, and her baby, involve social action and "an event in the social world is not something that just happens. It is made to happen" (Atkinson & Coffey, 2003, p. 425). From the symbolic interactionist perspective, meaning must be studied carefully. Charmaz (2003a) points out that even if actions or events are observed firsthand, they are not necessarily inherently filled with meaning. Atkinson and Coffey (2003) argue that actions become understandable because they can be talked about. In order to talk about or analyse actions, due consideration was given to the researcher's role as an observer, what data was attended to, and how it was recorded.

My first decision related to how I would place myself as the observer during the osteopathic treatment session. Different types of observation are described according to a continuum based on the level of the researcher's involvement with participants and their activities (Spradley, 1980). Burns (2000) describes this degree of involvement in four ways: the complete participant, the complete observer, the observer-as-participant, and the participant-as-observer. However, the notion of non-participant observation is questionable as the presence of the researcher, however inconspicuous, has some influence on social interaction (Sharkey & Larsen, 2005). I decided to take Burns' (2000) observer-as-participant role, which is an intermediate position, in which the observer role is more prominent than the participant role. A similar position has been described by Holloway and Wheeler (1996) as one where the observer is restrained from playing a role in the setting. This means that while my identity as an osteopath was acknowledged, I wanted to remain unobtrusive and allow the sequence of events and interactions to flow in a natural way. I decided to sit in the room at a site that was distant but allow my body language to remain open and attentive. This meant I could respond to the conversation and activities by appropriate facial expressions and comments but not play an active role. I felt most comfortable with this approach and felt that it suited the study's aims. As a series of events that unfolded over time, the osteopathic treatment session was structured into a beginning, middle, and an end. Within this framework, I took a broad approach, which drew attention to the following four key elements: who was in the room, the setting, each participant's purpose and goals, and the behaviour and interaction between participants (Burns, 2000; Spradley, 1980). An aid memoire was used to guide this

process (Appendix H). Observations became more focused, according to theoretical development as the study progressed⁴⁹.

4.6.2.1 Recording data from participant observation

Participant observation data is traditionally recorded by note taking (Burns, 2000; Spradley, 1980; Taylor et al., 2006). The option of video recording was considered and rejected due to the practical difficulties of setting up and organising equipment at multiple sites (Kellehear, 1993). Note taking was deemed the best option for recording observations, but I thought that writing extensive notes during the consultation could prove distracting to participants and interrupt my view of events. Brief notes were thus written intermittently during the treatment session following guidelines (Appendix H), which acted as prompts to assist with later recording of observations and fine tuning questions to be asked later during interviews. Observations were dictated onto an audio-recorder and later transcribed for analysis. This approach had the practical advantage of speed and convenience. The possible disadvantage of relying on recall was minimised by discreetly audio recording observations as soon as possible after the treatment session (within one hour), usually while sitting in the car.

4.6.3 Interviews

Typically, interviews with mothers took place in their homes, in accordance with their choice and convenience, although a few variant cases were interviewed in a private room in the osteopath's clinic. The home provided the natural setting for a mother, her baby, and breastfeeding. When first entering a mother's home, my aim was to help the mother feel at ease with my presence and the open-ended nature of the interview. This meant quickly becoming sensitive to the mother and baby's current situation and responding appropriately. For example, I could step into a room filled with laundry and cluttered with toys, dishes and other 'bits and pieces' or into a neat and ordered environment where the mother had obviously prepared for my visit in a way that was important to her. Whatever the scenario, it was important that I followed the mother's lead to help her settle her baby and generally relax in order to create an environment conducive to the sharing of personal information.

In general, health professionals are well aware of the value of interviews for generating useful and meaningful information. Weiss (1994) identifies seven reasons, according to the research aims, for using interviews as the method of choice. They are: developing detailed descriptions, integrating multiple perspectives, describing process, developing

⁴⁹ See section 4.8.1.

holistic description, learning how events are interpreted, bridging intersubjectivities, and identifying variables and framing hypotheses for quantitative research (pp. 9-11). Each of these reasons was applicable to this study but the following three reasons: integrating multiple perspectives, describing process, and developing holistic description were particularly relevant. The study is interested in the actions and processes that osteopaths employ to promote breastfeeding and their consequences. Breastfeeding, new mothering and the osteopath's clinical role involves complex human interaction and "qualitative interviewing permits description of the many sectors of a complex entity and how they go together" (Weiss, 1994, p.10).

Interviews used in social science research have historically been classified according to their level of structure (Fontana & Frey, 2000). In-depth interviews are placed at one end of the continuum and involve detailed non-structured conversations between the researcher and participant (Minichiello, Hays, Courtney, & St John, 1999). The in-depth interview was seen as the data collection method most suited to the study's aims of seeking open, detailed and richly personal information. Interview questions were open-ended and focused on the experience of the participant. However, as it is permissible and even desirable to use some structure in order to identify and delineate the phenomena under investigation (Babbie, 2007), I felt more comfortable using an aide memoire (Appendices F and G) for this purpose. As a neophyte researcher, I wanted to ensure that relevant issues were addressed without impeding the flow of ideas and conversation (Babbie, 2007; Holloway, 2008; Morse, 1994). As is the case with most grounded theory studies, the interviews became more structured as questions focused on the emerging key issues, necessary for theory development.

On the basis that successful interviewing is a skill; before commencing fieldwork, I undertook two practice interviews with osteopath colleagues and sought their feedback on the experience. From this, I learnt the importance of emphasising the investigatory process and my role as a researcher rather than a health professional. It helped also to develop strategies to facilitate my researcher skills⁵⁰. I was mindful of the concerns raised by Glaser (1992) about forcing data through the use of questions that reflected preconceived ideas, such as those concerning generally accepted models of osteopathic practice. The line of questioning was modified as the study progressed, according to the information gathered and analysed in previous interviews. More specific questions were sometimes asked to explicate and verify observations noted during the osteopathic

⁵⁰ Strategies to enhance my researcher role are presented in section 4.6.1 and 4.6.3.1.

treatment. In this way, data collection methods continued to be directed by participants along the way.

Data collection using interviews followed a format, which consisted of introductory, in-depth, and winding-down phases. Duration of interviews varied a little, but averaged about one hour. The introductory phase was mainly concerned with creating a level of comfort and understanding, such as giving the mother and baby time to settle, reiterating background information such as the purpose of the interview, and emphasising confidentiality and voluntary participation. This led into the more in-depth interviewing stage, when the audio recorder was turned on. Questions were initially broad but progressively become more focused and probing, an approach known as '*funnelling*' (Burns, 2000, p.429).

As key topics were discussed, and the participant had had sufficient opportunity to express her views, the interview was drawn to an end. The winding down phase was managed by strategies that led the interviewee gradually from discussion of sensitive to more mundane or lighter issues. Strategies for ending the interview included acknowledging the time spent, checking that relevant issues had been addressed, and asking if the participant had anything else that they would like to add (Burns, 2000; Morse & Field, 1995; Taylor et al., 2006). Once the audio recorder was turned off, chatting continued and a form of debriefing occurred. The participant was thanked for her contribution and informed about what would happen to information obtained from the interview. Confidentiality protocols were reiterated. In the case of the interviews with mothers, light conversation typically revolved around the baby, providing a comfortable way for the mother and researcher to withdraw gradually from the scene.

In any project involving in-depth interviews, the relationship between the researcher and interviewee is crucial (Burgess, 1993). Weiss (1994) sums up this relationship as "a partnership based on mutual respect, concerned with producing information useful to research" (p.127). The interview has become increasingly viewed as a conversation between people that is not neutral but influenced by the personal characteristics of interviewer, interviewee, and the context (Fontana & Frey, 2000). In a clinical setting, the researcher-participant relationship and issues of power can influence what information is shared and data collected, particularly and if the researcher is also a practitioner (Morse, 2001; Sharkey & Larsen, 2005). With this in mind, where possible, interviews were conducted in participants' familiar surroundings in an effort to put them at ease and minimise any perceived power imbalances.

4.6.3.1 Interviews with osteopaths

Interviews began with an acknowledgement of our past relationship. The osteopathic profession is small in number and at the very least, researcher and participant knew of each other, and in most cases, had met previously in a professional capacity. I had worked with, or been a teacher to some participants during their undergraduate education. Hence it was important that that relationship was articulated. It was then emphasised that I had a different role now. I used the expression, *'I am now wearing a student researcher's hat'*, and explained that this meant discovery, by being open to seeing and hearing in a new way. I reminded osteopaths that the research findings would be applicable to a variety of audiences and discipline specific language, concepts, and jargon would be discouraged. Adopting this perspective assisted me to delve beyond commonly held assumptions about osteopathic practice and encourage the osteopaths to offer more explicit explanations about what they meant, in everyday language.

4.6.3.2 Interviews with mothers

I had already met the mothers at their osteopathic appointments and had spoken, sometimes extensively, to them on the telephone at the recruitment stage, and while organising dates and times for meetings. I was aware that my personal background would, in some way, influence my relationship with them during the interview. I was aware, also, of the challenges of new mothering and the need to respond sensitively to mothers' needs on an individual basis. I adopted an open approach, advising mothers that I was comfortable with answering any of their questions and reiterated that they should let me know if they felt uncomfortable in any way, needed to tend to their baby, or have a break. This approach was met with mixed responses; some mothers sought more interaction from me than others, who preferred to maintain a little distance. The important thing that I learnt from this was to act in the spirit of reciprocity and follow the mother's lead; a finding supported by others (Carolan, 2003).

4.6.3.3 Recording data from interviews

Data collected from interviews were recorded in two ways: Interviews were audio recorded and later transcribed verbatim for detailed analysis, and field notes were written down as soon as possible after the interview. Audio-recording was seen as the best way to obtain raw data which could be studied later, in more detail, in order to illuminate key concepts (Burns, 2000; Travers, 2006). As the study aimed to delve more deeply and sensitively into personal experiences and meaning, this approach also had the advantage of allowing me to concentrate on the conversation, listen carefully, and attend to other non-verbal cues. The disadvantage of audio recording the interview lies with its potential to adversely

influence what is said. It can be argued that participants could be less willing to provide sensitive, revealing information knowing that their conversation was directly recorded (Travers, 2006). However, I found that, while attention was drawn to the recording device at the beginning of the interview; in time, interviewees seemed quite comfortable with it as the interview progressed. Mothers often needed to tend to the baby or another child and they worked cooperatively by letting me know when they needed a pause, and when they were ready for recording to resume. Bearing in mind that “words are not the whole message” (Burns, 2000, p.427), all verbal responses, which include laughter, sighs and pauses were included in the transcription. Field notes were taken, which included descriptions of facial expression, body positions, actions and gestures, all of which were used to gain a clearer understanding of what participants were trying to express. In this way, notes were used to support and enhance the quality of the recorded interview data.

4.6.3.4 Relationship between interviews and participant observation

While interviews and participant observation are distinctive forms of data collection that focus on what people do, and what people say they do, respectively, (Atkinson & Coffey, 2003; Silverman, 2000); they provide a narrative or reconstruction of events, thoughts and experiences (Charmaz, 2003a; Sandelowski, 1994) that are broadly viewed as complementary to each other (Bluff, 2005; Burgess, 1993; Denzin & Lincoln, 2003). In the current study, meeting participants and observing their interaction during the osteopathic treatment helped to frame some of the questions asked and topics discussed, during interviews. Observations also helped to build my credibility as a researcher and develop the trust needed for participants to provide more detailed information during interviews. Interviews provided a means for accessing information about situations that would be otherwise inaccessible (Burgess, 1993; Weiss, 1994). For example, interviews situated observations of the current treatment session, in time. They provided an account of the events leading up to the first visit to the osteopath, what took place at subsequent visits, and how they contributed to current circumstances, and future plans.

4.7 DATA MANAGEMENT

Fieldwork data were collected from three sources; observations, interviews, and field notes, all of which had to be prepared, stored, and made available for analysis⁵¹. Observations of osteopathic treatment sessions of dyads with breastfeeding difficulties were initially recorded by the researcher taking brief notes during the treatment session according to the Aid Memoire Observations (Appendix H). A more comprehensive account, using these notes as prompts, was then dictated onto an audio-recorder shortly

⁵¹ See Section 4.3.1. for an account of data storage, access, and disposal.

after the treatment session and transcribed later, by the researcher, into a word document. Observations of each treatment session were organised, dated, and labelled numerically according to each episode of fieldwork (13 in all). Field notes were also made. They consisted of handwritten notes of events and natural conversations that occurred while visiting clinics and mothers' homes for the purpose of interviewing them. Notes were dated and used to enhance data collection, write memos, and data analysis.

Twenty-six interviews were conducted, audio-recorded, and transcribed verbatim into word documents. Interviews involved the same participants that were observed during the treatment session. It was thought that interviewing the same participants would provide a deeper exploration and insight into the interactive processes involved. Most interviews were transcribed by a typist but the first two interviews were transcribed by the researcher who wanted to reflect on the experience of personally undertaking this task. Transcription involves repeated and careful listening to what is said, which emphasised, to the researcher, the importance of not only reading transcripts but listening to them in detail to appreciate the meaning conveyed by the words and the various nuances of language. It also alerted the researcher to cross check transcripts with audio files to ensure accuracy.

In summary, the documents relating to the fieldwork consisted of transcripts of 13 observations and 26 interviews, and handwritten field notes, which were labelled with the location, time, and individuals involved. Each participant was identified by a pseudonym. Printed copies of final transcripts were made after listening to audio recordings to correct any errors in transcription and to become familiar, in a general sense, with the data and individual modes of expression prior to commencing analysis.

4.8 DATA ANALYSIS

Analysis began with open coding after the first episode of fieldwork. In the early stage of analysis, the first four interviews and observational field notes were subjected to a micro-analytical or brainstorming approach. The aim was to open up the data to start the process of uncovering, naming, and developing concepts, which are the basis of analysis and form the foundation of research (Corbin & Strauss, 2008, p.64). Corbin emphasises the importance of taking time, in the early generative phase of analysis, to consider all possible meanings (p. 53). In this way, ideas started to be grouped under a common and more conceptual label (Table 1).

Table 1: Grouping ideas under conceptual labels or code

Data	Concepts
<i>The hardest thing I find in the whole initial consultation is <u>getting the parent's confidence</u> ... often both parents will turn up on the first consult because <u>they're not quite sure</u> ... So I sort of find that to start, they're <u>almost anxious</u>; so sort of <u>allaying those fears</u>; that <u>you are thorough</u> and you're getting the information (Edward, O 6/02).</i>	Gaining confidence Facing uncertainty Allaying Anxiety Showing Competence

The example in Table 1 illustrates a number of ideas and concepts found in interviews, which were supported by observational data as in the following example.

Mum was obviously flustered; her cheeks were flushed and she was breathing a little rapidly. Baby was lying in push chair, alert but quiet. The osteopath met mum with a "Hello. How are you doing?" Mum reacted by bursting into tears, saying she had had the worst past few days. The osteopath immediately changed his approach, adopting a more soothing tone of voice. He invited mum into his treatment room saying, "We will have a chat about it when we are all settled". He let her 'get it off her chest' first, then asked more specific questions (Obs 11, 22/04/09)

Concepts, derived from data can be low-level or high-level according to increasing levels of abstraction. In this study, concepts were organised as sub-strategies, strategies, and categories, as the level of abstraction grew. As new data was subjected to the same analytical processes of open coding, the dimensions of concepts became further developed. Different coloured highlighter pens were used on hard copies of transcripts to group similar ideas in the data under common conceptual labels. Links between concepts were developed and verified in vertical and horizontal directions and through abstraction; higher-order conceptual labels were formed. *Allaying Anxiety*, for example, in Table 1, was found to be a higher order concept, compared to the other concepts. It, in turn, became a sub-strategy of the higher-order concept or strategy, *Building Trust* (Table 2). Lower-level concepts, in Table 1: *Gaining confidence*, and *Showing Competence*, remained important, however, for filling in the detail of the related higher order concepts. The concept, *Facing uncertainty*, in Table 1, became further developed as a key contributing factor to the study's core problem.

Table 2: Conceptualisation of the strategy, *Building Trust*

- Allaying Anxiety
- Being Empathic

Axial coding occurred at the same time as open coding. Concepts that stood for blocks of raw data continued to be reassembled by relating them to each other. As higher-order concepts were linked, they became more abstract and elaborated. The strategy, *Building Trust* (Table 2), was, in turn, linked with other strategies, to form the category, *Connecting*, which encapsulates the broad concept of practitioner-patient relationship building. Corbin (2008) describes the process as “*like putting together a series of inter-linking blocks to build a pyramid*” (p. 199) (Figure 1).

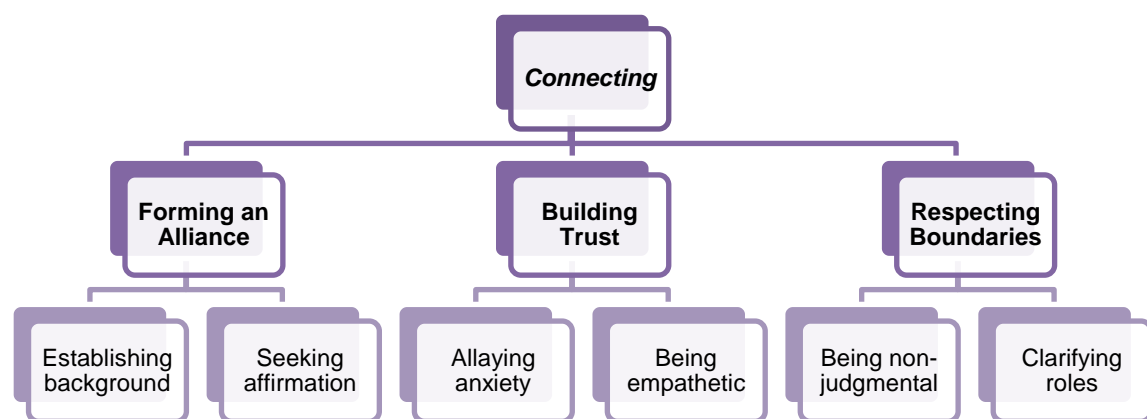


Figure 1: Conceptualisation of the category, *Connecting*

Selective coding was used as major categories, like *Connecting*, were developed. Relationships between categories were recognised, refined, and linked together until a core category was identified. Analytical tools such as theoretical memos and diagrams were particularly useful for integrating abstract concepts at this stage of analysis. Corbin (2008, p.264) describes this process as a drawing together of the research threads to construct an explanatory framework, or larger theoretical scheme.

Analysis was a challenging and evolving process that built over time; a finding that is supported by Strauss and Corbin’s (1998) contention that “integration is hard work” (p 144). Numerous concepts were derived from the first pieces of data and by using analytical tools, such as making comparisons and asking questions, new ideas were found and existing concepts were expanded, subsumed or rejected. Conceptual labels reduced in number as more abstract concepts or categories developed. Each change had implications for the whole theoretical and emerging construct. For example, at one stage

in the analysis, the category *Connecting*, as outlined in Figure 1, had a strategy called *Exchanging information* in the place of the current strategy, *Forming an alliance*. *Exchanging information* was made up of two sub-strategies, *Gathering information*, and *Explaining*. An analysis proceeded and another category, *Empowering*, evolved, it became apparent that some of the properties of one of its sub-strategies, called *Educating*, overlapped with the sub-strategy *Explaining*. Osteopaths provided explanations to mothers that varied in depth according to their purpose; to *connect with* or to *empower* mothers. After closer examination of the data, the strategy *Exchanging Information* was abandoned and eventually replaced by a new strategy, *Forming an Alliance*. This label represented, more accurately, the ideas in the data relating to the introductory processes of *Connecting*. As a result of this modification, two new sub-strategies of *Forming an Alliance*: *Establishing background* and *Seeking affirmation* were developed.

4.8.1 Theoretical sampling

Theoretical sampling within the data was used to enhance abstraction and integration of key concepts as the study methods progressed. This involved making more focused observations of participants' interactions and following particular lines of questioning during interviews to add conceptual depth to the developing categories. Hence the initial questions on the interview aid memoire and focus for observations were modified as a result of the primary data obtained. For example, osteopaths frequently used the term 'rebalancing', which became an in vivo code, when describing what they were doing when applying manual techniques to the baby. The idea of 'rebalancing' the body eventually became a high-order concept and category. Through theoretical sampling, the researcher deliberately paid greater attention to the detail of physical processes, body language and expressions that occurred between osteopath and baby during treatment and interview questions changed accordingly. The initial aid memoire of interview questions included questions such as, "Why did you choose those treatment techniques"? And "How do the treatment techniques work"? As the study progressed, questions became more focused on uncovering the meaning of the notion of 'rebalancing' in the situation of treating a baby by asking osteopaths to describe in detail their thoughts, actions and feelings when applying manual techniques. For example, based on observations of Stephen (osteopath) taking time to position and mother and baby for the purpose of "*using [applying] cranial osteopathy to balance out the cranial base [at the junction of the head and upper neck]*" (O 13/03), the researcher asked the following series of inter-related questions.

- What does that feel like?

- So when you contact one part of the body do you get a sense of the whole body or do you get a sense of where your hands are on?
- So how do you release the compression?
- You mentioned that you find a point of neutrality (balance); can you explain that in more detail?
- How do you know when your technique is done? (O13/03).

In this way, participants continue to guide the enquiry process but their explanations are moved from theoretical professional treatment models toward exploring their experiences and uncovering some of the more intuitive but less well articulated elements that take place during manual therapy the baby. Such an approach helps to fill in the detail of the concept of *rebalancing*.

Analysis, described thus far, pertains to the development and organisation of concepts. Analysis, however, also involves delineating other elements of the study's findings, such as the core problem and context. Context provides the structure under which events and processes occur and must also be identified so that meanings are clarified and made more accurate. Analysing data for context involves explicating the immediate set of conditions faced by mothers and osteopaths on a day-to-day basis and the larger social, cultural, and legal conditions that influence breastfeeding and the delivery of health care.

4.9 ESTABLISHING TRUSTWORTHINESS

Trustworthiness of a study concerns the truthfulness of the findings but the term 'truth', in qualitative research, is used in a "more pluralistic, than traditional, sense" (Corbin & Strauss, 2008, p. 298). Establishing the trustworthiness of a study concerns issues of rigour and quality; important considerations for all research, regardless of the design. It is important, for example, when making decisions about the implications of a study's findings for clinical practice and education. The way in which qualitative research and a grounded theory study, in particular, is evaluated for trustworthiness remains contentious. Some advocate using criteria and terminology that is used in mainstream science, such as validity and reliability (Morse, Barrett, Mayan, Olson, & Spiers, 2002). Others argue for a different approach; one that is deemed more appropriate for qualitative research designs (Chiovitti & Piran, 2003; Cooney, 2011; Sandelowski, 1993; Thorne, 2000). Sandelowski (1993) and Corbin (2008), for example, contend that quality and validity are not synonymous; they value the artistry and creativity of qualitative research as an important element of quality. Furthermore, some authors contend that each qualitative approach,

such as grounded theory, requires its own distinctive set of judgement criteria (Chiovitti & Piran, 2003; Corbin & Strauss, 2008; Rolfe, 2006).

Although a number of authors have proposed different criteria for evaluating the trustworthiness of qualitative research (Charmaz, 2006; Chiovitti & Piran, 2003; Malterud, 2001), the underlying principles have much in common (Malterud, 2001). There is general agreement on the importance of considering the enquiry process and the quality of the final product (Cooney, 2011; Corbin & Strauss, 2008; Strauss & Corbin, 1998) and on the need to maintain a discourse on the practical methods for enhancing rigour during the research process (Chiovitti & Piran, 2003). Contemporary literature tends to draw on the earlier work of Lincoln and Guba's (1985) four standards of trustworthiness; credibility, transferability, dependability, and confirmability (Petty, Thomson, & Stew, 2012; Powers & Knapp, 2006), and also on Beck's (1993) three standards of credibility, auditability, and fittingness (Chiovitti & Piran, 2003; Cooney, 2011). I decided to use the general framework of Beck (1993) for considering issues of rigour for the present study because her three criteria of credibility, auditability, and fittingness resonated well with the methodological and interpretive rigour associated with grounded theory methodology and methods. A similar approach has been used to discuss the practical application of standards of rigour in two grounded theory studies undertaken within a nursing context by Chiovitti and Piran (2003) and Cooney (2011).

4.9.1 Credibility

The term, credibility is widely accepted within the qualitative research literature as a criteria for evaluating trustworthiness because it indicates that a study's findings are plausible and resonate with participants' and professionals' experiences with the research situation and phenomenon that it intended to explain (Charmaz, 2006; Corbin & Strauss, 2008). Glaser and Strauss (1967) talk about credibility in terms of how well a grounded theory 'fits' the situation and how well it works; whether it is believable and helpful for those in the situation. In the present study, credibility is evidenced by others, such as osteopaths, mothers, and other health practitioners who work with new mothers and babies, recognising the study's findings and by how accurately the theory explains the situation. Chiovitti and Piran (2003) recommend four methods of research practice to enhance creditability, which are considered below.

4.9.1.1 Let participants guide the enquiry process

The close fit between data collection and analysis helped to ensure that participants' ideas and thoughts were conceptualised and used as the basis for further enquiry. Analytical

tools such as asking questions, making comparisons, and theoretical sampling⁵² in association with researcher reflexivity⁵³ helped to further develop participants' meanings and experiences and thus guide the enquiry process.

4.9.1.2 Check the theory against participants' meanings

Cross-checking developing concepts with participants' meanings during interviews helped validate their accuracy, dimensions, and relationships with other concepts. This methodological strategy was particularly important for uncovering participants' experiences and interpretations of more subtle, implicit, and intuitive elements of manual therapy and other therapeutic processes involved during a clinical consultation. Triangulation or the use of a variety of data sources and data gathering techniques (observations and interviews) was used to strengthen the credibility of research interpretations and findings (Powers & Knapp, 2006, p.180)⁵⁴. Interviewing two different participant groups meant that observations of participants' actions and accounts from those directly concerned with the research problem were obtained and concepts were explored from differing perspectives. In this way, triangulation can enrich description, and increase understanding of complex phenomena (Malterud, 2001).

4.9.1.3 Use participants' words in the theory

Using participants' own words helped to provide a more accurate representation of participants' meanings. For example, in Table 1, participant's words are taken from the primary interview data to develop conceptual labels during open coding. In the Results chapters of the thesis, in vivo codes are identified and exemplars using participants' own words from interviews are used throughout, to exemplify and support findings.

4.9.1.4 Articulate the researcher's views and insights

My assumptions and expectations have been discussed in some detail earlier in the chapter, in recognition of the influence of the researcher on the methods of the study. Making the researcher's views explicit and considering how these views impact on the study's findings is an important part of undertaking and producing quality research. Peer de-briefing is another tool for establishing credibility. I had the opportunity on several occasions to present aspects of my study at University Faculty Research Conferences, writing workshops, and informal gatherings with other doctoral research students. Discussion helped to clarify my interpretation of the data and sharpen my ability to discuss the methodology and present the analytical findings in abstract but comprehensible ways.

⁵² See section 4.8.1.

⁵³ See section 4.4.

⁵⁴ See Section 4.6.3.4 for discussion around the implications of using mixed methods of data collection.

Meeting regularly with my research supervisors to check, discuss, and clarify ideas and the relations between developing concepts was pivotal for maintaining credibility of the study's findings.

4.9.2 Auditability

Auditability concerns the ability for another researcher to verify the study's findings. It thus involves the maintenance of a comprehensive record of the research process, termed an audit or paper trail (Lincoln & Guba, 1985). By making the findings and logical processes visible, others can follow the different stages of analysis (Beck, 1993), which has important implications for evaluating the trustworthiness of a study's findings. For example, being able to ascertain the relation between the actual data and the conclusions drawn from the data is important when making decisions about the findings' applicability for clinical practice (Thorne, 2000, p.4).

In a grounded theory study, the research process is recorded through the use of analytical tools such as writing theoretical memos and drawing diagrams, which represent the researcher's interaction with the data at particular stages in the analysis. In the present study, emphasis has been placed on articulating the data collection and analysis procedures. This has included a detailed description of the rationale for decisions and processes involved in participant recruitment, methods employed, and data coding and abstraction. Memos and diagrams were used extensively throughout coding and in the Results Chapters; diagrams are presented to help clarify relationships between the structure and process of the study and between higher and lower order concepts. As recommended by Strauss and Corbin (1998), a personal journal was used to write down and express my thoughts, feelings and reactions during data collection and analysis. Implicit in these strategies is reflexivity, or an open account of the researcher's assumptions; an issue that has been addressed previously.

4.9.3 Fittingness

Fittingness is also described as transferability, which pertains to the extent to which the findings have meaning to others and can be applied to similar settings. Qualitative research accepts and values variations between people, contexts, and time, which mean that it cannot be replicated. Furthermore, a grounded theory study is generated within a specific but dynamic situation and through the interaction between participants, the researcher, and the data. It is also acknowledged as being modifiable as circumstances and variations change over time (Hutchinson, 1993). However, while each substantive theory is unique and defined by the context in which it takes place, the basic abstract

processes are relevant to other populations and likely to be applicable in other situations (Hutchinson, 1993; Strauss & Corbin, 1998). The more abstraction and variation built into a study's theory, the more likely it will 'fit' into another context, particularly if the two contexts are similar (Beck, 1993).

Chiovitti and Piran (2003) contend that it is the reader who ultimately passes the final judgement on the fittingness or transferability of a study's findings. Consequently, sufficient detail concerning the methods of the study and level of theory generated must be provided. In the present study, the characteristics of the sample groups and the paediatric osteopathic clinical setting have been described in detail. Socio-demographic information concerning participants and an overview of mother participants' obstetric and postpartum clinical backgrounds is provided in the Results section of the thesis⁵⁵. The data demonstrated that this contextual information was important because it impacted on dyads' experiences of breastfeeding difficulties, and how osteopaths responded to them. Such contextual data enhances the reader's ability to understand the circumstances in which the theoretical concepts were developed and decide if sufficient variation in the sample accounts for the complexity of the phenomenon of interest (Cooney, 2011).

Using the literature is another method for demonstrating transferability of a study's findings (Chiovitti & Piran, 2003; McCann & Clark, 2003). Similarities between findings of a study and other theoretical ideas presented in the literature demonstrate the likelihood that the research findings have meaning to others and are transferable. For example, after developing the concept of osteopaths treating babies with breastfeeding difficulties by facilitating a cyclic change process; a concept which became central to the study's core category, I was excited and reassured to discover the substantial body of work on the theoretical construct of 'transitions' in the field of nursing (Meleis, 2007), which resonated with my findings. The relationship between the current study's findings and the broader conceptual literature are discussed in Chapter 13.

4.10 CONCLUSION

The methods used to gather, manage, and analyse data have been discussed in detail to provide a systematic and comprehensive account of the conduct of the researcher and the investigatory process. Ethical implications, sampling and recruitment methods, and strategies used to ensure participants' rights were respected, were also discussed. Clinical observations and in-depth interviews with two different groups of study participants, osteopaths and mothers, provided the empirical material called data, which

⁵⁵ See Chapter 5.2.1. Table 4.

was gathered and analysed concurrently, according to grounded theory methods. The methodological procedures of Corbin and Strauss's (2008) grounded theory approach were used to give participants' actions, thoughts, and interpretations of events, primacy in the data. Researcher transparency and interplay with the data throughout collection and analysis was made explicit. Integration of concepts of various degrees of abstraction was shown to provide the foundation of analysis and the development of theory. Finally, issues concerning academic rigour, which tended to be built into the research process, were more specifically delineated.

PART B: RESULTS OF THE STUDY

CHAPTER FIVE

OVERVIEW OF THE RESULTS

5.1 INTRODUCTION

In this chapter, the key elements of the study's findings are introduced and a broad outline of the resultant substantive theory is presented. An overview of the theory, as a whole, and relevant background information is provided at the beginning of the results section of the thesis in order to enhance understanding of the relations between conceptual elements. The chapter commences with summaries and analyses of participants' socio-demographic backgrounds and information that relates to mothers' obstetric histories, postpartum clinical experiences and infant feeding problems. A tabular summary of key conceptual elements that make up the results then follows. A brief synopsis of these elements, which are explicated, in detail, throughout the remainder of the thesis, is presented. They comprise the study's contextual determinants, core problem, core category, categories, and strategies. The chapter concludes with an outline of the findings chapters to follow.

5.2 SOCIO-DEMOGRAPHIC AND CLINICAL INFORMATION

5.2.1 Characteristics of mother and baby participants

Information concerning mothers' ages, parity, education, and occupation is summarised in Table 3. In general, mother participants were well educated. All reported being employed up until the birth of their first child. One had returned to full-time, and a few, to part-time work after the birth of the baby in the present study. All had given thought to returning to employment at some time in the future.

Women in the study follow the growing trend, in Australia, of having children later in life. The median age of mothers was 32 years, which is similar to the median age of 30.6 years reported for all mothers for births registered in Australia in 2011 (Australian Bureau of Statistics, 2013) and is consistent with the median age of 31.7 years for women who gave birth in a nuptial relationship in Australia in 2009 (Australian Bureau of Statistics, 2010)).

Just over half of the women in the study were first-time mothers. The median age for the seven first-time mothers was 36 years, which is significantly higher than the median age of 29 years that has been reported for women's first birth, during 2005 and 2006 in Victoria (Carolan, Davey, Biro, & Kealy, 2011) and for first-time mothers in 2011, in Australia (Australian Bureau of Statistics, 2013).

Table 3: Socio-demographic characteristics of mother participants

Sample M	Pseudonym	Age (years)	Parity	Educational Level⁵⁶	Occupation
1	Tania	31	4	Year 12	Retail
2	Catherine	34	1	University degree	Solicitor
3	Vivienne	30	1	University degree	Teacher
4	Marie	30	2	TAFE	Personal trainer
5	Dianne	35	1	Year 12	Book keeper
6	Sonia	35	1	University degree	Speech pathologist
7	Kylie	32	1	University degree	Accountant
8	Jenny	41	3	University degree	Home duties
9	Wendy	29	2	TAFE	Administration
10	Nadia	32	3	University degree	Teacher
11	Karen	40	1	Year 12	Retail
12	Sally	34	2	University degree	Nurse, naturopath
13	Narelle	35	1	University degree	Teacher

Five mother participants, four of whom were first-time mothers, were aged 35 years and over, which is a commonly accepted parameter for defining older maternal age (Beischer, Mackay, & Colditz, 1997; Gabbe, Niebyl, Galan, Jauniaux, Landon, et al., 2012). In more recent times, research has identified this group of older first-time mothers as being predominantly healthy and of higher socioeconomic and educational status (Carolan, 2005; Carolan et al., 2011). Despite this finding, birth over 35 years continues, however, to be associated with adverse obstetric outcomes (Carolan et al., 2011). Mothers in the present study follow a similar trend of experiencing complicated births and difficult early post-natal circumstances.

An overview of mother participants' clinical problems associated with the birth and post-partum events is presented in Table 4. Clinical terminology and participants' own words are used to describe various problems that effected mothers and babies in different ways and that impacted upon their breastfeeding experiences. Referring to Table 4, it is noteworthy to consider the high rate of complicated births and early clinical problems reported by this group of women. Five of the 13 mothers had caesarean births; two were emergency procedures, and three were elective, following a previous birth of an older sibling by emergency caesarean section. Five women reported a complicated vaginal

⁵⁶ In Australia, Year 12 represents the final year of compulsory school education. TAFE is an acronym for Tertiary And Further Education.

delivery, either with a positional obstruction or intervention. Two were relatively uncomplicated but one had a very fast delivery with physical signs of trauma to the baby. Only one mother had an unassisted vaginal delivery which had gone according to her birth-plan⁵⁷.

At the time of interview, and while attending the osteopath for treatment, the babies' ages ranged from three weeks to 28 weeks, with a median age of 12 weeks. This variation in babies' ages correlates with the range and diversity of breastfeeding problems that are associated with different stages of breastfeeding, such as beginning, establishing, and established breastfeeding. The detail and consequences of these experiences and clinical problems were discussed by mothers and osteopaths throughout the data. For example, osteopaths gathered a detailed obstetric history, looking for connections between mother and baby dyad's past experiences and presenting problems. Mothers tended to view their breastfeeding difficulties in association with birth and early postpartum events; issues that are discussed in more detail throughout the findings chapters.

⁵⁷ There has been a growing research interest in exploring the determinants of interventions in labour and birth, such as advancing maternal age (Carolan et al., 2011) and the implications for breastfeeding outcomes (Baxter, 2006; Nissen et al., 1998).

Table 4: Mother-baby dyads' obstetric and postpartum histories

Dyad	Mother's age	Baby's age	Maternal parity	Method of Birth	Type of labour & other significant events	Clinical Problems - mother and baby
1	31	16 weeks	Multipara	Instrumental	Spontaneous with augmentation, posterior presentation- difficult & prolonged labour	Breast refusal from one breast only; fussy unsettled behaviour
2	34	8 weeks	Primipara	Normal	Unknown, described as quick and baby engaged early before labour, <i>'nine weeks compressed down there'</i> (M 02/13).	Attachment or suck dysfunction; sore nipples
3	30	6 weeks	Primipara	Caesarean - emergency	Spontaneous with augmentation, undiagnosed breech position	Attachment or suck dysfunction; concerns about baby's weight gain
4	30	6weeks	Multipara	Caesarean - planned	No labour Osteopath described a history of stressful psychosocial circumstances throughout mother's pregnancy (O04/09)	Fussy unsettled behaviour; reflux
5	35	7 weeks	Primipara	Normal	Spontaneous, no intervention	Breast refusal (short duration); no other clinical problems
6	35	16 weeks	Primipara	Caesarean - emergency	Spontaneous, not progressing. Baby was <i>"yanked out unexpectedly... I was fairly stressed because I was very against having a Caesar"</i> (M06/02).	Fussy unsettled behaviour; breast refusal
7	32	28 weeks	Primipara	Normal	Spontaneous with augmentation <i>"The drip really speed things up, extremely fast ,much more than everyone expected"</i> , (M07/04)	Swallowing difficulty; distressed when feeding; diagnosed with laryngomalacia at 10 weeks
8	41	3 weeks	Multipara	Caesarean - planned, forceps	No labour	Attachment or suck dysfunction
9	29	20 weeks	Multipara	Compound presentation	<i>"When she was born she came out with her head and one arm and the other arm was still inside"</i> (M09/05).	Sore nipples; mastitis; candidiasis; fussy unsettled behaviour
10	32	12 weeks	Multipara	Instrumental	Spontaneous, posterior presentation - difficult & prolonged delivery	Attachment or suck dysfunction; sore nipples
11	40	16 weeks	Multipara	Normal	Very fast delivery, large baby who was bruised and <i>"shot out like a cannon"</i> (M11/05).	Fussy unsettled behaviour; reflux
12	34	12 weeks	Primipara	Caesarean - emergency	No labour, mother developed HELLP Syndrome	Breast refusal; fussy unsettled behaviour; suck dysfunction; sore nipples; mastitis; concerns about baby's weight gain
13	35	4 weeks	Primipara	Instrumental	Spontaneous with augmentation- difficult & prolonged labour	Baby in intensive care for 24 hours after birth; suck dysfunction; concerns about baby's weight gain; mother had a postpartum infection

Definitions of terms relating to Table 4 (Beischer, 1997).

Method of birth is categorised as normal: unassisted vaginal birth; instrumental: vaginal birth (forceps, vacuum extraction); and caesarean section. Information on the timing of caesarean section is also included and described as emergency (due to maternal or infant distress) or planned.

Type of labour is categorised as spontaneous, spontaneous with augmentation, induced, or no labour (caesarean section before commencement of labour). Induced and augmented labours involve the use of drugs or procedures to speed up labour. Posterior presentation: Back of baby's head is directed to the back of the maternal pelvis; commonly associated with prolonged or difficult labour.

Clinical problems are categorised as breast refusal, fussy unsettled behaviour, attachment or suck dysfunction, sore nipples, mastitis, and concerns about baby's weight gain.

Multipara: a woman who has delivered more than one viable infant. Primipara: a woman who has given birth to one viable infant

Laryngomalacia: congenital deformity of the epiglottis which usually resolves clinically by 18 months of age.

Reflux (gastroesophageal): back flow of the contents of the stomach

Mastitis: inflammatory condition of the breast, usually caused by infection.

Candidiasis or thrush: infection caused by a species of *Candida*.

HELLP Syndrome: severe form of preeclampsia, a hypertensive complication of late pregnancy.

5.2.2 Characteristics of osteopath participants

The socio-demographic and educational background of paediatric osteopaths in the study is presented in Table 5.

In line with educational requirements for primary contact health disciplines in Australia, all osteopaths had a bachelor degree and just over half had an educational qualification above this level. There was a broad range of osteopaths' ages and years in clinical practice. Ages ranged from 28 to 54, with a median age of 37 years. Clinical practice experience ranged from five to 24, with a median of 11 years.

Table 5: Socio-demographic characteristics of osteopath participants

Sample O	Pseudonym	Age (years)	Gender	Years in Practice	Parent (Y or N)	Highest Academic Qualifications
1	Julie	37	F	11	Y	Masters
2	Lauren	44	F	9	N	Bachelor
3	Tom	28	M	5	N	Bachelor
4	Megan	40	F	17	Y	Grad Dip.
5	Karla	28	F	5	N	Masters
6	Edward	39	M	17	Y	Bachelor
7	Britt	31	F	5	N	Masters
8	Evelyn	54	F	24	N	Grad Dip.
9	Natasha	31	F	8	N	Grad Dip.
10	Janet	34	F	11	Y	Masters
11	Daniel	42	M	21	Y	Masters
12	Hannah	31	F	8	Y	Bachelor
13	Stephen	38	M	15	Y	Bachelor

Approximately half the osteopaths were parents. Four of the 13 participants were male and, of the four males, three were parents. Despite the widespread view that breastfeeding is primarily women's business, and some evidence in the literature that mothers prefer breastfeeding support from other women (Bowen, 2005; Dennis et al., 2002; Locklin & Naber, 1993; Mahon-Daly & Andrews, 2002), the gender of the osteopath treating a baby for breastfeeding difficulties did not arise as an issue or topic for discussion in the current study. The data demonstrated, however, that parenting experiences of osteopaths did influence the interaction between osteopaths and mothers; concepts that are developed in later chapters.

5.3 OVERVIEW OF RESULTS

Strauss and Corbin (1998) emphasise the interplay between participants' actions and interactions (process) and the micro and macro conditions (structure) that are part of the analytic story (p.199). On this basis, the key elements of the results of the study pertaining to structure and process are summarised in Table 6 (p.87). In the final analysis, the conceptual elements outlined in Table 6 are then put together in a way that generates a substantive explanatory theory, which is presented, in detail, in Chapter 12. A written synopsis of each of these key conceptual elements follows.

5.3.1 Contextual determinants

Contextual determinants are contained within the broader meaning of the context of the study. They arise from analysis as the overarching factors that impact on participants' interactions and thus influence their thoughts and actions. In this way, contextual determinants can shape participants' interpretations and experiences of breastfeeding problems and osteopathic treatment. They act to frame and expand the conceptual meanings and relationships of the study's findings. Three key contextual determinants or sets of conditions were identified; *Women's Views and Experiences*, *Osteopaths' Professional Identity*, and *Health Care as a Commodity*.

The first determinant concerns the perspective of mother participants, who, as a special group of women, share a number of common characteristics and life circumstances. Their experiences of breastfeeding difficulties tend to become merged with the birth and postpartum events. They are influenced also by a number of factors such as contemporary cultural and societal views, the expectations of family and friends, and personal beliefs and choices around birthing, good mothering, and infant feeding. The second contextual determinant relates to osteopaths' professional identity, which is shaped by how osteopath participants see themselves, their discipline and the specialised area of paediatric practice, and also by how others, from outside the profession, view them. As a group, paediatric osteopaths articulate a strong commitment to, and belief in, the value of osteopathy for paediatric patients. The data demonstrates diverse interpretations of who paediatric osteopaths are and what they do. This ambiguity has consequences for parents, who bring their baby to the osteopath for treatment, and for how paediatric osteopaths respond to them. The third determinant concerns the Australian health-care climate; its medico-legal organisation and broader social attitudes. It can be extrapolated from the data that participants discuss health care, in general, and osteopathic treatment, more specifically, as a commodity where the mother is the consumer and osteopath, the provider of a service that can be assigned a

monetary value. Paediatric osteopaths work in small professional clinics in the private health sector, which operate on a fee for service, small business model. Certain common expectations arise from this transactional relationship, which impacts upon the interaction between participants. For example, mothers and osteopaths articulate a common belief in the right for patients or consumers to make informed health care choices and to assume greater responsibility for managing individual health needs.

Table 6: Overview of results of the study

Contextual Determinants	1. Women's Views & Experiences Personal Choices & Expectations; Advice and Expectations of Significant Others			
	2. Osteopaths' Professional Identity The Osteopaths' Perspective; Perspective from Outside the Profession			
	3. Health Care as a Commodity Health Literacy; Shopping Around			
Core Problem	Struggling to Breastfeed Satisfactorily			
	Contributing Factors <ul style="list-style-type: none"> • Facing Uncertainty • Experiencing Distress 			
Core Category	Promoting Optimal Breastfeeding through the Osteopathic Therapeutic Cycle.			
	Transitional Themes: <ul style="list-style-type: none"> • Creating the Therapeutic Space • Facilitating Positive Change • Integrating 			
Categories	Connecting	Assimilating	Rebalancing	Empowering
Strategies	Forming an Alliance	Focusing	Tuning-in	Supporting
Sub-strategies	Establishing background	Seeking data	Releasing & Activating	Resourcing
	Seeking affirmation	Analysing	Finishing Well	Involving Educating
		Validating		
	Building Trust	Drawing Conclusions		
	Allaying anxiety Being empathetic	Creating new meanings Planning		
	Respecting Boundaries			
	Being non-judgmental Clarifying roles			

5.3.2 The core problem

The study's core problem is a common problem experienced by participants, although in individual ways. In grounded theory studies, the core problem is commonly known as the basic social problem or the basic social psychological problem (Powers & Knapp, 2006). In the current study however, it is described as the basic biopsychosocial problem because this term captures the complexity of breastfeeding difficulties in terms of their biological, psychological, and social determinants. Here, the core problem is conceptualised as '*struggling to breastfeed satisfactorily*'. It describes a trajectory of mother and baby dyads' experiences of attempting to breastfeed, over time, but with limited success. Perseverance, despite ongoing breastfeeding difficulties is associated with considerable distress and frustration as mothers try to understand the reasons why it is not working, seek solutions, and trial various interventions, one of which, is osteopathic treatment of the baby. The core problem is therefore, from the osteopaths' perspective, also a sensitive clinical problem that requires their detailed professional evaluation and response.

Two broad factors contribute to dyads' *struggle to breastfeed satisfactorily*; they are *Facing uncertainty* and *Experiencing distress*. *Facing uncertainty* pertains to learning new breastfeeding skills while simultaneously adjusting to unpredictable and challenging birth and early postnatal circumstances. Uncertainties escalate when mothers have to cope with unsettled babies who are not breastfeeding well and they cannot understand the underlying cause or how to resolve the problem. In addition, they describe a history of receiving inconsistent or ambiguous information and advice, and ineffective breastfeeding strategies. *Experiencing distress* occurs when dyads' encounter various ongoing physical and psychosocial stressors, which tend to have negative health consequences. For example, a significant stressor relates to maternal breast or nipple discomfort or pain. Emotional distress relates to mothers feeling confused, unsupported, and socially isolated. The core problem for osteopaths thus involves analysing the relative causative elements of the *breastfeeding struggle* such as unravelling the origins of a mother's distress and a baby's fussy breastfeeding behaviours in order to make decisions about implementing effective treatment plans.

5.3.3 The core category

After identifying the core problem, data analysis focuses on determining how paediatric osteopaths respond to mother and baby dyads who are *struggling to breastfeed satisfactorily*. The core category is the central phenomenon that accounts for this response and, in a grounded theory, is commonly referred to as the basic social

psychological process. Following similar logic as for the core problem before; in this study, the core category is described as the basic biopsychosocial process. Interaction between an osteopath, mother, and baby with breastfeeding difficulties is premised on biological, psychological, and social processes and the core category encapsulates all of these dimensions into one central concept. The core category has a high level of abstraction and range as it links together and explains the relationships between all the other categories. The core category, *Promoting optimal breastfeeding through the osteopathic therapeutic cycle* represents a transitional cyclic change process whereby a mother and baby are encouraged to move toward a more effective and personally satisfying form of breastfeeding. *Optimal breastfeeding* is upheld as an ideal but relative goal that is defined, and re-defined as necessary, according to dyads' circumstances. Progress toward this goal can be sequential in terms of inducing a series of therapeutic changes spaced strategically over time. Progress, however, does not necessarily follow a linear pathway. It might or might not be straightforward or possible to reach an individually determined ideal of *optimal breastfeeding*. In this case, the osteopathic therapeutic cycle might involve a reconciliatory approach in which the osteopath and mother negotiate and work toward new breastfeeding goals that offer a form of compromise; one that is perceived as the best option at that time.

The core category comprises three distinctive but interconnecting transitional themes that follow a cyclic pattern of response. The first transitional theme, *Creating the therapeutic space*, involves setting up a physical, mental, and emotional environment that fosters cooperative interaction and enables change to occur. The second transitional theme, *Facilitating positive change*, focuses on interventions that can take a number of forms, such as treating the baby with manual therapy, educating the mother, or referral to other health professionals. The third transitional theme, *Integrating*, means to make whole again. It encapsulates a broad range of activities and processes that affect the mother and baby according to the osteopath's therapeutic intention and treatment responses. The osteopath, for example, might do nothing but allow time for innate physiological processes in the baby's body to self-adjust, or she might enter into a strategic discussion with the mother to help clarify interpretations of events that will impact on future plans. The core category stands for and embraces the range of processes, strategies, and sub-strategies identified in the other categories.

5.3.4 Categories and strategies

Four categories are embedded within the core process. They are called *Connecting*, *Assimilating*, *Rebalancing*, and *Empowering*. Each category represents a conceptual

activity, derived from data and with a high level of abstraction. Together, the categories represent the key processes that osteopaths use when responding to mother and baby dyads who are *struggling to breastfeed satisfactorily*. Although each category has its own strategies; overall, they tend to be complimentary. In many instances, they enhance or augment the effectiveness of the strategies of other categories. For example, *Building trust* is a specific strategy for *Connecting*. It also assists the osteopath to examine the baby when *Assimilating* information and to apply manual techniques when *Rebalancing* the baby's body. Categories and their strategies and sub-strategies tend to work harmoniously to support the core category, *Promoting optimal breastfeeding through the osteopathic therapeutic cycle*.

5.3.4.1 *Connecting*

Connecting is a category that focuses on building comfortable and cooperative interpersonal relationships between the osteopath, mother, and baby. It relies on effective communication to enable participants to get to know each other in order to find common ground and sense of purpose. For the mother, this means comprehending and feeling sufficiently confident with paediatric osteopathic practice procedures to agree to treatment of her baby. For the osteopath, it means determining the dyads' relevant past and present circumstances, the nature of their breastfeeding difficulties, and what the mother wants. It also means being able to interact at a personal and physical level with the baby. Osteopaths recognise the special relationship between a mother and baby such that interacting with one will also have a flow on affect to the other. On this basis, they seek a *connected* relationship with each individual by employing three key strategies; *Forming an alliance*, *Building trust*, and *Respecting boundaries*.

Forming an alliance relates to osteopaths and mothers finding out about each other's backgrounds, seeking common goals and mutual understandings. *Building trust* provides the foundation for cooperative interaction. It is based upon osteopaths allaying mothers' concerns and demonstrating understanding through empathy. *Respecting boundaries* relates to respecting and clarifying practitioner and patient roles. For the osteopath, this means operating within a scope of professional practice and personal values. For the mother, this means the right or opportunity to make informed decisions about caring for and feeding her baby without coercion or judgement.

5.3.4.2 *Assimilating*

Assimilating is the process of acquiring knowledge relevant to the core problem. It occurs when osteopaths absorb and interpret information gathered from various sources in order to build an explanatory diagnostic framework. More specific information is

sought by observing the mother's and baby's behaviours, questioning the mother, and examining the baby. Osteopaths use deductive and inductive reasoning to gather, mix together, analyse, and validate different types of information and ideas. One important information source is palpation or what the osteopath feels in the baby's body through her hands. *Assimilating* thus involves transforming sensory phenomena into a conceptual professional language. Osteopaths use their background scientific knowledge, clinical experience, and sensitivity to the possibilities in order to draw practical and theoretical conclusions, as required. These conclusions explain what is going on with a mother and baby with breastfeeding difficulties and lay the foundation for treatment.

Assimilating relates to two key strategies; *Focusing* and *Drawing Conclusions*. *Focusing* is a process of seeking more selective information and interpreting it through a narrower critical lens. *Drawing conclusions* is the process of studying and thinking about information in order to reconstitute it into a professional format; one that can be shared with others, guide action, and map out treatment plans.

5.3.4.3 *Rebalancing*

Rebalancing is a category that addresses the way osteopaths apply manual techniques to the baby. It rests upon the idea that a state of physiological balance equivocates with healthy bodily structure and function. Such a balanced physiological state enhances a baby's breastfeeding capabilities by facilitating the coordinated actions of attachment, suck, swallow, and breathe. In more general terms, it also promotes a baby's sense of relaxation and wellbeing, which in turn, has a positive influence on the mother. *Rebalancing* can occur at a specific level, through the application of a particular manual technique, such as relaxing a tight muscle, and at a more generalised level, where the purpose is to achieve a sense of physical balance of the whole individual. When osteopaths apply manual techniques to redress a state of physiological imbalance, they follow a typical pattern of behaviour that involves three strategies; *Tuning-in*, *Activating and Releasing*, and *Finishing well*.

Tuning-in starts with osteopaths adopting a particular physical and mental state; one that optimises their sensory and motor skills and enhances their ability to apply manual techniques in controlled and precise ways. *Activating and Releasing* relates to how osteopaths use their hands and bodies to interact with the baby's physical tissues and make precise adjustments to bring about physiological reactions, responses, and changes. *Finishing well* accounts for how each technique and series of techniques are brought to an appropriate conclusion. Although *Rebalancing* emphasises physical

processes, manual therapy cannot be separated from the osteopaths' thoughts and interpretations regarding the baby's responses and the mother's behaviour. Treatment finishes when the osteopath makes a clinical decision that an appropriate response has been made, given the circumstances at the time.

5.3.4.4 *Empowering*

Empowering is a category that addresses the mother's needs by assisting her to regain a sense of control over her life. This group of mothers are adjusting to difficult early mothering circumstances and their experiences of *struggling to breastfeed satisfactorily* are highly emotive. Osteopaths recognise the importance of assisting mothers to feel confident and competent in caring for and feeding their babies. The two strategies of *Empowering* are *Supporting* and *Involving*. They have broad conceptual names that cover a range of processes and activities that are tailored according to individual needs. Strategies can be direct or quite subtle and lie embedded within the activities of clinical practice. Overall, they rely on sensitive interpersonal skills and acting towards mothers in ways that promote their self-esteem and emotional wellbeing.

Supporting relates to osteopaths providing physical and emotional support such as giving breastfeeding postural advice and acknowledging and encouraging a mother's efforts. It also involves extending the support network by drawing on other resources; a typical example being referral to another health professional such as a lactation consultant. *Involving* relates to making mothers feel included during the baby's treatment and in the broader treatment plan. This is achieved, where possible, by the osteopath seeking and valuing a mother's opinions and assistance, and by answering questions and offering explanations. *Involving* mothers in this way can progress to a form of educating. *Empowering* strategies thus aim to help mothers to make sense of their circumstances. Understanding helps coping and assists them to move forward in a healthy way.

5.4 OUTLINE OF THE FINDINGS CHAPTERS

In Chapter Six, the study's contextual determinants are presented. In Chapter Seven the basic biopsychosocial or core problem, *Struggling to breastfeed satisfactorily* is presented. In Chapter Eight, the first of four categories, *Connecting* and its three strategies; *Forming an alliance*, *Building trust*, and *Respecting boundaries* are presented. In Chapter Nine, a discussion of the category, *Assimilating* and its strategies; *Focusing* and *Drawing conclusions* takes place. In Chapter Ten, the category *Rebalancing* and its three strategies; *Tuning-in*, *Activating and releasing*, and *Finishing*

well are presented. In Chapter Eleven, the last of the four categories, *Empowering* is presented, which includes a discussion of its two strategies; *Supporting* and *Involving*. In Chapter Twelve, the core category, *Promoting optimal breastfeeding through the osteopathic therapeutic cycle* is explicated. A discussion takes place around its three transitional themes; *Creating a therapeutic space*, *Facilitating positive change*, and *Integrating*. This chapter also presents the final theory as linkages are made between the core category, core problem, categories, and contextual determinants. In Chapter Thirteen, the results of the study are discussed and examined in light of other relevant research findings. Finally, in Chapter Fourteen, the study's limitations and implications for paediatric osteopathic practice, education, and research are presented.

5.5 CONCLUSION

In this chapter, the aim has been to outline the results of the study, provide some important background information, and introduce the final substantive theory that is derived from analysis of data using grounded theory methods. The main conceptual elements of the study's findings, which consist of contextual determinants, the core problem, core category, and four categories, have been outlaid. Such an overview of the various theoretical and interlinking components that make up the results of the study serves as a prelude to more detailed analysis and discussion, which takes place in the following chapters.

CHAPTER SIX

CONTEXTUAL DETERMINANTS

6.1 INTRODUCTION

The purpose of this chapter is to explore the surroundings or context in which participants' experiences and interactions take place and to identify the contextual factors that impact on the study's findings. The chapter begins by clarifying the meaning of context and contextual determinants in a grounded theory study. Contextual determinants that relate to the current study are then identified and explicated in detail.

6.2 DEFINING THE STUDY'S CONTEXTUAL DETERMINANTS

According to Corbin (2008, p. 229), context is defined as “the sets of conditions that give rise to the problems or circumstances to which individuals respond by means of action/interaction/emotions”. The context of the current study is thus explored by analysing data to uncover the sets of conditions, also known as contextual determinants, that help to shape the core problem, *Struggling to breastfeed satisfactorily*, and impact on the core category, *Promoting optimal breast feeding through the osteopathic therapeutic cycle*. They are often talked about, by participants, as a series of obstacles or issues that can both enhance and constrain their experiences and interactions and can be considered generally in terms of micro or macro forms (Corbin & Strauss, 2008, p. 230).

Micro conditions relate to more specific or immediate factors, which can simultaneously add to, or decrease, a mother's and baby's vulnerability or ability to engage with the osteopath and respond to treatment. In this study, micro conditions relate to individual circumstances and beliefs; primarily that concern breastfeeding, the birth, new mothering, and family perceptions. Macro stands for broader sets of social, cultural, and medico-legal conditions that have given rise to the more particular circumstances of participants' experiences. Macro conditions pertain to the situation of osteopathy as a manual therapy health care profession, the structure of the private health care sector, and societal attitudes toward complimentary health disciplines, breastfeeding, and new mothering. On this basis, three key contextual determinants and their underlying themes were analysed from data, as set out in Figure 2, below.

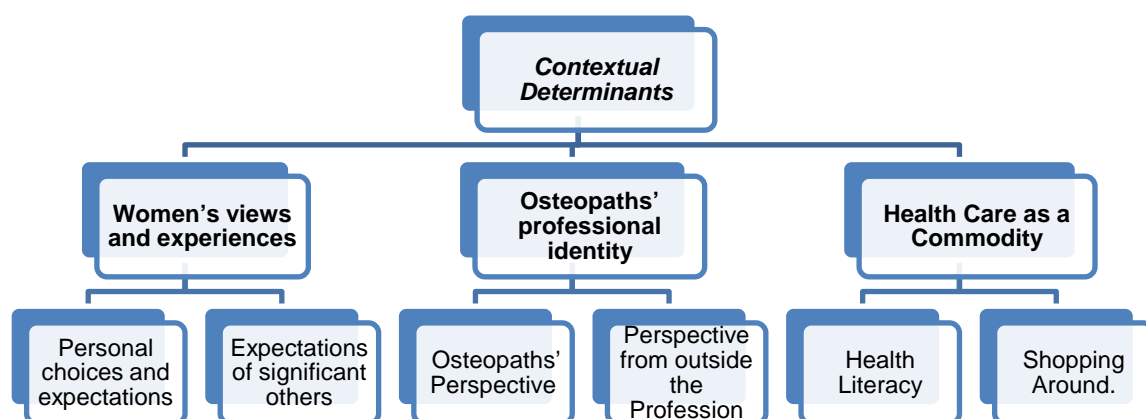


Figure 2: Contextual determinants

6.2.1 Women's views and experiences

It became clear during early analysis of data that mother participants share similar socio-demographic backgrounds⁵⁸, are generally healthy, of good social circumstance, and have a supportive partner who is the baby's father⁵⁹. Exploration of women's common views and experiences improves understanding of the breastfeeding difficulties they face and how this might influence the way in which paediatric osteopaths identify and deal with presenting problems.

Mothers' views of mothering and breastfeeding are influenced by the social circumstances of contemporary women's lives. Modern attitudes toward mothering reflect changing social discourses that have been identified by post-structuralist and feminist critiques (Bobel, 2010; Carolan, 2004; Liss & Erchull, 2012). Currently, in Australia, women value their careers and freedom to make life choices such as motherhood. How mothers manage to balance work and family is, however, generally acknowledged as a key social issue (Maher, 2010). Mixed attitudes to mothering have been reported but a commonly held view, evident in the data of the current study⁶⁰, is that motherhood comes with the expectation that a new mother is required to be fully committed to the care and welfare of her baby. This approach to motherhood was first described by Hays (1996) as "intensive mothering" (p.20) whereby mothers are expected to be selfless, available, and actively engaged with their babies' development at every level. According to Green (2010), the culture of intensive mothering in developed countries has continued to grow from the 1980s to the present in association with widespread media marketing and availability of maternal advice. Intensive mothering is generally viewed as a mainstream model for 'good

⁵⁸ See Chapter 5.2.1

⁵⁹ The father's influence as a 'significant other' is discussed in Section 6.3.3.

⁶⁰ See Chapter 7.3.2.1

mothering' and as a significant influence on popular parenting styles, such as attachment parenting (Friedman, 2010; Liss & Erchull, 2012) and natural mothering (Bobel, 2010). Contemporary views on mothering have been influenced also by substantial foundational research undertaken by Mercer (1981, 1985) on maternal role attainment, which has impacted on societal expectations of 'good mothering'. Mercer highlights the step-by-step developmental processes of achieving a maternal identity through attending to the baby's physical and emotional needs, over time⁶¹.

Knowledge and ideas surrounding maternal identity and the ideology of being a 'good mother' are important to women in the current study. In general, breastfeeding has become endorsed as part of this ideology⁶². In the current study, it became evident that women's interpretations and responses to becoming a mother and encountering breastfeeding difficulties cannot be viewed in isolation from each other and from the birth and other postnatal experiences; a finding supported by the literature (Fredriksson, Hogberg, & Lundman, 2003; Sheehan, Schmied, & Barclay, 2009). In the present study, mothers were not specifically asked about these experiences; nevertheless, they shared them with the researcher, often in an emotive and detailed way. For example, when asked about her breastfeeding decisions, Narelle (mother) responds by linking it with her mothering and birth plans.

Well we had planned quite a natural birth from the beginning, so everything we wanted to do was as natural as possible. When that kind of went haywire and we ended up having quite a lot of intervention; in the delivery I sort of thought, well despite all that, I still had this goal of breastfeeding; it's always been something I wanted to do (M 13/04).

After a complicated birth, Narelle and baby Brian went on to experience a series of clinical complications, which were medically managed and generally considered to be out of Narelle's direct control. This situation intensified her commitment to breastfeed, which became an even more important personal goal that linked to her ideal view of becoming a mother.

We had a lot of ups and downs before leaving the hospital ... but the breastfeeding was a constant. I need to keep on track with this [breastfeeding] even though we were having difficulties. That's one thing I've got time to work on; everything else

⁶¹ See Chapter 11.3 for further discussion relating to the transition to motherhood.

⁶² See section 6.2.1.2 for further discussion of these issues.

can heal and do its thing for the first couple of weeks, but we've got a journey that we must carry on with (M13/04).

Throughout the data, the association between complicated birth and subsequent breastfeeding difficulties is a frequent and significant finding of the study⁶³; one that impacts negatively on mothers' breastfeeding experiences, and influences the osteopaths' treatment approach, and the study's results, in general.

6.2.1.1 Personal choices and expectations

In general, women in the study articulate a strong desire to do the best job of mothering possible. Within this central ideal, they share a number of common expectations; however, they also express much individuality. Knowing how mothers expect or desire things to be creates a backdrop for osteopaths to evaluate the various obstacles to assisting women to achieve their breastfeeding goals. Women participants describe a well-organised approach to preparing for motherhood. It begins with pre-birth planning and gathering information from a range of sources, including written, online, discussion with experts, family and friends, and antenatal education classes. From this knowledge base, they develop an ideal or mental image of what to expect and the potential for flexibility and making individual choices. Other studies have similarly reported visualisation as a common strategy used by women to assist their transition to motherhood (Barnard & Solchany, 2002; Heinicke, 2002). The following exemplar encapsulates much of these ideas concerning how women prepare for motherhood.

For me, even when I fell pregnant, I did a lot of reading and I'm one of those people if I do something, I have to do it right, and mothering is also ... and so then when I was pregnant I read up all the books on child development. This [breastfeeding] is what I need to do and so that's how I found out that I had told myself I'm going to have a natural birth, do everything the natural way. I ended up [with] a caesarean, but it was something in my mind was not going to happen (Jenny, M 08/05).

Like Jenny, women's choices and expectations centre on doing the best mothering job possible, which is, in turn, linked to birth circumstances and breastfeeding; two issues that are often based upon the underlying idea that 'natural' is best. The desire for a 'natural' approach to childbirth and infant feeding has been reported in the literature as a growing contemporary lifestyle attitude or belief system which sees 'natural mothering' as a form of

⁶³ See Chapter 5.2.1. Table 4, for an overview of mothers' obstetric histories, breastfeeding difficulties, and clinical problems.

embodied female knowing (Bobel, 2010, p. 86). In the literature, tension and debate surrounds contemporary attitudes toward childbirth and the provision of appropriate maternity services, which are influenced by two dominant and competing discourses; namely the biomedical and naturalistic approaches (Walsh, 2010). One pervasive view of the advantages of natural childbirth and breastfeeding is that they represent normality and an acceptance of complexity and uncertainty (Downe & McCourt, 2008) and a shift away from medicalisation, and external control of women's bodies. This idea is expanded by applying theories of embodiment such that childbirth (Walsh, 2010) and breastfeeding (Ryan, Todres, & Alexander, 2011) are perceived as innate and fulfilling womanly achievements. When giving birth and making decisions about infant feeding, however, women can face unpredictable and ambiguous circumstances. They, and their partners and supporting health care team, must often negotiate a pathway between competing discourses and beliefs, particularly when problems arise and health risks have to be managed (Bryant, Porter, Tracy, & Sullivan, 2007; Turner et al., 2008).

For women in the current study, the term 'natural' means a normal vaginal birth without intervention and breastfeeding. For some, the idea of 'natural mothering' has a wider conceptual meaning that is not always clearly articulated but lies embedded within their personal and family values and underpins their behaviour at a deeper level.

Well, I was always going to breastfeed; obviously it's my belief system; breastfeeding is good and the way that I've been educated ... and then I was going to be home, so it just seemed like a natural thing to do (Sally, M12/02).

Women participants generally demonstrate a strong commitment to breastfeed. Their motivation is linked to the importance they place on breastfeeding, their high expectations of themselves at a personal level and as new mothers. They give three prime reasons for choosing to breastfeed; the health benefits, convenience, and to enhance mother-baby bonding. Mothers tend to differ in their emphasis on each of these three elements, but in the following exemplar, Nadia (mother) interlinks them seamlessly and follows a course of action that is based upon what feels intuitively right for her.

It would've been easy to stop [breastfeeding] but I don't think; it's not as convenient in the long term and stuff for his [baby's] health and for our relationship too; to keep breastfeeding is very nice, it's comfy (M10/05).

Nadia has breast attachment problems with her third baby, which causes her considerable nipple discomfort. While bottle feeding offers an easy immediate solution, she maintains a

longer term perspective, believing that the benefits of persevering with breastfeeding outweigh the alternatives. The message that breast milk and breastfeeding is the healthiest option for baby and mother is frequently articulated by this group of women, and it is a powerful motivator for them to breastfeed. Typically, knowledge concerning the extensive health related advantages of breastfeeding is expressed in the data as a form of pressure, of varying degrees, on mothers to breastfeed, or at least, to ensure their babies receive breast milk⁶⁴. Women in this study apply personal pressure to live up to their breastfeeding expectations. They might not articulate exactly where this sense of pressure to breastfeed comes from, but it is evident in the data and expressed in emotive ways.

I mean, you sort of do this thing where breast milk's the best, and she [baby] has to have it, at all costs (Kylie, M07/05).

Personal expectations of breastfeeding range from idealistic to more pragmatic. Each woman has her own perception of breastfeeding and its advantages. A similar finding was reported in another Australian grounded theory study, which explored women's infant feeding experiences and decisions in the first six weeks after birth (Sheehan et al., 2009). In this study, women's infant feeding decisions were made on the basis of individuals 'deconstructing best' which means women working out what 'best' (infant feeding) means to them given that everybody's experience is different.

Women in the current study consider, and prioritise, a number of factors when making their infant feeding choices. In general, the practical and nutritional elements of breastfeeding receive a lot of attention. Some view breastfeeding as an expedient way to feed a baby; linked to the notion of ready availability and transportability. The notion of breastfeeding as a convenient option, however, depends on how well breastfeeding works for each dyad. At times, bottle feeding is also seen as convenient and women build a lot of flexibility into how they choose to breastfeed. Variations relate to duration, exclusivity, and complementary feeding with artificial feeding products. For example, a common feeding strategy used by mothers in the study is breast milk feeding⁶⁵ with a bottle for a number of different reasons. Some mothers, whose babies have attachment and suck problems, want to ensure adequate delivery of breast milk. Others use this method as a temporary measure, either to allow someone else to feed the baby, to feel more comfortable feeding the baby with a bottle in public, or due to nipple pain or damage. An exemplar of an individualized breastfeeding approach follows.

⁶⁴ The concept of 'pressure to breastfeed' is discussed in Section 6.2.1.2 of this chapter.

⁶⁵ Breast milk feeding is defined in Chapter 1.52.

For Catherine, who comes from a long family tradition of women with breastfeeding difficulties, breastfeeding means ensuring her baby has breast milk as the healthiest option and also represents a sense of personal achievement. As she experiences initial attachment difficulties, she is more focused on the nutritional value of breast milk than how it is delivered to her baby.

But also the challenge of it [breastfeeding]; just to see whether I could do it or not, because I can be pretty determined when I want to be, but also I'm a bit of a 'wuss' [weakling], so I'll do it in my own time ... Given that I was actually successfully giving her [expressed] milk [from a bottle], I didn't want to ruin it by breastfeeding as well, at the same time. So from time to time, I would put her on [the breast] and see how it goes, but my main concern was to make sure at least she gets the milk and that I keep going with that (Catherine, M 02/).

Not all mothers enjoy breastfeeding; however all are generally aware that it enhances mother-baby bonding but can find it difficult to articulate what this means, exactly. The concept of bonding tends to be expressed more innately by the intimate way in which dyads interact, particularly by the way they look at each other and touch during breastfeeding. The emotional benefits that dyads attach to breastfeeding tend to emerge from the data in more subtle ways when mothers describe intimate moments during their everyday lives. For example, Sally (mother), who has an older child, describes breastfeeding as a much needed special time together for her and her new baby.

The only time we [mother and baby] really get together by ourselves is in the middle of the night. So it's actually really quite nice, just to sort of sit there and admire him, and have that little time by ourselves. I think the bonding experience when you breastfeed is just amazing, yes it's great ... they're so close to you, it's really lovely. I would have been sad if I couldn't breastfeed (M 12/12).

Most women participants, who make a choice to breastfeed, expect to be able to do so. In general, they anticipate that breastfeeding will require some effort; they might need some initial assistance, but it is a realistic and achievable goal. This idea fits with the notion of breastfeeding as a combination of natural and learnt processes which is the predominant discourse that underpins contemporary breastfeeding education⁶⁶. All women, having initiated breastfeeding, regardless of their early breastfeeding choices, demonstrate considerable perseverance with this course of action. Despite encountering difficulties, they refuse to give up on breastfeeding; an attitude that can be understood, in part, on the

⁶⁶ See Chapter 2.8.1.

basis of individual factors such as strong personal beliefs. Other influencing factors are now considered.

6.2.1.2 *Expectations of significant others*

Much research has been undertaken to better understand the many factors that can influence women's infant feeding decisions (Binns & Scott, 2002; James, 2004; Sheehan et al., 2009)⁶⁷. In the current study, women's personal breastfeeding choices are similarly influenced by a range of factors and to varying degrees. Such factors include the contemporary breastfeeding culture and the opinions of 'significant others' such as health professionals, family, and friends.

In Australia, the contemporary breastfeeding culture clearly encourages women to breastfeed. It assumes that women are able to make a voluntary and informed decision to breastfeed (or not); however, this is not always a straightforward process. Breastfeeding in modern times is a complex phenomenon that has been subjected to increasing medicalization (Craig & Dietsch, 2010). It is linked physiologically, to the pregnancy and birth, and described simultaneously as natural and in terms of acquired technical skill (Locke, 2009; Thompson, Kildea, Barclay, & Kruske, 2011). For current study participants, who face breastfeeding difficulties, the pro-breastfeeding culture is frequently experienced or perceived as a form of 'pressure to breastfeed'. This notion is linked to broader societal views on breastfeeding that are made widely available through the media and educational programs.

The current fashion is breastfeeding, and women are fairly well bombarded with the information about breastfeeding; you know, that it makes the child smarter and less sick and all the things you hear on television (Lauren, O 02/05).

I had to rush out and buy that tin [of formula] out of fear that I wouldn't be able to get the milk she needs, and even on the tin it says that breastfeeding is best and you know, you [should] try; so it's everywhere (Karen, M11/08).

The essential message is that breastfeeding is the right thing for mothers to do, largely on the basis of its health advantages, particularly for the baby; a finding that is supported by other studies (Battersby, 2000; Dykes, 2005). At times, women feel confronted by the one-sided view of breastfeeding as the only acceptable form of infant feeding; that a baby will miss out if not breastfed.

⁶⁷ Refer to Chapter 2.3.1 for a more detailed account of factors that influence women's infant feeding decisions found in the literature.

I remember my experience in the hospital. He [baby] was just so distressed that, and the nurse is going, “Just keep trying to [breast] feed him”, and I had tried to feed him pretty much continuously for about five hoursThe hard part is, I guess, being open-minded about formula as well as breastfeeding. There’s a lot of pressure to breastfeed (Sally, M12/02).

In this exemplar, Sally (mother) raises a concern about health professionals’ attitudes toward new mothers, which can contribute to their breastfeeding difficulties; an experience that is similarly described by others in the study, and discussed in the next chapter⁶⁸.

Women are influenced also by others who are closely involved in their lives. In this study, fathers play a key influential role in women’s breastfeeding decisions, generally in positive ways by providing emotional and practical support. The closeness of the mother and father parenting partnership is evidenced by a common finding in the data; that women think in terms of ‘we’ rather than ‘I’ when discussing their breastfeeding views.

It was never really a decision for us [to breastfeed their daughter]; it was never really an option; it was just was, um, just something that we feel really committed to. Um, just ‘cos it’s so much better for her (Vivienne, M 03/04).

In general, women describe many varied situations of paternal participation in infant feeding matters. For example, fathers are interested in the detail of different strategies to assist with breastfeeding. Most have accompanied the mother and baby to at least one visit to the osteopath. They are interested in osteopathy and want to be assured that treatment is safe and appropriate. If fathers are unable to attend visits to various health professionals, mothers still provide them with a detailed account of what took place. How fathers support breastfeeding varies among partnerships, but the importance of this support is acknowledged uniformly by mothers, and osteopaths. Catherine (mother) sums up a commonly held view of, “Yeah, if he hadn’t supported me, I wouldn’t have got this far” (M 02/04).

The mother’s mother is another family member, who is frequently brought into the breastfeeding discussion; a finding that is supported by the literature (Barnard & Solchany, 2002). The extent to which the mother’s mother influences current breastfeeding practices varies but most women talk about how their mother fed them as a baby, as a starting point for further discussion. The data demonstrate diverse family

⁶⁸ See Chapter 7.3.1.2 *Ambiguity of information, attitudes, and strategies*, where the context of health professionals’ approaches to providing breastfeeding support is uncovered in more detail.

breastfeeding histories but a common theme emerges concerning the impact of differing generational attitudes toward breastfeeding. In general, the mothers of women participants fed their babies during a less pro-breastfeeding era; an idea that is supported by the literature⁶⁹. Some women describe in detail their emotive interactions with their mothers in relation to breastfeeding, but on the whole, it is apparent that most women's mothers are prepared to accept their daughters' decision to breastfeed until this course of action becomes problematic. Once breastfeeding difficulties arise, women describe their mothers as being more vocal and active in discouraging continued breastfeeding. Osteopaths are also aware of the sensitive nature of interfamily relationships and the potential for conflict. Megan (osteopath) gives an account of her view of a typical intergenerational scenario; one that is found frequently in the data.

I know that generation wasn't as into breastfeeding and I guess that comes possibly from a caring point of view. I think if they've seen an unsettled, fussy baby and it's stressing the mum out, they probably think, well breastfeeding might just be one of the things that she should let go of and put them on a bottle (Megan, O 04/04).

In a similar way, friends offer a variety of opinions on breastfeeding. The typical response, however, is to discourage continued breastfeeding, under circumstances where they believe it is increasingly stressful for the mother and baby. Mothers discuss openly the various opinions offered by significant others, but more as a way of framing their thoughts and reaffirming their own views. It is difficult to unravel from the data, how much, and in what way the views of family members and friends influence mothers' expectations and choices. Overall, they appear to have limited influence on a mother's commitment to breastfeed, other than to reinforce her resolve to continue until she determines that it is time to stop. Significant others do, however, play a part in shaping mothers' and osteopaths' experiences and responses to the study's core problem. Essentially, this group of women is determined to persevere with breastfeeding and they do so with the support of the baby's father. Having this support is a significant contextual factor that influences study findings.

6.2.2 Osteopaths' professional identity

How osteopaths, in this study, behave and see themselves is shaped by broad professional issues and social attitudes (macro conditions) and by personal experiences of clinical practice and how others, such as patients and health professionals, relate to

⁶⁹ Low breastfeeding rates peaked around the 1970's. See Chapter 2.2.1.

them (micro conditions). A general finding, extrapolated from the data, is that mothers, family members, and health professionals have quite mixed perceptions and levels of understanding concerning osteopathy and more specifically, paediatric osteopathic clinical practice. The literature also reports a general societal attitude of ambiguity concerning who osteopaths are and what they do. This notion is aligned to osteopaths' history of struggling with their professional identity (Cameron, 1998; Hawkins & O'Neill, 1990); a situation that continues to the present day (Qureshi & Kusienksi, 2010). An explanation is offered on the basis of osteopathy's historical course of professional development⁷⁰ and the relatively small numbers of osteopaths to give this professional group a prominent voice⁷¹.

Osteopathy, like all health-care disciplines, has evolved alongside changing social attitudes and medico-legal regulations. In Australia, over the past 30 years, osteopathy has undergone significant government regulatory change. Legal regulation began in 1978 when osteopathy developed in close association with chiropractic⁷² (Baer, 2009), before achieving independent regulation in 2007⁷³. While perceptions of osteopathy, as a relatively alternative discipline, have shifted toward that of a more formally recognised mainstream complementary health profession⁷⁴, societal views do not necessarily keep up with legislative change. People in Australia today are increasingly using an assortment of complementary and alternative medicines (CAM)⁷⁵ (Shorufi, 2011; Sibbritt, Adams, & Young, 2004; Xue et al., 2006). Different CAM therapies range from conventional and complementary toward alternative or unorthodox, according to individual interpretation and cultural views⁷⁶.

Despite a background of changing professional identity, osteopathic principles have remained fundamentally unchanged from their origins. It is evident from the data that these basic principles underpin paediatric osteopaths' actions and thoughts as they respond to dyads, who are *struggling to breastfeed satisfactorily*. When explaining their

⁷⁰ Internationally, osteopathy has evolved and is practised in different ways. In America for example, it is known as osteopathic medicine and has become integrated with mainstream medicine, whereby osteopaths have full medical practice rights, working as physicians and surgeons within the public and private health sectors (Qureshi & Kusienksi, 2010).

⁷¹ In 2013, 1,823 osteopaths were registered to practise in Australia (Osteopathy Board of Australia, 2014), compared to 24,703 physiotherapists (Physiotherapy Board of Australia, 2014).

⁷² Before, 2007, and from 1978, in Australia, Osteopathy and Chiropractic were regulated by joint disciplinary State Registration Boards under the provisions of the Chiropractors and Osteopaths Act 1978 (Baer, 2009).

⁷³ Osteopathy was first recognised as an autonomous health profession in Victoria by the Health Professions Registration Act of 2005, which came into effect July first, 2007 (Victorian Government, 2005).

⁷⁴ See Chapter 1.5 for osteopathy's current regulatory status under the Australian Health Practitioner Regulation Agency (AHPRA).

⁷⁵ See Chapter 1.5 for a definition of CAM.

⁷⁶ A national population based study of CAM use in Australia identified 17 CAM therapies in which osteopathy was classified as one of five other manipulative and body-based methods (Xue et al., 2006).

treatment processes, osteopaths refer to three basic principles; the body is a unit, the body has its own self-regulating mechanisms, and the body's structure and function is reciprocally interrelated (Dowling & Martinke, 2005; Kuchera & Kuchera, 1994; Parsons & Marcer, 2006; Ward, 2003). A brief synopsis of each principle follows.

- The body is a unit

This principle underlies osteopathy's holistic approach; its meaning is defined by Parsons and Marcer (2006) as "a change in one of the body's systems, whether caused by an internal or external agent, will have an effect on other areas, be they in the body, the mind, or the spirit and affecting one will affect all of the others" (p.10).

- The body has its own self-regulating mechanisms

There is an underlying belief that if the body is functioning efficiently, its inherent self-healing mechanisms can operate effectively, thereby alleviating symptoms, promoting well-being, and maintaining health.

- Structure and function are reciprocally interrelated

The osteopath aims to determine and resolve any abnormal states of structure (anatomy) and function (physiology) thereby restoring normal homeostatic balance and preventing pathological change. This principle underlies osteopathy's role as a form of preventative therapy.

Rational treatment, which primarily incorporates osteopathic manual therapy, is based upon an understanding and application of these principles. The following exemplar highlights the typical approach adopted by osteopaths in this study to paediatric practice; one which rests upon a merging of osteopathic principles and the application of manual therapy.

Then that memory [of trauma] is held in the [baby's body] tissues and it will come out later in the development of that child, whether it be in an asymmetrical crawl or an asymmetrical walk or an ear infection that leads to antibiotics and then perhaps affects the whole gut, brain connections. So I suppose, for me, it's not only the muscular skeletal framework but also if there's compression that affects physiological functions then it can have an effect on the whole system of the baby or the child (Janet O10/02)

While osteopaths' professional identity rests upon its principles, it is influenced also by the current circumstances of paediatric osteopathic practice and individual professional and personal interpretations and views. The sets of conditions that contribute toward osteopath participants' professional identities and which impact upon the processes that take place during a treatment session are explored from two perspectives; osteopaths' personal and professional views and the viewpoints of those from outside the profession.

6.2.2.1 Osteopaths' perspective

Osteopath participants are a diverse group, in terms of their gender, age, years in practice, and family circumstances⁷⁷. Their sense of professional identity, however, has a number of common features; it is firmly grounded in osteopathic principles and treatment models that are applied to paediatric practice in specific and similar ways and they are highly motivated to treat paediatric patients. Osteopaths in this study assume that mothers, who bring their babies with breastfeeding difficulties for treatment, do not necessarily have a basic level of knowledge about osteopathy and more specifically, paediatric osteopathy. Osteopaths are better known for applying manual therapy to adults with back pain than treating babies. As such, osteopaths are aware of the potential consequences of a mother's poor understanding of osteopathic paediatric practice. For example, when mother and baby enter a relatively unknown clinical environment, osteopaths appreciate that they might feel vulnerable. Furthermore, this situation can be compounded if mothers are exposed to other peoples' various and possibly ill-informed perceptions and opinions of paediatric osteopathy. As a group, however, the osteopaths portray a strong sense of professional purpose. They adhere to professional guidelines and principles and inculcate patients' ambiguity concerning osteopathy into their general mode of practice. They articulate a sense of confidence and commitment to their professional work in the field of paediatrics.

A common finding of the study is that osteopath participants have selectively pursued a career in paediatrics by following similar pathways. It is common practice for less experienced osteopaths to work as associates in established clinics, thereby entering supportive environments. In a similar way, becoming a paediatric osteopath involves finding and working alongside a mentor; someone who has a paediatric knowledge base and clinical experience that she is willing to share. It also involves the neophyte paediatric osteopath placing herself in a clinical situation where she has the opportunity to treat babies and learn techniques considered more applicable to a paediatric population. This pathway follows an oral and skills-based apprenticeship style vocational tradition, which

⁷⁷ See Chapter 5.22.

might be explained, in part, by the limited availability of formalised paediatric-specific postgraduate programs. The common pathway to becoming a paediatric practitioner is encapsulated by the following exemplar.

Really, from day one, I made that decision; I was going to be heading in that direction; to treat babies and children ... I sought an appointment with osteopaths who were treating children, who were using indirect techniques. I became an associate at two practices that were doing that and at one of the practices I would sit in and be mentored by the principal osteopath (Lauren, O02/02).

Paediatric osteopaths share a number of common views regarding paediatric practice. They express a keen interest, putting forward a moral argument that their work in this field not only fosters many important immediate benefits, but through its long-term and holistic perspective, can change people's lives for the better. Such a prophylactic approach rests upon the idea that early intervention gives babies the opportunity to grow and develop in order to reach their full potential.

I think because a lot of the work that I do with babies and children is preventative for later whereas a lot of work with adults is, you know, it helps and it makes them feel better but I really feel with the babies and the children, you can really change what's ahead of them in life really... which is such an amazing thing to be able to do. I mean it helps them at the time as well; just that preventative side of it is much bigger with a younger patient (Megan, O04/02).

Although osteopath participants discuss the pros and cons and complexities of working with paediatric patients, in general, they enjoy this field of work for a variety of reasons. Some enjoy the personal interaction and others enjoy the nature of the professional work. Some report that babies are easy to treat, while others find them challenging. At times, osteopaths cannot articulate the source of this enjoyment, just that they feel comfortable, stimulated, and rewarded by treating this group of patients.

It's quite satisfying and I enjoy the contact with the mother and I get a real kick out of little ones. The fact that you get a good response; with little smiles and they start to feel better; their face lights up when they see you (Britt, O7/01).

I guess it's just adds a different dimension to practice. It's something different to the normal everyday lower back pain, neck pain, headaches that kind of thing; so it I guess it broadens your horizons; challenges you a little bit, that kind of thing (Hannah, O12/01).

Paediatric osteopaths often recognise and demonstrate a duality within their work. They consistently put forward an objective professional face, but are also aware that they bring various personal elements with them. They appear to strike a balance between these dual influences, talking about them in complementary ways that enhance their overall approach to treating dyads with breastfeeding difficulties. This merging of their professional and personal perspectives is evident mainly in two areas; breastfeeding and early parenting.

Osteopath participants offer a professional view which upholds breastfeeding as the optimal way to feed a baby on the basis of its health benefits and the research evidence. This viewpoint, however, is always qualified by the need to look at the bigger picture of the mother and baby's overall wellbeing. They are particularly aware of the deleterious effects of women feeling pressured rather than supported to breastfeed. A general finding of this study is that osteopaths adopt a pragmatic approach toward breastfeeding based upon an evaluation of individual needs; one that is measured, yet open and fluid. This approach is derived from a mix of professional knowledge, clinically based influences, and personal experiences.

I think it's [breastfeeding] an important thing obviously and certainly all the research demonstrates the nutritional, emotional benefits; so I'm a big supporter of it. I think there should be proactive support of mothers, families, parents to breastfeed but there are a few people make it the be all and end all and then if you can't do it then there's something wrong with you. I think that's just an unrealistic expectation (Daniel, O11/10).

I don't have children and I haven't breastfed. I think it's obvious from talking to women and anecdotal evidence as opposed to personal experience, I think the role of breastfeeding is really important and most people in the health profession are keen to encourage people to breastfeed ... there are sometimes very good reasons for giving up [breastfeeding] and I do like to support women on that as well (Natasha, O 9/11).

Approximately half the osteopaths in the present study are parents who acknowledge that their own parenting and infant feeding experiences have some impact on how they view breastfeeding and how they interact with other parents. In general, they believe that their personal experiences become absorbed within their professional identities and enable them to respond to mothers and babies in more empathic ways. The concept of

osteopaths inculcating their own experiences into their professional practice is explored further in later chapters⁷⁸.

6.2.2.2 Perspective from outside the profession

In the current study, outsiders include mother participants, their families, friends, and the health professionals who are involved in their care. In general, a number of different perceptions of paediatric osteopathy are expressed throughout the data. Perceptions are conveyed through mothers' stories or interpretations of their experiences and interactions with others, when discussing osteopathic treatment of their babies. Some mothers are extremely satisfied with osteopathic treatment and incorporate it regularly into their family health care; however they did not always feel this way. Typically, mothers describe a history of uncertainty associated with their first visit to an osteopath. Furthermore, osteopathy for babies is a particularly new concept for most mothers and their families.

Perception of paediatric osteopathy is underpinned by how people talk about it and understand it, and ultimately through personal knowledge and experience of osteopathy. The main areas of concern or ambiguity relate to deliberations on whether paediatric osteopathy is widely accepted, safe, and appropriate for a baby with breastfeeding difficulties, and whether the individual practitioner has the necessary expertise and skill. Often these issues are intertwined and individual views on paediatric osteopathy can range from extreme to moderate. In the following exemplar, Narelle (mother), who has a particular understanding of how the paediatric osteopath treats her baby, describes her interaction with another health professional who has different views.

She [physiotherapist] said, "I don't know why you're seeing an osteo, but babies have a lot of blood vessels around them and they just can be damaged at such a young age ... Look I'm not saying that you shouldn't see your osteo; it's your choice but I just don't think it's a good idea. She said, "He's too young", and I don't know what she was thinking; if she lumps them in with chiropractors. I just sort of thought she would be a bit more, sort of, educated about them (Narelle, M 13/14).

Here, Narelle describes one manual therapist's perception of osteopathic treatment of a baby, which conflicts with her personal views and expectations of a health practitioner's knowledge. Issues of safety and suitability on the basis of the patient's age are raised, which create some stress and uncertainty. To add to the complexity, we do not know how Narelle perceives chiropractors, but she uses them as a comparison by which to define osteopathy, even if it is only in terms of the two disciplines being different from each other.

⁷⁸ See Chapter 8.4.2.2 *Being empathetic*.

In the current study, mothers' perceptions of how an osteopath works are based frequently upon making comparisons to other manual therapies⁷⁹. In addition, concerns are raised about different manual therapy approaches for adults compared to babies. Tania (mother), for example, is unsure about taking her baby son to an osteopath, in whom she has great confidence for her own treatment.

I found an osteopath and he turned out to be brilliant No I haven't heard that osteopaths worked on babies. We were a bit sceptical to start with, probably like we were right at the beginning for ourselves. Umm, and a little bit apprehensive, 'cos we had our own osteopath, but I don't know that he has that much experience with babies (M 01/03).

Instead, Tania (above) sources another osteopath, known to treat babies, on the recommendation of a friend. Typically, mothers in this study find that not all osteopaths work in the same way. This notion is supported by the data, where osteopath participants report that they regularly receive referrals from other osteopaths and health practitioners. Referrals are made on the basis that a particular osteopath or practice is known to have expertise in treating babies.

They [parents and baby] were referred by a lactation consultant and by their maternal health care nurse; so they had two professionals in the paediatric baby area referring to the same place. So I think that also gave them a level of confidence and they wanted a solution ... They've [health professionals] sent them here on the understanding that we've had good results in the past, that the process is non-invasive and not harmful (Lauren, O02/11).

The referral pattern, highlighted above, is somewhat inconsistent with findings from an Australian survey-based study of osteopathic practice, which reports a low rate of inter-professional referrals to osteopaths compared to a high rate of referral from other patients (Orrock, 2009). Osteopaths in this study, typically have good working relationships with other health professionals who share a special interest in mother and baby health. This finding is premised on the basis that they communicate regularly and refer patients to each other, which, in turn, indicates trust and some level of understanding of what each other do.

In summary, osteopath participants emerge as a group of practitioners who are recognised informally by members of their own profession as paediatric osteopaths. They

⁷⁹ The three better known manual therapy health professions are osteopathy, chiropractic, and physiotherapy.

share a common view concerning the importance of a holistic and preventative approach to health care for families with young babies, have particular technical skills appropriate for paediatric patients, take a multidisciplinary approach to dealing with breastfeeding difficulties, and have built effective inter-practitioner relationships. Despite evidence of widespread poor understanding of the discipline of paediatric osteopathy, this group of practitioners demonstrate a strong sense of professional identity⁸⁰.

6.2.3 Health care as a commodity

The third contextual determinant relates to the health-care organisational framework in which paediatric osteopaths and mother and baby dyads interact. Osteopaths, in this study, work in a homogenous clinical environment; as sole practitioners within the private health sector, in small suburban clinics. Osteopath and mother participants' behaviours, actions, and thoughts reflect a number of trends concerning the contemporary culture of health-care in Australia and more specifically, allied health services that operate alongside the public hospital and community health-care sectors. This trend has been reported in the literature as a phenomenon known as "commodification of health care" (Lumby, 2001, p.54). Health-care becomes a commodity or article that can be traded and thus assigned an economic value. This concept can be quite complex when health-care is viewed as part of a large government and social structure. Within the more confined scope of paediatric osteopathic clinical practice, it follows a fee for service model. This model implies that mothers and osteopaths interact on a transactional basis whereby the osteopath is a provider, and the mother, a consumer of a specific health service for which a direct monetary payment is made. Lumby (2001) traces the history of health-care in Australia, which has become increasingly conceptualised as a business. Factors such as economic pressures, population growth, the expanding range of health services, and technological advances have impacted upon the delivery of health-care, which is tied to politics and funding. The culture of health-care has been seen to change within an era of economic rationalism⁸¹ whereby it has "shifted from a welfare state to a market state" (Lumby, 2001, p.67). The advantages and disadvantages of changes in attitude and organisation of health-care are open to ongoing debate. However, some of the consequences of this change that are relevant to this study include a growing social awareness of health issues and a shift in responsibility to individuals to pay for and manage their own health-care needs. A greater emphasis on choice concerning health services has become part of the wider phenomenon known as consumerism.

⁸⁰ Paediatric osteopaths' professional identity is discussed further in Chapter 13.5.

⁸¹ Economic rationalists seek greater efficiency through a dynamic unregulated economy that is driven by market forces and assumed to have an inherent tendency toward equilibrium (Whitwell, 1998).

Consumerism is known as a movement that involves educating people about their rights and protecting their interests (Butler, 2009, p268). Within a health-care context, patients are viewed as consumers who require access to health-related knowledge and who have rights such as informed consent and treatment choice (Allsop, Jones, & Baggott, 2004; Williamson, 1999), although Lumby (2001) points out that freedom to choose depends on socio-economic circumstance (p. 65). As osteopathy is not routinely funded by government sources, participants in this study consider the impact of its financial costs, which are explored later in the chapter. They are sensitive also to the broader issue of affordability of CAM therapies, such as osteopathy, for some families.

For those that are struggling financially I think it [the cost] would have a significant impact. I've got a cousin and I definitely think that osteo would be of benefit but they just can't afford it; they've had to drop their private health insurance. So yes I think certainly if it's more accessible maybe through Medicare⁸², I think that would help for sure (Sonia, M 06/10).

The notion of osteopathic treatment as a commodity frames individual patient-practitioner relationships and expectations. As well as delivering manual therapy to the baby, paediatric osteopaths are expected to provide mothers with reliable and accurate information and advice, expressed in a readily comprehensive way. This information equips the mother to participate in decision making that concerns her and her baby's health-care, which is considered part of good professional practice (Osteopathy Board of Australia, 2013). Typically, osteopaths are not only health practitioners who abide by a professional code and government regulations; they are also self-employed small business owners and operators.

Being self-employed and operating within a small private business structure, paediatric osteopaths have scope for self-management of their working arrangements. In general, however, they adopt similar approaches and clinical protocols. Based on observations, it is evident that considerable thought is put into creating a pleasant, informal, but organised clinical setting. For example, a significant range of quality toys and books suited to different age groups is available in the waiting area and in individual consultation rooms. First names are used routinely. On a number of occasions, the receptionist was observed to interact at a close personal level with mothers and babies. A typical scenario involves the receptionist cuddling a baby while the mother attends to an older sibling. Evelyn

⁸² Medicare is the name of Australia's national health scheme which provides access to free hospital admission and financial support for visits to general medical practitioners (Maher, 2010).

(osteopath), for example, chooses to develop this aspect of her clinical practice in order to enhance the level of care that she can provide.

The whole set up is to give as much support as possible for mothers to be able to bring their baby here. There's a waiting room area where the receptionist gets involved ... she's actually got a child care qualification, and loves babies so it's a very, very conducive and supportive situation ... Mothers come early because it's so nice that children love playing there so they don't leave straight away because they can always breastfeed in the corner (Evelyn, O 08/12).

While not all osteopaths adopt the approach outlined by Evelyn above, this exemplar illustrates the freedom that individual practitioners have to develop particular aspects of the service that they provide that they deem to be important and which reflects their individual approach to clinical practice.

An important element of the service that osteopaths provide, in general, relates to the quality and amount of time given to individuals and allocated for each consultation. Appointment times, being typically an hour for an initial, and 30 minutes for a subsequent consultation, provide extended periods of one-on-one patient-practitioner time. As times are generally adhered to, mothers and babies aren't kept waiting, which is a common complaint from those within the public health system (Lumby, 2001, p.64). Mother and baby also have continuity of care from the same practitioner throughout the course of their treatment, which allows time for relationships to develop. These features, which are often lacking in busy public health facilities, enable osteopaths to provide personalised care and may help them to address mothers' psychological needs. Although osteopaths traditionally use the term patient; it does not reflect the nature of the relationship between persons involved in the consultation. Mother and baby dyads experiencing breastfeeding difficulties are vulnerable but not necessarily ill. Mothers, who are trying to take control of a difficult situation, come to the osteopath for a specific purpose; often already equipped with acquired knowledge and experience. The concept of their relationship as a personalised business transaction is further developed by exploring two interrelated concepts

6.2.3.1 Health literacy

Health literacy relates to patients' abilities to seek, comprehend and utilise health-related information. It is increasingly recognised as a multidimensional and important social and public health issue (Briggs & Jordan, 2010). Information technology, such as the internet, plays a key role in the availability and abundance of information accessible to the public.

Mothers in the study demonstrate a high level of health literacy, which is not surprising given their educational background and motivation. A similar finding has been reported by Carolan (2007) in her study concerning first-time mothers over 35 years. Women actively source information to prepare for parenting and in response to unexpected and difficult circumstances. For example, in the current study, Sonia's (mother) immediate response to encountering breast refusal⁸³ is to learn more about it by seeking verbal and written information from expert and lay sources.

I basically spoke to the maternal health nurse, I spoke to the doctor as well, spoke to friends; any information you could get, read a lot in regards to you know, his [baby] symptoms (M 06/03).

Health literacy emerges as an important contextual factor that moderates how mothers and osteopaths endeavour to find the best way to deal with breastfeeding difficulties. Women arrive at the osteopath's practice, typically with a history of experience and with knowledge acquired from different sources, which influences their expectations and treatment choices. For example, Marie, mother of two, self-diagnoses her baby's breastfeeding difficulties as reflux, on the basis of informal internet research, conferring with another mother, and her prior experiences with an older sibling when he was a baby. This knowledge builds self-confidence and underlies her assertive approach.

I had this friend of mine and her baby well and truly had problems. And we both became experts on silent reflux... there are three types of acids that come up from the stomach. Zoton [medication] gets all three and some of the other medications which I just skipped, knowing full well that they didn't affect all three acids (M 04/02).

While it assumed that knowledge enhances understanding and enables mothers to make decisions, not all forms of knowledge are helpful to mothers who have to analyse and apply it. The legitimacy of some forms of information can be confusing and questionable. Not all mothers, for example, want to access and understand detailed medical information or the underlying mechanisms of osteopathic treatment. Dianne (mother), for example, places more value on trusting the integrity, competence, and educational expertise of the individual practitioner.

I don't understand [about osteopathy], isn't that great! I just know that it's helped me in the past and it's helped a lot of other people that I knew and I read about

⁸³ Breast refusal refers to a baby's behaviour of fussing or refusing to latch and suck from the breast.

helping babies and that sounds really good. So I guess they're [osteopaths] the ones that are studying it (M 05/04).

In another example, Sally, a nurse and naturopath, wants to focus on her mothering role and move away from a medical focus and the responsibility that comes with it. Detailed or complex information is a burden for her at this time and she expresses a desire to, “*step away and let someone else do the treatment (M 12/08)*”. To provide effective care, osteopaths must be sensitive to mothers’ individual health-related information needs and preferences; an issue that is discussed in more detail in later chapters. Information has to be delivered in a way that is readily understandable, and matches individual circumstances. Within the context of breastfeeding choices, osteopaths adopt a uniform approach of refraining from giving advice on women’s infant feeding decisions unless asked.

Sometimes they [mothers] even ask me what my thoughts are, then I'll share my information but it's on the basis of I feel that they are wanting to hear it. I don't preach to the patients on what they should do about breastfeeding (Lauren O2/06).

Typically, osteopaths follow the mother’s lead and respect her breastfeeding choices and offer support and advice where deemed appropriate. This action is linked to the notion that the health practitioner is not the sole possessor of expertise, and lay knowledge and choice is increasingly seen as valuable or legitimate, a finding supported by other authors (Briggs & Jordan, 2010; Grace & Higgs, 2010). Matching the service provided with consumer needs underpins the concept of shopping around, which is now explored.

6.2.3.2 Shopping around

In a health-care context, ‘shopping around’ is an expression that relates to seeking help from different practitioners, according to consumers’ perception of their needs, quality of care and advice given, and level of satisfaction. It is a concept that links with the general idea of individuals taking responsibility for managing their health requirements. A common finding of the study is that mothers visit health professionals from different disciplines, often concurrently, for a variety of problems and reasons. There is, however, overlap in the care provided, as health professionals share the common responsibility of promoting mother and baby health.

She [mother's mother] said, "Well all this money, you're paying out a lot of money and you're running round here, there, and everywhere. Do you think you need to

be going to the osteo?" and I said, "Well yes, I prefer the benefit, like the breastfeeding and the persevering" (Narelle M13/15).

Shopping around gives the mother an opportunity to be proactive and take charge of her baby's health by deciding who she will visit and whose advice she will follow. In the following exemplar, Marie's (mother) behaviour demonstrates a number of features of the idea of 'shopping around.' Having a very unsettled baby, she seeks answers and interventions from a maternal child health nurse, medical doctor, paediatrician, and chiropractor before consulting an osteopath. She dismisses the advice of some; chooses her doctor on the basis that he is prepared to listen to, and accept, her views; and did not continue with one form of manual therapy when she wasn't satisfied with the results. Her journey of 'shopping around' to find a solution to her breastfeeding difficulties is illustrated by the following excerpts.

The GP we see is a very, very good GP; he is very pro believing mums. I didn't have to try and convince him at all (M 04/02).

She [maternal child health nurse] told me to lock him [baby] in a room for three hours and just let him scream as its just colic. With a child that has reflux, you know it's quite obvious to a mum; it's not normal crying ... The paediatrician will say to me, 'It's [reflux] not really recognisable until six to eight weeks [of age]'. But I think that's due to the fact that you can't get into see them for six to eight weeks [Laugh]! (M 04/04).

I was desperate; I would try anything, like I gave the chiropractors a first call. And she was great, but then it sort of didn't seem to be getting any better in the end (M 04/06).

A typical attitude adopted by women in this study is if they aren't satisfied with the quality of care offered or the results achieved, they try something and someone else. The financial costs of this course of action are an important consideration for many women as they are seeking the services of health professionals who predominantly work within the private health sector. They are looking for value for the money they spend, premised on the notion of a fair exchange. Mothers perceive value for their money in different ways, often weighing up the pros and cons of investing money into strategies to support breastfeeding. This counterbalancing argument is illustrated by Catherine (mother), who weighs up the financial costs of strategies to assist her to breastfeed, compared to the benefits.

Apart from the fact that it's costing us \$125 a week to hire the [breast] pump, it's just I'm tied down ... Well in terms of the cost, I'm probably not going to save money if I manage to breastfeed now as opposed to continuing to express [breast milk], so when you add that to the cost of what we've already outlaid ... if it [osteopathic treatment] does help her [baby] breast feed so that it gives me more mobility and sanity in my life, then it's worth it (M 02/09).

When focusing on the value of osteopathic treatment, mothers consider such factors as the time, skill and effort that the osteopath puts into the treatment, and extent of perceived benefits. In general, osteopaths work with an awareness of the same expectation of providing good service in exchange for payment. This means delivering all that entails good professional practice: giving clear information and advice, including parents in the decision making process, applying effective manual therapies, and hopefully, seeing beneficial changes. The latter result is the most convincing one for everyone involved.

You get a few [parents] that during the treatment; they're sitting there looking at you going [thinking], 'What is this 'shit'? I've paid seventy bucks to watch you do this;' but then they come back the next time and they're like, "I don't know what you did but you know the baby's a lot better", so they don't really care what you do after that, as long as they're getting enough sleep and doing better (Tom, O 03/13).

6.3 CONCLUSION

In this chapter, the context of the study has been examined. Context is made up of three key contextual determinants that influence the core problem and moderate the processes, by which paediatric osteopaths and mother and baby dyads with breastfeeding difficulties, interact. Three key contextual determinants were identified as *Women's views and experiences*, *Osteopaths' professional identity*, and *Health-care as a commodity*. The first two concern the characteristics of the study's two participant groups, mothers and osteopaths, who emerge as special groups of people for particular reasons. Mothers share a common socio-demographic background, similar views and expectations of mothering and breastfeeding, and a complicated obstetric and early postnatal history. Osteopaths demonstrate a robust sense of professional identity despite osteopathy's history of struggling for legitimacy and recognition. They have developed a reputation and background of expertise in paediatrics; an acknowledged but poorly defined field of osteopathic practice. In addition to their unique qualities, the two participant groups interact with each other within the domain of the private health-care sector and a small

business framework where health-care is viewed as a commodity. These three contextual determinants represent direct and indirect moderating influences that intertwine to create the background in which participants' experiences take place. Contextual determinants are uncovered first, at the beginning of the results section of the thesis, in order to provide a background to participants' experiences and interactions and thus add depth and enhance understanding of the study's more focused conceptual findings

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CHAPTER SEVEN

THE CORE PROBLEM

Struggling to Breastfeed Satisfactorily

7.1 INTRODUCTION

The study's core problem is conceptualised as '*Struggling to breastfeed satisfactorily*'. It is abstracted from data through the breastfeeding experiences of mother and baby dyads, and relates to a clinical problem faced by osteopaths who contemplate the best way to evaluate the situation and provide assistance. This chapter commences with a definition of the core problem, which is followed by an analysis of the two main factors that contribute to it; *Facing uncertainty* and *Experiencing distress*. The chapter finishes with concluding statements.

7.2 STRUGGLING TO BREASTFEED SATISFACTORILY

The study's core problem is a complex biopsychosocial problem⁸⁴ that is evident in the data, and which becomes defined through analysis, using grounded theory methods. *Struggling to Breastfeed Satisfactorily* typically starts with women's awareness of a growing gap between their initial breastfeeding expectations⁸⁵ and the opposing reality of current circumstances. The core problem then develops as more emphasis is placed on the challenges of identifying and overcoming the various contributing factors to, and negative consequences of, incompatible breastfeeding expectations and experiences. The breastfeeding literature provides a significant sensitising source of information that relates to the study's core problem. For example, the various determinants of effective breastfeeding have been identified as involving a combination of physiological processes, technical skill, and family and social influences⁸⁶. Data in the current study similarly demonstrates that breastfeeding difficulties arise through a complex interplay between physical, psychological, and individual elements. The study's core problem, *Struggling to breastfeed satisfactorily* has a broad conceptual range because it accounts for these various contributing elements, according to individual circumstance. It is a problem shared by dyads and osteopaths in the sense that both groups want to find a solution. However, as it is based upon participants' experiences and interpretations, the core problem manifests in different ways according to the lens through which it is viewed. For mothers, it is defined in relative terms, according to their emotional state, evidence of a satisfied baby, and by individual signs of breastfeeding success or otherwise. Osteopaths view the

⁸⁴ See Chapter 5.3.2 for an explanation of the concept of a biopsychosocial problem.

⁸⁵ See Chapter 6.2.1 for an account of the study's contextual determinant, *Women's views and expectations*.

⁸⁶ See Chapter 2.3.

core problem from a clinical perspective according to dyads' histories, feeding behaviours, growth parameters, and individual preferences.

Babies are the patients in that they are brought, by their mothers, for osteopathic assessment and treatment; however the breastfeeding problem is generally acknowledged as one that affects both members of the breastfeeding dyad, but in different ways. The osteopath must unravel the elements of the breastfeeding *struggle* in ways that relate to their area of clinical expertise. As manual therapists who have a particular interest in the structure and function of the physical body, *struggling to breastfeed satisfactorily* is considered in terms of the biomechanics of effective breastfeeding behaviours and postures, and normal physiological processes. As holistic practitioners, the problem must be viewed also according to the mother's and baby's general health status, family situation, and relevant cultural and psychosocial influences.

The term '*struggling*' is the pivotal concept of the core problem. It is defined as "a strong effort or series of efforts, against any adverse agencies or conditions" (Butler, 2009, p. 1252). For mothers, *struggling* emerges as a trajectory of discovering breastfeeding problems, seeking help, sorting through a range of advice and options, and trialling different interventions before ultimately arriving at the osteopath's practice. The *struggle* then continues as mothers narrate their breastfeeding histories and incorporate the paediatric osteopaths' responses, thoughts, and actions into their experience of the problem. The dimensions of the breastfeeding difficulties and strategies employed might change over time, but the *struggle* remains; although for some participants, it shows signs of resolving as babies are able to feed more effectively at the breast or dyads re-negotiate their breastfeeding goals.

Struggling incorporates the idea of persevering in order to overcome difficulties in relation to establishing, maintaining, and supporting what is, ultimately, a unique and dynamic mother-baby breastfeeding relationship. Osteopaths experience the problem in terms of ascertaining the biological, psychological, and social circumstances of the dyad's *struggle* to breastfeed. This means, for example, analysing if, where, and how the lactation cycle is breaking down; whether the problem lies primarily with the mother or baby; whether the emphasis of the problem rests upon physical or psychological factors. Analysing and understanding the detail of the *struggle* enables paediatric osteopaths to determine treatment goals, implement the most appropriate interventions to promote effective breastfeeding, and define what constitutes *satisfactory breastfeeding* for each mother and baby, at that time, and over time.

Breastfeeding satisfactorily is the general goal that lies at the end of, or resolves, the *struggle*; a goal that is highly valued by mothers and osteopaths but one whose meaning can be difficult to articulate. *Breastfeeding satisfactorily* is a process that is defined according to subjective and objective determinants and can be unpredictable and require refinement or negotiation according to changing circumstances. *Breastfeeding satisfactorily* has a particular personal meaning attached to it. For mothers, it implies a sense of achievement, according to a mother's philosophy, breastfeeding expectations, and interpretation of current circumstances. In this study, and as reported in other studies (Graffy & Taylor, 2005; Hauck & Iruita, 2003; Sheehan et al., 2009), breastfeeding cannot be easily separated from new mothering expectations. Breastfeeding that is associated with signs of a content and thriving baby reassures a mother that she is responding adequately to her baby's needs, which enhances her feelings of maternal competence (Meleis, Sawyer, Im, Hilfinger Messias, & Schaumacher, 2010a; Mercer, 2010; Nelson, 2003).

Osteopaths view *breastfeeding satisfactorily* from a more professional perspective that takes into account a number of influencing factors. It relates to achieving observable measures that indicate positive health outcomes and aligns with the idea of providing good patient-centred care. Osteopaths monitor the mother's physical and psychological needs and well-being as well as the baby's healthy development. *Breastfeeding satisfactorily* can be viewed, for example, in terms of a baby's coordinated sucking actions, normal growth and development patterns, good breastfeeding postures, and signs that the mother is interacting positively with her baby and coping at home. *Breastfeeding satisfactorily*, therefore, can have multiple meanings embedded within it but as a broad concept, it refers to meeting a number of maternal and infant feeding requirements that interlink but might not necessarily occur simultaneously. For example, *breastfeeding satisfactorily* has a clear physiological component with regard to a baby's weight gain, comfort, and ability to settle. The baby's weight is a tangible measure of health, which implies successful breastfeeding; however this is not always the mother's experience. A common finding for mothers in the current study is that despite being assured that their babies are developing normally, breastfeeding is still problematic and the babies remain difficult to settle; a situation that has psychological and emotional implications. The notion of *breastfeeding satisfactorily* incorporates a balance between the different meanings, significance, and evidence of success that breastfeeding can have for each participant. Ultimately, the aim is to have a happy, healthy baby, which generally means a satisfied mother.

7.3 FACTORS CONTRIBUTING TO THE CORE PROBLEM

Greater insight into the nature of the core problem is essential for osteopaths and mothers to understand the strategies required to reach some form of resolution. The key factors that were identified in the data as contributing to the core problem are set out in Figure 3, below.

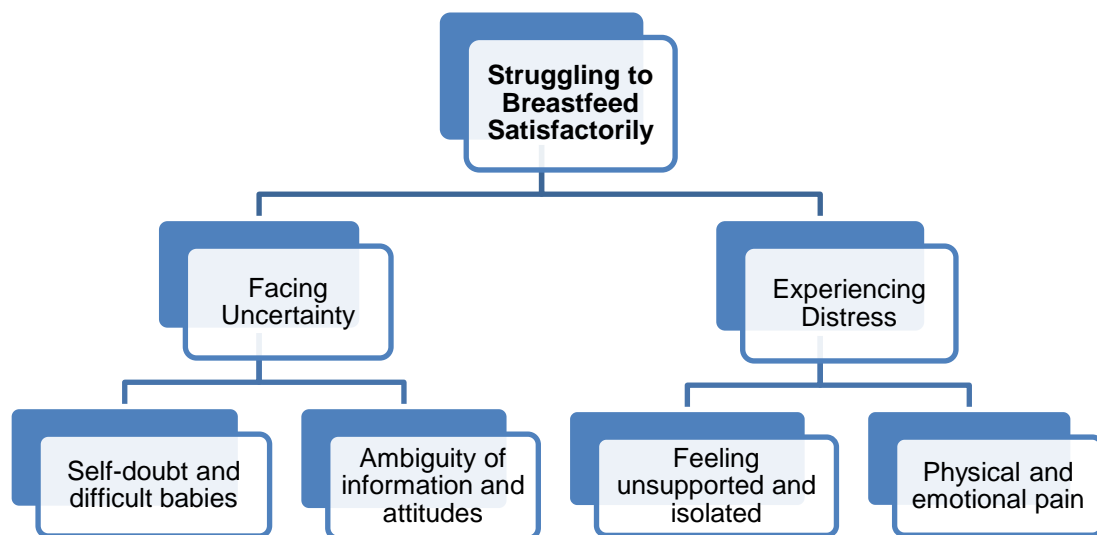


Figure 3: Contributing factors to “Struggling to breastfeed satisfactorily”.

7.3.1 Facing uncertainty

The arrival of a new baby into a family is a time of change and adjustment, considered to be part of a normal transitional process (Martell, 2001; Meleis et al., 2010a). Within this context, mother participants wanted, and prepared for, a normal birth and to breastfeed. Most, however, experienced some form of obstetric complication and got off to a difficult start with their baby⁸⁷. These conditions lead to considerable disappointment and physiological stress, which women have to deal with, while at the same time, initiate and sustain breastfeeding. While coping with breastfeeding difficulties, new mothers *face further uncertainty*, which is expressed in highly emotive ways. Osteopaths relate to maternal experiences of *facing uncertainty* from a more objective professional stance; however, both perspectives are important and need to be taken into account when determining the best way forward.

Most women come to accept that they have limited control over birth circumstances and clinical postpartum events. The general view is that, to minimise potential health risks,

⁸⁷ See Chapter 5, Table 4.

they had to follow a course of action determined by medical experts. Breastfeeding, however, is seen as one of the things that they want, and should be able to do. For some, *breastfeeding satisfactorily* assumes greater importance because it represents one last aspect of their difficult new mothering experiences over which they can exert some control. The following exemplars highlight the emotional intensity, and the rapid change of circumstances that some women must adjust to when unexpected birth difficulties arise.

I had a brilliant pregnancy, I didn't have any morning sickness; I didn't have any blood pressure issues; weight gain was pretty average. Yes I really didn't have any complications at all ... until we had the emergency Caesar. I know that I was fairly stressed because I was very against having a Caesar; everything's fine but mentally I was like, I was beating the obstetrician, "I don't want a Caesar; is there any way around it?" and he was saying like, "No there's not" (Sonia M 06/02).

Most women in the current study have a background of initial birth stress and uncertainty and face another significant hurdle when breastfeeding proves difficult. Some, like Jenny (mother), in the following exemplar feel overwhelmed.

We didn't know what we were doing; we got the baby home and the baby just cried and cried. I knew I had to breastfeed, but I didn't know how, and I probably wasn't doing it right (Jenny, M08/02).

Women need to make sense of their current circumstances in order to regain a sense of control, build self-esteem and feelings of maternal competence as they learn to care for their highly dependent babies. Solving the breastfeeding problem is a complex task that is approached by women and osteopath participants in particular ways.

Osteopaths adopt a systematic investigatory approach that is framed by a biomedical perspective. They rely on mothers' histories or accounts of events, which typically assist but, at times, can also impede their understanding and analysis of the core problem. While women's stories provide insight into the breastfeeding *struggle*, they are frequently, however, emotively driven interpretations that reflect personal views. Such interpretations might not necessarily provide the type of accurate clinical information that osteopaths seek. They must rely on observation and examination skills to draw diagnostic conclusions. The problem for the osteopath is that of analysing *struggling to breastfeed satisfactorily* as a clinical problem according to their prescribed special interest in bodily processes while maintaining a holistic approach and remaining sensitive to mothers'

physical and psychological needs. In order to provide timely and appropriate assistance, they must also stay attuned to dyads' ongoing and changing breastfeeding experiences.

In general, when mother participants encounter a breastfeeding problem, they describe a similar pattern of response, which involves information gathering and analysis, followed by choosing and trialling various strategies. Throughout this process, they face a number of influences and inconsistencies which add to the complexity and uncertainty of the breastfeeding problems that they face.

7.3.1.1 Self-doubt and difficult babies

One of the common questions that women in the current study raise relates to whether the problem lies primarily with them or their babies. Osteopaths face a similar dilemma when determining the relative causes of complex breastfeeding difficulties. The problem for them in this instance, however, lies more with exploring the issue of, "to what extent is it the baby or the mother?", and with awareness of mothers' psychological vulnerability to avoid intensifying negative thoughts and feelings of self-doubt.

Generally, mothers understand that breastfeeding involves specific positioning skills and the need to work with the baby in order to establish an effective lactation cycle. Doubts relate to a mother's confidence in her skills and biological capabilities and in relation to the baby's feeding actions and behaviours. In addition, mothers who are seeking help for breastfeeding difficulties from others must be able to articulate their concerns, which is challenging if a mother is unsure about what is happening. When trying to draw out this information, osteopaths must do so in an efficient but sensitive manner. First-time parents, in particular, face many new challenges. Approximately half the women in the study are first-time mothers. These mothers, new to breastfeeding, readily seek affirmation from health professionals that they are breastfeeding correctly.

I actually got a lactation consultant to come and see me just after I got home, um and just to, she goes 'Well what's your problem'? Well not really [a problem], I'm trying to make sure I'm doing everything OK (Dianne, M05/05).

Despite generally being proactive in seeking professional assurance, some mothers remain concerned about their ability to meet their babies' nutritional requirements. They express uncertainty in their biological capabilities with regard to sufficient quality and quantity of breast milk, which is exacerbated by an inability to exactly measure a breastfed baby's milk intake. This finding is similarly commonly reported in the literature⁸⁸. Some

⁸⁸ See Chapter 2.5.1.2.

authors propose that a generalised social mistrust of breastfeeding on the basis of its less visible and innate regulatory processes, has currently arisen, in part, because it does not fit with the specific, controlled, and more highly valued scientific approach (Fiona Dykes, 2005; Thomas, 2006). The different experiences of two first-time mothers whose babies were not gaining weight at a satisfactory rate illustrate different dimensions of the way women's self-doubt can be expressed. Here, Narelle is concerned her baby is not getting enough milk and Dianne doubts the quality of her milk.

At the hospital, it was all about weight gain, how much volume we should be pumping into him; when you go onto the breast it's hard to know how much he's getting ... I couldn't get him on the other side [breast] and he was fussing around and it was all so new and I didn't want to kind of starve him, I guess, is what was going on in my head (Narelle M13/08).

He stopped feeding on my left breast. And oh, not completely stop but he just did not want to, and I didn't know if I was producing 'funny milk' or what was happening (Dianne M 05/02).

Not only first-time mothers, however, face uncertainty and self-doubt. For those who already have children, the new baby brings a unique set of circumstances, and drawing on past experiences does not necessarily help. At times, mothers are frustrated by the inconsistency between breastfeeding experiences with different babies, particularly as they want all their children to receive the same benefits of breastfeeding. In some cases, mothers are better prepared for difficulties if they are similar to previous experiences with an older child; however the data demonstrates a wide range of breastfeeding problems with various levels of complexity experienced by each dyad. Tania (mother), for example, who breastfed three older siblings, is frustrated by a new and confounding problem of breast refusal with her fourth baby.

Yeah I kept trying him on it [the right breast] and he'd always [refuse]; we'd always encounter the same problems, until I just said, "that's it, and I'm not [going to keep trying]". You know, I ended up in tears of frustration because of; [I] just couldn't feed him on that side! (Tania M 01/08).

Typically, babies with breastfeeding difficulties, are described as fussy and irritable, which is often interpreted as a sign of hunger. However, mothers can attribute this behaviour to other causes such as the baby's personality. For example, Wendy (mother) describes her daughter as *"an opinionated baby and she tells us what she likes and what she doesn't*

like and she just didn't want to be lying down [to breastfeed]" (M 09/07). Catherine (mother) states that, when attempting to breastfeed, *"if she's [baby] not got the attitude to try it, then there's no point hurting myself"* (Catherine, M 02/06). Although Wendy and Catherine believe their babies are expressing preferences that relate to individual personality traits, they are attempting to make sense of their situations. Breastfeeding problems are particularly confounding, as with Tania before, when women cannot understand why their babies behave the way they do. Mothers describe a wide variety of individual infant behaviours that they desperately want to understand.

Somewhere between week four and week six, he was feeding beautifully and then all of a sudden, it was like this little switch of "Why are you yanking off [the breast] all the time?" We had weeks of screaming incessantly and Bill [father] was back at work at that time and we were always in the corridors going, you know, fed, changed, can't understand, we don't know what else is going on (Sonia M 06/03).

Struggling to breastfeed satisfactorily represents a dynamic and often complex, unpredictable situation. Once a particular problem is sorted, another one can arise as circumstances change and the reasons remain obscure. While mothers typically feel frustrated by their babies' behaviours, osteopaths take a more objective analytical perspective. Babies' behaviours provide diagnostic clues to explain the cause of, or factors that contribute to, breastfeeding difficulties. One common example, cited in the data, relates to babies' asymmetrical postures or uneven movement patterns that are made visible by their reluctance to turn the head in a particular direction or their inability to open the mouth wide. Physical motion restrictions are thought to impede babies' neuromotor skills and make feeding at the breast tiring, difficult, or uncomfortable. Based on their professional knowledge, osteopaths postulate that the changing nature of breastfeeding difficulties and babies' behaviours can be attributed, in part, to the consequences of unresolved physical dysfunctions that become more obvious at different stages of a baby's development.

As mothers in the current study *face uncertainty* in regard to understanding the underlying cause of their breastfeeding difficulties, the problem is confounded by difficulty in accessing comprehensive answers. Breastfeeding information and support is typically perceived as complicated, confusing and even contradictory, which adds to, rather than ameliorates, their ongoing *struggle to breastfeed satisfactorily*.

7.3.1.2 Ambiguity of information and attitudes

In general, women expect that the recognised medical experts such as doctors, midwives, and lactation consultants will be able to diagnose their breastfeeding problem and instigate appropriate interventions. Mothers are prepared to play their part by working hard, developing their skills, and doing whatever is recommended to fix the problem. They come to realise, however, with some disbelief, that this is neither a straightforward process nor always an achievable outcome. Women describe feeling frustrated, angry, and let down because, while breastfeeding is actively promoted; the answers about how to achieve it are not necessarily available⁸⁹. Karen (mother) laments, *“I just want someone to say, “This is why [it’s not working], but no one can do that”* (M 11/04). In another situation, Wendy (mother), who has a clear medical diagnosis of nipple thrush⁹⁰, a well-known breastfeeding problem, still cannot find a treatment that works. She states, *“I’m going, “there must be something else you can give me, you’re a doctor”. They just had no idea”* (M 09/09). In addition to not being able to access clear and effective diagnoses and treatment strategies, women frequently report receiving conflicting professional advice, which causes further disappointment and confusion.

She [lactation consultant] came many times and she actually said “Look I think her throat condition is causing her feeding problem”, and then the paediatrician over-ruled that. I was so confused. I mean I had put my faith in him, entirely, and he just actually just didn’t know that there could be a connection between the condition and breastfeeding (Kylie, M 07/04).

When mothers receive advice that is unhelpful or incompatible with their needs; it poses a problem for osteopaths, who must determine the best way to deal with the situation. Most osteopaths acknowledge that breastfeeding is not their speciality and are cautious about their recommendations. Typically, they gather information about the type, quality and reliability of advice given to mothers and a comprehensive account of interventions that have been tried and their outcomes. Such an evaluation is necessary before deciding what advice, if any, they will give and how to best deliver it. The typical response from women, who have tried unsuccessfully to overcome their breastfeeding problem, is to feel initially frustrated, then overwhelmed. The data demonstrates significant negative emotional consequences for mothers as a result of receiving what is perceived as inconsistent, insensitive, or unhelpful professional support; a similar finding from other

⁸⁹ *Ambiguity of information and attitudes* links closely to the contextual determinant, *Health care as a commodity* and its sub theme of *shopping around*. See chapter 6.2.3.

⁹⁰ Thrush is a lay term for infection with candida. See Chapter 5.2.1, Table 4, for a clinical definition.

studies of women's early postpartum and breastfeeding experiences (Binns & Scott, 2002; Graffy & Taylor, 2005; James, 2004; Locklin & Naber, 1993).

Mothers in this study, who are highly motivated to breastfeed, come to realise, over time, that if they want to continue to breastfeed, they must assume greater responsibility for finding a solution. This is a significant burden as it involves sorting through a plethora of information and making decisions about the trustworthiness and accuracy of the source and whether to try a particular intervention.

There's so much conflicting information out there though. You really have to trawl through a lot to try and find different things that actually seem like they might work; that there is enough of the same thing to say, "Ok that's good, we'll try that" (Wendy, M 09/10).

When one resource fails to meet their needs, women tend to consider alternate forms of assistance on the basis of past experiences and personal preferences. Some mothers, for example, seek lay information from outside their immediate social network and standard medically based resources; the most common being the internet and hearsay from other mothers. Marie (mother), for example, places more faith in learning from other mothers' experiences, preferring to seek advice from internet sites that were, *"not from doctors, but with information more from mothers 'nutting' out what was wrong with their babies"* (M 04/03).

When mothers move away from professionally based breastfeeding support toward wider social and family support they can continue to *face uncertainty* when exposed to others' diverse breastfeeding opinions⁹¹. Typically, they report feeling caught in the middle of disparate attitudes toward breastfeeding. One example of conflicting breastfeeding views relates to mothers' feelings about breastfeeding in public places.

I don't know [what] I'd say to someone if they came up to me and said, "You shouldn't be doing that [breastfeeding] in public". I just don't want to put myself in that situation ... especially older people are really funny about it. They want you to breastfeed; that's the ultimate thing; but then they're really funny about it if you do it in public (Sally, M 12/11).

Here, Sally wants to avoid causing others' and her own discomfort and embarrassment; a complex issue that has been discussed in other studies (Lavender et al., 2006; Mahon-Daly & Andrews, 2002; Ryan et al., 2011). Public places are not the only environment in

⁹¹ See Chapter 6.2.1.2 *Advice and Expectations of Significant Others*.

which some women report feeling uncomfortable while breastfeeding. In general, women express a desire for privacy when breastfeeding, for different reasons. Overall, they articulate a need to create an environment conducive to breastfeeding; one that is removed from disruptive elements, where they can simultaneously relax and focus on their baby and the task. In the present study, mothers describe a range of situations that reflect an unfriendly breastfeeding culture in the sense that their efforts to breastfeed are not actively supported by family and friends, or even undermined, in subtle and more obvious ways. For example, a common finding is that family and friends typically adopt an attitude to breastfeeding, encapsulated by Nadia (mother) as, “*if it’s [breastfeeding] not working, just put him [baby] on the bottle*” (M 10/10). The intent may be well-meaning but the effect is discouraging for a mother determined to breastfeed. As discussed before⁹², conflicting generational views are thought to contribute to the complexity of issues with which some mothers must contend.

Mother participants, who describe a range of frustrating experiences relating to others’ breastfeeding views, which are incompatible with their own, typically describe reaching a point where they are reluctant to accept advice or assistance from anyone, including perceived ‘experts’, until they have had an opportunity to process it, perhaps test it, and draw their own conclusions. The data highlight numerous possible breastfeeding support strategies, recommended by a variety of sources that mothers have to choose from and which are employed with mixed results. Breastfeeding interventions are, however, generally associated with emotive maternal responses that reflect considerable distress.

Ultimately, women with breastfeeding difficulties make decisions and take action based on their confidence in a proposed strategy, the perceived reliability of the source, and interplay of less readily identifiable intuitive processes. Mothers often use trial and error, employing a range of combinations of strategies that include artificial feeding products such as nipple shields, bottles, and pumps to express milk as well as adjusting timing, positioning and the feeding environment. Infant feeding emerges as a dynamic complicated activity, which involves different strategies in different combinations at different times. Vivienne, a first-time mother, sums this situation up as, “*a bit of everything is what’s working for us at the moment*” (M03/02).

Osteopathy emerges as one of the strategies that mothers believe might assist; however the initial visit to the osteopath is often associated with considerable uncertainty and anxiety. As noted in the previous chapter⁹³, osteopathy is a relatively unknown or poorly

⁹² See Chapter 6.2.1.2.

⁹³ See Chapter 6.3.2.2.

understood health discipline. Different perceptions of osteopathy are expressed throughout the data, which can create uncertainty and some anxiety for mothers, who have mixed levels of understanding of osteopathy for babies according to their knowledge and experience of it. Most women choose more orthodox forms of treatment at first, but finding that they have not helped, move onto other less well-known therapies, such as osteopathy.

The first time [visit to the osteopath] it did [worry me] because I guess I was really unsure, not having had an osteopathic treatment before, I didn't know if it hurt (Sally, M 12/07).

Mothers weigh up a number of factors before deciding to take their baby to an osteopath. Some act on the recommendation of one, or a combination of, a health professional, another mother, or friend. Some already have a long history of association with osteopathic treatment, such that it has become an integral part of their general approach to family health; however all participants began this initial association with the same ambiguity about what osteopathic treatment of babies entails.

Those who are generally supportive of osteopathy still hold some concerns regarding its suitability for a baby. This idea is linked to individuals' perceptions of different types of manual therapy and the perceived risks, particularly for a baby. Babies are considered vulnerable due to the immaturity of their anatomy and physiological systems, and consent and communication difficulties. The expertise of the osteopath in the field of paediatrics becomes another form of uncertainty faced by parents. Mothers who have experienced elements of self-doubt, difficult babies, and ambiguous information and interventions and who are also unfamiliar with osteopathy, typically seek breastfeeding assistance from a paediatric osteopath in an anxious state. At this stage, they are often feeling desperate and overwhelmed.

7.3.2 Experiencing distress

Mother participants describe a range of significant and ongoing physical and psychological stressors that, for most, ultimately lead to a state of distress. It is evident also that a mother's and baby's stress responses are inextricably linked. The term 'distress' has a broad conceptual meaning that includes physical and emotional pain, anxiety, suffering, and exhaustion (Butler, 2009, p. 358). It relates to the negative consequences of recurrent exposure to everyday stressors. The human stress response system is well-known for its role in maintaining an individual's health status. Theories of stress are complex but the overall consensus is that, at a biological level, the human

stress response system functions to coordinate appropriate and adaptive physiological and behavioural responses to physical and psychological challenges and thus acts as a filter to potentially overwhelming environmental influences (Giudice, Ellis, & Shirtcliff, 2011).

According to their professional principles, osteopaths promote health by facilitating good bodily structure and function, which supports a person's ability to self-regulate and respond positively to life stressors⁹⁴. Health is a complex multi-dimensional concept but applying this fundamental principle to breastfeeding women who are experiencing ongoing high levels of stress implies that their stress response systems are placed under an increased load; a situation that potentiates negative health consequences. Osteopaths are also aware that a new mother and baby are going through a period of normal but significant adjustment and are particularly vulnerable to additional stress.

One of the proposed health advantages of breastfeeding, reported in the literature, is its association with decreased maternal stress on the basis of physiological and subjective stress measures (Blincoe, 2005; Mezzacappa, 2004; Nissen et al., 1998). However, other studies that have investigated stress in new mothers report an interdependent relationship between maternal confidence and competence, and parenting stress (Liu, Chen, Yeh, & Hsieh, 2012; Morawska & Sanders, 2007). Results suggest that maternal confidence and competence mediate parenting stress and that maternal confidence is negatively related to parenting stress. This finding is supported by data from the current study. Here, women's experiences of *struggling to breastfeed satisfactorily* erode their feelings of breastfeeding confidence and competence, and elevates their feelings of distress.

Maternal distress is expressed in individual ways and with different levels of intensity but tends to build over time as *struggling to breastfeed satisfactorily* continues. The general consensus from participants, including those who have had a previous positive breastfeeding experience with another child, is that breastfeeding is hard to do. This comes as a surprise for most of the first-time mothers, in the current study, because they believe that despite a lack of practical experience, they are well prepared with breastfeeding information and ready to seek assistance as needed. When difficulties arise, the general attitude for those who are committed to breastfeed is that it just means working harder and getting on with it. Over a period of time, however, women reach a point where the degree of difficulty shifts to a higher level and breastfeeding becomes a distressing experience. Karen, a first-time mother, who is anxious about her baby's weight

⁹⁴ See Chapter 6.2.2.

gain, likens her breastfeeding experience to a “nightmare” (M11/06) when she believes that her milk supply has dropped. Sally sums up her experience as, “No one tells you how dramatic the whole breastfeeding thing is” (M 12/02). Wendy’s experience of nipple pain, below, reflects an extreme level of distress.

There were times where I was curled up in a ball [breast] feeding her, just holding on to pillows, restraining myself from pulling her off [the breast] because it was just absolute agony; but it was best for her, giving her what she needed to be strong and healthy and all of that and I just wanted to persevere, to try and hope that it would get better and carry on (Wendy, M 09/12).

Trying to cope with, and overcome, ongoing breastfeeding difficulties, with limited success, has negative consequences. However, most women, like Wendy, persist with breastfeeding as part of the notion of making personal sacrifices for the benefit of the baby. The concept of ‘sacrifice’ comes through the data within a variety of contexts; it can be clearly articulated or emerge in more subtle ways. Catherine (mother), for example, describes her mother’s attitude toward her ongoing attempts to breastfeed as, “acting like a martyr. I think it’s completely unnecessary” (M 02/03). The notion of sacrifice where a mother puts her baby’s needs before her own, aligns with contemporary social expectations of ‘good mothering’ and the discourse of ‘intensive mothering’ discussed in the previous chapter.⁹⁵ Another form of distress, evident in the data, is the general belief that mothers are carrying a burden or overriding share of responsibility for the baby, linked to their choice to breastfeed. At times, this belief leads to resentment, particularly when mothers feel alienated from, and unsupported by others. Babies also demonstrate distress through their unsettled behaviours when breastfeeding and at other times when they appear to be irritable or difficult to soothe. Such behaviours tend to be interpreted by mothers and osteopaths as indicators of babies’ distress in relation to hunger, fatigue, or pain, often of uncertain origin.

Responding sensitively to distressed mothers and babies is a complicated and challenging task for osteopaths, who must first break down the causative elements in order to find ways to reduce the stressors.

7.3.2.1 Feeling unsupported and isolated

New mothering is a particularly challenging time that is dominated by responsible caring such as feeding, bathing, and soothing a highly dependent baby. Problematic breastfeeding adds significantly to a mother’s responsibilities at this time. It becomes a

⁹⁵ See Chapter 6.2.1.

burden of varying proportions that can be expressed with increasing intensity from feeling unsupported to a sense of alienation, isolation, and resentment. A particular feature of breastfeeding is that only mothers can do it. In general, participants' partners provide high levels of support, but ultimately, breastfeeding is viewed as the mother's prime responsibility. This notion is expressed by mothers in individual ways. Tania (mother) states, "*I found it [breastfeeding] really umm, really impinged on my, not my freedom, but the ability for anyone else to care for the baby* (M 01/06). Kylie describes some of the negative personal consequences of having to constantly manage breastfeeding difficulties.

I could never go anywhere for more than two or three hours; the whole expressing [breast milk] thing combined with worrying about her and trying to manage her weight gain and things; not a good time" (M 07/04).

Here, Kylie raises some common breastfeeding issues shared by most women in the study. They concern lack of time for themselves or time-out from the constant underlying anxiety associated with feeling directly responsible for feeding their babies. One of the perceived advantages of breastfeeding is the idea of portability and convenience but this is not necessarily true for everyone. Some breastfeeding mothers, like Sally in the next exemplar, want the option of breast milk feeding with a bottle but their breastfed babies refuse to cooperate. Sally is angry and places some blame for this on the way that health-care is delivered to new mothers. She reports feeling alienated and unsupported by nurses in the hospital. With the emphasis on encouraging breastfeeding, practical advice on other forms of infant feeding are overlooked. The information and skills provided do not necessarily match individual needs.

She would never take the bottle and that was the thing that caused me the most distress because it just really socially isolated me more than anything else. I couldn't go anywhere for longer than three hours because she had to feed ... You learn how to breastfeed in hospital and all that sort of stuff, and they're so rough, they sit there and they just shove the baby on and there's no talk, ever, about how to, especially if you're breastfeeding, on how to prepare a bottle for when you've expressed the milk or anything along that line (Sally M 12/11).

Mothers describe feeling isolated and unsupported in other ways but fundamentally on the basis that they are misunderstood or unheard. They believe that family and friends do not appreciate the personal meaning that breastfeeding has to them and what they are going through. Mothers are disappointed that the people who they usually rely upon are not

able, or willing to support them; a situation that can result in considerable emotional distress.

They [friends] don't understand why I can't return phone calls. They can't understand why I'm not listening to my mobile. I just don't have time to turn my mobile on and check messages and I don't have time to call people for a chat because I don't have time to go to the toilet sometimes. I can't find half an hour to call somebody. So I don't think they really understand that (Catherine, M 02/05).

Although Catherine's situation might represent an extreme case, most women in the study express a sense of tension that relates to being restricted from participating in everyday social activities, viewed primarily as a consequence of their commitment to breastfeed. They often find it difficult to leave the house, meet with friends or go shopping because managing breastfeeding difficulties involves excessive time spent expressing breast milk, feeding a fussy baby, or feeding frequently on demand.

Breast milk feeding with a bottle, in particular, emerges as one of the most commonly used strategies to manage breastfeeding difficulties associated with attachment problems. Breast milk feeding, however, was found to be a complex, demanding, and emotionally charged infant feeding strategy. For example, Tania, describes feeling like a 'barn yard animal' when expressing milk (M 01/09). Kylie states, "*It's [expressing milk] terrible! I think that was the worst part of the whole [breastfeeding] experience*" (M 07/05). Some women find expressing milk difficult or uncomfortable and all are generally frustrated by the time it takes. Lack of time for themselves, their family and activities of daily living is particularly stressful for women in the study. They lose a sense of personal identity and control in their lives, which have become unduly focused on breastfeeding. Mothers' frustration and resentment of the many different and difficult situations they find themselves in, linked to their determination to breastfeed, is illustrated by the following exemplars.

From about two, three weeks onwards he was fussy feeding, like he would feed every hour and a half and that's when the reflux really kicked in. So I spent all day on the couch feeding, so I started to get a bit resentful of the whole breastfeeding thing (Sally, M 12/04).

I hardly get anything done, it takes me half an hour to even put a load of washing in the machine, let alone hang it out, and fold it and the ironings been there for four months (Tania, M 01/15).

Apart from the impact of breastfeeding difficulties on women's daily lives and social relationships, mothers describe also the distress of physical and emotional pain.

7.3.2.2 *Physical and emotional pain*

Pain is a powerful stressor and pain management is an integral part of osteopathic clinical practice. In general, women anticipate some initial physical discomfort in the early days of establishing breastfeeding, but several participants describe ongoing and intense breast and nipple pain that is associated with clinical conditions such as increased nipple and breast sensitivity, thrush⁹⁶, and mastitis⁹⁷. Pain is also linked to attachment problems and the baby's dysfunctional sucking action, which can irritate and damage sensitive maternal breast tissues. When talking about their babies' poor sucking actions, mothers use descriptors such as biting, clamping down, and chomping. Women give vivid accounts of their pain experiences through verbal and non-verbal language.

My nipples go kind of white and mulberry coloured, and get really, really painful, like a stinging pain ... she [baby] was just chomping and I can maybe stand up to a minute of it and then it would just get way too sore (Catherine M 02/01).

She started pulling away when she was feeding and she'd take my breast with her and I had terrible nipple thrush and it was just killing me; the pain of it ... and I just couldn't handle it anymore (Wendy 09/03).

Osteopaths and some mothers speculate that while breastfeeding, babies might also experience various levels of discomfort or pain on the basis that they cry frequently and are difficult to settle. A crying baby and her responses to painful stimuli are not well understood or the cause easily substantiated and requires further investigation by the osteopath. Paediatric osteopaths and other health professionals⁹⁸ postulate that such irritability could be the baby's response to pain of a muscular or biomechanical nature thought to be due to unresolved birth-related injuries, which in turn, interfere with breastfeeding capabilities. The concept of 'difficult babies' has been discussed earlier in this chapter. The idea that babies may be suffering pain adds another layer of complexity to the *breastfeeding struggle*. It causes considerable emotional distress for parents who worry about and cannot find a way to calm their babies. Emotional distress follows a reciprocating pattern, whereby a distressed baby leads to a distressed mother and family, and vice versa.

⁹⁶ Thrush is the typical manifestation of Candida infection. See Chapter 5.2.1.

⁹⁷ Mastitis is an inflammatory condition of the breast usually caused by infection.

⁹⁸ Refer to Chapter 2.7.

An unsettled baby upsets the rest of the household. Most babies in the study are described as poor sleepers. Parents, in turn, frequently complain of disrupted sleep, which becomes a key contributor to a stressful family environment.

I ended up spending hours just sitting on the edge of the bed, you know and trying to settle him, and in the end, I just put him in my bed, and kicked Nathan [husband] out.... When Charlie [baby] is unsettled, everybody gets frazzled because there's just screaming noise in the house and they [siblings] try and run away to their room, unless I'm busy and say, "Go and talk to your brother!" (Tania M 01/28).

Similar to Tania above; anger, frustration, and desperation are the emotions most commonly expressed by mothers in this study. They arise in response to *facing the uncertainty* and *distress* of coping with complex and ongoing breastfeeding difficulties. Emotional responses are evidenced also by the tone of women's voices and body language. Some responses can assume an intensity that collectively, represents a form of emotional pain.

When she was about nine weeks old; we called the Children's Hospital out of desperation... and said, "Can we see somebody?", because we hadn't been able to get any answers from any other source (Kylie, M07/01).

The maternal health line [telephone support]; I tried that last night. They've got a call back facility but it didn't work. I kept hanging on and hanging on, pressing whatever, and that didn't work (Karen, M 11/08).

At times, it might seem that the intensity of expressed emotion and the perceived magnitude of the breastfeeding difficulties are disproportionate to the actual breastfeeding problem. However, it is evident from the data that the core problem is experienced by mothers as a deeply personal, complex, and significant problem; one that is compounded by the finding that they refuse to give up on breastfeeding.

7.4 CONCLUSION

The study's basic biopsychosocial problem, *struggling to breastfeed satisfactorily* is an abstract concept, derived from the data, which draws together a range of conceptual elements that explain mother and baby dyads' experiences of encountering and attempting to overcome breastfeeding difficulties. The core problem starts with women's individual breastfeeding expectations and their general determination to bring them to fruition within the context of maternal transition and difficult birth and early post natal circumstances. *Struggling* is a dynamic process that follows a trajectory in the sense that

mothers respond to breastfeeding problems as they develop, shift, or change over time. Breastfeeding difficulties are made up of complex and intertwining physical and psychological elements that are influenced by two key contributing factors; *Facing uncertainty*, and *Experiencing distress*.

For osteopaths, the implication of identifying and uncovering the core problem is that it impacts upon the therapeutic processes that they use to help mother and baby dyads. *Struggling to breastfeed satisfactorily* is perceived as a complex biomedical and psychosocial clinical problem that relates to two individuals with different needs but who also function as a single biological entity. The general aim of osteopathic treatment is to enable dyads' to *breastfeed satisfactorily*. This concept, however, is not easy to define because it involves an individualised or patient-centred construct of breastfeeding that is meaningful to each dyad and their particular circumstances and satisfies the osteopaths' professional commitment and responsibility to promote mother and baby health. While evidence of effective breastfeeding actions, infant growth, and settled manageable behavior reflect common parameters of *breastfeeding satisfactorily*, success is perceived also by participants at a personal level, through a sense of maternal understanding and achievement.

CHAPTER EIGHT

CONNECTING

I find that with most of the parents, when the baby looks comfortable with the [treatment] process and happy to be held, that makes the parents a lot more comfortable; that well, if the baby's comfortable, then we're comfortable (Lauren O 2/11).

8.1 INTRODUCTION

The category, *Connecting*, relates to the building of practitioner-patient relationships between a mother, baby, and osteopath within the context of *struggling to breastfeed satisfactorily*. It recognises the special *connection* that exists between mother and baby, which influences all forms of interaction. Being comfortable with each other and the procedural elements of the osteopathic consultation, as illustrated by Lauren (osteopath) above, is an important starting point for developing a purposeful therapeutic relationship. The chapter commences by defining and contextualising the concept of *Connecting*. Then follows an explication of the individual strategies and sub-strategies that osteopaths employ to create and then maintain *connected* practitioner-patient relationships over the course of treatment.

8.2 DEFINITION OF CONNECTING

In a broad sense, the term *Connecting* means unifying or linking together in a purposeful way. *Connecting* between people is defined as “associating mentally and communicating” (Butler, 2009, p.264). ‘Associating mentally’ implies being able to relate to each other and share ideas to reach some form of consensual agreement. This is achieved through ‘communicating’; sending and receiving messages by various means such as dialogue, body language, action, and physical touch. Using the human senses in a variety of forms is particularly relevant when interacting with a baby, who has limited means of communication. *Connecting* occurs as a consequence of communicating effectively, according to individual needs and circumstance. It underpins all interactive processes that take place when an osteopath meets, responds to, and treats dyads with breastfeeding difficulties. Communicating effectively with dyads requires particular skills that are explored in more detail in subsequent paragraphs as the strategies and sub-strategies of *Connecting*.

Collaboration is a prime element of the *connected* osteopath-dyad relationship, which essentially involves identifying mother and baby health needs and goals, and facilitating informed decision-making and consent to proceed with examination and manual therapy

treatment of the baby. It is a dynamic process that adjusts to changing circumstances and individual needs over the course of treatment. *Connecting* thus includes seeking ongoing agreement or permission to continue the therapeutic relationship over time. It tends to start with an orientation process as osteopaths, mothers, and babies, get to know each other and find common ground.

I find with mothers, generally you don't have to ask them many questions; they just go. If there are any gaps I suppose I'll fill them in. The patient history is huge and the big thing is I try to get a feel for what they want and why they're here (Britt O 7/03).

Here, Britt (osteopath) describes a typical scenario when she first meets a mother and baby seeking her help. It begins with an awareness of some mothers' sense of urgency and the most effectual response involves allowing them to tell their stories without undue interruption. At the same time, Britt must be prepared to listen closely and look for opportunities to gather specific information as appropriate; a situation that is a common finding of the study. Observational data demonstrates also that mothers arrive at the osteopaths' clinics, often in a highly emotive state.

In general, *Connecting* begins with the opportunity for a mother to be heard and her concerns articulated and acknowledged. Paediatric osteopaths typically employ targeted strategies to settle mother and baby, gain their trust, and provide background information about clinical principles and procedures. The mother is thus encouraged to feel sufficiently comfortable with the treatment process to give her informal permission to proceed. Her comfort is inextricably linked to the knowledge that her baby is also comfortable and safe. On this basis, the osteopath, eventually, *connects* with dyads at personal and physical levels in order to examine the baby and apply manual techniques. As osteopaths, mothers, and babies become more familiar with each other over the course of treatment, their way of *connecting* might change as self-understanding and relationships evolve but essentially *connecting* means being able to relate to each other in a meaningful way and on an ongoing and dynamic basis. It is achieved through interplay between interpersonal, physical, and self-reflective processes.

The interpersonal processes of *Connecting* involve three key interlinking relationships: one between an osteopath and mother, one between an osteopath and baby, and another between an osteopath and the mother- baby dyad as a unit. Each relationship has distinctive features. The way in which the osteopath communicates with a baby, for example, requires an approach that is quite different from that used for a child or adult,

and rests upon the mother's cooperation and approval. How an osteopath communicates with a new mother who is *struggling to breastfeed satisfactorily* is based upon a sensitive appreciation of the potential issues involved. In addition, the relationships between participants merge together such that the *connection* between osteopath and baby has implications for the osteopath's interpersonal relationship with the mother, and vice versa.

Coming to the point where we're treating the baby; the baby will very much be on the state of the mother. So if you've got a highly stressed mother, you've got a more difficult baby to treat. So the more of all that 'stuff' [strategies] to get the mother to be relaxed, the more straight forward the treatment with the baby (Lauren, O 2/03).

Like Lauren, paediatric osteopaths generally reflect upon the nature of the mother-baby bond and its implications for clinical practice. Their thoughts around new mothering are shaped by clinical and personal experiences, background knowledge, and broader contextual factors such as contemporary views of new mothering⁹⁹ and breastfeeding (Ryan et al., 2011; Sheehan et al., 2009). Paediatric osteopaths often express a sense of identity with mothers, in terms of sharing some form of common ground. They discuss breastfeeding issues, for example, not only from a professional perspective but also on the basis of personal experiences, particularly as a parent.

The physical processes of *Connecting* involve therapeutic touch, which is a special form of human interaction¹⁰⁰. Touch was observed to be as simple and subtle as placing a hand on a mother in a reassuring way or as part of getting physically close to her and the baby while breastfeeding and is taken to another level when osteopaths contact the baby, for the purpose of examination and applying manual therapy. *Connecting* in a physical way implies that the baby, at first, feels and accepts the osteopath's touch, which is then followed by the more purposeful activities of diagnostic examination and applying manual techniques; physical processes that are explicated as the strategies of *Assimilating* and *Rebalancing* in the following chapters. The interactive physical processes of *Connecting* involve phenomena that can be difficult for the osteopath to articulate, but are clearly felt, familiar, and recognised as an important part of the therapeutic relationship.

The first one for me is always making that contact with the baby, so there's a physical hands-on contact and then there's that feeling the more subtle internal inherent movement ... that there's a sense of that connection; of the baby being

⁹⁹ Contemporary attitudes toward new mothering are discussed in Chapter 6.2.1.

¹⁰⁰ Therapeutic touch as part of manual therapy is explored further in Chapter 10, *Rebalancing*.

aware of me, and me being in contact with that subtle [physiological] component of the baby. So that's always a key point and a necessary point for the process [treatment] to go forward (Lauren, O 2/14).

Connecting with the baby, as in the exemplar above, rests upon osteopaths' self-reflective processes. Taking a reflective approach enhances osteopaths' sensitivity to dyads' emotional, physical, and communication needs and enables them to use appropriate strategies to ensure dyads feel comfortable and ready for treatment. *Connecting* includes the notion of acquiring permission from the mother, as guardian, and the baby, as the patient. The context in which osteopaths *connect* with, and gain a dyad's cooperation and consent to treatment, is now considered.

8.3 CONTEXT OF CONNECTING

Each visit to the osteopath involves a case history and physical examination before treatment begins. This introductory part of the consultation includes an evaluation of current circumstances and the gathering of background information in order to make or revise a theoretical diagnosis and treatment rationale. *Connecting* incorporates the professional requirement of summarising and communicating relevant information to the patient, in this case, the mother, as the baby's legal guardian, to enable her to provide informed consent for osteopathic treatment. Informed consent is a complex professional concept based on legal and moral obligations grounded in respect for patient autonomy (Delany, 2007; Verma, Paterson, & Medves, 2006). Implicit in this concept is the notion that the mother understands the osteopath, and what she proposes to do, sufficiently well to make a voluntary decision. This is an important consideration when dealing with vulnerable patients such as new mothers who are *struggling to breastfeed satisfactorily*. Osteopaths were observed to consistently seek confirmation of a mother's and baby's consent through the strategy of *seeking affirmation*, discussed later.

Gathering relevant information starts with participants meeting and entering into a conversation that is directed toward a common purpose. The baby is included in this interaction by discussing and tending to her needs; whether she is settled, hungry or tired. Hence, the osteopath guides the case history and examination but demonstrates considerable flexibility in how this is done. A common finding of the study is that once the osteopath places her hands on the baby, assessment and treatment, as discrete phases, tend to merge as the consultation progresses. A sense of staying aware or *connected* to the mother and baby is, however, maintained.

I sort of find during that whole process [case history taking] that there will come a point where the parents relax and the baby relaxes because they've had time to get used to you ... [if] I haven't quite finished the case history; maybe I'll just start treating them because I sense that it's a good time and then get the rest of the information later. So it's a fluid thing; it depends on where the parents are 'at' or the baby's 'at', but at some point I'll put my hands on (Edward, O 06/02).

The above exemplar draws attention to one parental pairs' emotional state when they first bring their baby to see the osteopath. A common finding of the study is that, during an initial visit, mothers and accompanying family members, such as the father or a sibling, can feel uncertain or anxious about what to expect. Osteopaths respond by establishing a relationship with each individual and adapting the processes of *Connecting* accordingly. Typically, they note that fathers, who accompany the mother and baby to an initial consultation, assume a mostly protective role. Once fathers are reassured by the osteopaths' integrity and an awareness of the treatment process, they feel comfortable for their partners and babies to continue visits on their own.

Often the first treatment they'll [fathers] come just to see what's going on; which is good. I'd say about fifty percent of times that the husband will come at the first treatment and then once they know what's going on, they usually don't come (Megan, O 4/16).

The exemplar above introduces the idea of parents' need to trust in the osteopath and treatment process, particularly when placed in unfamiliar circumstances. Mothers who are *struggling to breastfeed satisfactorily* face a number of uncertainties that were explored in chapter seven¹⁰¹. One such uncertainty is a lack of experience and understanding of what osteopathic treatment entails. Many women, who are adjusting to the challenges of new mothering and breastfeeding difficulties, have trialled more conventional treatments to assist with their breastfeeding problems before moving on to osteopathy as a new strategy, frequently as a last resort. This situation compounds their already vulnerable state and the need to form a *well-connected* relationship with the osteopath is even more apparent. Mothers need to be able to communicate their wishes and concerns and trust in the osteopath at a personal and professional level. Osteopaths acknowledge fully these women's special needs but are also aware that the mother acts as a bridge to facilitate their ability to *connect* and interact with the baby.

¹⁰¹ See Chapter 7.2.1

My main aim is just to gain the trust, especially of the mother, but also the father if he should come to the first consultation, and just make them relaxed and they can [come to] realise that they need to basically just behave as naturally as possible [by] comforting the child; so that the child feels most comfortable with me. (Evelyn, O 08/02).

Establishing a physical connection with a baby is underpinned by the concepts of trust and respect. A new mother, whose primary role is protector and nurturer of her baby, literally places her in the hands of the osteopath. She does so on the premise that breastfeeding is, in part, a physical act that involves biomechanical processes; knowledge of which, lies within the osteopath's area of expertise. Implicit in this action is a sense of trust; however, this trust needs to be earned. Establishing a relationship with a common purpose based on trust and cooperation is a complex task. The data shows that paediatric osteopaths use specific strategies to achieve this.

8.4 STRATEGIES FOR CONNECTING

Osteopaths in this study are able to achieve a sense of relatedness with dyads through using a strategic approach. The strategies and sub-strategies that they use are outlined in Figure 4.

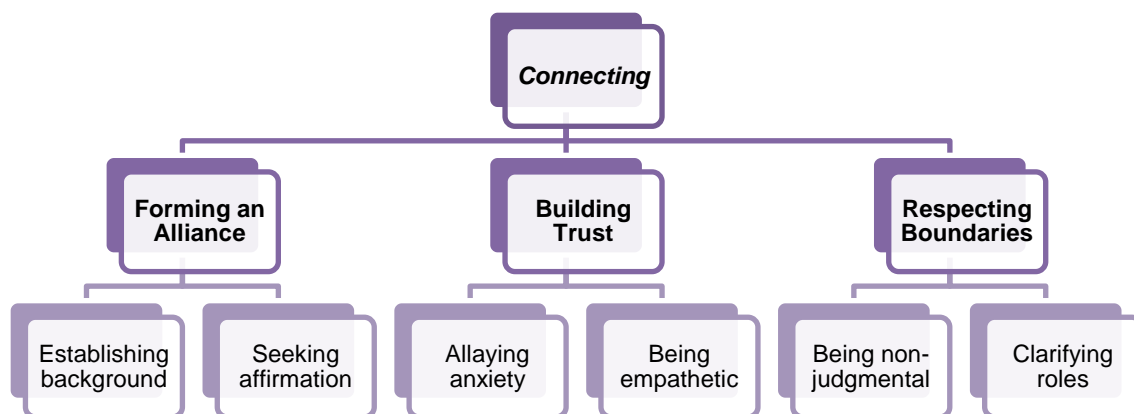


Figure 4: Strategies and sub-strategies of *Connecting*

Paediatric osteopaths employ three key strategies to develop comfortable and purposeful working relationships with dyads; they are *Forming an Alliance*, *Building Trust*, and *Respecting Boundaries*. Although *Connecting* is particularly relevant at the initial consultation and the start of each subsequent visit, it is equally important to maintain throughout each session and over the course of treatment. Due to changing

circumstances, participants might need to *reconnect* in a new way at critical points in time as is the case in the following scenario.

Karen (mother) arrives at the osteopath's practice in an anxious state after spending a stressful few days dealing with new breastfeeding difficulties. She has mastitis and her baby is irritable and unwell with a cold. Daniel's (osteopath) approach to *connecting* with Karen and her baby on this day changes accordingly. He was observed to direct his attention toward settling the mother while limiting his treatment expectations for the baby.

I think it was interesting for me in that the case was completely not how I thought it would be. I mean the mother's nearly in tears when she walked in the door. Well this is her third visit, so normally by then you've got a pretty good handle on the case, and she certainly hasn't been this upset. I suppose that's the reality of breastfeeding [difficulties], kind of moving its way along ... you know, I was trying to treat two people [mother and baby] at the same time (Daniel O 11/18).

When Daniel, above, discusses treating two people; mother and baby, he uses the term 'treat' loosely in reference to addressing the mother's emotional state; a response that represents one of the more subtle elements of osteopathic treatment. This exemplar highlights also the complexity and unpredictability of clinical paediatric practice and the need for adopting a sensitive and flexible approach. Throughout the data, osteopaths and mothers discuss their thoughts, emotions, and actions concerning breastfeeding and osteopathic treatment at varying points along a time continuum; their first meeting, what has happened since, the current situation, and how they view the future breastfeeding relationship. Over time, osteopaths use a number of different strategies to strengthen interpersonal practitioner-patient relationships as their association progresses.

8.4.1 Forming an alliance

Mother, baby, and osteopath *form an alliance* by joining their efforts and interests to achieve the common goal of effective breastfeeding. Such a collaborative approach is shaped by what each individual brings to the group interaction. In general, the osteopath has clinical and manual therapy skills, the mother has acquired breastfeeding knowledge, experience, and purpose, and the baby has innate reflexive and learnt feeding behaviours. In addition, each individual brings personal attributes and perceptions of the situation. Embedded within this notion are the special characteristics of the mother-baby bond and family circumstance. In order to find common ground, individual histories and interests need to be uncovered and made explicit in order to articulate the common purpose. Although promoting effective breastfeeding is the common goal in its broader

sense, each alliance is unique and its members might view and approach this goal in different ways. *Forming an alliance* involves finding a mutually agreeable reference point or meeting place, from which the osteopath, mother, and baby can move forward. Such a meeting place encompasses the idea of a meeting of minds and bodies; of feeling sufficiently comfortable to proceed in a state of mutual cooperation. At a first meeting, mother and baby bring a history with them. The mother seeks help from the osteopath for reasons that have been set in motion well before she makes her first appointment. For the osteopath, *forming an alliance* starts by exploring the circumstances that have brought a mother and baby to the clinic at this time. One osteopath's approach to *connecting* with a distressed mother early in their relationship follows.

I find some mothers are so distressed that they need to just get out the bit that's distressing them the most ... so sometimes what you're listening to isn't really even relevant to what you'll actually be treating. It's just letting them have a sounding board for a few minutes; it's that they are being heard and that, you know, they can debrief a bit (Lauren, O2/04).

Here, Lauren (osteopath) demonstrates effective communication skills. Being a good listener enables her to start the process of acquiring background information and establishing common purpose. In their roles as health professionals, osteopaths guide operational activities, which may require adjustment according to individual factors and perceived needs at the time. Osteopaths were observed to adopt an assured and attentive approach when a mother appeared distressed, lacking confidence or feeling insecure. If a baby is tired and unsettled, the osteopath might decide that the *alliance* is no longer sustainable at that time.

If they're [babies] just really strung out, tired, they're not going to 'be here'; I'm not going to force a treatment on the baby... most parents can really handle you treating a crying, screaming baby. They get really uncomfortable because they don't know what to do ... yes it's just easier to not put everyone through that, and even if I don't treat their baby that day, that's OK, bring them back the next day and go from there (Edward O 6/03).

In the above scenario, Edward (osteopath) sees a clear constraint to treating the baby at this time. He advises an alternate course of action that is in everyone's interest and enables him to maintain mother and baby as cooperative *allies* for future visits; a general principle that is typically adopted by other osteopath participants. Over a course of treatment, each *alliance* needs to be reevaluated and refined according to new

experiences and events, such as when a mother's confidence and the dyad's breastfeeding skills improve, deteriorate or change direction. *Forming an alliance* thus continues to rely on effective communication in terms of acquiring relevant information, keeping mothers informed and comfortable, and monitoring mother and baby responses. These issues are explicated as the sub-strategies *Establishing background* and *Seeking affirmation*.

8.4.1.1 *Establishing background*

Establishing background is a bi-directional process. It relates to osteopaths determining dyads' personal and clinical histories and mothers acquiring information about paediatric osteopathic clinical practice. These two different backgrounds are merged to provide a framework in which the *alliance* can effectively develop and operate. Background knowledge of each other is established through an exchange of information and sharing of thoughts and ideas. Osteopaths want to gather relevant personal and clinical information, in a timely manner. In general, they were seen to strike a balance between acquiring information that a mother freely offers and seeking more selective information that is deemed more clinically relevant and important. They need to do this efficiently yet sensitively. At the same time, they provide mothers with an explanation of how an osteopath works, their clinical findings and views, and how they intend to deal with them; information that is summarised and transformed into comprehensible language. In this way it is anticipated that mothers can then make informed decisions about their babies' health-care.

For an *alliance* to be successful and move towards an appropriate intervention and solution, mothers' and osteopaths' conceptual goals or basic ideas must align. To achieve this, the osteopath needs to know the mother and baby as people, understand their breastfeeding problems, and ascertain the mother's views on osteopathy. In order to find a suitable starting point, the dyad's breastfeeding, birth and postpartum experiences must be situated in time and place. This information provides a baseline from which mothers and osteopaths can articulate and align mutually acceptable expectations. A typical introductory attitude to *establishing background* follows.

I always ask if they've seen an osteopath before and ask what they know about what we do and explain a little bit about what we'll do, and just let them know that we're going to ask a lot of questions and some might not seem relevant but it's all important and it helps me to understand why they are here and how they've ended up in my practice (Karla, O 05/12).

Similar to the exemplar above, *Establishing background* requires paediatric osteopaths to adopt a sensitive and receptive attitude that involves asking a range of questions. It is evident from the data that much background information is also acquired from observing body language, facial expressions, and mother-baby interaction. This information tends to then guide and direct subsequent actions and the line and flow of questioning. Typically, *establishing background* begins with welcoming behaviours, and asking open-ended questions that are exploratory in nature. Mothers are more likely to share their thoughts and concerns if they know that the osteopath is interested and what they offer is readily accepted and valued.

First is in the waiting room when I first greet them so for me it's important with any of the patients to make eye contact and try and build a rapport, you know, big smile, eye contact, introduce myself to the baby as well as the mother ... then invite them into the room, and guide them to where I have them sit, so have the mum seated next to the desk where I may take notes and just go through a process of getting to know the mother and what her concerns are for the baby. The first thing I ask is, 'How can I help?' or what's concerning them about their baby and then depending on how that flows ... (Lauren O 2/03).

This exemplar represents a general approach that osteopaths were observed to adopt when beginning a consultation. They start with a friendly and open-ended enquiry before moving toward a more focused line of questioning¹⁰². This includes, for example, case history taking or trying to ascertain the detail of a dyad's feeding regime, or exactly how the baby responded to a previous treatment. As the line of questioning shifts from getting mother and baby comfortable and prepared to a more disciplined diagnostic approach, the processes involved merge into the strategies of *Assimilating*, discussed in the next chapter.

In general, paediatric osteopaths provide mothers with some personal but primarily, professional background information through explanation. Explaining is an integral part of interpersonal communication that involves making 'something' clear; in this case the osteopath's approach to examining and treating babies with breastfeeding difficulties. Parents are more likely to feel comfortable with the treatment process if they have some understanding of what osteopathy is and how it works. Expressed understanding implies the ability to make an informed decision.

¹⁰² How the osteopath adopts a more focused approach to gathering information is discussed in Chapter 9.3.1.1.

And they [parents] both said, "Oh that makes sense." So I guess in a way, that was their approval (Julie, O1/08).

Here, a mother's understanding, which is frequently expressed as an ability to "make sense" of particular circumstances and experiences, underpins her confidence in a particular practitioner or course of action. Typically, osteopaths combine verbal explanation with demonstration on the baby where appropriate or with anatomical models and pictures. Several offer pamphlets, which provide brief generic explanations of the osteopathic approach to treating babies. Such written material reinforces verbal explanations and assists mothers to pass information onto others. The data demonstrates that osteopaths use thoughtful and creative methods to explain their clinical approach.

I just feel for tension or patterns of strain. I often use the analogy of a person with clothing; their shirt's kind of pulling a bit tight under one arm. You can kind of feel a pull across your chest or your back, that kind of feeling. Babies are very much reliant on the connective tissues or the fascia so it's the 'glad wrap'¹⁰³ of the muscles if you like (Daniel, O 11/12).

Like Daniel above, paediatric osteopaths typically use metaphors to enhance description of some of the more confounding treatment ideas. Explaining what they feel and do with their hands on the babies' bodies can be challenging because many of these ideas are unfamiliar, abstract, and difficult to appreciate even when demonstrated. Mothers often report not being able to see any overt activity during manual treatment of their babies because the techniques used are known for being gentle and subtle¹⁰⁴. By explaining the sensory experience according to what they are feeling and doing at the time, osteopaths keep mothers personally involved and *connected* with the process. They also need to translate what they feel when touching the baby into language that mothers can understand, and as a dyad's circumstances and the treatment context changes over time, the accompanying explanation must adjust accordingly. For example, a mother who has no prior knowledge or experience of osteopathy requires a basic overview of osteopathic practice procedures. She might, however, seek more in-depth explanation of treatment processes when she is further along the treatment program. The progressive nature of the osteopath-mother *alliance* according to a growing understanding each other's backgrounds is illustrated by the next exemplar.

¹⁰³ 'Glad wrap' is an Australian brand name for clear plastic stretch film.

¹⁰⁴ Osteopathic treatment techniques are explicated in Chapter 10.3.

I was unsure initially. I thought, 'Well, I know there'll be a bit of an interview and discussions, [let's] see where we go from there.' When I first saw Edward [osteopath] treating him [baby] lying down, I was asking questions, 'Exactly what are you doing?' because it was quite different to something that I've seen before. The second visit I was a lot more at ease but I was getting a bit of skepticism from Steve's [father] parents. His dad thought of manipulation and [said], 'Oh, that's a load of crap.' I was explaining, going, 'No, no, no it's not like that at all, it's actually helping'. So that was a bit hard to deal with initially. Edward gave me a couple of brochures that I did show him [father-in-law] which I think helped a little bit (Sonia, M 6/06).

Here, Sonia (mother), a health professional, has some preconceived ideas about clinical practice routines. As her uncertainty of osteopathy dissipates and sense of comfort with the treatment process grows, she has to deal with concerns raised by other family members; a contextual factor identified previously¹⁰⁵ and common finding of the study. Being put into the position of explaining to others is one commonly accepted way of clarifying or enhancing a person's self-understanding. When osteopaths provide explanations at a deeper conceptual level and mothers are encouraged to engage more with analytical reasoning processes, a form of *educating* takes place¹⁰⁶. In summary, paediatric osteopaths take into account severable variables to create the most appropriate explanation at the time in order to *form an alliance* and ensure its continuity over time. Much of the complexity of this idea and the intuitive processes involved¹⁰⁷ is captured by the following exemplar.

I mean you've got to sense how, like the best approach to explain something to each person. So I don't think I've explained the same thing [in] the same way to several people; you've just got to wait and see what comes to you (Edward, O 6/07).

Seeking feedback is another important element of maintaining a *connected* relationship over time.

8.4.1.2 Seeking affirmation

Seeking affirmation is a strategy for checking that mother and baby are comfortable with the treatment situation over time and as circumstances change. It is linked with the professional competency of gaining and maintaining a patient's informed consent,

¹⁰⁵ See Chapter 6.2.1.2.

¹⁰⁶ See Chapter 11.4.2.1.

¹⁰⁷ Osteopaths' use of intuition is a common thread found in the data that is discussed further in Chapter 13.5.

presented earlier. Mothers become informed through the sub-strategy of *establishing background*. Consent or *affirmation* occurs through communication, interaction, and feedback. In this study, *Seeking affirmation* is an ongoing dynamic concept that is viewed by osteopaths as more than the formal medico-legal agreement between practitioner and patient. It is an essential element of making positive interpersonal *connections* between themselves and the dyads who seek their help. Overall, it is a strategy for ensuring a mother's and baby's agreement and cooperation, which in turn, ultimately enhances examination and treatment processes. Mothers and babies express their comfort (or discomfort) in individual ways, and osteopaths, in turn, seek and acknowledge this expression. Hence, *Seeking affirmation* involves monitoring behaviors and responses, but with the specific intent of confirming dyads' comfort and permission. In this interactive way, participants continue to build a trusting relationship and remain *connected* to each other over the course of treatment.

Seeking affirmation from the baby is explored first because, in general, if the baby is comfortable, the mother and osteopath are too. *Seeking affirmation* is found frequently in the data in the context of osteopaths' responses to unsettled and crying babies. In general, they have high regard for a baby's visible comfort as an indicator that, the baby, as an individual, gives her consent to take part in examination and treatment. Ensuring that everyone is comfortable is an interrelated process. Osteopaths were often observed to recruit the mother's assistance, for example, to find ways to ensure that the baby is ready for treatment. A typical interactive clinical situation follows.

I could just tell he [baby] wasn't comfortable with that position and I couldn't get a feel for what I needed to do in that position. He just generally seemed like he liked being upright and having spoken to his mum, there was definitely some air [wind] trapped under there from his previous feed (Karla O 5/08).

Karla (osteopath) feels constrained in her efforts to treat the baby or apply a manual technique, effectively. She senses the baby's discomfort and seeks advice from the mother who confirms her idea about the probable cause. Karla is then better placed to make appropriate decisions about the best course of action. Through palpating (feeling) the body's physiological responses, osteopaths pick up clues relating to the baby's relative compliance with treatment. This subtle but informative means of *seeking affirmation* provides an opportunity to take preventative measures to avoid making a baby become unnecessarily unsettled. Osteopaths tend to respond to the scenario above, by either adjusting the baby's position and their choice of technique or by handing the baby

back to the mother as the most capable person to deal with the problem effectively. As a group, they can then return to the original treatment activity when ready.

In general, paediatric osteopaths prefer not to treat a baby who is unsettled. In the main, they avoid treating a crying baby on the premise that an upset baby makes the mother uncomfortable and generally hinders the development of positive interpersonal relationships, and in most cases, reduces the success of the treatment. There are, however, degrees of discomfort and *seeking affirmation* when a mother and baby are involved is not always a straightforward process, as illustrated in the following exemplar.

It's [treatment] very gentle and very subtle but I think occasionally they'll [mothers] think that the baby is uncomfortable with the treatment ... but yesterday when the baby was crying I was treating the Caesarean strain and that crying actually really helps to crank everything up. I know it sounds a bit mean but that's why I let it go on for a little while because it was actually responding ... but look, if they were really distressed I wouldn't do that. I'm very aware of how the mum and the baby are but I think Marie [mother] was alright, yes, the baby was obviously tired; she fell asleep soon after the treatment (Megan, O 4/16).

In this situation, Megan (osteopath) continues to treat an unhappy baby after weighing up factors such as the degree of discomfort, its cause, how the treatment is progressing, and the mother's reaction to it. She reasons that the baby's crying is actually facilitating her treatment; that important beneficial changes are taking place and the mother can cope with the situation. In other words, she feels sufficiently well *connected* to this mother and baby to decide that the benefits of continuing to treat outweigh the disadvantages of invoking potential but temporary feelings of discomfort.

Seeking affirmation from the mother relies on effective communication in the form of a reciprocating feedback loop. The osteopath provides an explanation and seeks assurance that the mother has sufficient understanding of the findings, procedures, and rationale to give permission for treatment to continue. Such permission is based upon some form of the mother's expressed understanding and approval. This is not necessarily clearly articulated but often assumed by monitoring verbal cues and body language. At times of doubt, however, osteopaths typically seek more explicit feedback from the mother as follows.

I keep an eye on the mum and if the mum's distressed I usually stop and if the baby's crying I say, 'Tell me if you want me to stop, yes, let me know if you've had enough' (Julie, O1/11).

Working with dyads *struggling to breastfeed satisfactorily* can take place within an unpredictable and emotionally charged environment and thus relies on highly attuned receptive processes. Osteopaths cannot always be sure that a mother is able to understand what is going on sufficiently well to provide consent at all times. In the main, *Seeking affirmation* rests upon the quality of the osteopath-mother interpersonal relationship, which can be expressed in various and subtle ways.

She [mother] seemed happy with the explanation that I gave her. I mean it's always hard to know. I think there's a 'leap of faith' with every patient that even if they can't fully understand what you're doing, they can either suspend their disbelief enough to let the results speak for themselves (Edward, O 6/08).

For Edward (osteopath), *Seeking affirmation* from a mother is associated with a sense of trust, expressed here as a 'leap of faith', which can be imparted in different ways; not always clearly articulated, but often communicated through a mother's and baby's behaviours and responses. Trust is an element that contributes to *Connecting* in other contexts.

8.4.2 Building trust

Trust is a humanistic value that emerges from the data as an essential basis for *Connecting*. It is a many-layered concept that takes time to develop and is discussed often in terms of degrees of depth and quality. In this study, trust is linked to, and expressed by, a mother's growing confidence in the paediatric osteopath's personal and professional integrity and the therapeutic process, expressed in a variety of ways. Osteopaths acknowledge the importance of gaining dyads' trust and set out to establish and build it in explicit and implicit ways. In this study, there is a trend whereby a mother's trust builds in a transitional way, starting with an awareness of osteopathy, a growing understanding and acceptance of the way an osteopath works with a baby with breastfeeding difficulties, and finally moving towards a commitment to osteopathy or a particular osteopath. Commitment often arises as a consequence of feeling safe and experiencing benefits from osteopathic treatment.

Throughout the conduct of the study, dyads were situated at various points along the *building trust* continuum. Initially, levels of trust tended to link directly to the amount of a

mother's prior knowledge or experience of osteopathy. Approximately half were new to osteopathy and the other half had some previous experience. For example, the osteopath might have treated the mother throughout her pregnancy or had treated an older sibling as a baby. In these cases, mothers and osteopaths were renewing a past relationship or continuing to build on a changing relationship. These mothers articulate a strong sense of trust, either in the value of osteopathic treatment as a whole or in a particular practitioner. They continue to use osteopathy because they have a level of comfort and confidence in it and most convincingly, they have found it helpful. Ultimately, seeing results strengthens a mother's trust¹⁰⁸. In the following exemplar, Wendy (mother) had already experienced osteopathic treatment for herself and her older daughter. After relocating, she brought her baby for treatment with a new osteopath.

I took my first daughter to an osteopath when she was a baby because I had breastfeeding problems with her and they were fixed magically; I'm sure of that. And I just wanted to do the same thing for Miranda [new baby]; to give her the opportunity to have her body all put back the way it should be (Wendy, M 9/01).

The osteopath's approach to *building trust* with the mother and baby, above, is adjusted according to their previous experience of osteopathy. She continues the process of relationship building but a level of trust in the osteopathic treatment process is already present.

She was referred by an osteopath that doesn't treat kids so she came in, I guess, with a plan of knowing what we could do. We had talked over the phone; it was very obvious that she had a reasonable understanding of osteopathy and what we needed so we did skip some of the preliminaries. I offered her a brochure, which she wasn't that keen to take because she was happy with brief verbal explanations. She's been very positive and confident with how things would go; so she was quite an easy mum to work with (Natasha, O 9/02).

In general, mothers express their level of trust or belief in osteopathy by their preparedness to promote osteopathy or an osteopath to other mothers with breastfeeding difficulties. In a similar way, when mothers are referred to an osteopath by other health practitioners, it facilitates the process of establishing initial trust. Many elements of study participants experiences of *building trust* within the context of *struggling to breastfeed satisfactorily* are summarised by the following exemplars.

¹⁰⁸ See Chapter 6.2.3.2 for discussion relating to the contextual determinant, Health Care as a Commodity and an association between trust in osteopathy and positive treatment outcomes.

We ask the parents that they trust the person that recommend they came here; usually it's by referral. They've sent them here on the understanding that we've had good results in the past, that the process is non-invasive, and not harmful. So if they feel comfortable to trust in the process that they may not understand, and proceed (Lauren, O 2/10).

Even if she didn't understand what I was doing, she thought that I had her child's best interest at heart, and hopefully she saw some improvement (Edward, O 6/08).

Here, a common ideology concerning the nature of the practitioner-patient relationship is raised. It proposes that a health professional, by definition, has a moral obligation to act always with beneficence toward a patient. This assumption underpins a generic form of trust in the osteopath, which is developed further by personal experience of their commitment to genuine patient-centred practice. While osteopaths cannot exert control over, or guarantee, a positive treatment outcome such as improved breastfeeding; they all believe strongly in osteopathic principles and that their techniques are appropriate for a baby with breastfeeding difficulties and that they work¹⁰⁹. Osteopaths' self-belief and trust in professional principles and practice impact upon their interactions with dyads. Their enthusiasm and motivation for paediatric osteopathy tends to be embedded within their therapeutic approach, which has positive flow on effects by inspiring maternal confidence. Osteopaths do, however, set out to *build trust* by adopting particular approaches and taking explicit actions according to dyads' individual circumstances, through the sub-strategies of *Allaying anxiety* and *Being empathic*.

8.4.2.1 Allaying anxiety

Recognising and taking steps to minimise a dyad's anxiety emerges as an important sub-strategy for *Building trust*, particularly during the early stages of interaction. Osteopaths tend to focus on allaying parents' anxiety first, a strategy which also assists in settling the baby. *Allaying anxiety* involves seeking and gaining parents', as new patients, confidence and cooperation. Such an approach tends to reflect their overall attitude to paediatric clinical practice and usually starts by being generally friendly and inclusive.

I will introduce myself to the parents first and the baby; obviously the baby's the one on the booking, so I know the name, and then if there's a sibling, I make sure they're acknowledged as well. And then get the parents really comfortable (Britt, O 7/03).

¹⁰⁹ See Chapter 6.2.2.1 where paediatric osteopaths' professional identity is presented as a contextual determinant of the study.

More explicit processes for *allaying anxiety* were observed and found to be clearly thought out and articulated. They include taking time, encouraging 'normal' mother-baby interaction, and demonstrating professional competence. Parents need to feel that their baby is safe and the osteopath is capable and skilful. Osteopaths need time to build relationships, demonstrate their competence, and to help parents relax. In this study, paediatric osteopaths routinely schedule an hour for a first appointment to give them sufficient time to do this and they recognise that this is time well spent.

I allow an hour first of all and probably not a large part of it is actually treating the baby, so a lot of it is information gathering. I like to really slow it down ... The hardest thing I find in the whole initial consultation is getting the parent's confidence. Often both parents will turn up on the first consult because they're not quite [sure]; someone's told them to come and see an 'osteo' but they're not really sure what an 'osteo' does. So I sort of find that to start, they're almost anxious ... so sort of allaying those fears; that you are thorough and you're getting the information. So a lot of it is just to pander to them really (Edward, O 6/02).

In this exemplar, Edward (osteopath) discusses some of the features of case history taking when dealing with parents and a baby at an initial visit. He deliberately slows down events and engages with the parents by including them in a detailed discussion that provides him with the opportunity to show his interest, gather the information that he needs and simultaneously, demonstrate professional competence. Such an approach and allowing time for an initial visit is a common finding of the study. In addition, osteopaths typically set up individualised practice protocols that specifically assist them to allay parents' anxiety. Examples include acquiring preliminary information through written questionnaires, greeting dyads and engaging in informal conversation in the waiting room. Such strategies provide an opportunity for osteopaths to observe and evaluate a dyad's emotional state and thus respond in appropriate ways that encourage relaxation and inspire confidence. *Allaying anxiety* thus involves being attuned to individual circumstances and tends to merge closely with the sub-strategy, *Being empathic*. How these two fundamental processes intertwine to *build trust* is illustrated by the following exemplar.

We ask how we can help. Yes sometimes too, you see it in the waiting room. You see a really unsettled baby or an upset mum. I might start a little bit differently if I see an unsettled baby or a mum attempting to feed. I might start with, 'Oh what's going on there?' rather than 'How can I help you?' I guess I would first of all try and

make the mum or the parents comfortable, that it's OK; you don't have to try and keep the baby quiet at all; if the baby needs a feed, do so (Julie, O 01/02).

Julie (osteopath) observes and immediately recognises a dyad's anxiety or distress. She deliberately sets out to *allay anxiety* by adopting a sensitive individualised approach. She thinks carefully about the best way to help this mother and baby feel at ease by starting with an open-ended question that emphasises that she is there to help. She observes keenly and changes her approach very slightly by choosing her words and suggested course of action carefully. She demonstrates that *being empathic* by adjusting her responses can be quite subtle but nevertheless important. It is evident from the data that meaningful *connections* between osteopaths and dyads rely often upon attending to the detail of human expression, emotion, and interaction.

8.4.2.2 *Being empathic*

Empathy is the ability for a person to enter into the thoughts and emotions of another (Butler, 2009). *Being empathic* starts from this premise and its meaning is expanded to include being caring, appreciative and perceptive. In this study, osteopaths demonstrate empathy by identifying with, and expressing understanding of, women in their new mothering roles, their individual situation, and in particular their *struggle to breastfeed satisfactorily*. They can express empathy in various ways such as being good listeners, being inclusive, and putting thought and detail into what they say and do. Many of these features are evidenced by the following exemplar.

Yes, it's like a three-way [mother, baby, and osteopath] type of treatment really, isn't it? Stephen (osteopath) is just very caring and he asks quite concerning questions I suppose. He's always asking me about my wellbeing and keeping me informed of what he's doing as well. He gives me clues as to what might need some correction or what he's actually working on so I'm not just sitting there thinking, 'What's he doing? (Narelle, M 13/12).

As in the exemplar above, *Being empathic* generally starts with osteopaths making sensitive appraisals of dyads' physical and psychological wellbeing, followed by an appropriate and appreciative response. By continuing to observe body language and ask questions, they monitor or reappraise the situation and adjust their responses as required. *Being empathic*, therefore, allows osteopaths to stay *connected* in a dynamic way and continue to *build trust*. *Being empathic* with babies is more difficult to define but involves being perceptive to their basic needs regarding hunger, fatigue, comfort and social interaction and then responding accordingly.

Due to the symbiotic relationship between mother and baby, *building trust* with one will affect the other. As seen in many of the previous exemplars, osteopaths start *building trust* with a baby by encouraging parents to relax, which has a flow on effect to the baby. In a similar way, a mother's sense of trust grows when the osteopath is seen to show genuine concern for the baby's wellbeing. Osteopaths understand that mothers' continually monitor their babies' behaviour and know that a mother is reassured by visible evidence of her baby interacting positively with the osteopath. A common example relates to the way that osteopaths generally chat to babies at a personal level while interacting with them at a clinical level.

Yes, well they're [babies] people; they need to know what's going on too! ... Probably they are just listening to your tone of voice or maybe to you recognising what they are trying to say (Julie, O 1/10).

Typically, mothers are reassured by watching general social interaction between baby and osteopath. However, osteopaths also use specific strategies to build a baby's trust that are not always so overtly evident to others. In this situation, *being empathic* involves more subtle nuances of touch, eye-contact, facial expressions, and verbalisations, at particular times, which collectively, represent more intuitive practice processes. An example of this subtle form of *empathic* communication with babies follows.

I don't like to come from behind the baby at the start because you have no eye contact with them and I don't think it helps them relax. Babies like to see who you are and know you on a different level. So if you just come from behind them and start doing things to them, generally I find that you don't get a good result ... So anyway I like to come from the front of the baby; then I get a sense that they're ready for me to treat them (Edward, O 6/10).

Being empathic with mothers and babies is influenced also by osteopaths' reflection on related clinical and personal experiences. This element of paediatric practice emerges most commonly from the data through osteopaths' recollection of parenting and breastfeeding experiences of self or someone close. Just over half the osteopaths in this study are parents of young children and relevant personal experiences tend to become subsumed within each individual and his or her overall approach to their clinical work. All, however, agree that these experiences have sensitised them to a broad range of relevant issues such that they feel better enabled to respond to mothers and babies *struggling to breastfeed satisfactorily* in more appropriate and empathic ways. An example of how one

osteopath incorporates a heightened awareness of managing breastfeeding difficulties into her overall practice approach follows.

My second one [baby] didn't [breast] feed particularly well and I thought, 'No wonder women feel like this, it's really hard'... I think it just gave me a deeper understanding; it's OK to go another way, to breastfeed or not to breastfeed. I always knew that it was, but this just gave me a deeper understanding or appreciation of it (Julie, O 1/03).

Responding to mothers and babies in empathic ways merges with the next strategy *Respecting boundaries*, which focuses more on finding a balance between supporting without interfering with a mother's autonomy.

8.4.3 Respecting boundaries

Paediatric osteopaths are careful to work with mothers and babies in respectful ways within defined professional and personal parameters. *Respecting*, in the context of the study, means to treat dyads with consideration and refrain from interfering unnecessarily with the primacy and intimacy of the mother-baby bond and women's emerging roles as new mothers. This notion includes personalised breastfeeding decisions and practices. Professional boundaries relate to paediatric osteopaths clarifying the various ways in which they can (and cannot) offer assistance to dyads who are *struggling to breastfeed satisfactorily*. One of their fundamental roles, for example, relates to the more generic responsibility of health professionals to identify and manage potential health risks for mothers and babies.

For paediatric osteopaths, personal boundaries concern limiting the influence of their subjective parenting and infant feeding views, on potentially vulnerable mothers and families. For mothers, *boundaries* emerge around their right to make personal and well-informed choices concerning themselves, their bodies and their babies' welfare. For babies, *boundaries* concern their need to feel comfortable and ready to cooperate during the physical examination and application of manual techniques. Elements of this boundary have been discussed previously as the sub-strategy of *seeking affirmation*. Osteopaths, however, acknowledge that there are, at times, situations when they must be prepared to make a professional judgment to treat, or not to treat, babies because it is in their best interest.

Paediatric osteopaths demonstrate respect for the intimacy of the mother-baby bond by including mothers in decision-making and other activities that involve their babies. For

example, mothers are generally encouraged to stay in close physical contact with their babies and assist where possible, during treatment. When developed further, these processes have therapeutic consequences for mothers, which are discussed later in Chapter Eleven. In some cases, respecting the individual approach to mothering is more clearly articulated and integrated into the overall clinical approach.

I mean these days you know some mums are just following certain ways of bringing up their children, which means they really don't want to lose body contact with them. So I may in actual fact adjust how I treat them accordingly, if I feel that mum really doesn't want to let go of baby (Evelyn, O 8/02).

It is evident from the exemplar above that *Respecting boundaries* merges with the strategy of *Building trust*, through adopting an empathic approach. *Respecting boundaries*, however, offers a slightly different perspective to *Connecting* by considering some of the constraints of clinical practice. It incorporates the concept of osteopaths' making sensitive, discretionary decisions about how to deal with dyads as a special group of patients and helps also to define osteopaths' role in supporting women to breastfeed. *Respecting boundaries*, as a strategy for *Connecting* is discussed further in terms of two sub-strategies; *Being non-judgmental* and *Clarifying roles*.

8.4.3.1 Being non-judgmental

Osteopaths are mindful of their potential for unduly influencing a new mother's breastfeeding decisions and actions. All osteopaths, even the most enthusiastic breastfeeding advocates, acknowledge the primacy of the mother with regard to how she chooses to feed her baby. They demonstrate respect for the mother by being open-minded about her infant feeding choices and selective concerning the type of breastfeeding related information and advice that they give. *Respecting boundaries* means giving mothers space to make their own breastfeeding decisions and then finding ways to best support them.

I certainly would never tell a parent what to do, in terms of whether they do or not [breastfeed]. I don't really mind one way or the other; it's not my role to judge on whether they're breastfeeding. All the parent can be told is that studies currently show that there are health benefits to it and that it's their decision to breastfeed or not (Edward, O 6/04).

The word 'judge', as in the exemplar above, is found frequently in the data in the context of infant feeding choices. Being open-minded or 'non-judgmental' about breastfeeding (or

not), is an essential element of osteopaths successfully *connecting* with mothers. The concept of women feeling a form of social and personal pressure to breastfeed has been discussed previously¹¹⁰. Osteopaths in this study demonstrate sensitivity to this contemporary issue and attune themselves to the mother's breastfeeding goals, and emotional state. They take considerable care to choose their words and actions carefully to avoid putting any further sense of pressure on mothers and concentrate on finding ways to assist them to achieve what they choose to do. Many of these ideas are summarised and contextualised by the following exemplar.

I don't lecture my patients but I think they're aware that I'm in favour of breastfeeding and most of the people want to continue breastfeeding anyway; that's why they come. So that makes it easier, and I usually just explain the benefits of it and explain what I went through with breastfeeding my children. I have a lot of contacts now with breastfeeding because I had a lot of [breastfeeding] issues myself so I can put them in contact with lactation consultants and that sort of thing, but I think that if they're coming to us and they are wanting to breastfeed, we have a huge role to play in encouraging that (Megan, O 4/02).

Megan, (above) discusses how her personal and professional breastfeeding experiences and beliefs tend to be subsumed within her overall practice approach when responding to dyads with breastfeeding difficulties. Although a strong advocate for breastfeeding, she is, however, unwilling to impose her breastfeeding views but rather provide as much support, in various ways, as she can¹¹¹; an attitude that is generally shared by osteopaths in the study.

8.4.3.2 Clarifying roles

By clarifying their professional roles, osteopaths are better able to delineate the parameters in which they work and provide, to mothers, clearer guidelines about what to expect from them. The general consensus amongst osteopath participants is that they play three key roles when assisting dyads with breastfeeding difficulties; many of the elements of which are expressed by Megan, in the previous exemplar. First, their role is to support a mother to feed her baby according to individual circumstance and choice. Second, they focus clearly on dealing with physical or what they routinely refer to as 'structural' problems. Third, they provide an important supportive role by offering

¹¹⁰ See Chapter 6.2.1.2.

¹¹¹ How osteopaths support mothers is explicated in Chapter 11.3.1.

encouragement, providing practical postural breastfeeding advice, and referring to other breastfeeding support services.

The first role concerns acknowledging a mother's right to feed her baby as she chooses. This issue has been discussed previously in terms of adopting a non-judgmental approach to breastfeeding. As health professionals, osteopaths acknowledge and encourage breastfeeding as the healthiest means of infant feeding, but only in a way that aligns with the mother's wishes and health needs. Hence, the sense of *connection* between an osteopath and dyad is developed and maintained, whatever the breastfeeding outcome. *Respecting boundaries* in this way can, at times, be challenging for an osteopath, when her belief in a particular health promoting behavior, such as breastfeeding, is not similarly matched by the mother. Janet (osteopath), a strong breastfeeding advocate, for example, discusses how she deals with the situation of a mother choosing not to continue breastfeeding.

Obviously I place very high value on breastfeeding but of course I never put that onto people. I support them and I just get a sense of what they [mothers] want out of it and then I suppose there's a little part of me that has to let go. I may have a patient that gave up [breastfeeding], and sometimes I get frustrated as I feel like people give up too soon (Janet, O10/03).

When Janet describes how she has to 'let go' of something within, she is acknowledging a personal boundary and accepting her professional role in terms of respecting a mother-led decision.

The second key role that osteopaths play concerns that of a manual therapist, who has a primary interest in anatomy and physiology and specialised manual techniques. In this study, this interest is confined to the evaluation and treatment of the baby's body, although a number of osteopaths recommend manual therapy treatment for the mother as well. The osteopath's role is based on a traditional biomedical discourse that assumes that physical strains interfere in some way with physiological function, which can, in turn, affect the baby's behaviour and more specifically, the biomechanical processes that underpin effective breastfeeding. This view is summarised by Edward (osteopath) as follows.

My job is to try and get their baby functioning as well as possible ... So in terms of breastfeeding, what that involves is making sure physically that they are as capable as possible of being able to breastfeed and aiding that process. So that's

attachment, feeding itself and trying to make that whole process happen as well as possible (O 6/05).

Osteopaths articulate, in great detail, their 'structural' findings and how they might have implications for breastfeeding. Their role, therefore, is to normalise physical dysfunctions through the application of manual techniques. In general, paediatric osteopaths take this role a step further, beyond the more immediate goal of facilitating effective breastfeeding. They view the restoration of normal physiological function in a baby as a measure for preventing ongoing health problems. Several express a high level of responsibility and motivation for performing this role satisfactorily¹¹².

The third role of the osteopath is a more generalised supportive one. This is articulated as improving a mother's posture or the baby's position while breastfeeding, reinforcing the advice of other health professionals or linking the mother to other breastfeeding resources where appropriate¹¹³. Although paediatric osteopaths clearly provide psychological or emotional support to mothers¹¹⁴, *Respecting boundaries* is made explicit by the commonly held view that if a significant element of the breastfeeding problem emerges outside of a physical domain, then it is not within the osteopath's scope of practice, rather an indication to refer to others with the appropriate expertise.

In summary, *Respecting boundaries*, involves osteopaths providing clear guidelines relating to their interest and expertise in a physical domain and as a health practitioner within the broader health-care system. Within the context of *Connecting*, this strategy is part of the initial process of osteopaths outlining their intentions, and some of the constraints of clinical practice. In this way, osteopaths and mothers are better able to discuss issues of concern and work cooperatively within a mutually acceptable and clear framework.

8.5 CONCLUSION

Connecting is an abstraction that draws together the interpersonal, self-reflective, and physical processes by which paediatric osteopaths, mothers, and babies engage with each other and develop positive practitioner-patient relationships. These relationships are positive in the broad sense that they foster comfortable, purposeful and cooperative interactions, which form the basis for therapeutic intervention. Dyads who are *struggling to breastfeed satisfactorily* face difficult circumstances that require paediatric osteopaths to

¹¹² The ideology of prophylactic medicine is a common basis upon which the osteopaths in this study choose to work in paediatric practice; discussed further in Chapter 6.2.2.1.

¹¹³ See Chapter 11.4.1.2.

¹¹⁴ See Chapter 11, *Empowering*.

take particularly sensitive and encouraging practice approaches. The symbiotic nature of the mother-baby relationship means that how the osteopath relates to one will impact the other. The development of meaningful osteopath-dyad relationships, at professional and personal levels, is achieved through a merging of strategies, which are conceptualised as *Forming an Alliance*, *Building Trust*, and *Respecting Boundaries*. They and their sub-strategies; *establishing background*, *seeking affirmation*, *allaying anxiety*, *being empathic*, *being non-judgemental*, and *clarifying roles* represent the processes of relationship building, which provide the foundation for a holistic patient-centred approach.

CHAPTER NINE

ASSIMILATING

Well, he [baby] was only [breast] feeding on one side [breast] ... I explained the way a baby is normally born and how they turn and if that process doesn't happen, if it gets held up for some reason, what could happen. Then I showed the baby's movement and how he only went one way and the shape of his spinal curve and so from there I said, "Well that's my job to address; that's mechanical structural issues" (Julie, O1/08).

9.1 INTRODUCTION

The category *Assimilating* relates to paediatric osteopaths taking an informed critical approach to a dyad's breastfeeding difficulties and individual circumstances in order to find the best way to provide assistance. The exemplar above represents a typical clinical situation that relates to the category, *Assimilating*. Here, Julie (osteopath) *assimilates* several interconnecting sources of information such as the mother's concerns, examination findings, birth history, and biomechanics in order to create a framework of understanding that explains what is going on, and which, in turn, directs treatment choices. *Assimilating* moves beyond the introductory processes of *Connecting* to a more focused approach to defining the breastfeeding problem; this then becomes articulated in a more formal way, as a diagnosis. *Assimilating* thus aligns strongly with clinical assessment and diagnostic reasoning. The chapter commences with a definition of *Assimilating*, which is followed by a presentation of how it relates to the context of osteopathic clinical practice. The strategies and sub-strategies of *Assimilating* are then explicated. Finally, concluding statements are made.

9.2 DEFINITION OF ASSIMILATING

Assimilating means to take in and incorporate as one's own (Butler, 2009 p. 64). In this study, it involves osteopaths deliberately seeking particular information in order to build upon existing information. In this way, information becomes absorbed within the osteopath's professional and experiential knowledge base, and is transformed into new meanings. *Assimilating* thus incorporates the acquisition of knowledge. According to Macquarie dictionary (Butler, 2009), knowledge is "the body of truths or facts accumulated by human beings in the course of time" (p. 689).

Time is an important element of this definition because knowledge is an evolving concept. Acquiring knowledge starts with gathering and putting together information in a coherent and logical way. In the previous chapter, osteopaths started the process of *Connecting*

with mothers and babies with the intention of getting to know them and their breastfeeding concerns, and making them comfortable with the osteopathic treatment process. The processes of *Assimilating* continue to build upon this approach but shift to a sharpened focus. An ongoing interplay between acquiring information, thinking about how this information fits together and influences the whole, and validation of these ideas, then follows. New knowledge is constructed and learning takes place.

Knowledge and learning are linked inextricably. "Learning is knowledge acquired by systematic study in any field of scholarly application" (Butler, 2009 p. 708). Learning, for osteopaths in this study, occurs implicitly within the clinical setting. It involves the acquisition and application of knowledge and practical skills to meet the immediate and changing needs of mothers and babies with breastfeeding difficulties. Learning is influenced by what osteopaths already know such as the biomedical sciences and the principles and protocols of osteopathic practice. They possess more specific knowledge concerning the physiology of pregnancy, birth, and a baby's development. With advancing experience in the treatment of babies, they know more about when and why, or the conditions under which, to apply this knowledge. Hence learning involves reflective and analytical processes. The interplay between the processes of *Assimilating* is illustrated by the following exemplar.

O: Her baby was five months old and she hadn't had any feeding difficulties until that point. I got the mum to feed the baby in the room so that I could see what the fussing problems [irritable behaviour] were, and it was obvious that for whatever reason, she [baby] was uncomfortable. Basically, with taking the history and, obviously, the examination of the baby overall, as well as observing the feeding process, what came to me that I thought was important, was when she was born they noted that she left her hand behind [baby's position at delivery]; so she basically had one hand up and one hand down and that [piece of information] also seemed to correlate with her being vaccinated a week before the feeding difficulties started.

I: So how do you correlate the onset of these symptoms and the immunisations; how did you make that link?

O: I guess it's one of those things that I would really only have anecdotal evidence from; that when there seems to be, I guess, an insult with the immune system, and it doesn't have to be a vaccination; it can even be a baby gets a run of illnesses,

and if there was an underlying strain [physical dysfunction], it exaggerates it and it's more obvious at that time (Natasha, 09/04).

Natasha (osteopath) was observed to incorporate routine assessment practices with more targeted sources of information such as observing the baby feeding and ascertaining details concerning the baby's position at the time of delivery. She considers the significance of the timing of the onset of breastfeeding difficulties, and analyses the way various factors link together to support a pre-existing theory that underlying physical strains tend to express themselves more strongly at times of stress. Her theory, which is based on an understanding of the dyad's situation and conceptualisation of similar past clinical experiences is one that is generally shared by osteopath participants. For paediatric osteopaths, the processes of *Assimilating* involve formulating, testing, validating, and developing or eliminating ideas until comprehensive conclusions are drawn. The outcome of this deliberation is an important element of *Assimilating* as it leads to decision-making and formulating treatment plans. The theoretical explanation becomes transformed into a working diagnosis that focuses on the baby's physical structures that are amenable to osteopathic treatment techniques. Positive treatment responses also support the accuracy of the diagnosis and conclusions. Over time, treatment responses feedback into the information cycle and once *assimilated*, lead to new understandings and actions. As osteopaths' learning and reflective processes continue to develop, knowledge is used in a functional way to improve their clinical practice, and add to the broader professional knowledge base. This is a consequence of *Assimilating*.

Assimilating takes place within a clinical setting that influences how it unfolds. The osteopath's therapeutic approach incorporates osteopathic principles, routines and professional expectations. The context of this setting, as the background in which the processes of *Assimilating* take place, is now presented.

9.3 CONTEXT OF ASSIMILATING

Reaching a clinical diagnosis is a critical part of osteopathic practice because it provides the rationale for treatment. A diagnosis must be expressed in common professional language that can be written down. The nomenclature for osteopaths lies primarily within a biomedical neuromusculoskeletal framework. The diagnosis concerns articulating findings relevant to the body's structure and function, which are amenable to manual therapy. Structure and function are viewed as reciprocal and interlinking concepts, traditionally defined by the term '*somatic dysfunction*' as follows:

Impaired or altered function of related components of the somatic (body framework) system: skeletal, arthroal, myofascial structures, and related vascular, lymphatic and neural elements (DiGiovanna, 2001 p.87).

Somatic dysfunction is, therefore, a complex paradigm involving a number of interlinking physiological mechanisms. It is identified by the case history and examination findings. Osteopaths describe various quantitative and qualitative characteristics of somatic dysfunction that are compared to an existing perception of an expected norm. The diagnostic criteria include, for example, awareness of tissue texture, temperature, asymmetry in form and range of movement, as well as subjective input from the patient. Osteopaths in this study were observed to examine the babies carefully and articulate freely such detail contained within the concept of somatic dysfunction, expressed by Julie, previously, as '*mechanical structural issues*' and illustrated by the following exemplar.

When I held the baby up off the table, head and tail ... you'll feel the dural (ligament) strain right through, and there was an absolute torsion right through the middle of her body really, where the top half was going one way and the bottom half was going the other, which I imagine was a mould thing in-utero, but the stress point was right around the gut; so that was the major thing I treated in the first session (Megan, O4/10).

Here, a biomechanical appraisal that is based primarily on what osteopaths observe and feel in babies' bodies is directly linked to manual treatment goals. There are other considerations, however, that Megan, above, also raises, that might have impacted on this dyad's breastfeeding difficulties, as follows.

Marie (mother) was sick for 20 weeks. She also had a lot of stress during her pregnancy. I think she was very worried about screening results about Down's syndrome and I think that freaked her out. They also moved house right at the end, so there was a lot of stress and I think that feeds directly through into the baby as well (Megan, O4/10).

It can be seen that, although somatic dysfunction is an important concept that provides an empirical basis for osteopathic treatment, it does not explicitly include interplay of other contextual and individual psychosocial influences. In more recent times, osteopaths have moved forward from a purely mechanistic model of practice toward a biopsychosocial model (Lucas, 2005a, 2005b; Penney, 2010) that acknowledges the significance of psychosocial influences. This trend is reflected by paediatric osteopaths in the current

study. They describe detail that relates to somatic dysfunction but consistently situate and qualify their physical findings within a broad and individualised context.

An important part of the osteopath's evaluation of each dyad's individual situation involves consideration of all the possible biological and psychosocial influences of prenatal, birth, and early postnatal events, on current problems. A common finding of this study is that osteopaths incorporate a discussion of these events into their diagnostic framework. Osteopaths have general medically-based knowledge of pregnancy and obstetrics. Paediatric osteopaths also possess a particular view and understanding of physiological events associated with these fields of study. A body of theoretical literature describes the various forces of intrauterine postural influences and birth trauma, and their potential for creating somatic dysfunction in the bodies of otherwise healthy infants (Carreiro, 2003; Centres et al., 2003; King, 1998; Lay, 1997; Magoun, 1976; Turner, 1994). Osteopaths in this study, place great importance on ascertaining the detail of a dyad's clinical and birth history, based on this theoretical perspective, and as a vital element that contributes to an accurate diagnosis. In light of this comment, it is noteworthy that another finding of this study, presented in Chapter Five¹¹⁵, is that most mothers had a complicated birth history and were disappointed with their birth experiences. Osteopaths' analysis of the impact of birth trauma on breastfeeding outcomes is presented later in this chapter.

9.4 STRATEGIES FOR ASSIMILATING

Assimilating involves accumulating information that is at first dissected, thought about, tested, and then reconstructed in a meaningful way. It is thus achieved by mixing together various mental and physical activities and processes that feedback into, and guide, clinical practice. On this basis, the strategies and sub-strategies of *Assimilating*, which are set out in Figure 5, are now explicated.

9.4.1 Focusing

Assimilating requires the osteopath to adopt and move between broad and more focused perspectives. *Focusing* is a strategy of *Assimilating* that involves filling in the detail of the initial broad picture. Lauren (osteopath) describes this process as, “*With any of these issues about [breast] feeding, I am always asking questions to get a full picture of where they are struggling and what advice they’re getting (O 2/06)*”.

¹¹⁵ See Chapter 5.2.1, Table 4.

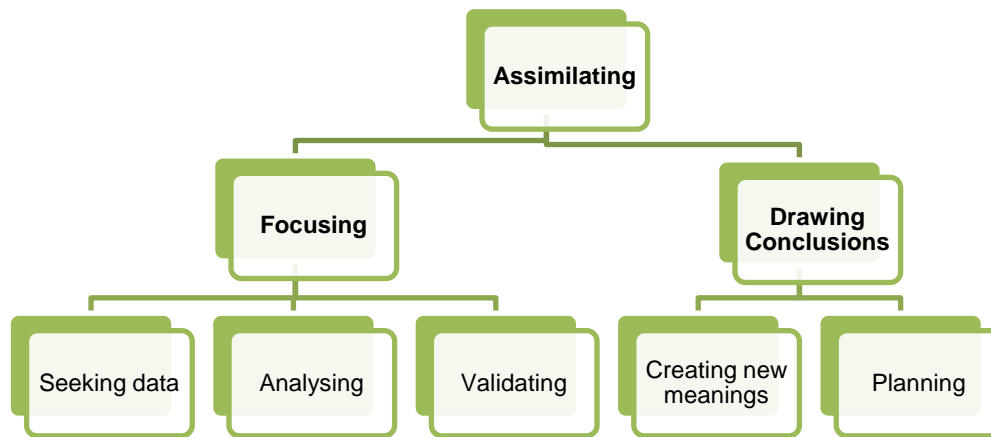


Figure 5: Strategies and sub-strategies of *Assimilating*

Viewing the situation through a sharpened lens renders more complex understandings that will, in turn, lead to more purposeful and effective treatment approaches. *Focusing* involves obtaining and piecing together information that links together in a logical and cohesive way. The term ‘information’ has a broad meaning. According to the definition of knowledge in Section 9.2, information can be construed as ‘a body of truths or facts’. Facts have a more concrete quality to them; a sense of having been tried and tested and generally accepted. ‘A body of truths’ reflects a more subjective perspective because truth means different things to different people. Both types of information are useful and osteopaths pursue one type, deliberately, at different times, in preference to another. They do so, on the basis of deciding what information is most accessible, reliable, useful, and appropriate. Typically, they need to hypothesise and test information to ascertain its validity. *Focusing*, therefore, involves concentration and analytic thought. It is a deliberate but complex strategy, made up interlinking processes that are discussed as three sub-strategies; *Seeking data*, *Analysing*, and *Validating*.

9.4.1.1 *Seeking data*

Through *Connecting* with dyads, osteopaths have a basic understanding of why each mother has brought her baby to the practice, the nature of the breastfeeding difficulties, and the medical background. From this reference point, they look for more specific information according to the developing ideas about what is going on. They are also aware of, or sensitised to, various possible physical, personal, and social breastfeeding related factors that might influence the diagnostic picture. Information is described as ‘data’; a term used commonly in a research context, to highlight the investigatory nature of *Focusing*. Osteopaths, who are exploring the breastfeeding problem, seek out particular

information that is valued for its contribution to clinical decision making. Data comes from multiple sources and was observed to be gathered in a variety of ways. *Seeking data* includes asking questions, listening to the mother's story and her response to more structured and probing questions, listening to the baby's verbal cues, setting up opportunities to observe individual interactions, postures, and expressions, and, ultimately through feeling and moving the baby's body tissues.

Data is gathered through the formal process of case history taking. All osteopaths in this study explore the chronological clinical history of the mother's pregnancy, birth and early postnatal experiences in great detail.

We go through the history and it's broken up into different sections I guess where, we ask a lot of questions about the baby here and now and what's going on; and then about the pregnancy, and the year before the pregnancy, and we go into the labour and quite a lot of detail about that, and the birth, and then just like a general medical history of the mum and the baby being born. My history gives me a lot of information and that helps direct where I'll [go] to with my assessment and my treatment of the baby (Karla, O 5/12).

Paediatric osteopaths have a particular perspective of recent clinical events, looking for clues that might not seem so relevant to other health practitioners. Their interest in biomechanical detail, for example, such as the position of the baby at the time of delivery, described by Natasha (osteopath) earlier in the chapter, is based on the belief that this information provides a potential link to current issues. It provides the clues for further investigation and consideration, and hence, guides the progress of the consultation. At each follow-up visit, osteopaths continue to gain substantial information by asking the mother explicit questions. At the beginning of a consultation, they would typically start with an open introductory question, but very quickly pick up on an element of the mother's response and develop it further by methodically asking more focused questions to uncover the detail. With regard to breastfeeding, osteopaths question mothers about all its dimensions; how the baby's attachment and suck feels; how long the baby feeds at each breast; whether the baby is settled while feeding; how the baby reacted after the last treatment, and so on.

While osteopaths acknowledge the structure of case history taking, asking direct questions, and following examination methods, they also *seek data* in more flexible ways. In the following exemplar, Evelyn (osteopath) describes how she might respond to a

mother and unsettled baby in an effort to simultaneously calm the situation and gather valuable information.

If it's a breastfeeding problem and the baby's already screaming because they're hungry, I may say, "Why don't you try and feed them", so I already get the first initial impressions of how mum handles the baby, how they put the baby to the breast (Evelyn, O 8/03).

In general, osteopaths can be quite strategic in setting up an opportunity to seek data from observation of specific but informal mother-baby activities. For example, they might deliberately ask mothers to undress their babies as a means of involving them, observing the nature of their interaction, and being perceptive to opportunities for asking more questions along the way. These informal mother-baby activities are merged into the flow of the treatment session as appropriate. Evelyn (osteopath) describes this process as “a constant continuum of case history taking that happens over time (O 08/06)”.

Examination can, similarly, follow a structured or more flexible format. At a first visit, osteopaths claim that they are more likely to follow a standardised examination protocol that includes a general medical screen. At subsequent visits, examination tends to merge into the flow of the treatment session. Sometimes, at follow-up visits, after a few preliminary questions, osteopaths move quickly onto examination as a preferred means of seeking data through palpation of the baby's body. The osteopathic approach to examination and palpation was observed to move back and forth between a broad and sharpened perspective, according to the type of data of interest. However, both forms of data are valued.

Normally I'd do gross movement [testing] and check-up through his back, just getting a feel for how things are generally and then quite specifically go back and reassess things or just break things up depending on the baby really, not always the same things (Karla, O 5/07).

In general, osteopaths discuss their sensory experience in detailed ways that convey an appreciation of differences in motion and quality of the baby's physiological tissues, as a whole, and in different body regions or specific anatomical structures. They gather much complex information from physical touch and they use similar language to describe what they feel. The most common descriptors of the tactile experience relate to a sense of fluidity, compression, tension, and freedom of motion as illustrated in the following exemplars.

He [baby] does have a lot of compression through the base of his skull where it meets the neck ... The way that it feels to me is it's harder, so the actual joint is not gliding smoothly over its surfaces; 'it's stuck' would be, I guess, the way to describe it (Hannah, O 12/09).

She [baby] had that posterior drag through the head but she also was kind of compressed down through the middle face into her anterior neck and chest so that then held down the front, restricting her lifting her head up and getting the tongue on the roof of her mouth properly (Tom, O 3/03).

In the latter exemplar, Tom (osteopath) extrapolates his general palpatory findings concerning this baby's head and neck to infer how they might impede the baby's tongue function. He thus moves toward a narrower focus that has a specific clinical application to breastfeeding. A common way that osteopaths seek *data* more specific to breastfeeding relates to evaluation of the structure and function of the baby's jaw and mouth. For example, most paediatric osteopaths were observed to evaluate the baby's suck by placing a finger in the mouth. In doing so, they gather information that can be broken down into smaller and more specific components, such as “*feeling the movement and motion of the tongue and the way the tongue interacts with the finger, the shape of the roof of the mouth, the palate and the quality of the whole sucking motion* (Lauren, O 2/07)”. Obtaining such detailed data provides a diagnostic rationale to adopt particular treatment approaches and the osteopath is also able to use a structured examination procedure to monitor a baby's sucking capabilities as they change over the course of treatment. This means a purposeful gathering of particular information that is compared to previous findings and considered within the context of the whole treatment plan. A natural consequence of *seeking data*, therefore, is the mental processing or analysis of findings and how they fit within the emerging diagnostic picture.

9.4.1.2 Analysing

Analysing is a cognitive process whereby osteopaths attempt to understand and interpret information that has been systematically acquired. Typically, they view each piece of data, in detail, to ascertain its significance and consider how it links to other pieces of information and the core problem, *struggling to breastfeed satisfactorily*. New information can strengthen and support, or weaken and eliminate an emerging idea.

She [baby] didn't seem to have a lot of mouth issues with the jaw and tongue and suck reflexes, so I felt that it was more [a problem] through the body, but also ... as soon as the milk hit her stomach, there was a physical irritation. So I felt there

was an overlay between those physical structures [that were] causing some irritation within the stomach itself (Natasha, O 9/05).

In this exemplar, some likely causes of the baby's fussy feeding behaviour are, at first, considered and discarded. Further analysis, involves linking together other factors such as physical findings, knowledge of visceral physiology, and the timing of the baby's symptoms. In general, *Analysing* involves making comparisons between newly acquired and existing information, and in a broad sense, through osteopaths' professional knowledge and experience. *Analysing* thus involves deductive and inductive reasoning. Deductive thinking relates more to drawing upon established forms of knowledge such as biomedical sciences and principles that relate to the birthing process, lactation, and the biomechanics of breastfeeding. Inductive thinking represents a more abstract way of thinking about and linking together particular findings or facts into an explanatory schema or proposition.

In this study, three sources of information that feature most prominently in the analytic process are the birth history, physical examination findings, and the nature of the breastfeeding difficulties. Osteopaths explore the possible relationships between these three different and complex events or elements and combine deductive and inductive reasoning according to how clearly and logically the links between the three sources of information fit together. At times, a straightforward link can be made. One case, for example involves evidence of bruising near the baby's jaw from a forceps delivery and subsequent inability to open the mouth wide, which has direct breastfeeding implications. In this situation, Evelyn (osteopath) states, "*My diagnosis was very much by deduction; it's like, that's what I found, that's what I treated, and he [baby] seemed to improve there and then with the latching* (O8/05).

In most cases, the association between birth history, examination findings, and breastfeeding difficulties are apparent, but less obvious, and osteopaths' analysis is based upon a combination of deductive and inductive reasoning. A consistent finding in the data relates to the association made between a baby's physical dysfunction, such as restricted neck mobility, that is assumed to be a consequence of birth-related events, and subsequent breastfeeding difficulties that are expressed in individual ways. For example, in another case, baby Charlie, who clearly was unable to turn his neck to one side, consistently refused to feed from one breast. Here, the osteopath reasons that Charlie's breast refusal is related to discomfort due to the neck dysfunction, which is exaggerated by particular breastfeeding positions or which impedes his sucking capabilities. In other cases, such links are less biomechanical and more difficult to define. Here, babies are

typically described as fussy and unsettled when breastfeeding and osteopaths must try to understand why. Their analyses rely more on inductive thinking, what they feel and interpret is happening within the baby's body, and reflection on past clinical experiences. For example, Hannah (osteopath) describes what she feels in one unsettled baby's body as *"a very generalised irritability through his system, through his body ... and I just think his body was in shock"* (O 12/06). This conclusion was linked also to a history of a very fast labour¹¹⁶. When asked to explain what she feels, and is meant by the term 'irritability', exactly, she cannot. She is, however, confident that she recognises a familiar sensory phenomenon that aligns with a particular clinical pattern.

Analysing is a dynamic sub-strategy of *Focusing* because osteopaths' analyses are continually being updated. Findings and experiences from previous treatment sessions provide a basis for comparison with the current situation. Making comparisons leads to further interpretation of how changes fit with the original diagnosis, which may need to be modified or updated. Hence, there is a layering effect of analysing material at one level and updating or building upon this analysis as circumstances dictate. This idea has been alluded to previously, in the situation of osteopaths tracking and interpreting changes in the baby's sucking action by placing a finger in her mouth¹¹⁷. It is further illustrated by the following exemplar.

The first treatment was basically trying to get that ignition or vitality in the baby's whole system; the second treatment, his system has a lot more of this vitality in it and what we're doing is we're looking for how the motion is going on through the tissues ... and there were a number of areas that were quite restricted to movement, motion, which were in his right thorax, left occiput (Edward, O 6/06).

In this example, Edward's analysis of the baby's body becomes progressively more focused such that particular body regions are identified as not functioning as well as others. This finding only became apparent, however, as other more global issues concerning the baby's physiological mechanisms, were addressed. Like Edward, each time the osteopath gathers new data, it is mentally processed and put into context. As the strategy of *Focusing* proceeds, osteopaths need to confirm that their analyses are based on reliable information sources and accurate or plausible reasoning.

¹¹⁶ See Chapter 5.1, Table 4: Mother-baby dyads' obstetric and postpartum histories.

¹¹⁷ See section 9.4.1.1.

9.4.1.3 Validating

Validating is a process of checking that conclusions made are well-founded and osteopathic treatment is heading in the right direction. It also has an evaluative quality in terms of ascertaining the strength and detail of emerging ideas. *Validating* occurs whenever each piece of information fits or doesn't fit into the diagnostic picture. It reinforces the analytic process of building a logical explanation that accounts for different elements of *struggling to breastfeed satisfactorily*. However, *Validating* involves particular actions and thoughts for the purpose of substantiating and confirming emerging ideas. In the first instance, osteopaths need to know that they have an accurate account of the dyad's clinical history. They are interested in the mother's account of such events, but also routinely study the contents of the baby's health record book, which parents are asked to bring with them. This action provides a means for checking the reliability of medically based information provided by parents. This is important because osteopaths recognise that mothers are likely to be limited in their abilities to provide an accurate and objective or more clinical account of the birth.

Validating relates to strengthening paediatric osteopaths' understandings of a central diagnostic idea. Typically, this idea has many layers that become progressively more evident as more information is gathered to support it (or not), and more detail is added. Osteopaths refer to previous findings that are connected to current findings, a process described as '*mentally checking*' in the following exemplar.

Because it was the third time [treatment] and I had a fair idea from the other two times what I was looking for. I guess I was, in my mind, mentally checking to see how things were feeling from the last time (Karla, O5/07).

The reliability of each piece of data is influenced also by how clearly it is expressed or how confidently it is perceived and interpreted. Ultimately, one of the strongest forms of validation is improvement following treatment. Improvement is expressed in terms of the osteopath's evaluation of the physical dysfunctions, the baby's behaviour, and evidence of more effective breastfeeding. Improvement can be subtle and incremental or dramatic. Immediate improvement that is closely timed or associated with osteopathic treatment is a strong form of validation. Sometimes, however, even a small change can have significant therapeutic consequences.

M: We've had three sessions so far and at the first session Donna [baby] had a gag reflex so basically when Lauren (osteopath) put her gloved finger into Donna's mouth, she couldn't get past the first part of the hard palate. By the next session

she could get to the next part of the hard palate, and at the session yesterday, she was able to reach the soft palate. Although occasionally Donna was gagging, she was actually getting there.

I: So you can see results? Is that what you are saying?

M: I tried breastfeeding her in the last week and I have found over the weekend that she took the breast for half an hour; seemed quite happy.

I: How do you feel about that?

M: Oh thrilled! (Catherine, M 2/06)

In this exemplar, Lauren (osteopath) was able to use examination of the baby's suck to demonstrate changes to Catherine (mother), which, when reinforced by a small but positive change from no breastfeeding to some breastfeeding, became a form of validation. In this case, due consideration was given to the nature and rate of predicted change. If positive changes following treatment are less clearly evident, paediatric osteopaths typically re-evaluate their clinical reasoning.

Validating can mean *refocusing* on a problem and considering the degree to which the breastfeeding difficulties are deemed to be related to physical elements that are amenable to osteopathic manual therapy. This idea is illustrated by the next exemplar, where Megan (osteopath) proposes a time frame by which she would expect to see treatment results, and after which, she is prepared to consider other elements that might be contributing to a dyad's *breastfeeding struggle*.

I do look at the diet with everybody but there was so much going on with this baby 'osteopathically' that I thought that we wouldn't go there yet ... unless the baby kept coming back, sort of, after the third treatment, if the baby wasn't showing any improvement, then I would probably look more at the diet (Megan, O4/11).

In summary, through the strategy of *Focusing*, paediatric osteopaths *gather data* that is *analysed* and *validated* and transformed into knowledge that can be used in meaningful ways to inform paediatric osteopaths' diagnostic decisions and therapeutic approaches.

9.4.2 Drawing conclusions

Osteopaths *draw conclusions* as a logical consequence of *Focusing*. They seek and analyse information, explore and check possibilities in order to arrive at a diagnosis that informs treatment decisions. *Drawing Conclusions* is, however, a cognitive process that

involves more than articulating a clinical diagnosis. It means arriving at an end-point of understanding, within which the diagnosis is embedded. *Drawing Conclusions* incorporates high level abstract thinking that reflects a deep understanding of a dyad's breastfeeding situation; one that facilitates osteopaths' forward thinking and ability to make appropriate and predictive treatment plans. The diagnosis is frequently referred to as a working diagnosis as it is a work in progress. It is continually being re-evaluated over time; within a single or over a series of treatment sessions, and in response to changing circumstances. *Assimilating* thus involves interplay between the two strategies that follow a cycle of *Focusing*, *Drawing Conclusions*, and *Re-focusing*.

Drawing conclusions concerns a mix of physical and psychosocial influences and issues that are viewed through a narrow and broad lens. Osteopaths move back and forth between these various perspectives and bring them together in ways that makes sense. This idea is illustrated by the following exemplar where Karla (osteopath) *draws conclusions* about the various elements that contribute to a dyad's breastfeeding difficulties. In the first instance, when examining baby Keith, Karla makes a definitive decision about the primary source of the clinical problem, which thus needs to be addressed.

I had a feel through his ribcage and just tried to get a good sense of whether there was any tension or rotational tightness that he did have the first two times. So that seemed OK today, and then we moved up to his head where I thought, 'That's the focal point of the problem' (O 5/07).

In contrast to this tightly drawn conclusion, Karla then adopts a broader perspective by considering Dianne's (mother) needs and situating the dyad's breastfeeding circumstances within their particular psychosocial background. Karla has got to know Dianne over an extended time period by treating her throughout the pregnancy and predicts that *"if there was even the slightest thing wrong with Keith (baby) not wanting to breastfeed, that could deter her from continuing and thinking 'Oh, I need to start using a bottle (O 5/9).* *Drawing Conclusions* based on a full understanding of the interaction between various components of *struggling to breastfeed satisfactorily* gives osteopaths, like Karla, the opportunity to adjust their treatment approaches accordingly. For Karla, this might mean offering more emotional support or seeing the baby at more regular intervals. Overall, this approach enhances osteopaths' clinical practice because it is more likely to result in positive therapeutic outcomes, now and into the future. The two sub-strategies of *Drawing conclusions*; *Creating new meanings* and *Planning* are now presented.

9.4.2.1 Creating new meanings

Osteopaths' findings, perceptions and ideas, past and present, are merged together and re-constructed to *create new meanings*. A *new meaning* can be well-defined and related to a particular context or more substantive in that it can be applied across a wider range of situations. This characteristic occurs according to the degree to which the central idea of the *new meaning* accounts for and explains groups or patterns of breastfeeding related findings and behaviours. The *new meaning* that has a sharper focus tends to relate to individual circumstances or understandings of a clinical case. It represents a form of *new meaning* that occurs as part of the diagnostic process associated with routine osteopathic practice. At times, however, paediatric osteopaths discuss more abstract diagnostic ideas that are derived from reflection and experience, but are not necessarily widely accepted by other osteopaths or medical models. Such ideas are hypotheses that require further testing but this is the way in which *new meanings* are *created*. In the following exemplar, Megan (osteopath) proposes such an individual hypothesis.

In about the last year or two, just through my own knowledge, I've started to think that a lot of babies have digestive problems when the mother has been quite sick during pregnancy. It's just something that seems to go together quite a lot. So the mums who've been nauseous and had a lot of morning sickness, you know, longer than the first three months; often the babies' gut will feel sluggish and not work properly (O 4/09).

It is not evident from the data whether other osteopaths have similar thoughts and experiences as Megan, above. Osteopaths in this study, however, do express and share some common theoretical ideas that are supported or unsupported to varying degrees by the broader literature. These *new meanings* are called themes because, as a group, the osteopaths share a central theoretical idea, but individuals will describe it in different ways with emphasis on different dimensions. Such themes, in this study, relate frequently to the physical and psychological impact of a difficult birth on subsequent parenting and breastfeeding difficulties. The association between complicated births and operative deliveries and early parenting and breastfeeding outcomes has been a subject of interest within the broader medical and research literature, which draws mixed conclusions (Patel, Liebling, & Murphy, 2003; L. Smith, 2007). Osteopaths present, however, their unique perspective on the potential implications of these events. Their understanding, for example, involves a merging of osteopathic principles with the biomechanics and physiology of the birthing process. This concept is well summarised by Lauren (osteopath) as follows.

Part of our philosophy is that the body has the capacity to care for itself and to be presented with problems and resolve them, a self-maintaining system ... When we're treating babies, usually their biggest event in life before we've met them, is birth, and as dramatic as it is, if it goes smoothly, the normal mechanism of self-repair and self-correction occurs. Some babies, that doesn't seem to occur; they retain the compressive forces of birth, which may be visible or it may be more a subtle sense of compression from within the structures of the head (Lauren, O 2/09).

The theme, expressed by Lauren, above, provides a broad platform or rationale for osteopathic assessment and treatment of babies, who have had a complicated birth, regardless of their symptoms and mothers' concerns. It is supported by most osteopaths in this study, who believe that their work with babies with breastfeeding difficulties extends to a longer-term preventative health role. This idea has been discussed previously as the contextual determinant; *Osteopaths' professional identity*¹¹⁸, and is summed up succinctly by Janet (osteopath) as follows.

That memory [of trauma] is held in the [body] tissues and it will come out later in the development of that child; whether it be in an asymmetrical crawl, an asymmetrical walk, or an ear infection (O 10/02).

Building upon the concept of the potential implications of a difficult birth, another common theme that emerges in this study, concerns osteopaths' thoughts about caesarean deliveries. With increasing rates of babies being born by caesarean section, there has been much interest in studying associated health consequences, including breastfeeding, for mothers and babies (Baxter, 2006; Chalmers et al., 2010). Paediatric osteopaths discuss a trend whereby these babies get off to a more difficult start for particular physically-based reasons, which are attributable to the circumstances of their birth. In the data, they describe familiar physiological expressions and patterns of motion that they palpate in the body of a baby who has had a caesarean birth. In the following exemplars, two osteopaths propose similar theories about the different physiological mechanisms of a normal birth compared to a caesarean birth, and how this can influence the baby's early development.

The problem with the 'caesar babies', they're cranial function is low; the amplitude isn't as big as it possibly could be so it's almost like they haven't had that big deep breath when they've come out and got everything cranked up ... yes, they need a

¹¹⁸ See Chapter 6.2.2.1.

bit of encouragement to get that full expansion and contraction going (Megan, O 4/13).

He [baby] attached well after the birth and fed well but was getting irritated and upset the second half of the feed. That's the history there and I put my hands on him I found that his whole system didn't have much of what we would call 'ignition' ... because of the emergency 'caesar' and the fact that he didn't go through the [normal] birth [where] they take a big breath and respiration kicks in. So if they don't go through that whole process, then there can be problems afterwards (Edward, O 6/07).

Similar to Megan and Edward, paediatric osteopaths routinely discuss and take into account the baby's feeding difficulties and their understanding of different birth processes. They correlate the detail of an individual birth experience with what they feel in the baby's body and *assimilate* this knowledge with past experiences to *create a new meaning*. A broad *new meaning*, such as the potential effects of a caesarean delivery, represents a clinical pattern, which is useful for practice because it offers a plausible explanation, which can potentially be applied to other babies in similar circumstances. Clinical experience over time gives paediatric osteopaths the opportunity to reflect on the strength of patterns or trends that they observe and interact with. Their understandings thus provide the basis for *planning* the best treatment approach.

9.4.2.2 Planning

Planning is a sub-strategy of *Drawing Conclusions* that involves osteopaths making decisions about what needs to be addressed or changed, and the most effective time and way to achieve this. It provides the impetus for active intervention; the detail of which is presented by the categories, *Rebalancing* and *Empowering* in the following chapters. The core problem, *struggling to breastfeed satisfactorily*, is broken down, where possible, into manageable components and osteopaths decide how to deal most effectively with them. It relates to choosing the best treatment techniques and ordering the flow of events throughout the treatment session. As changes are made, they are then integrated into the whole, which might result in supporting or revising the original plan. *Planning* is thus a complex cognitive process that requires osteopaths to simultaneously have a present focus and a broader long-term outlook. In a way, similar to the sub-strategy *Analysing*, discussed previously, *Planning* involves a combination of deductive and inductive thinking processes. It starts with defining treatment goals. In some cases, a clear and logical link is made between diagnosis and treatment aims and choices, as follows.

They've [babies] got a tight muscle; it's there all the time, it's not going to make them happy and they express it with crying. So by reducing that, simply just with pressing on the muscle and softening up that tight muscle, you're removing the trigger ... it's a pretty straightforward equation (Daniel, O 11/05).

At other times, treatment goals are not so readily identified or easily and methodically defined and dealt with. In some cases, osteopaths' clinical decision-making has more emphasis on weighing up dyads' on-going treatment and broader health needs, which represents a form of greater forward *planning*. This concept is expressed frequently in terms of the rationale for osteopathic treatment as a prophylactic health-care measure; an idea that has been discussed already within the context of the potential consequences of unresolved birth trauma. In general, paediatric osteopaths advocate that perceiving and improving the breastfeeding problem is only part of the treatment plan. For example, while Daniel, above, discusses the immediate aim of relaxing a tight muscle to make a baby more comfortable for breastfeeding, he continues to discuss the breastfeeding problem as, *"I think that it's a multi-factorial thing which they probably mostly are anyway ... and it's about confidence-building in the parent (O11/07)*. Each facet of *struggling to breastfeed satisfactorily* influences the whole and paediatric osteopaths use a combination of deductive and inductive thinking to *plan* a course of action and make adjustments according to immediate and future considerations. *Planning* effectively involves timing, prioritising, predicting, and judgement. Elements of this idea are illustrated by comparing two osteopaths' *planning* approach to a similar breastfeeding problem that concerns the baby's dysfunctional suck.

In terms of breastfeeding, I feel with osteopathy it can work straight away with one treatment but this particular case, well the first treatment I felt that he 'woke up'; he was more alert. It took the shock out of his system but the 'chomping' [on the breast] was still there ... it shifted after the second treatment (O 10/09).

I think that we will get a good resolution of the baby's physical [sucking] problem ... So I feel the anatomical component of what's stopping the breastfeeding will resolve within the next week or two ... The challenge will be the mother learning how to work with moving back to the breast and the challenge of a baby fussing until it gets used to idea it has to work for the food (O 2/13).

Janet and Lauren demonstrate clear and logical reasoning when prioritising elements of their treatment approach and predictive conclusions are integrated into their treatment plans. In general, predicting outcomes, or making a prognosis, is an important part of

planning. Forecasting particular treatment responses and a broader summation of expected outcomes or events guides treatment decisions and provides a means of checking on plans if they do not follow expected pathways. More generalised predictive views tend to develop over time and the osteopath's ability to formulate an accurate prognosis rests upon a deep level of understanding of the problem, background knowledge, and prior experience; all elements of *Assimilating*.

9.5 CONCLUSION

Assimilating is essentially a mental process in terms of paediatric osteopaths thinking about, absorbing, and integrating information and experience in ways that deepen their understanding of the study's core problem, *struggling to breastfeed satisfactorily*. One of the osteopath's initial tasks is to articulate a clinical diagnosis, which provides the rationale for treatment. Paediatric osteopaths articulate a diagnostic framework that focuses on the baby's body and the biomechanics of breastfeeding and thus fits within a biomedical perspective. This diagnosis is, however, always put into a psychosocial context; an approach that is particularly relevant to the current study because dyads with breastfeeding difficulties are influenced by many and varied individual and broad factors. Paediatric osteopaths use the strategy of *Focusing* and its sub-strategies; *Seeking data*, *Analysing*, and *Validating* to acquire and blend various types of knowledge in order to *Draw Conclusions* or make diagnostic (*Creating new meanings*) and treatment decisions (*Planning*). Common examples of different forms of knowledge include taking into account the impact of obstetric histories, babies' growth and development patterns, and women's personal breastfeeding needs and goals.

CHAPTER TEN

REBALANCING

I had a feel around his [baby's] jaw; just a little bit of myofascial work around his jaw muscles and balanced around his Temporomandibular Joint (jaw) and then to finish off, just tried to get a nice balance through his whole spine; just to make sure everything's 'in sync' and that he was nice and balanced and calm (Karla, O 5/07).

10.1 INTRODUCTION

Rebalancing represents paediatric osteopaths' therapeutic approach when treating babies with breastfeeding difficulties. Essentially, it involves the application of manual techniques, to the baby, in sensitive, measured, and skilful ways to redress any physical dysfunctions or *imbalances*, which might interfere with a baby's breastfeeding capabilities. A typical *Rebalancing* scenario is presented in the exemplar above. Here, Karla (osteopath) treats the baby by successively *balancing* specific body tissues (muscles), a localised anatomical structure (the jaw), followed by a series of joints and their interrelated tissues (the spine). Finally, she seeks a sense of 'balance' or 'calm' through the body as a whole; an indicator of a successful treatment outcome. Each *balance* is a *rebalance* of the baby's current state, toward an overall and improved state of physiological *balance*.

In this chapter, the conceptual meaning of *Rebalancing* as a manual therapy process is defined. The category is then situated within the theoretical context of osteopathic manual therapy in general, and more specifically, in the field of paediatrics. The three key underlying strategies of *Rebalancing* are then explicated before final conclusions are presented.

10.2 DEFINITION OF REBALANCING

In broad terms, *Rebalancing* means seeking an end-point of equilibrium, which, in this study, is synonymous with health. It is situated within a physiological domain, and can be defined further by considering the meaning of its two components; the 'seeking' and the 'end-point of equilibrium'. In other words, *how* osteopaths achieve *balance* by applying manual therapy, *what* constitutes physiological *balance*, and how they *know* they have reached it. The *how* relates to the application of manual therapy, which essentially involves the osteopath touching, feeling, moving and manipulating the baby's body structures in subtle and specific ways to remove restrictions and promote normal healthy function. The interrelated steps by which osteopaths perform manual techniques to effectively treat the baby are organised into three strategies, *Tuning-in, Releasing and*

Activating, and *Finishing Well*, which are explicated later in the chapter. The 'end-point of equilibrium' relates to the concept of *balance* versus *imbalance* as a way of defining a person's relative state of health; mental and physical. This idea is based on an appreciation of the complexity and interconnectedness of body structures, psychological processes, and homeostatic feedback mechanisms. *Balance* means that these systems, and their individual components, are well-integrated and working together harmoniously. *Rebalancing* involves corrective action to redress a state of *imbalance*. In the data, osteopaths frequently draw upon this theoretical model to explain how their manual therapy intervention works¹¹⁹.

Seeking and maintaining a state of physiological *balance* is not a static concept and there are varying degrees of *balance* or *imbalance*. Paediatric osteopaths readily talk about *balancing*, *rebalancing*, or finding a *point* or *state of balance* when discussing their manual therapy goals and activities. These terms tend to be used loosely and interchangeably but *Rebalancing*, as an in vivo code, best accounts for how they think and act when treating a baby with breastfeeding difficulties. It represents a recurring pattern of osteopath-patient interaction, better known as osteopathic manual therapy. It concerns a dynamic physiological change process, which is brought about by applying manual techniques in purposeful and progressive ways.

Rebalancing is also a cyclic process whereby osteopaths' manual techniques or series of techniques induce physiological changes that feedback into the baby's body as a whole. Changes are commonly described as 'releases' that generally enhance mobility and normalise relationships between body structures and systems; conceptualised as renewed and improved states of *balance*. The cyclic process can continue until the osteopath determines that an appropriate end-point of *balance* has been achieved. An improved state of *balance* can mean different things according to treatment goals but fundamentally, good *balance* equates with good function or performance. For a baby with breastfeeding difficulties this might, for example, translate into improved coordination of latch, suck, swallow, and breathe; actions necessary for effective breastfeeding.

Osteopaths overall approach to *Rebalancing* is influenced by their understanding of the breastfeeding problem and what they believe manual therapy intervention can achieve. In general, paediatric osteopaths think of *Rebalancing* from a holistic stance that is expressed in different ways. Typically, they adopt or move between a biomechanical or psychosomatic perspective in which to frame their treatment approach. It can be

¹¹⁹ The theoretical basis of osteopathic manual techniques is discussed in Section 10.3.

somewhat artificial to separate mind-body elements because their physiological processes are so closely intertwined but there tends to be an emphasis on one over the other. A breastfeeding problem that is thought to be based on a local anatomical dysfunction, for example, is dealt with differently than a problem attributed to a baby's poor adaption to life stressors. The most common source of stress for dyads in this study is thought to be related to the consequences of a complicated birth with resultant trauma to the baby's body and in association with maternal distress, which feeds back into the baby. Individual approaches were thus observed to vary according to whether osteopaths placed more emphasis on generally calming or stimulating the baby or whether they wanted to address a specific local physical dysfunction. Stephen, for example, adopts a holistic but essentially biomechanical interpretation of this dyad's breastfeeding difficulties, which, in turn, influences how he applies manual techniques.

Osteopathy is primarily to me, all about treating the body as one whole unit rather than a region of the body. Through birth posture or trauma, a lot of babies present with changes in their whole body mechanics so there'll be a tendency to compensate with a pelvic imbalance; with a preference to rotate one side more than the other, and then that will often show up in the shoulders as well, and also in the skull; so there's almost like a spiral (Stephen O 13/05).

Stephen was observed to address the 'spiral' or overarching *imbalance* by applying a number of manual techniques; each one was applied to redress a specific *imbalance* by restoring free range of motion in all directions and at key sites. Releasing restrictions and adjusting components of the body, such as the pelvis and shoulders ultimately *rebalances* the whole. Hannah (osteopath), on the other hand, who describes the baby's body as being '*in shock*' (O12/06), views the problem from a psychosomatic perspective. She applies cranial techniques to induce relaxation because, "*they're very effective in reducing that irritability and I guess easing that person's body into feeling more normal (O 12/07)*". Babies' physiological responses to manual therapy tend also to be viewed in physical or psychosomatic terms. Physical outcomes of *Rebalancing* tend to be viewed as biomechanical changes in joints and body tissues, such as the baby's ability to open the mouth wide enough to effectively latch onto the breast. Psychosomatic outcomes are expressed by more generic behavioural responses that reflect a baby's overall wellbeing, such as improved sleep patterns, and calm or socially interactive behaviours.

As a treatment process, *Rebalancing* was observed to have a procedural element to it, in terms of how osteopaths used their bodies and hands; how they changed the shape of their contact with the baby and applied subtle leverages, with controlled forces, and in

specific directions. Thought, touch, and action cannot be separated and during the performance of a technique; thinking, feeling, and doing tends to merge at an intuitive level; ideas that are explored later in the chapter. The aim of manual therapy is to restore normal physiological *balance*, regardless of how it is achieved or expressed, on the premise that this will, ultimately, assist the baby to breastfeed satisfactorily. Osteopaths make individual treatment choices by matching the baby's perceived needs with the most appropriate manual techniques. These techniques are then finely tuned according to physiological responses. Some relevant aspects of manual techniques used by osteopaths in the study are now presented.

10.3 CONTEXT OF REBALANCING

Applying manual therapy is a standard treatment procedure of osteopathic professional practice. However, paediatric osteopaths in this study tend to use particular techniques; a characteristic which helps define their treatment approach, compared to other manual therapists, and some other osteopaths. Understanding these particular techniques sheds light on the way paediatric osteopaths go about treating babies with breastfeeding difficulties. For this reason, some aspects concerning the underlying theoretical basis of osteopathic manual therapy, follows.

Osteopaths in general practice can draw on a large repertoire of different treatment approaches and techniques, collectively known as osteopathic manipulative treatment (OMT). OMT is defined as,

The therapeutic application of manually guided forces by an osteopath to improve physiologic function and/or support homeostasis that has been altered by somatic dysfunction. OMT employs a variety of techniques... (Educational Council on Osteopathic Principles, 2009, p.28).

There are several types of OMT; each has its own distinct theoretical model but all share common principles that acknowledge the importance of the body's inherent free motion and self-healing, self-regulating mechanisms. A key aim of OMT is to restore free physiologic motion; hence, techniques involve evaluating and changing restrictive barriers to this motion. Some of the commonly used and better known techniques are joint articulation and manipulation¹²⁰, soft tissue massage, and muscle energy technique¹²¹. Collectively, they are called *direct* techniques because a corrective force, exerted by the

¹²⁰ The osteopath passively moves the patient's joints in a controlled way, applying repetitive movements or a precise activating force.

¹²¹ The patient's muscles are actively used on request, from a precisely controlled position, in a specific direction, and against a distinct counterforce (Educational Council on Osteopathic Principles, 2009, p.31).

osteopath or patient, is used to overcome the restrictive barrier. A simple example is applying a controlled force to stretch a shortened muscle and using the patient's breathing to assist with the process. In contrast to *direct* techniques, osteopaths also employ *indirect* techniques, defined as follows.

A manipulative technique where the restrictive barrier is disengaged and the dysfunctional body part is moved away from the restrictive barrier until tissue tension is equal in one or all planes and directions (Educational Council on Osteopathic Principles, 2009, p.30).

Indirect techniques share a common principle, whereby the activating force for therapeutic change comes from within the patient's body. The osteopath plays a key but less physically overt role in this process. She places her hands on and moves the various body tissues, in a finely tuned way to find a feeling of ease known as a dynamic *balance point*. She then holds the position or applies a further subtle guiding or compressive force to facilitate spontaneous readjustment. By taking the relevant part of the body structure toward a position of *balance*, the patient's body is able to normalise through its own self-correcting mechanisms and the restrictive barrier is reduced or gone (Wales, 1990). Osteopaths in this study articulate a preference for using *indirect* techniques when treating the baby.

The theory that underpins the therapeutic process of *indirect* techniques is further illuminated by Lauren (osteopath), who explains how she uses them in paediatric practice.

So using an indirect technique to release joint and body restrictions; as opposed to the other direct techniques where you go towards the area of restriction and use some sort of a more forceful process to release the tension ... When I was introduced to indirect techniques, I suddenly was very enamoured by them and decided that that's what I wanted to use and as that rolls on, you learn about using indirect technique on children because they're very gentle; you're not pushing and shoving or doing anything considered more invasive (O 2/02).

Like Lauren, osteopath participants view *indirect* treatment techniques as most appropriate for paediatric practice. As they do not directly engage a physical barrier, they are considered gentle and more comfortable for the baby and also, in Lauren's case, the osteopath. Others, similarly, express personal preferences for working with particular *indirect* techniques. For example, when asked about her choice of techniques for treating a baby, Julie states, "*Indirect cranial techniques. They're the ones that work; they're the*

ones that work for me (Julie, O 1/09). In the osteopathic literature, paediatric practice has a long history of being closely aligned with *indirect* and '*cranial*' or more accurately named, 'osteopathy in the cranial field' (OCF) techniques (Carreiro, 2003; Magoun, 1976; Moeckel & Mitha, 2008; Wales, 1990). OCF applies osteopathic principles in a detailed way to the head as a part of the whole body. Its interest in the anatomy and physiology of the head has particular relevance when considering a baby's development and the potential deleterious effects of birth-related events on the immature cranium, spine, nervous, and musculoskeletal systems.

OCF has also a special interest in the biodynamic forces of embryological development¹²². It postulates that the primary forces of human development persist throughout life and continue to be expressed, throughout the body, in a pattern of normal physiological motion, which is palpable to the trained osteopath. This motion pattern is called the Primary Respiratory Mechanism because it involves internal tissue respiration and interchange of fluids, essential for normal metabolism and health. OCF techniques involve osteopaths feeling and influencing the baby's Primary Respiratory Mechanism to enhance free physiological motion. As this mechanism is essentially a theoretical phenomenon based on the osteopath's palpatory experience, it is also known by other names. Janet, for example, uses the terms 'inherent health' or 'life force' to describe it and the role it plays during the application of a particular OCF technique that she uses to treat a baby with breastfeeding difficulties.

You take it [the baby's body tissues] to a point of balance and being aware of those [cranial] membranes and the osseous [bone] compression through the occiput [base of skull] that was there as well and trying to get it to a balanced point, and then the [baby's] body goes into its own treatment mode. So I'm creating a balance point for the inherent health, life force, whatever you want to call it, to come in and work for that area (Janet O 10/07).

Rebalancing, by setting up a '*balanced point*', is a particular feature of *indirect* techniques that are used by osteopaths in this study. They describe how they must focus their actions and intention to achieve this state, which, in turn, activates an innate therapeutic response. The idea that the baby's body then takes over the treatment process does not readily fit into traditional biomedical models of practice but is grounded firmly in osteopathic principles. This idea emerges frequently in the data and can be problematic for osteopaths, who try to provide a credible explanation to those outside the profession.

¹²² Biodynamics is the study of embryology with an emphasis on the forces of growth that are expressed by living cells, from conception to birth, in the science of human ontogenetic development (Freeman, 2004).

It's quite a subtle way to treat and can often be a hard one to explain because it's not a concept in our current medical science model; that there's this capacity for [physiological] change [within] and there's a capacity to interact with that process of change (Lauren O 2/10).

The aims, methods, and mechanisms that underpin some manual techniques, relevant to this study, have been outlined. Osteopaths use manual techniques as their primary treatment tools to achieve physiological *balance*, but like all tools, they must be applied with skill, sensitivity, and professional judgment to have a therapeutic effect. With this in mind, the strategies of *Rebalancing* are now explored in detail.

10.4 STRATEGIES FOR REBALANCING

The strategies of *Rebalancing*; *Tuning-in*, *Releasing and Activating*, and *Finishing Well* represent three different stages of the osteopath's performance of manual therapy and are set out in Figure 6, below.

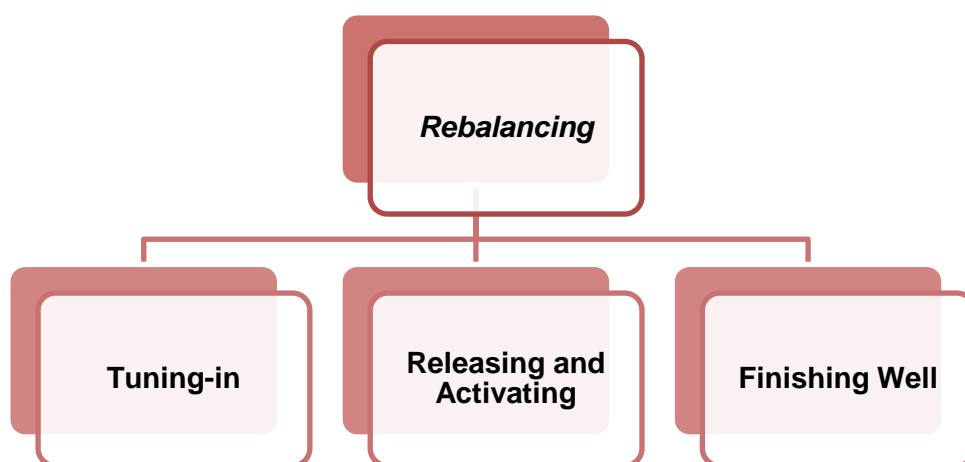


Figure 6: Strategies of *Rebalancing*

Although each strategy is underpinned by specific thoughts and actions; all rely upon a special form of physiological interaction between osteopath and baby; two bodies or biological systems. The mother's presence undoubtedly influences the treatment at a physiological level, to varying degrees and according to her involvement, but she does not assume a key role in the therapeutic change processes. The three strategies of *Rebalancing* are interdependent in terms of enabling osteopaths to apply manual techniques successfully, in ways that achieve their therapeutic goals. In addition, each treatment situation is unique and a degree of flexibility and creativity is embedded within individual strategies and how they link together.

In a spatial sense and as the prime therapeutic event, manual therapy is prescribed by participants' actions as they were observed to gather together, with the baby as the central figure, interact, and then disperse. Janet (osteopath) explains how she begins treating the baby according to "*a fine line, I suppose a continual line of having a sense of what's going on and then you go into treatment mode* (Janet, O 10/07)". 'Treatment mode' is an expression that simplifies many complex processes. It is a state of action that has special meaning for osteopaths, like Janet. It represents a familiar, almost automatic, pattern of response to treating a baby with breastfeeding difficulties. The idea of *Rebalancing* by applying manual therapy as a recurring pattern of behaviour has been presented previously¹²³ and is further supported by observations of individual treatment sessions, which tend to follow a similar course of action.

Rebalancing starts with osteopaths taking time to position everyone, including themselves, before placing their hands carefully on the baby to apply a manual technique. They appear to concentrate and adopt relatively still postures, while simultaneously making fine, almost undetectable, movements or adjustments with their hands or bodies. This activity is interrupted at various intervals by a pause, followed by a change of tempo. At this stage, visible signs of relaxation or release by the baby such as a sigh, deep breath or stretch are frequently evident before the cycle is repeated with another technique, in a new position or with a new hand contact. The overall interaction tends to flow in a symbiotic manner and, at most times, with the baby's cooperation and the mother's approval and assistance. Daniel (osteopath) describes this treatment situation as, "*both [mother and baby] have to be along for the ride* (O 6/14). The idea of a 'ride' aptly describes the continuity, momentum, and changes of pace and direction that can occur during manual therapy, although the nature of the 'ride' varies on an individual basis.

10.4.1 Tuning-in

Tuning-in involves paediatric osteopaths adopting a particular physical and mental state in order to make physiological contact with babies for the purpose of applying manual techniques. It accounts for the processes involved in preparing for; beginning and maintaining a form of therapeutic touch between osteopath and baby during manual therapy. *Tuning-in* occurs primarily at a physical level through osteopaths' hands and bodies. It differs from the physical processes of *Connecting* and *Assimilating* described previously, in its intention. *Tuning-in* requires a particular form of touch; one that is used for the purpose of feeling body tissues and internal physiological processes in order to influence them in a healing way.

¹²³ See section 10.2.

Paediatric osteopaths touch the baby with a specific intention and they purposely develop and hone their palpation, sensory, and manual skills through training and practice. Through touch, the osteopath's hands become the interface or common point at which one biological system meets that of another. A form of physiological communication channel or pathway is set up. Messages are sent and received in a bidirectional way between the two interacting bodies; in this case, between osteopath and baby. The application of manual techniques rests upon this physiological pathway. From an anatomical perspective, messages are conveyed at a local tissue level. They move from skin at the surface to deeper layers such that there is a sense of physical continuity. They also have the potential to modulate physiologic processes at a distance from the area of initial contact because they have the capacity to influence the body's normal regulatory pathways¹²⁴.

Like all complex and practised motor skills, paediatric osteopaths were observed to apply manual techniques in precise ways, which requires control over their minds and bodies. *Tuning-in* starts with osteopaths paying attention to their physical and mental states; a process commonly described as 'centring' or a form of *rebalancing* themselves. In general, when preparing to treat babies, osteopaths became visibly calm and focused. They took time to position everyone comfortably before touching the baby with specific and deliberate hand contacts. *Tuning-in* to babies is expressed by paediatric osteopaths as a form of intuitive recognition or heightened awareness of what they feel at a deep level in the baby's body tissues.

I guess just sitting back and 'listening' with your hands. You listen for exactly what's going on with that person ... on more of a deeper level and sometimes you can just sense it (Hannah O 12/08).

It is evident, from this exemplar, that *tuning-in* to the baby involves the acquisition of detailed tacit knowledge through a form of therapeutic touch that is difficult to make explicit. This notion is consistently evident in the data and observed as a form of expectant waiting; a situation where osteopaths adopt a composed attitude where their state of mind is open to, and focused on, the sensory experience under and through their hands.

I: So when you put your hands on the baby's head, what are you doing?

¹²⁴ Regulatory pathways include the endocrine, neurological, and circulatory systems.

O: 'Feel' is a good word, just feel for tension or patterns of strain. Babies are very much reliant on the connective tissues or the fascia, and the strains are very much in those tissues ... I wait for the tensions which I think are most significant and then I'll look at treating those (Daniel O 11/12).

Similar to Hannah and Daniel, osteopaths describe how they wait for the sensory information to make itself clear to them, which helps fine-tune and guide their technical approach. While they begin to analyse what they feel with their hands by drawing on background anatomical knowledge; in the first instance, it is not an intellectual or cognitive process. The first step is to *tune-in* and allow the messages, in their raw form, to be delivered and received. The receptive processes of *tuning-in* specific to paediatric practice are further illustrated by the following exemplar.

When we treat kids we try and go to what's called a 'meeting place' which is where you empty out all you preconceptions; sort of dumb your IQ down a little bit, and try and be really present, and wait for the sense that you're in the same perception space as the child (Tom O 3/06).

Here, Tom (osteopath) raises a number of abstract ideas concerning what happens when he touches the baby with a therapeutic intention. It is hard to know what a child's 'perception space' is like, or feels like, but basically, he clears his mind and *tunes-in* to the baby. In general, a similar approach is adopted by osteopath participants and it is enhanced by a quiet treatment space without undue distractions. Paediatric osteopaths place high importance of being able to *tune-in* to a baby's internal physiological rhythms and motions because they are the means by which the body expresses its capacity to function efficiently. They also provide a source of continuous feedback that enables osteopaths to map the changing physiology during the manual therapy process.

With cranial technique, it's very fluid technique so you can feel the ebbs and flows through that fluid dynamic in the person's body and that has its own rate and amplitude; so that will change according to how the person's body's changing. You just keep your hands on and sit with it; perceive the changes as they happen (Janet O 10/08).

Most osteopaths contend that *tuning-in* to babies involves somewhat different processes than those used for adults. Babies also bring their unique physiological and personal qualities to the communication transaction and osteopaths must *tune-in*, and adapt, to their cues accordingly. Physical contact is a particularly potent form of interaction because

a baby's first experiences of the world are mediated through touch. Overall, babies are perceived to be more open, responsive, and less psychologically complicated; attributes that can assist with the treatment.

Generally, they [babies] need fewer treatments; they take less time to respond, I think because the strain patterns are not so ingrained; they've got higher energy levels than a lot of adults; it's quicker to get the change and it just takes less of my energy to work on them (Megan O 4/02).

Philosophically, I think that maybe there's just no inhibitions in a baby. I just see them as a clean slate with no emotional baggage, physical baggage, all this stuff that we carry as adults; so they're just happy to let go and let you do what you need to (Karla, O 5/10).

Despite babies' special attributes described in the exemplars above; it is evident in the data, that *tuning-in* to babies is not always so straightforward. Challenges can arise when *tuning-in* to physical strains in sensitive body structures. To do this, and maintain a baby's cooperation, osteopaths must be receptive, at a fine level, to more subtle cues. This process is augmented by comparing how the baby's external cues correspond to what is felt within the body. They are external in the sense that information comes from outside the body. This element of *tuning-in* involves a heightened awareness of the baby's posture, movements, breathing, verbalisations, and expressions. The next two exemplars highlight this process of matching internal and external cues within different treatment scenarios.

I: And what about their [babies'] physical response to what you are feeling?

O: I think they correlate; when the tissues relax, the baby generally settles. I do think it's a different cry when there's something going on and you're tweaking it, to 'I'm hungry, I don't want to be here; I'm tired' (Julie, O 1/10).

She [baby] didn't mind me putting pressure on that [muscle]; she was just sensitive ... and she was certainly tuned [in]; as soon as you even thought about looking at her right temporal bone [ear region] she was squawking and unhappy (Daniel O11/16).

In these exemplars, sensitive communication is taking place within a physiological domain. Although a form of analysis is also taking place, thinking cannot be separated from the sensory and motor processes involved. *Rebalancing* the baby requires

osteopaths to work with dynamic change mechanisms, in the moment. *Tuning-in* is important for setting up a treatment technique and for taking it, effectively, through to completion.

10.4.2 Releasing and activating

This strategy focuses on what osteopaths do; how they use their hands and bodies to affect a change within the baby's body. *Releasing* and *Activating* account for two fundamental but slightly different approaches to how manual techniques are applied to bring about physiological change. They vary according to the way change is implemented and the osteopath's role in the process; as a *releaser* or *activator*. The differences between the two are, at first, clarified and then they are explored together, according to their shared characteristics.

Releasing represents a slightly more traditional approach of applying manual techniques to address a specific physical problem, technically known as 'somatic dysfunction'¹²⁵. The focus is on reducing or removing abnormal or restraining physical influences within the baby's body.

Yes I mean that's the whole point of osteopathy; to release tensions in the body to allow the normal human mechanisms to occur ... my whole aim is to pick up the tensions and reduce them (Daniel O11/06).

Through the strategy of *Tuning-in*, areas of abnormal tension are felt, identified and qualified. On this basis, osteopaths determine the best way to reverse or change the dysfunctional physiological state and to then recognise a desirable or appropriate *release* response. They use a variety of manual techniques¹²⁶ but their overall approach is one of taking a more directive role. For example, osteopaths frequently describe a physical dysfunction according to a particular quality of 'compression', which implies that a structure has been forced into an abnormal position or space. In this situation, *Releasing* occurs as a result of, "*depressurising... so if there has been a compression force, you might disengage it, which means that you want to open up that area* (Stephen O 13/05)".

In general terms, a *release* or re-expanding process is induced by the osteopath interacting with, and adjusting, body tissues in direct, specific, and intuitive ways. The manual technique involved can be applied briefly or gradually, over time, according to how the restraining influence is resolving. Paediatric osteopaths tend to discuss *releasing* in

¹²⁵ Somatic dysfunction is defined in Chapter 9.3.

¹²⁶ See section 10.3 for a definition of Direct and Indirect Techniques.

terms of *easing*, *guiding*, and *encouraging* the body tissues, although they can find it difficult to articulate exactly what they do throughout this interactive process. In the following exemplar, Daniel attempts to break down the steps that he uses to *release* abnormal tensions.

So that [technique] is kind of using the tension [present in the tissues], by using the pressure of my fingers or my hands on the particular structure in the head, [and] applying guidance to help use that tension or release the tightness in the particular structure you're working on, whether it's a muscle or a bone or fascial structures (Daniel O11/15).

Here, Daniel explains how he produces a guiding force by applying pressure with his fingers and introduces a new concept of using the existing tension that he feels in individual structures to help with the *releasing* process. He cannot, however, explain how this works; just that he does it and knows how to do it. When asked to explain, in a more systematic way, how they *release* abnormal tensions, paediatric osteopaths tend to answer by discussing general principles and treatment models to provide an explanatory framework.

The physiological *release* that takes place in the baby's tissues is the end-product or goal of the manual technique. It becomes tangible through the osteopaths' experiences of it; how it is expressed by the babies' tissues and how it corresponds with their responses and cues, discussed previously. The sensation of *releasing* is obvious to the osteopath, and positive, in that it feels like the 'right response'. It is brought to life, often by rich description.

Then you get that sense, I often describe it to patients as like butter melting on a stove, that sense of dropping away and then you feel it all open up (Janet O 10/07).

Yes you're doing the treatment; it's great; it's shifted and you feel, yes you can feel all the things changing with the fluids and it's kind of interesting and it feels really good (Tom O3/06).

In these exemplars, Janet and Tom experience the physical *release* as a clear and beneficial shift or change in the dynamic quality and consistency of the body tissues. Janet introduces also a sense of warmth in her analogy of 'melting butter'; a quality similarly expressed by other participants. The *release* then has a flow-on effect of

promoting free mobility and evenly distributed tension within the body tissues, which, in turn, enhances normal function.

As *activators*, paediatric osteopaths tend to use ‘indirect techniques’ where the emphasis is on stimulating the body’s natural healing mechanisms. This involves setting up the circumstances that will enable the body to self-correct and then withdrawing from further involvement other than to remain aware and monitor the physiological responses as they occur. Osteopaths use terms such as *allowing*, *letting*, and *supporting* normal physiological processes. In the study, the set-up for *activating* a change is achieved by two distinctive processes that are described as creating a balance-point or synchronising with the baby’s internal physiological motions. Each of these processes is discussed in more detail. The first requires the osteopath to deliberately move body structures in subtle ways toward a specific position of balanced tension. This balance-point¹²⁷ is subjective but tangible to the osteopath according to what she feels at the time. It is known by other names such as a fulcrum, neutral or still point as it represents a pivot around which the body reorganises itself. Achieving and holding this position triggers a physiological response. Hannah (osteopath) describes an indirect technique in the following exemplar where she assumes an *activator* role.

Well basically with cranial technique you’re working with that person’s body to promote health in the area so it’s actually not necessarily me really doing the work; it’s that person’s body’s own self-healing mechanism that’s being activated by I guess, my hands and my perception of what’s going on (O12/07).

It is not apparent how Hannah’s hands and perception activate a therapeutic response; just that they are an important part of an intuitive process. When asked to elaborate, Hannah finds the concept difficult to articulate.

I don’t know; it just does, I mean it doesn’t just change like that; it’s a gradual thing that happens so, I don’t know, you just keep your hands on and sit with it, perceive the changes as they happen (O 12/08).

In this scenario, the osteopath might initiate change but it is also important that she remains in physical and mental contact with the baby as the change plays out. She participates but at a distance or without interfering with the expression or course of change as it proceeds.

¹²⁷ See Section 10.3.

The second method or means of *activating* a baby's innate self-regulating mechanisms involves the concept of *synchronising*, which emerges as an in-vivo code. This term is used to describe a type of harmonising process that takes place between the osteopath's body and that of the baby.

If you synchronise with the motion that's going on in the [baby's] fluid body, you'll find that generally that there's another pause or a still point and then the body will start to get going into an automatic treating mode ... we allow that treatment to take place (Edward O 6/11).

According to the dictionary, 'synchronise' means "to coincide or agree in time; to cause to go on at the same rate" (Butler, 2009, p. 1279). 'Synchronising' in a physiological domain, as described by Edward and others in the study, is an unusual concept in the biomedical tradition. It is not clear how a synchronised state is achieved exactly but it is a phenomenon that is felt and recognised by a number of osteopaths in this study as an important element of performing certain indirect techniques¹²⁸. It is different to the strategy of *Tuning-in* to the baby as it involves a specific form of parallel dynamic interaction between two independent physiological systems. It implies that a type of 'biological resonance' is taking place, which has the capacity to stimulate therapeutic changes in one of the systems; the recipient of the manual technique. It is based also on the belief that the recipient's, or baby's, physiology has a form of innate knowing of what it needs to do to achieve a healthier state of internal balance.

Another feature of *activating* is that the intention is one of *initiating*, *stimulating* or *expanding* physiological processes. This approach is useful for babies whose bodily functions are depressed. It is used, for example, with a number of babies who had complicated or caesarean deliveries; who were initially tired and unable to latch, or feed for sustained periods of time, at the breast. *Activating*, for these babies, involves the osteopath facilitating a general physiological response that is imbued with qualities of increasing energy; described as "*ignition*" and "*vitality*" (Edward O 6/06) and "*sense of healing*" and "*potency*" (Stephen O 13/06). After *activating* and perceiving some of these more abstract notions of physiological change, as above, osteopaths then typically transform what they feel or sense into more comprehensible professional language that can explain physical responses to manual therapy such as a re-evaluation of ranges of motion and tissue tensions.

¹²⁸ See section 10.3 for an explanation of indirect cranial and biodynamic techniques.

Releasing and *Activating* have been defined according to the osteopaths' actions and intentions when applying manual techniques to the baby. At times, the difference between them is blurred; more an emphasis on one over the other, and they can be used interchangeably during a treatment. They share common characteristics such as using gentle forces where the emphasis is on inducing, not forcing, a response. In most cases, the *release* is produced by gentle, almost undetectable manually guided forces and associated with signs of increasing comfort for the baby. The central idea is to work in harmony with the baby's physiology; in a smooth and respectful manner. The following exemplar demonstrates qualities of both approaches.

I use osteopathy in the cranial field, and I suppose with this, I sort of, follow the pattern [of motion or tension], and then try to coax it in to functioning better (Britt, O 7/07).

A significant level of trust in the innate physiology's capacity to self-correct underpins the processes of *Releasing* and *Activating*. Some osteopaths place more emphasis on this aspect of a technique than others but the physiological changes are perceived to be driven, primarily, by the patient, not the practitioner. Having said this, osteopaths acknowledge that their presence and influence is still an essential element for the success of the technique.

There's something about having the ability to perceive the strain pattern or the restriction in the baby's body and then being present to the baby's capacity to change; it somehow enhances that ability for the baby to change the restrictions or strain patterns that they have (Lauren O 2/10).

Releasing and *Activating* involves osteopaths using finely tuned and purposeful manual manipulative skills. They know what they feel and try to do with their hands, often at an intuitive level, on the premise that the baby's body will work with them and respond in a positive way. While a sense of physiological change or *release* is the goal of each manual technique; successfully treating the baby is more complex than this. The next strategy of *Rebalancing*, *Finishing well*, involves drawing together the different elements of manual therapy to reach an end-point that results in a beneficial outcome.

10.4.3 Finishing well

Finishing Well means to complete treatment of the baby in a satisfactory or advantageous manner. It involves integrating and reviewing physiological responses, and determining when it is appropriate and timely to end manual therapy. It represents the final *rebalance*

of the baby's body, which is undertaken with skilful professional technique and judgment. How manual techniques are taken to completion and then integrated into the treatment as a whole has therapeutic consequences. A complete and effective manual treatment is a fluid process, made up of a series of interrelated techniques applied with well-considered thought and action.

Well I guess it depends on primarily, at the time, what areas I perceive to be influencing the system as a whole and so I go from there. So as I move up [the body] I will be able to see change [taking place] in those areas; so I feel that I can move to the next stage (Hannah O12/08).

It is evident from this exemplar that *Finishing Well* rests upon the success of the other strategies of *Rebalancing*, in terms of *releasing and activating* physical tissues and *tuning-in* to physiological responses. However, as the prime aim of *Finishing well* is to achieve a final beneficial outcome or state of *balance*, this strategy is more concerned with integration of treatment responses into an overall and meaningful whole. This concept rests upon an appreciation of what needs to be done to ensure that the best overall treatment outcome is attained. It incorporates the summation of interlinking bodily changes, but it also starts the process of situating the baby, as an individual, and as a part of a mother-baby unit, back into the current environment. *Finishing well* involves a shift in emphasis from the baby's body back to the world that she lives in. This shift in attention was observed in participants' body language and is highlighted by Tom's (osteopath) experience of it, as follows.

But when it [manual therapy] finishes and things [physiological activities] kind of switch off; [then] your perception has kind of shifted back; it's just a boring everyday perception in the end (Tom O3/06).

The changing focus from therapeutic touch to other forms of interaction is not always so clearly delineated, as in the exemplar above. *Finishing well* most commonly involves a smooth merging of these phases. The osteopath takes a critical approach to determine the most appropriate way and time to finish treating the baby. Determining this end-point is a complex decision-making process that involves taking into account various interlinking factors, weighing up their influence on each other, and the overall effect on the baby and mother. Some factors that paediatric osteopaths must manage include the baby's ability to continue or not, to what extent treatment goals have been met, what constitutes too much or too little treatment, the mother's views and needs, and timing constraints. The data demonstrates that osteopaths take a broad balanced approach to *Finishing well*; however,

the babies' responses, physiological and behavioural, are paramount. When determining a satisfactory conclusion of treatment, osteopaths tend to heed and follow the baby's cues.

I guess how the baby is, at that point, is a good indicator. He'd fallen asleep at that stage so generally I find, not always, but for that to happen and they're calm and relaxed when you finish; that's a good sign that things have been released and they're feeling happy because of what you've done (Karla O 5/08).

Well I think a good thing about treating babies is that more often than not, when they've had enough, or perhaps when you're in fear of over-treating, they somehow send us a signal, whether it be a tear, or wriggling, or have 'just had enough'. So [whether] that be seven minutes of hands-on or twenty-five minutes; you just tend to get a better feel for it I think (Britt O 7/01).

Finishing well is underpinned by sensitive communication between osteopath and baby, and a feature of this communication is that it involves intuitive interpersonal processes that have been honed by clinical experience. Here, the issue of 'over-treating' is raised; a common concern that is discussed by others in the study. Stephen, for example, describes it as “‘over-cooking the baby; so when you've done too much treatment, the baby often responds by being unsettled (Stephen O 13/07)”. Osteopaths recognise that too much treatment can destabilise the final treatment outcome and determining *when* to stop actively treating the baby has important consequences for the end result. Cooking is an analogy that some other osteopaths use to explain the nuances of how they determine the right amount of treatment. Not unlike the cooking process, the therapeutic change process can continue beyond the immediate situation. Internal physiological mechanisms continue to adjust over time and after the treatment session has concluded. The degree to which this process might continue varies according to individual circumstances and needs to be included in the final clinical judgment.

You can take your hands off but treatment was still happening inside the baby; so that's kind of what I mean by 'still cooking'; I'm just waiting for things to balance out as much as they were going to do for today ... yes it's time to go, she'll keep treating probably for another few days, which is good (Tom, O 3/09).

In contrast to the potential for over-treating, paediatric osteopaths want to be sure that they have made sufficient advances in the baby's physiological structure and function that are likely to be significant and helpful for ultimately improving breastfeeding efficacy.

Using the cooking analogy again, 'under-cooking' means that osteopaths are not satisfied with the type and amount of positive change that was achieved at a particular visit. This scenario frequently involves contextual circumstances that are deemed to be beyond the osteopaths' control or at least need to be taken into account. They impede initial expectations of what constitutes a suitable end-point of treatment, which might then need to be modified. For example, the baby is ill, tired, or too unsettled to cooperate and this can also affect the mother's wellbeing.

It's an area fraught with tension because often they [babies] will be unsettled just before you get a release, and sometimes you think it's going to come and it just hangs off and hangs off, and the mum's getting anxious and so if the parents are getting anxious, these days I'll just stop ... they're [babies] not going to die from missing out (Daniel O11/13).

In this situation, Daniel decides that the disadvantages of an increasingly anxious parent outweigh the advantages of successfully achieving the desired physical response from the baby. In similar circumstances, however, a few key factors might prompt the osteopath to make different choices about the advantages of stopping versus continuing treatment. Hannah, for example, decides that, although the baby is crying, she will continue to treat him for a number of reasons.

Well I guess it depends on whether or not I see that a change is going to happen relatively soon, and it also depends on the mothers reaction, because I know that she [mother] trusts what I'm doing so I don't tend to have to worry about him crying that much (Hannah O12/09).

Treating the baby is a dynamic process and arriving at the best time and place to end the physical interaction is a practised skill. Some of the relevant factors that influence this strategy have been explored but ultimately how manual therapy treatment of the baby is concluded and *finished well* relies on sensitive appraisal of each unique situation and professional judgment.

10.5 CONCLUSION

Rebalancing is based on the central idea that the baby's breastfeeding difficulties are due, at least in part, to a state of relative physiological *imbalance*; often thought to be associated with difficult birthing and perinatal events. *Rebalancing* occurs through the sensitive and strategic application of osteopathic manual techniques to the baby's body to *release* restrictions and *activate* natural self-regulating mechanisms, and thus promote a

better state of physiological *balance*. Such an improved state can involve local body tissues, their inter-relationships, and body systems as a whole. *Rebalancing* thus normalises body structure and function and improves overall wellbeing, which then contributes, in various ways, to more effective breastfeeding, according to individual circumstance.

Paediatric osteopaths choose particular 'indirect' manual techniques that are gentle and considered most suited to babies' physical and emotional needs. Interacting with a baby's physiology, which is complex and ever changing, and applying manual techniques effectively, requires specific skills and practice knowledge. *Rebalancing* is achieved through three key strategies; *Tuning-in*, *Releasing and Activating*, and *Finishing well*. These strategies enable osteopaths to access, touch, and make finely tuned physical adjustments in order to induce positive physiological changes that, ultimately, lead to beneficial health outcomes.

CHAPTER ELEVEN

EMPOWERING

I do enjoy it [visit to the osteopath] because I usually find out something new each time and we go back over what might have happened last time. Stephen [osteopath] will say, "How has the in-between period been?" and he usually gives me some feedback on the progress since the last treatment. Yes, so his [baby's] diaphragm's really loosened up now. Working on the jaw has loosened [it] up since the last time and he's got good movement. There's definitely some progress and it's good to get that feedback (Narelle M 13/13).

11.1 INTRODUCTION

Empowering is a category that encapsulates osteopaths' therapeutic approach to assisting mothers who are *struggling to breastfeed satisfactorily*. The previous chapter focuses on treatment processes (*Rebalancing*) that enhance the baby's physiological capacity to breastfeed. This chapter addresses other aspects of the core problem that relate to the mother's concerns and her general wellbeing. Overall, paediatric osteopaths aim to *empower* mothers by helping them to regain a sense of control over their lives, as new mothers, and more specifically, their breastfeeding difficulties. *Empowering* methods, however, are not always readily defined or articulated. Often, they involve some of the more tacit therapeutic processes that relate to practitioner-patient interaction, which are interwoven with more structured or visible treatment activities. For example, Narelle (mother), above, is reassured by, and takes pleasure from, her developing understanding of the step-by-step nature of her baby's physical progress in response to manual therapy, which is readily encouraged by Stephen (osteopath). Overall, she has a positive experience of osteopathy through her close and personal involvement, which enhances her understanding of the situation and brings her closer to achieving personal breastfeeding goals; a subtle form of *empowerment*.

The chapter commences with discussion of the principles of *Empowering* within a clinical setting before its meaning is defined according to the specific context of the study. Further explanation is then provided by contextualising *Empowering* within contemporary understandings of paediatric practice and the particular needs of new mothers. The strategies and sub-strategies of *Empowering* are then explicated. The chapter finishes with concluding statements.

11.2 DEFINITION OF EMPOWERING

Empowering is a process whereby paediatric osteopaths use words, gestures, and actions in individualised ways for the purpose of assisting women to acquire the knowledge, skills,

confidence, and self-reliance needed to reach personalised breastfeeding and new mothering goals. According to the *Macquarie Concise Dictionary*, *Empowering* means “to cause (a person) to feel confident and in control of their own life” (Butler, 2009, p.403). The basic idea of patient *empowerment* or being in control in a health-care situation, relates to the principles of patient autonomy and self-determination, which have general applicability across a range of health disciplines and settings. The meaning of patient *empowerment* in complex clinical settings, however, can be ambiguous because it is an abstract individualised idea that is subject to different interpretations. A review of 55 studies pertaining to *empowerment* of patients with chronic conditions was undertaken by Aujoulat, d'Hoore, and Deccache (2007) in an effort to explore its meaning and develop a precise and functional definition of the term. Such a definition was not, however, forthcoming; rather the guiding principles and values of patient *empowerment* were identified as a complex experience of personal change guided by the principle of self-determination (p.18). There are thus various levels of *empowerment* according to the relative degree and experience of personal change involved. For some patients, this might mean significant personal transformation, while others might experience *empowerment* in other less powerful but nonetheless, meaningful ways.

Attention to the concepts of autonomy and self-determination in general osteopathic practice is reflected by practitioners' commitment to promoting patients' independence and quality of life. In broad terms, this is achieved by delivering professional patient-centred services¹²⁹ that take into account individual preferences, physical and psychosocial circumstances as well as technical competence. Apart from using manual therapy to improve physiological function and pain-free mobility, osteopathy typically incorporates setting up self-help home-based exercise programmes, ergonomic and postural advice, and providing appropriate and accessible health information to enable patients to make informed decisions about their health-care management (Osteopathy Board of Australia, 2013). The meaning of *Empowering* in general osteopathic practice, thus tends to be framed as an empowerment-orientated approach, compared to a more traditional compliance-orientated approach, to guide practitioner-patient interaction and delivery of care.

In the current study, it is evident that paediatric osteopaths apply the general principles of an *empowerment*-orientated approach when responding to dyads *struggling to breastfeed satisfactorily*. However, their therapeutic approach is framed also by awareness of, and sensitivity to, dyads' specific problems and circumstances. While learning new mothering

¹²⁹ The concept of patient-centred care and how it relates to the notion of patient empowerment is discussed in Chapter 13.4.4.

and breastfeeding skills, women must balance a number of complex factors when making decisions that impact upon their own, their family's, and their baby's health and wellbeing. In the data, maternal *empowerment* tends to be expressed in terms of self-confidence relating to decision-making capability and breastfeeding self-efficacy; concepts that are explicated in the following paragraphs.

In the first instance, women participants are going through a significant period of personal change as part of a normal lifespan transition to motherhood¹³⁰. Within this background, the study's core problem is complex and challenging and mothers' experiences of it are highly emotive¹³¹. Choosing and being able to breastfeed their babies is an important element of women's systematic preparation for motherhood; initially viewed as a realistic expectation. Despite their best efforts, they are unable to breastfeed satisfactorily and feel frustrated, distressed and *disempowered* because they seem to have limited control over current life circumstances and choices.

Understanding the background to, and consequences of, mothers feeling *disempowered* impacts upon paediatric osteopaths' therapeutic approach to redressing the breastfeeding problems. They are aware that such a situation, over a sustained period of time is likely to be detrimental to women's psychological wellbeing and emerging maternal identity.

She's [mother] got this ideal that breastfeeding's the important thing to do and if she's not doing it, she's a failure; so you imagine if you're on your own in the middle of the night; those kind of thoughts would be very destructive to her health (Daniel, O 11/03).

Paediatric osteopaths, like Daniel above, recognise that feeling *disempowered* damages a mothers' self-esteem at a critical time in her life and requires intervention. It not only affects her well-being but also that of her baby and family. Unresolved breastfeeding issues and negative early mothering experiences impede ongoing breastfeeding efforts and confidence in a mother's ability to care for her baby in other ways. Feeling *disempowered* often starts with a history of medical intervention during a complicated birth and a difficult postpartum recovery period. Coping with a fussy unsettled baby and receiving confusing breastfeeding advice and unhelpful interventions, compounds an already difficult transition process. In the data, one consistent source of *disempowerment* relates to women's expressed lack of self-confidence and perceived competence in their breastfeeding capabilities and not being able to understand or address the underlying

¹³⁰ See section 11.3 for discussion of the concept of transition to motherhood.

¹³¹ See Chapter 7.3.

causes. Hence the concept of *Empowering dyads struggling to breastfeed satisfactorily* is closely aligned with the notion of promoting maternal breastfeeding self-efficacy.

Self-efficacy is defined as “the capacity to produce an intended result” (Butler, 2009, p. 393); in this case, the ability to perform the specific task of breastfeeding¹³². Self-efficacy strategies are typically directed toward building a mother’s self-esteem and breastfeeding skills through encouraging feedback, and promoting her physical and emotional wellbeing (Dennis & Sword, 2007). Such an approach is consistent with findings from the current study. Overall, this means paediatric osteopaths taking a mother-led approach and shifting the focus of breastfeeding decision-making and actions, including credit for any breastfeeding success, toward the mother rather than themselves, or at least, viewing it as a shared experience. Typically, the osteopath-mother relationship rests upon a collaborative effort that involves sharing of knowledge, ideas, thoughts, values, and power, which, though not necessarily apportioned equally, is focused primarily on strategies that enhance maternal confidence and perceived competence and which are customised according to individual goals and needs.

While some women take their baby to the osteopath for treatment because they are desperate, most do so on the premise that there might be an underlying physical basis to the baby’s breastfeeding difficulties. If, after manual therapy (*Rebalancing*), the baby is more settled and proficient at feeding from the breast, then this result can have beneficial flow-on affects for the mother. The baby is more responsive to maternal breastfeeding efforts and signs of success increase self-confidence. The mother has also demonstrated self-reliance by sourcing a solution.

I sort of noticed from ‘the word Go’, just a slight improvement from that [treatment] session and then we saw each other a week later, where we had more treatment; and from then it [breastfeeding] just improved; it was just like, ‘Wow, this is great!’, and basically then [we] just started spacing out [treatment intervals] (Sonia M 6/05).

In general, mothers, like Sonia are excited and relieved by any positive changes in their baby’s behaviour following osteopathic treatment. Even a small improvement is significant for mothers; often linked to the extent and depth of their feelings of *disempowerment*. This situation arises often as a result of a series of disappointing and negative early mothering

¹³² See Chapter 2.5.3 for more information on the Breastfeeding Self-Efficacy Scale for measuring effective breastfeeding.

experiences such that a small sign of improvement gives them hope and enhances self-confidence and motivation.

Manual therapy of the baby does not, however, always translate automatically into effective breastfeeding, as in the exemplar above. Each case is complex and typically, further emotional and practical support is required. One common situation relates to returning to breastfeeding after a period of time feeding the baby from a bottle, for various reasons. For example, the osteopath, who has prioritised treating a baby's suck dysfunction, might then consider other treatment approaches that focus on the mother's breastfeeding skills. In general, osteopaths recognise that breastfeeding self-efficacy requires the mother's ongoing commitment and practice. Appropriate strategies to assist her might include any combination of encouragement, practical postural advice, or referral to another health professional such as a lactation consultant to refine more technical breastfeeding skills. Some mothers seek more encouragement, emotional support, and practical assistance than others, who prefer to take a more proactive self-directed role. Breastfeeding success (or failure) tends to occur in small steps but any sense of progressive understanding of the situation has therapeutic consequences. Hence an *empowering*-oriented approach involves understanding individual breastfeeding needs and then implementing and coordinating the most effective intervention at the most appropriate time.

11.3 CONTEXT OF EMPOWERING

Paediatric osteopaths' approach to *empowering dyads struggling to breastfeed satisfactorily* is shaped by the contemporary psychosocial framework in which they interact. This includes an appreciation of the current breastfeeding culture and the broader theoretical background concerning maternal role attainment. The latter subject has been of much interest to health professionals because insight into the processes involved in becoming a mother helps with the provision of meaningful and relevant assistance. Mercer (2010) reviewed much of the early and contemporary research in this area when exploring women's experiences of becoming a mother as part of a developmental transitional process. She reports common trends found in several studies whereby women move from a known pre-pregnancy reality, through different stages, toward a new reality as a mother. The chronological stages of acquiring a maternal identity are characterised by anticipation and preparation, relying on expert advice, then developing individual judgement and mastery as maternal self-confidence and competence in caring for her baby grows. Martell's (2001) study of women's postpartum experience supports and summarises this notion as one of "heading towards the new normal" (p.496). These

research results are similarly supported by findings from this study¹³³; through the perspectives of mothers and osteopaths. One woman's account of her early mothering experiences, which is representative, in general, of women's *struggle* to overcome breastfeeding difficulties, follows.

Now every little piece of advice I've received, I'm putting it into the mix and saying if it's not [helping], I'm dropping it off; rather than being paranoid about it and really trying to make it work. I think that's just come over the last two weeks of having to filter it all out and figure out what works for us because some things work and other things don't, and I've decided if it's not working, just drop it; don't get all hung up about it (Narelle M 13/09).

Narelle's maternal identity is emerging as she becomes more self-assured and starts to make critical decisions about what is best for her and her baby. Narelle's views resonate with osteopaths' general perception of new mothering experiences. Understanding the processes of becoming a mother is important to osteopaths when attempting to provide effective and timely breastfeeding support.

I think once they [mothers] hit the 12- week mark, everything improves enormously ... they're starting to get more sleep and they settle-in to more of a pattern and they understand the baby more. So I think the first 12 weeks, you're really just getting them through however you can; you know they just have to do what they can to cope; a lot of support at that time (Megan O 4/13).

Overall, paediatric osteopaths' views, as expressed by Megan above, align also with findings from the literature, which contend that most women achieve a maternal identity when the baby is about four months old (Martell, 2001; Mercer, 2010). It follows a period of negotiating early challenges and developing maternal feelings of attachment and competence; conceptualised as a 'settling-in' period (Martell, 2001 p.500). Nelson's (2003) meta-synthesis of several studies that investigate maternal transition among well, adult mothers in North America and Australia involves women with a similar social demographic to those in the current study. Although mothers in Nelson's (2003) synthesis were not experiencing specific problems in the early postnatal period, such as breastfeeding difficulties, nonetheless, they reported feeling overwhelmed, underprepared, and exhausted; needing time to master maternal skills and get to know their babies. This knowledge is generally applicable to mothers in the current study, who

¹³³ Refer to Chapter Seven, which explores the dimensions of the study's core problem

report similar experiences but with the additional challenge of coping with breastfeeding difficulties.

Breastfeeding is an important goal for mothers in this study. Appreciating the current social context of breastfeeding is relevant¹³⁴ when seeking to *empower* mothers who place a high value on breastfeeding success. Women who have a strong desire to breastfeed but find it problematic and who also feel a form of pressure to continue trying to do so under difficult circumstances are particularly vulnerable. In general, paediatric osteopaths express awareness of the potential harmful consequences to a mother's health if this issue is not well managed. They also articulate a heightened awareness of the emotional stress associated with *struggling to breastfeed satisfactorily* and the need to provide mothers with substantial support.

I'm also aware of the social pressures that create a lot of stress around breastfeeding and pressure to continue ... so I kind of try and support them as much as possible without them getting burnt out and falling in an emotional heap (Janet O10/03).

A specific finding from Mercer's (2010) review was that mothers of exceptionally fussy infants found it more difficult to attain a maternal identity (p.98). Such results are particularly relevant to participants of the current study. They suggest that these dyads require ongoing professionally based assistance, which should focus on self-efficacy strategies that encourage and enhance mothers' capacities to care for and feed their babies in personally fulfilling ways. On the basis of their research findings, Nelson (2003) and Mercer (2010) make the following recommendations; maternal engagement is encouraged through active involvement, which provides mothers with the opportunity for personal growth and transformation. As new mothers feel insecure, health care should be consistently positive, supportive, and sensitive to individual needs. The data in the current study demonstrates that paediatric osteopaths employ strategies that align, in principle, with these recommendations.

11.4 STRATEGIES OF EMPOWERING

Empowering mothers, who are *struggling to breastfeed satisfactorily*, requires paediatric osteopaths to provide genuine individualised care that is aligned with the mother's goals and in the best interest of the dyad. Therapeutic strategies might focus on a particular need such as learning breastfeeding positioning skills or be broader such as enhancing a mother's overall emotional wellbeing. A fundamental starting point is that all forms of

¹³⁴ The contextual determinants concerning social views on breastfeeding are discussed in Chapter 6.2.1.

intervention must be delivered in a positive, sensitive, and respectful manner. Two conceptually broad strategies that osteopaths use to *empower* mothers, *Supporting* and *Involving*, were generated from the data. They, and their respective sub-strategies, *Resourcing* and *Educating*, are organised according to Figure 7.



Figure 7: Strategies and sub-strategies of *Empowering*

Essentially, *Supporting* and *Involving* are strategies that adopt a maternal self-determination and breastfeeding self-efficacy focus but differ in emphasis, whereby, *Supporting* involves some form of intervention or purposeful action whereas *Involving* means that osteopath and mother share, to varying degrees, a more critical interactive perspective.

11.4.1 Supporting

The term, *Supporting* can have diverse meanings but, in this study, fits with the following dictionary-based concepts as, “to give help or countenance to; keep from falling, sinking or failing; enable to last out; give strength to; encourage” (Moore, 2004, p. 1296). Common to all ideas of *Supporting* is a sense of providing a form of structured response. The type of *support* that osteopaths were observed to provide to mothers who are *struggling to breastfeed satisfactorily* could be emotional, physical, or practical and also delivered in subtle or obvious ways. Support is provided on the basis of a mother’s perceived needs and which form of support is deemed most likely to evoke the best outcome. Services provided can consist of a combination of advice and specified courses of action or they can be more abstract and involve expressions of understanding, empathy, and encouragement. The following exemplar highlights the mix of *support* services that an osteopath might offer to *empower* a mother.

I just try and phone them and see how they're going. Sometimes, I kind of think, 'Now, which homeopath can I refer to?' Perhaps [use more] 'support osteopathy' and I try to see them in three or four days, don't give them long between visits but also I talk to them; [tell them] they've done a great job and it is thirteen weeks and if you can do another month or two weeks then that's great (Janet O 10/04).

It is evident that Janet is committed to finding appropriate strategies to *support* breastfeeding mothers. She is also prepared to extend her professional and personal *support* by being emotionally and physically available. She takes on a breastfeeding mentor role by offering encouragement and validating the mother's breastfeeding efforts. She also considers the advantages of referral to another health professional. Her overall approach is representative of the range of strategies that paediatric osteopaths consider and use under the umbrella of the notion of *Supporting*. For convenience, strategies are grouped according to an emphasis on emotional or practical forms but in clinical practice the lines between the two are blurred. Osteopaths' roles in seeking additional *support* services outside of their clinical practice is discussed later as the sub-strategy, *Resourcing*.

Emotional or psychological *support* is provided on the basis that the mother and osteopath have an existing relationship or *connection*¹³⁵. Typically, a rapport has developed over time; built on a foundation of trust, empathy, and respect. These fundamental values and interpersonal processes are developed further such that they become *therapeutic* processes and a means for *empowering* mothers. Generally, emotional *support* is provided through being open, interested, caring, and encouraging. These attributes are basic human-to-human interactive processes but are guided also by respect for the mother's personal goals and the osteopath's professional boundaries; a strategy that has been discussed previously¹³⁶. A common belief expressed by osteopaths is that as long as mother and baby are not at risk, the mother has a basic right to make her own decisions about caring for and feeding her baby and should be encouraged to do so. This general idea is summed up by the following exemplars, in which two osteopaths discuss their thoughts on giving breastfeeding related advice to mothers.

Only really if mum is so desperate that she really wants to know what else there is [to assist]; otherwise I very much just support what the parents have decided to do (Evelyn O 8/10).

¹³⁵ See Chapter 8 for discussion of the strategies involved in forming and maintaining practitioner-patient relationships.

¹³⁶ See Chapter 8.3.2.

I can only encourage and support but I'd never say, 'I think you should [breastfeed]'. I think that could only just make things a lot more stressful for somebody and if that's their decision, well they've obviously thought about it and have talked it through. It's not like they've just decided one day, 'Well I'll stop now' (Karla, 05/15).

Encouragement and emotional *support*, as the central idea behind *empowering* a mother to take decisive action, as with Karla above, is frequently based on the concept of 'talking it through'. In general, osteopaths were observed to set up opportunities for discussion as a routine part of each visit and the mother's interests and concerns are given priority.

I treat a lot of women who are trying to breastfeed; they feel very comfortable because of the length of time that we have for our treatments and the amount of talking that we do with the women; that they find that role very helpful and supportive (Natasha 09/12).

General discussion, somewhat guided but without pressure to conform to a particular viewpoint is one way that mothers are able to evaluate issues that are important to them. The osteopath takes on elements of a counsellor role, more in terms of attentive listening and bringing issues into the open, which is a basic starting point for exploring possible actions and responses. They apportion time according to perceived need; a situation of balancing or dividing their attention between mother and baby. For example, Britt (osteopath) has a clear strategy for allocating time for a mother and baby on an individual basis.

I try to get as much talking as I can done before I put my hands on [the baby's body] so I can actually concentrate when I'm doing that. I'll sit here answering questions until there are no more questions (Britt 07/04).

In this scenario, Britt chooses to address the mother's concerns first, which assists her to then have quality uninterrupted time to treat the baby. By explaining how she intends to allocate her time during the consultation, Britt encourages a collaborative approach while simultaneously demonstrating an interest in the mother's experiences. Taking time to focus attention on the mother enhances the osteopath's ability to determine the best way to provide individual *support*. Typically, paediatric osteopaths make themselves available to speak with mothers during, and also at times, outside of the allocated appointment time; some extend their accessibility to outside normal working hours. Janet, for example,

who works from a home-based practice, is prepared to see a mother and baby under special circumstances, as follows.

One patient rang me at ten o'clock at night in tears. She came up here [to the clinic]; she'd already bought the formula. It's like she just wanted [me] to go, 'It's OK to let go', but she'd already made the decision so I didn't push her to have treatment (O10/04).

Janet acknowledges that she can best assist this mother by *supporting* her decision to *not* breastfeed. Extending care, late at night, is not considered usual osteopathic practice. It is more reflective of individual practitioner commitment and the nature of her relationship with the mother. Most osteopaths do, however, make themselves accessible to a mother should she be unduly concerned and invite her to telephone them under these circumstances. For mothers, knowing they have this option is reassuring because *support* is available, just in case.

I always explain that if they [the baby] are a little bit irritable in the next day or two [after treatment], it's generally that things are still changing; it's nothing to be too worried about but give us a call if necessary (Tom O3/09).

Similar to Tom above, osteopaths typically explain treatment expectations, which encourages mothers to monitor babies' responses and potentially gain some insight into their progress while also providing a backup resource. The practice of advising patients regarding possible short term treatment reactions is part of standard professional care and is a typical example of how practical and psychological professional *support* strategies work together.

Practical *support* takes the form of postural or more physically based breastfeeding related advice and sometimes includes manual therapy for the mother. Generally, osteopaths are reluctant to give advice to mothers unless under certain conditions; that the mother asks for it and they believe it is within their area of expertise and likely to be helpful. Advice on posture and positioning, relevant to mother and baby, is assumed to be a standard part of osteopathic clinical practice because it is grounded in knowledge of biomechanics and the function of the musculoskeletal system. Some mothers seek this type of 'expert' advice and osteopaths readily respond. Typically, mothers are also interested in exploring practical ways in which they can help their babies' physical development and wellbeing when at home. Vivienne (mother), for example, seeks advice regarding how she might augment the baby's responses to manual treatment.

I guess my questions were really just practical. "What can I do; is there anything we can [do]?" "Should we be holding her differently?" "Should we be putting her down to sleep differently, to help her, kind of, adjust herself?" (Vivienne M 03/12).

In general, although osteopaths are comfortable giving postural advice in response to the type of questions asked by Vivienne (mother) above, they are cautious about giving breastfeeding specific advice for a number of reasons. First, they are sensitive to the deleterious effects of confounding advice. As unnecessary or conflicting information might interfere with a mother's developing breastfeeding skills, they tend to defer back to the mother and follow her lead. Where possible, they *support* her by exploring and reinforcing any reliable, professionally based advice that has been given already.

A lot of these women seem to be already well educated in their options, so they've already been seeking help via the maternal health care nurse or a lactation consultant, so a lot of those areas [breastfeeding strategies] were already covered and I'm just confirming what's already been suggested for them, so that's often the role I'm playing (Lauren O 2/06).

Osteopaths, like Lauren are thus able to *support* women by building upon their prior breastfeeding related interventions, activities and efforts. Some osteopaths avoid giving breastfeeding advice because they believe they have insufficient or limited expertise in this area. The exception to this finding relates to osteopath participants who have had extensive breastfeeding experience with their own babies, particularly pertaining to overcoming difficulties. They see this experiential background knowledge as valuable and are prepared to share elements of it but only under conditions, outlined previously; that mothers want such advice and it is relevant and likely to be beneficial. They believe that framing breastfeeding advice within a personalised story can make it more meaningful to mothers. Such reciprocity adds depth and sensitivity to their provision of professional *support*. One example follows.

My wife had twins and she fed the twins for eighteen months so having four children I've been exposed to a lot of breastfeeding facts ... the stuff that you learn most from experience, from being exposed to it, rather than you'd probably read about (Stephen O13/07).

Overall, osteopaths are comfortable giving practical advice that relates to the mother's breastfeeding posture. According to osteopathic principles, the relative balance of the

anatomy and physiology of the mother's body will influence her general wellbeing¹³⁷. In addition, the osteopathic literature advocates that a woman's posture can influence lactation (Moeckel & Mitha, 2008; Stone, 2007). It is not uncommon for osteopaths to treat women specifically to promote breast health and lactation. Stephen, as above, discusses some of these treatment principles.

Poor posture during breastfeeding sets the mother up for issues with her back and also can affect the supply of the milk and that can then affect the baby's ability to feed as well. So there's a whole gamut of areas which osteopaths can help out with breastfeeding, not just for the baby alone but also the mother (Stephen O 13/08).

Apart from providing the mother with postural advice, as above, practical *support* can take the form of manual therapy. Approximately half the mothers in this study were having manual therapy for themselves at around the same time as their babies were also receiving it, but not necessarily from the same osteopath. In the data, paediatric osteopaths express a common view that mothers, who are experiencing stressful physical or psychological circumstances, could benefit from manual therapy as well as their babies. They are, however, careful not to impose this idea if mothers aren't open to the suggestion. In some special cases, the osteopath views treatment of the mother as important. Evelyn (osteopath), for example, sees osteopathic treatment of the mother in the exemplar below, not only as a significant element in *supporting* her to breastfeed but as a means to promote or monitor her emotional health as well.

Mum came for a treatment [when pregnant] and told me that psychologically she'd found it very hard to cope [with a previous baby]. In actual fact there was a [past] problem on her side; I'd been very aware of that maybe contributing to that kind of whole interaction, after this baby is born and after dad has gone back to work, and I've been very, very aware. So I'd treat mum because there may be some dynamic from mum towards not coping that may feed back into the baby (Evelyn O 08/08).

Evelyn emphasises her concerns regarding this mother's history and potential need for psychological *support*. She might consider it appropriate, at some stage, to refer her to another health professional whose expertise lies more specifically in evaluating mental health problems. Osteopaths in this study readily incorporate additional *support* from outside their professional practice as part of their means to *empower* mothers.

¹³⁷ The idea of a physiological *balanced* state of health is discussed in Chapter 10.1.

11.4.1.1 Resourcing

The sub-strategy, *Resourcing*, involves recommending, accessing, and using other resources to assist mothers to find a solution to their breastfeeding difficulties. In the study, osteopaths routinely direct mothers to other professional health services including lactation consultants, maternal child health nurses, medical practitioners, homeopaths, psychologists, and the Australian Breastfeeding Association. The central idea behind *Resourcing*, from a broad health professional perspective, is summed up by Hannah (osteopath) as follows.

I guess as health professionals we can reiterate how important breastfeeding is for all the benefits I've just said before but it's also important I guess from a primary care practitioner perspective; we can help direct them to other services and things that are available too so I think that's important (Hannah O 12/04)

Hannah advocates a professional evidence-informed approach and recommends allied services that operate within this framework. Typically, osteopath participants adopt a similar view and take a critical approach to incorporating assistance from other services and health practitioners into their overall management strategies. Most are careful to follow the mother's lead on this issue, being sensitive to her wishes unless they feel particularly strongly about recommending a service or have serious concerns about potential health risks.

Resourcing appropriately is a useful professional tool for *supporting* mothers and babies with breastfeeding difficulties. It involves determining *when* manual therapy is most appropriate or if it is not the only suitable intervention; *when* a problem is outside of the osteopath's scope of practice, and then *who* or *what* is most likely to be of assistance, and *how* this resource is best introduced and coordinated with the current treatment program. Some of these ideas are summarised by Julie (osteopath), below.

If I think there's more than a structural issue going on; it may mean that the osteopathic treatment is not the best thing at that timelooking a little bit further, if you've got a mum that doesn't want anything to do with a baby that's obviously distressed and she's exhausted; you can start to think well, "What's going on with this relationship here; do I need to actually look at something for the mum?" It's not my role to deal with it, it's to recognise it and maybe point them in the right direction (Julie O 1/13).

As discussed previously¹³⁸, osteopaths view a '*structural issue*' as one that pertains to the physical body and an indication for manual therapy. Part of the osteopath's *supportive* role is to identify other health concerns, and ensure that the mother is aware of the range of potential support services available to her and that she and her baby receive health-care most applicable to their unique situation.

When giving advice, osteopaths are generally cautious if it does not specifically relate to their field of manually based medicine. They also claim to have different degrees of expertise concerning breastfeeding knowledge. For example, most know about the biomechanics and physiology of breastfeeding, and are comfortable addressing physical dysfunctions that might interfere with these processes but if the focus is on correct breastfeeding positioning, options, and skills, they tend to defer to lactation consultants as the recognised experts in this area. Typically, osteopaths think carefully about their referrals. Referring to the right practitioner at the right time is an important element of *Resourcing*. When making *Resourcing* decisions, they take into account the mother's perceived health needs, preferences, and goals and a particular practitioner's professional skills and personal attributes. Some mothers, for example, are more open to, and comfortable with, complementary alternative disciplines than orthodox medicine, and vice versa. Generally, paediatric osteopaths refer to a particular practitioner, not just from an appropriate discipline but someone with whom they have a history. Where possible, they refer to health professionals, with whom they are able to liaise on an ongoing basis. Effective inter-professional communication not only helps to avoid the potentially negative consequences of mothers facing conflicting advice and interventions but is more likely to augment a successful breastfeeding outcome through cooperative action between the health practitioners involved. A common finding of this study, for example, is that osteopathic treatment of the baby and services provided by a lactation consultant are seen as complimentary. From the data, it is evident that most osteopath participants have developed comfortable mutually beneficial inter-disciplinary relationships with health practitioners who share a common interest and expertise in *supporting* mother and baby health.

11.4.2 Involving

Involving means, "to cause (a person) to participate or share the experience or effect; to include in operations" (B. Moore, 2004, p. 658). As an *empowering* strategy, it is based on the fundamental idea that maternal confidence and competence is advanced through participation and collaboration; two closely linked concepts. Individuals will, and can, find

¹³⁸ See Chapter 8.4.3.2, *Clarifying roles*.

ways to collaborate more effectively if they are *involved*. Participation involves mothers engaging with osteopaths and their babies during treatment and in other ways that promote breastfeeding self-efficacy. Collaboration implies that osteopath and mother work together toward a common purpose. While breastfeeding satisfactorily is the overall goal, the common purpose can also be broken down into smaller, more readily achievable goals. Osteopaths not only *involve* mothers by being inclusive; they seek and value their opinions and actions. Viewing mothers as valuable members of the health team has a number of therapeutic consequences. It facilitates the treatment of the baby, enhances a mother's self-esteem, and brings her unique individual perspective into the mix. Considering the breastfeeding problem from the mother's viewpoint enables the osteopath to pursue intervention strategies that are more meaningful to her.

In general, mothers want to learn as much as possible about their babies. They are, for example, interested in the detail of the osteopath's physical findings and their babies' responses during treatment. As mothers observe treatment of the baby, osteopaths, include them by discussing what they are thinking and doing, in the moment. In this way, according to the depth of the osteopath's response to their interest, mothers' understanding of osteopathy and their babies' behaviours tends to grow, and they desire to know more. The strategy of *Involving* moves beyond the preliminary processes of *Connecting*¹³⁹ toward a deeper sense of commitment to seeking a solution through a shared interactive approach that is characterised by mutual effort and critical appraisal, as in the following exemplar.

By this stage, Sonia [mother] had spoken to the maternal child health care nurse who had given her a tip about feeding Sam [baby] on an angle; just to slow down the [milk] supply. I think that tip really helped a lot as well. So it's unclear how much of his irritation, during and after feeding, was due to restriction through the thorax that I was treating and his inability to cope with the fast flow, or the combination of the two. Certainly, treating him on both levels helped resolve the problem anyway (Daniel O 6/07).

In this situation, Daniel (osteopath) accepts and values Sonia's (mother's) contribution to managing the breastfeeding problem. Paediatric osteopaths are typically supportive of mothers' proactive attitude and recognise that a mother is *empowered* by assuming responsibility for building personal breastfeeding knowledge and expertise. Generally, osteopaths start from the premise that a mother is *empowered* through her *involvement*

¹³⁹ See Chapter 8.1.

and they continue to generate opportunities for interacting with her in meaningful ways that augment the baby's treatment and their overall progress. Often, this means creating learning opportunities that enhance a mother's understanding of her situation; issues that are explored later as the sub-strategy *Educating*. At times, the processes of *Involving* are subtle and merged within standard clinical routines. The following exemplar illustrates this feature and draws attention to the therapeutic effects of one mother's inclusion in her baby's treatment.

With Stephen [osteopath] he's [baby] really relaxed; he's usually quite sleepy and he'll sit there on the table and either fall asleep which is wonderful or he'll just sit there quietly and observe Stephen. He looks around for me but then he kind of looks back to Stephen. He doesn't seem to mind and often Stephen will treat us when [breast] feeding and he seems really relaxed then too (Narelle M 13/11).

In this exemplar, physiological and interpersonal processes merge such that mother, baby, and osteopath become contented collaborators. As her baby responds to manual therapy, Narelle, similarly, relaxes. She is so intimately *involved* while her baby is treated while feeding at the breast that she inadvertently uses the term 'us' to include herself as a recipient or part of the therapeutic interaction.

Osteopaths *involve* mothers also in more overt ways. A common example observed in the data is the practise of recruiting mothers' help to settle the baby. Finding the best way to settle a baby and give the osteopath access to apply manual therapy, typically relies upon a shared interactive approach. It might include discussion, suggestion, and trial and error but osteopaths seek and value the mothers' input. Two different but typical treatment scenarios illustrate this idea.

Sometimes when they're really unsettled I'll just give the mum space and let them rock them to sleep and I'll treat them while they are asleep (Janet O 10/11).

Sometimes I find [that working] with babies, you need to give a little break in between [treatment episodes], so if they're getting upset, I'll have a cuddle or give the baby to the mum, and then we can have a little chat and just play it by ear (Karla, O 5/12).

Throughout the data, osteopaths and mothers communicate with each other to determine how they can best facilitate the baby's treatment, together, and according to what is appropriate, at the time. This might include, for example, changing positions, limiting conversation, or encouraging the mother to distract or comfort the baby. As mothers'

understanding of their breastfeeding difficulties and the underlying processes and principles of osteopathic treatment grows, they can assume a more active and confident role in assisting the osteopath. For example, mothers' insights concerning their babies' behaviours and treatment responses can provide important clues for the osteopath and a means for monitoring babies' physical progress and adjusting treatment plans. When an osteopath acts upon such information, the mother's contribution is validated. Overall, observations of mother-osteopath interaction during treatment of the baby suggest a familiar and integrated pattern of working together.

Each mother's sense of regaining control follows a unique trajectory. At different times, they express readiness to become more *involved* the osteopathic treatment experience and assume more responsibility for their breastfeeding progress. Paediatric osteopaths continue to seek ways to extend a mother's *involvement* outside of the immediate treatment environment. A common example is encouraging a form of homework or home-based participation.

He [osteopath] also tells us things maybe to work on in the next ten days. He said at the last visit, "Just space it out to ten days; you can come in earlier if you feel it's not getting better but just monitor the improvement". So you think about those things and [are] a bit more aware of what's going on from one day to the next ... but you do want to demonstrate that you have persevered and you've had some progress or you haven't had progress and you're mindful of it (Narelle M13/13).

Here, Narelle's (mother) *involvement* extends to being encouraged to be reflective, committed, and ready to provide helpful feedback. Through this type of experience, mothers gradually acquire knowledge, which brings with it, a sense of achievement, which reflects also a shift toward the osteopath assuming more of an educator role.

11.4.2.1 Educating

As a well-educated group, the women in this study are generally familiar with *how* to learn and are aware its benefits. Typically, they have great interest in all aspects of their babies' behaviours and development because they want to get to know them and learn how to best care for them. They are also *struggling to breastfeed satisfactorily* and the need to understand *why* tends to consume them. Hence they are motivated to learn but require some guidance.

In general, osteopaths are sensitive to mothers' desire to comprehend their circumstances and are aware that facilitating their learning in ways that are relevant to their lives will

empower them. In this study, *Educating* concerns advancing mothers' understanding in three key areas; the reasons behind their breastfeeding difficulties; the baby's physical wellbeing and how this relates to osteopathic treatment; and more broadly, to make sense of their early mothering experiences. These particular areas of educational interest tend to overlap and are examined further after consideration of paediatric osteopaths' particular approach to *Educating* as a sub-strategy of *Empowering*.

Paediatric osteopaths *educate* mothers through sharing information, explaining, demonstrating, and using teaching aids such as models and pictures. Similar processes and activities have been described previously as the strategy, *Forming an alliance*¹⁴⁰. When used for the purposes of *educating*, however, they are taken to deeper, more analytical levels. They are used with the specific intention of promoting insight or positive change relating to the way women think, feel, and act in response to personal breastfeeding and mothering experiences, goals, and skills. *Educating* processes tend to be based upon similar principles of experiential learning but their mode, range, and depth are adjusted according to individual circumstance. *Educating* is a sub-strategy of *Involving* because osteopaths, in general, adopt a multi-level interactive participatory approach to enhance mothers' self-understanding. Mothers typically learn breastfeeding self-efficacy through participation that is reinforced by instruction and feedback or as a consequence of osteopaths setting up learning opportunities that stimulate mothers' interest, thoughts, and reflection.

The following exemplar illustrates how one mother, Tania, gains new insight into why her baby feeds from one breast exclusively and refuses to feed from the other.

M: I don't know how she [osteopath] put it but basically, to me, well, his 'neck was out'! [Laugh] And then she [osteopath] moved around to his left side and said, "He won't turn around, he won't turn his head to the left and that's the side he would have to turn to [when] feeding on the right [breast]". So, ah, then it all kind of went 'click, click' because I always just thought it was me! I never really associated that it would be him at all (Tania, M 01/10).

It is evident that, at first, Tania struggles to understand Julie's (osteopath) account of the baby's neck dysfunction and she creates a more meaningful version of her own; describing it in lay terms as *'his neck was out'*. By demonstrating the baby's posture and movement restrictions and linking them to his breast refusal behaviour, Julie draws together and simplifies a number of complex ideas. This gives Tania the opportunity to

¹⁴⁰ See Chapter 8.4.1.

make her own logical connections between various interrelated pieces of information. Julie uses practical demonstration as a form of *educating* that is more consistent with Tania's learning style, and Tania is able to view her breastfeeding problem from a new perspective. It is not clear how this new meaning might impact on Tania's self-confidence or relationship with her baby but essentially it *empowers* her by demystifying her current perplexing circumstances. Knowing 'why' has psychological benefits and potential practical consequences in terms of finding an appropriate solution. Understanding assists coping and acquiring the right or relevant knowledge is *empowering*.

In general, when *educating* mothers, paediatric osteopaths combine professional knowledge, experience, and reasoning to transform clinical knowledge into a more comprehensible format that is suited to the mother's learning style and needs. This is not always successful at first but through interaction, *educating* methods are refined to result in a more meaningful learning experience. The following exemplar illustrates how one osteopath adjusts her educational approach to match the mother's learning needs. Catherine (mother) describes her experience of watching her baby receive manual therapy.

It was just kind of hard for me to understand exactly what she [osteopath] was doing ... to be honest, at first, I don't think she explained it very well. She talked about some holistic body healing itself 'stuff' and it didn't explain what her role was, which I found a bit frustrating. So I asked her again, and then she explained it in quite comprehensible terms (Catherine, M 2/07).

In this scenario, the osteopath offers the bigger picture or abstract view of osteopathic treatment principles, which some mothers readily engage with. This perspective does not, however, resonate with Catherine's expectations at this time. The osteopath is able to remedy the situation by providing an alternative, more concrete or meaningful version.

The data demonstrates that mothers, like Catherine and Tania, are interested in the physical detail concerning their babies and the physiological processes of manual therapy. This is not surprising considering the substantial physical changes that take place when a woman becomes a mother. Her personal experiences of physical change take place throughout pregnancy, birthing, postpartum recovery, and lactation. The emphasis on physical processes and appreciation of bodily functions continues with a focus on the baby's growth and developmental parameters; a finding that is similarly reported in the literature (Martell 2001) and illustrated by the following exemplar.

He was feeding better on one side than the other and she [mother] noticed that he didn't like to turn his head the other way and she was having trouble dressing him. She found he was really tight and bunched up. There was a lot of tension all the way through his spine, and the neck and jaw were restricted and that wasn't allowing him to open his mouth and latch on properly, and he might have been uncomfortable doing that because of compression of the muscles in that area ... It's more when you question a bit further, they [mothers] go, 'Oh yes that makes sense' or 'So that's what's happening!' (Karla O 5/05).

The scenario, above, represents a typical osteopath-mother discussion around the baby's bodily functions. Here, Karla (osteopath) and Dianne (mother) piece together the various physical elements that contribute to particular breastfeeding difficulties. Dianne observes and identifies specific physical restrictions and baby behaviours but is only able to '*make sense*' of her findings when they are confirmed by Karla's examination and professional perspective. This new understanding is *empowering* to Dianne and particularly so because she has been *involved* in its construction. It helps her also to better understand the general osteopathic approach to resolving physical problems through manually based therapy.

A common approach to *educating* involves stimulating mothers' reasoning and self-reflective processes, as illustrated in the two previous exemplars. Here, paediatric osteopaths place more emphasis on presenting mothers with the raw data, gathered from the history and examination, which is accompanied by an analysis of how they dissect and make sense of it¹⁴¹. In this way they involve mothers in their clinical reasoning and invite her to do likewise. Mothers can draw their own conclusions; accept and agree with the osteopath's interpretation or modify it somewhat so that it more closely aligns with their own ideas about what is going on. This type of self-directed and reflective approach is thought to promote deep learning because it is constructed according to individual preferences and meanings.

From the osteopath's perspective, there is also an in-built legitimacy to *educating* in this way because their therapeutic approach is laid open. This is an important feature of trustworthiness because some osteopathic ideas remain untested and are situated outside of orthodox medical models. Such transparency validates how the osteopath's thoughts and actions originate, interlink and develop. The following exemplar illustrates one mother's perception of the distinctive way that the osteopath treats her baby.

¹⁴¹ See Chapter 9.4.1 for discussion relating to how osteopaths gather and analyse data.

I've been impressed actually because we've [mother and baby] seen a lot of [medical] specialists over the last months and he's [baby] the most relaxed around Stephen [osteopath] than he is with anyone ... I wonder if it's just the sensitivity of the touch. I think he's [Stephen] more in tune with his [baby's] reactions. He's [Stephen] looking at Brian as a whole rather than bits of him which everyone else seems to be (Narelle M 13/15).

Here, Narelle (mother) expresses an appreciation of the osteopath's manual skill and holistic principles. She embraces osteopathy because the theory is supported by her observations, which provides a strong argument to support its validity.

Typically, paediatric osteopaths help women find meaning to some of their early mothering experiences by introducing new ideas or ways of looking at their breastfeeding difficulties and prenatal, birthing, and early postnatal events. Physical findings in the baby's structure, and explanation that links these findings, further back along the causative chain, to other potential influences such as a complicated birth, provides mothers with new insights. It enables them to reflect on their early mothering life trajectories and place their breastfeeding experiences within a context, which helps to validate their struggle. Mothers are not the only ones who benefit from the interactive learning experience. *Educating*, based upon open-minded sharing of ideas, emotions, and activities, in turn, enhances osteopaths' understanding of new mothering and breastfeeding experiences and challenges, which better prepares them for the complexities of paediatric practice.

11.5 CONCLUSION

In the situation of responding to dyads *struggling to breastfeed satisfactorily*, the category *Empowering* focuses on promoting maternal wellbeing. New mothers are going through a period of significant adjustment and their wellbeing is linked to a sense of regaining control over their lives. This relates to feeling sufficiently relaxed, confident, and capable to care for, and feed, their babies as they choose, and to make decisions that impact positively upon the immediate and future health management of self, baby, and family. For this particular group of mothers, feeling *empowered* is associated with being able to achieve personal breastfeeding goals. On this basis, *empowering* strategies used by paediatric osteopaths follow the principles of promoting maternal self-determination and breastfeeding self-efficacy, and rely on interpersonal skills, a mother-led approach, and professional judgement. They extend also to assisting mothers to understand their current life circumstances and to make personal changes that enable them to breastfeed their

babies where possible, as best they can, and lead fulfilling and healthy lives. Although dyads' share some common challenges relating to perinatal complications and breastfeeding difficulties, each dyad presents a unique case. Thus the notion of *empowerment* is expressed in personal ways and *empowering* strategies of *Supporting* and *Involving* and sub-strategies of *Resourcing* and *Educating* are conceptually broad, yet targeted individually, and delivered in a consistently positive and sensitive manner. Overall, *Empowering* relates to mothers acquiring personal knowledge and skills that enables them to find meaning to their breastfeeding experiences and lives.

CHAPTER TWELVE

CORE CATEGORY

Promoting Optimal Breastfeeding through the Osteopathic Therapeutic Cycle

12.1 INTRODUCTION

The purpose of this chapter is to uncover the meaning of the core category, before presenting the study's final substantive theory. According to Strauss and Corbin (1998), the core category is an abstraction that "consists of all the products of analysis condensed into a few words that seem to explain 'what this research is all about'" (p.146). It thus represents the central theme of the study, which in this case, is encapsulated as *Promoting optimal breastfeeding through the osteopathic therapeutic cycle*. The chapter commences by defining the core category according to its two key underpinning theoretical elements; *Promoting optimal breastfeeding* and *the osteopathic therapeutic cycle*. Then follows an explication of its three underlying transitional themes; *Creating the therapeutic space*, *Facilitating positive changes*, and *Integrating*. The study's final unifying substantive theory is then presented by explaining how all the findings fit together logically into a plausible theoretical schema. The core category, as the central theoretical construct, is linked with other findings; categories, strategies, sub-strategies, and contextual determinants. In this way, the study's overall findings are raised to the level of theory (Corbin & Strauss, 2008, p. 104).

12.2 THE CORE CATEGORY

As a central explanatory concept, the core category must address the multi-dimensional factors that contribute to the study's core problem of dyads' *struggling to breastfeed satisfactorily*. Just as the core problem is described as a basic biopsychosocial problem¹⁴² according to its various contributory factors; the basic therapeutic process relating to the core category can similarly be broken down into biological, psychological, and social domains. To address these various contributing and interlinking elements, the core category must have a broad dimensional range that takes into account the different processes involved in reaching some form of resolution as well as an abstract understanding of what constitutes a satisfactory or beneficial breastfeeding outcome. In addition, the basic therapeutic process and desirable breastfeeding end-goal must have general applicability across a variety of cases, changing circumstances, and individual views and preferences. In the current study, these general requirements of a core

¹⁴² See Chapter 7.2.

category are fulfilled by the notion of *Promoting optimal breastfeeding through the osteopathic therapeutic cycle*.

The central idea of the study's core category emerges as a trajectory of paediatric osteopaths' thoughts, actions, and interactions with mother and baby dyads, over time; during a single consultation and over a course of treatment. In general terms, paediatric osteopaths approach the core problem by inducing incremental changes in dyads' breastfeeding capabilities that move them toward an improved state of breastfeeding and closer to their ultimate breastfeeding goals. The various dimensions and characteristics of this trajectory embody properties of a situational transition experience. Dyads transition towards the goal of *optimal breastfeeding* and osteopaths assist them to do so by using *the osteopathic therapeutic cycle*. The core category is thus made up of these two interlinking conceptual elements that inform each other.

12.2.1 Promoting optimal breastfeeding

Promoting optimal breastfeeding is a multilayered concept, which drives the osteopathic treatment process. Paediatric osteopaths formulate a generic notion of *optimal breastfeeding* and how to *promote* it, which becomes modified and adapted to each dyad and their circumstances. Their interpretations and responses to the core problem, *struggling to breastfeed satisfactorily*, and related events are influenced by their evaluation of a dyad's situation, over time, and through a course of treatment and changing conditions. The term *optimal* means 'best' but determining what this means in the situation of infant feeding is complex. The term '*breastfeeding*' is also not necessarily straightforward because it can mean different things to different people. To the osteopath, the mother's breastfeeding posture and the biomechanics of the baby's feeding behaviours are fundamental to the idea of *optimal breastfeeding*. It is evident also from the data that there are many variations on breastfeeding and infant feeding methods and there is no one prescriptive form that fits all cases. Women's experiences of breastfeeding differ such that their idea of the *optimal* way to feed their baby tends to start with an ideal, which becomes modified in response to a number of inter-related challenges and immediate and changing needs. The term *optimal*, not *optimum*, is used because it implies a more dynamic, individualised, and evolving concept of 'best' that can be re-negotiated as circumstances change. For osteopaths, the notion of *optimal breastfeeding* is also a relative concept that is founded on common professional principles and breastfeeding knowledge but shaped by various and unpredictable influences; the main ones being the breastfeeding woman's goals, her health status and that of her baby.

Hence, it is a concept that has a unique interpretation and application for each dyad and their situation.

In general, study participants express the idea that breastfeeding is the ideal form of infant feeding. Women want to breastfeed and paediatric osteopaths want to help them to do so. Because participants, in general, advocate breastfeeding, and in support of the argument to normalise breastfeeding¹⁴³; the various forms of infant feeding used by women in this study, are referred to collectively as *breastfeeding*, regardless of how, and how much, it is performed, compared to formula feeding. Here, the overall meaning of breastfeeding is expanded to include the biological and nutritional elements of breast milk, the intimacy of the breastfeeding relationship, and the personal meaning that breastfeeding has for each mother and family. Some women place more emphasis on one element over another, which impacts upon their breastfeeding practices and decisions.

The problem for paediatric osteopaths is to arrive at a multi-dimensional understanding of *optimal breastfeeding* that is simultaneously acceptable and workable for themselves, as health professionals, and for the dyads that they treat. Such an expanded understanding of breastfeeding helps them to determine the best way to provide assistance on an individual basis. This idea is explored later after a consideration of osteopaths' roles as *promoters of optimal breastfeeding*. In general, when responding to dyads who are *struggling to breastfeed satisfactorily*, they adopt a holistic mother-baby-centred approach. This means that they tend to follow mothers' leads and respect their rights to choose how they want to care for their babies. This idea has been discussed previously as the strategy, *Respecting boundaries*¹⁴⁴, and is based upon the principle of maternal *empowerment*¹⁴⁵. They *promote* infant feeding as health professionals who encourage and advance dyads' breastfeeding capabilities and progress but are simultaneously cautious about interfering unduly with what is recognised as an intimate partnership and deeply personal and potentially fulfilling human behaviour. Their thoughts and actions are, however, framed by an osteopathic clinical perspective and commitment to providing good evidence-informed health-care that is tailored to individual circumstance. They thus take a multi-dimensional perspective of *optimal breastfeeding* that rests upon professional knowledge and principles, a patient-centred biopsychosocial approach, the responsibilities of a health professional, and pragmatism¹⁴⁶. When these dimensions are combined and

¹⁴³ See Chapter 13.4 for discussion of the implications of language used to describe breastfeeding in the research literature.

¹⁴⁴ See Chapter 8.4.3.

¹⁴⁵ See Chapter 11.2.

¹⁴⁶ In the context of the study, pragmatism relates to being "concerned with practical consequences or values" (Butler, 2009, p. 986).

reconciled, the overall attitude is summed up and expressed succinctly by Julie, (osteopath), as *“I think it’s [breastfeeding] great if it works and it’s convenient and easy, but if it doesn’t work and Mum doesn’t want to persist, it’s not worth stressing the unit, the mother-baby unit (O 01/03).* Like Julie, osteopaths frequently refer to mother and baby as a unique entity and ultimately, the health and wellbeing of the unit is of prime concern; however, this is not always a straightforward concept. The general consensus is that osteopaths are supportive of breastfeeding as a health promoting behaviour, but qualify this view by placing breastfeeding within a wider health and psychosocial context. Coping with breastfeeding difficulties is typically not the only health issue that impacts upon mother, baby, and family. Paediatric osteopaths tend to discuss health and wellbeing as a unified concept that encompasses objective indicators, such as physiological measures and physical findings, which correlate with subjective indicators, such as how dyads behave and express what they feel in a physical and emotional sense. Advising mothers to feed their babies in particular ways and according to health-based recommendations does not necessarily fit into osteopath participants’ understanding of *promoting optimal breastfeeding*. In general, they support mothers’ infant feeding decisions and demonstrate a commitment to assist dyads to breastfeed effectively. This approach, with its emphasis upon coordinated neuromuscular activity, is part of their field of expertise. They believe, however, that they might also play a role in supporting women who choose *not* to breastfeed. Not breastfeeding can fit into their definition of *optimal breastfeeding*. Elements of this approach, expressed by Julie previously, are similarly illustrated and developed by Daniel (osteopath) in the exemplar below.

I think in a country like a first-world nation, like Australia, that there’s a variety of options to manage the growth of children and I don’t think formula’s a great way, but I think destroying a family with trying to breastfeed and the anxieties that go with it is much more destructive. So you’ve got to balance the things. I certainly think it should be every effort to support the mother in breastfeeding but not to the point where she feels that [if] she can’t do it, she’s a failure (O 11/10).

Daniel raises a potential serious health concern that relates to the negative psychological consequences of an ongoing unsuccessful or distressing breastfeeding experience. Consequences are weighed up and situated within the broader Australian social context. For osteopaths, in general, the concept of *optimal breastfeeding* is influenced by a number of competing factors, which broadly, include biological or physical processes necessary for effective breastfeeding, and associated psychosocial and cultural influences. They also take into account what the mother wants to do, an evaluation of her

vulnerability and their overriding responsibility to ensure dyads are safe. For example, they generally agree that a mother's anxiety can contribute significantly to the *breastfeeding struggle*; in some cases, it is seen as the prime health concern. While breastfeeding has significant advantages, a baby's overall physical and emotional needs are more likely to be met by a mother who is relaxed and developing confidence and mastery in her new mothering role. Achieving this outcome might be viewed as a priority, which involves encouraging infant feeding methods other than breastfeeding that simultaneously satisfy infants' immediate nutritional requirements and enhance maternal wellbeing.

Like Daniel before, *promoting optimal breastfeeding* thus involves a balancing or reconciliation process of weighing up various health and wellbeing indicators, associated factors, and mothers' preferences to arrive at an interpretation that aligns with the mother's goals and is compatible with the osteopath's professional responsibilities. Essentially, this process involves applying holistic treatment principles in pragmatic ways. A theoretical perspective of *optimal breastfeeding* is transformed into a practical version or means to function as best as possible given current circumstances. Paediatric osteopaths are able to deal with the complexity of *promoting optimal breastfeeding* by following a fundamental theoretical process that is conceptualised as *the osteopathic therapeutic cycle*.

12.2.2 The osteopathic therapeutic cycle

The *osteopathic therapeutic cycle* represents a basic treatment method or approach that unifies a number of abstract ideas, strategies, and techniques. It is called a *therapeutic cycle* because its prime objective is to bring about a healing effect or beneficial outcome. Essentially, it involves a progressive cyclic change process that is driven by the specific intention of *promoting optimal breastfeeding*; a concept that is inextricably linked to improving a dyad's state of health and wellbeing. When the term, *therapeutic* is used within the context of an *Osteopathic therapeutic cycle*, it is linked to notion of treatment and aligned with the traditional idea of practice routines, and medicinal or remedial interventions. The word 'treat' is used loosely by osteopath participants to encompass a number of situations and means by which they provide assistance to mothers and babies. Generally speaking, osteopaths, and their patients perceive manual therapy as the distinguishing feature and central element of their clinical work. It is the means by which the body's structure and function is improved and the patient's self-regulating mechanisms are enabled or stimulated. This is, however, only part of the treatment process.

In the current study, osteopaths talk about treatment in different ways. Its meaning can be used interchangeably with the term therapeutic, which implies a broader curative, healing or normalising characteristic. They discuss treatment as a response to a problem or as an impediment to achieving a state of normality or freedom to express health and wellbeing. Osteopaths were observed to simultaneously treat from a broad conceptual perspective, or as required, with a sharp more concrete focus. For example, they might apply a specific manual technique to address a movement restriction in a precise direction while, at the same time, attend to the person and environment as a whole. In the current study, this typically involves the baby's specific and general behaviours, the mother's responses, and the dyad's health and social situation; factors that influence and modify the overall treatment approach. Broader holistic considerations include the inter-relatedness of mind-body connections¹⁴⁷, the mother-baby bond, individual circumstances, and contemporary expectations of breastfeeding, new mothering and osteopaths' professional responsibilities. Elements of this idea are expressed by Edward (osteopath) in the exemplar below.

Well, osteopathy works on a lot of levels ... a mind, body, spirit [concept]; so the whole [person]. I don't like to break a person down too much into those separate components because we're just a single organism. So we treat the individual; we treat the baby; we treat the mum; and try to allow that physical process to happen as naturally as it can ... so whatever levels you think that occurs on, I don't know; we've all got our [theoretical] models; we just give people a treatment (O 6/04).

Edward acknowledges that people are complex beings and any interaction with them involves many interconnected underlying therapeutic mechanisms. He deals with the intricacy of the task, however, by adopting a familiar pattern of action that fits with the idea of applying manual therapy within the structure of a progressive cyclic schema. This schema, however, inculcates a range of therapeutic strategies that extend beyond manual therapy of the baby and which are directed toward influencing the way mothers' think, feel, and act in response to their personal and breastfeeding circumstances. One common example involves osteopaths advancing mothers' understanding of their babies' bodily responses and functions and how they might be contributing to their babies' behaviours. Hence the therapeutic processes involved in the *osteopathic therapeutic cycle* relate also to more subtle, but nonetheless important, effective interpersonal and communication skills.

¹⁴⁷Discussion of mind-body connections is a common theme in the data. A few osteopath participants allude also to a spiritual element but this dimension is not well developed.

Taking a focused yet broad holistic perspective is generally representative of osteopaths' approach to responding to dyads, regardless of individual breastfeeding difficulties. Treatment is not necessarily applied in response to disease but also to prevent disease. Dyads, *struggling to breastfeed satisfactorily* are not typically ill; they are encountering difficulties, while undergoing significant life challenges, which, for some, might potentiate illness. In the current study, the meaning of *therapeutic* is linked closely to the notion of addressing dysfunction rather than disease; of 'normalising' or restoring a state of physiological balance¹⁴⁸; physical and emotional. The *therapeutic cycle* is specifically *osteopathic* because it rests upon osteopathic principles, and science-based educational and treatment models that use manual therapy as their prime techniques or tools. It is structured in order to provide a practical clinical framework that fosters consistency, predictability and an ordered, schematic approach, yet is also open to creativity and flexibility. The former qualities satisfy professional, medico-legal, and public expectations of osteopaths and the latter qualities enhance their scope to respond to the core problem on an individual basis and according to professional and personal judgement.

At its simplest, the *osteopathic therapeutic cycle* represents a basic treatment cycle whereby manual techniques are applied to facilitate physically-based changes such as relaxing a tight muscle. As a basic process, it can be repeated a number of times within a treatment session or over a series of treatment sessions. From this perspective, the *therapeutic cycle* embodies the scientific medical paradigm which, in general terms, upholds traditional views relating to osteopathic education, professional conduct, and community expectations regarding what a visit to a health professional entails. This approach involves making a diagnosis, providing a structured intervention and evaluating treatment effects, which in turn, link back to the beginning by influencing the diagnosis and events of the next cyclic phase. Hence the diagnosis is often referred to as a working diagnosis that is reaffirmed or altered according to recent responses and events.

As well as its more systematic and technical characteristics, the *osteopathic therapeutic cycle* also has a broad dimensional range according to participants' personal goals and responses that take place, over time. Participants engage with the *therapeutic cycle* by becoming actively and mutually involved in it. Essentially, it represents a dynamic change cycle that feeds back into itself to influence the whole, and begin again. It thus implies ongoing momentum; flowing and evolving according to present and changing circumstances. Its course, however, does not always follow a linear trajectory but varies according to whether the *struggle to breastfeed satisfactorily* is resolving (or worsening) or

¹⁴⁸ See Chapter 10.2.

changing direction. Overall, the *osteopathic therapeutic cycle* follows a course that is influenced by three underlying transitional themes, which are now presented.

12.3 THE CORE CATEGORY'S THREE TRANSITIONAL THEMES

The functional arrangement of the core category, *Promoting optimal breastfeeding through the osteopathic therapeutic cycle* follows three interlinking transitional themes; *Creating the therapeutic space*, *Facilitating positive change*, and *Integrating*. Together, these themes explain, over a range of different conceptual levels, the process by which osteopaths respond to dyads *struggling to breastfeed satisfactorily*.

At a procedural level, the three themes align with general observations of a typical treatment session, which consists of beginning, middle, and end phases and the notion of a single or series of basic treatment cycles, as outlined previously¹⁴⁹. This more traditional biomedical approach follows a practice routine consisting of clinical assessment, intervention, and re-evaluation. In this situation, the first theme, *Creating the therapeutic space*, represents the beginning of the treatment session and involves setting the scene, establishing an enabling environment, and exploring and defining the clinical problem. It is particularly pertinent when an osteopath meets a mother and baby for the first time, but is equally important to maintain, and recreate if necessary, throughout different stages of practitioner-patient interaction. It augments the success of processes that take place within the two other transitional themes. The second theme, *Facilitating positive changes* involves intervening through action or explanation to induce a physical or mental response or difference that has health-related benefits for individuals, dyads, and their circumstances. It is situated primarily in the middle phase such as, but not limited to, when the osteopath makes a physical connection to the baby and applies manual therapy. The third theme, *Integrating*, involves a drawing together and analysis of treatment responses, thoughts and events in order to fit them logically into the general framework of clinical osteopathic paediatric practice. It is particularly relevant as a treatment technique finishes or the consultation draws to an end. Differences are noted, summarised and incorporated into the overall clinical picture, which feeds back into the therapeutic cycle and provides a basis for future actions and plans that are played out in the format of another treatment cycle. For osteopath participants, the theoretical approach to the core problem, based upon the idea of a fundamental cyclic treatment schema is a useful concept that explains the nature of their clinical work in a way that is easily articulated and understood.

¹⁴⁹ See section 12.2.2.

The particular features attributed to each of the three transitional themes and their progression through sequential stages can be, however, in some situations, simplistic and somewhat artificial. In the clinical setting of the study, the characteristics of each transitional theme and their relationships to each other tend to be more synchronous and complex. It is evident from the data that osteopaths discuss and follow elements of the biomedical approach to treatment but they adopt also a more relative, interpretive stance in order to respond to the core problem from a holistic multi-dimensional perspective. Clinical practice, in the situation of dealing with dyads *struggling to breastfeed satisfactorily*, tends to be conceptually complicated and at times, requires a more abstract explanatory framework. Together, the three transitional themes can account for the various biopsychosocial layers that underpin the core category and the progressive nature of the therapeutic change process. They inculcate various abstract ideas to explain the interplay of physical, interpersonal, cognitive, intuitive, and social processes involved when paediatric osteopaths interact with dyads, over a timespan.

The three themes that comprise the core category are described as transitional themes on the basis that they foster, and demonstrate the properties of, a transition experience for participants. Dyads are undergoing a transition toward *optimal breastfeeding* and osteopaths are *facilitating* the transitional process. In essence, the transitional themes of the core category involve processes, used by osteopaths to move a mother and baby from one point to another point, over a time span, in a progressive way. In other words, they facilitate a change from one breastfeeding state toward another with the ultimate aim of reaching a final state of *optimal breastfeeding*. According to Transition Theory¹⁵⁰, mother and baby dyads are going through and adapting to significant long-term life-changing processes that can make them vulnerable and open to personal change. From a physiological perspective, babies must make significant adjustments as they transition from intrauterine life to the external world and continue to develop and grow. Overcoming breastfeeding and other birth and postnatal difficulties represents a series of interrelated situational challenges, which are superimposed upon, and have the potential to disrupt, dyads' normal developmental transition experiences. The study's core category, and its three underpinning transitional themes, concern not only facilitating the situational transition of *Promoting optimal breastfeeding through the osteopathic therapeutic cycle* but also promoting, in a general sense, dyads' broader health transitions.

¹⁵⁰ See Chapter 11.3 for discussion of Transition Theory as it relates to the context of mother participants' experiences in the current study.

12.3.1 Creating the therapeutic space

It is evident from observation and discussion with paediatric osteopaths that they invest time and effort into creating an interactive environment in which they, mothers, and babies, can feel comfortable, relaxed, and ready for treatment. Such an enabling environment is conceptualised as a *therapeutic space* that embodies a number of physical and psychosocial qualities. It is fundamentally a positive, encouraging and supportive physical, emotional, and social environment that augments osteopaths' abilities to arrive at individualised understandings of *optimal breastfeeding* and to implement specific treatment strategies.

A *therapeutic space* inculcates a feeling, on behalf of osteopaths and dyads, of being in a place that enables them to interact, as individuals, in mutual, meaningful, and considerate ways. It incorporates the notion of a respectful and confidential *space*, in which mothers' problems can be discussed openly, drawn out, and analysed, and babies handled with sensitivity and care. A *therapeutic space* thus implies a permissive space; a quality that can be expressed in different ways. Permission relates to the more literal act of dyads' consent to treatment and includes other ideas such as acceptance of the osteopath's touch, exploration of a mother's deeper thoughts and experiences, and acknowledging her *breastfeeding struggle* without criticism or judgement.

The idea of the osteopath's room and treatment environment as a *space* opens it up, conceptually. A *space* can be defined according to its structural properties and its less tangible dimensions. In a physical sense, the *therapeutic space* is contained and defined by the size, shape, plan, and content of the osteopath's treatment room. The decor and set-up typifies a move away from a formal clinical setting to a friendlier relaxed environment¹⁵¹, which reflects elements of the osteopath's personality, background, and professional approach. The *space's* less tangible qualities include its capacity for changing shape, purpose and arrangement. It can be filled by objects such as furniture, toys, and pictures, and used by people in various ways according to their purpose and changing needs. The notion of the treatment environment as a *space* implies the ability to expand or contract in ways that foster creativity and adaptation as required; a quality that is particularly useful for the unpredictable nature of paediatric practice. For example, a flexible treatment environment enhances osteopaths' capacity for finding ways to keep a mother relaxed and involved, and a baby happy and cooperative during treatment. Study participants, who have been referred to as actors in grounded theory studies (Charmaz, 2006, p. 22), were observed to move, act, and occupy different spaces and positions at

¹⁵¹ See Chapter 4.2.1.

different times throughout the consultation. They would begin at one place with everyone seated around the desk, move to the treatment table in the centre of the room and then continue to move and change positions according to how events unfolded. This meant any number of different interactive combinations of postures, use of chairs, toys and floor space to enable the osteopath to work harmoniously with mother and baby.

The treatment room or *space* embodies more than a physical setting; it can imbue a pervasive mood or feeling. Conceptually, it has the ability to absorb and reflect participants' actions, thoughts and emotions. For example, intimate spaces were often observed as participants became quiet and physically close. Typically, a mother held, fed, or soothed her baby while the osteopath applied gentle and subtle manual techniques. At other times, the treatment environment could also reflect emotional qualities that had a potentially disruptive effect.

Because if they're [parents] stressed then I find the whole room is stressed and the baby senses it and you're not going to get access on a deep level to treat the baby ... No-one's happy and I find it very difficult to treat (Edward, O 06/02).

In this exemplar, the treatment room takes on a character of its own, mirroring the emotion of the individuals who occupy it and influence each other. Here, the feeling of participants in the room disrupts the environment such that it is not a *therapeutic space*. In such circumstances, paediatric osteopaths employ specific strategies such as *Forming an Alliance* and *Building Trust* in an attempt to change the atmosphere before treatment is continued. As the *therapeutic space* also concerns uncovering and defining dyads' breastfeeding difficulties, osteopaths use the strategies of *Assimilating* to focus on the problem and gather, analyse, and validate relevant information. In this way, *Creating the therapeutic space* includes formulating a clinical diagnosis in association with a broader understanding of the specific and contextual factors that contribute to dyads' breastfeeding difficulties. It thus prepares the way and interlinks closely with the implementation of specific treatment approaches.

12.3.2 Facilitating positive change

The concept of *change* is instrumental to being able to alter and improve current breastfeeding circumstances, which are problematic, unsustainable, and potentially detrimental to dyads' health and wellbeing. *Change* can occur in various ways and is described as *positive* on the basis of a clear intention of beneficence. For example, *positive change* might involve restoring a baby's normal physiological balance, reducing a mother's anxiety, or enhancing dyads' practical breastfeeding skills. It is possible that

osteopaths' actions, although well-intended, might nevertheless be incongruent with dyads' thoughts, emotions, and needs and thus result in negative responses or *change*; however, this was not evident in the data¹⁵².

Paediatric osteopaths discuss and explore the dimensions of *change* considered necessary or desirable to bring dyads closer to their ultimate goal of *optimal breastfeeding*. Understanding the dimensions of *change* underpins their choice and instigation of appropriate treatment strategies. Although dyads experience the *change* and osteopaths assume the role of *change* agent, the relationship between these two elements is close and complex. Dyads undergo *changes* that can be described, initially, as treatment responses. Osteopaths experience responses, in a physical sense, as they occur in the baby's tissues, and in a psychological sense, through their interaction and discussion with mothers. Responses become *changes* as they are absorbed into the baby's body and into dyads' everyday lives. For convenience, the dimensions of *change* are presented according to an emphasis on their biological or psychosocial properties, although these two elements tend to merge.

Application of manual therapy emerges as the predominant process by which osteopaths facilitate biological or physiological *changes*. At each consultation, participants were observed to interact in consistent ways, by following a basic treatment cycle, which overall, represents an organised and reasoned approach to determining treatment aims and instigating techniques to bring about specified physiological *changes* in the baby's body. *Changes* are expressed as differences in anatomy and function that osteopaths can feel, see and describe. Typically, physiological *change* is incremental and accumulative such that, overall, it translates into more relaxed behaviours and improved motor skills needed for effective breastfeeding. Physiological changes are however, not necessarily confined to a biomechanical perspective. They are facilitated on an individual basis, according to osteopaths' clinical reasoning, what they palpate in the body tissues and how they relate their findings and treatment aims to the breastfeeding goals. These ideas have been discussed previously, as the strategies of *Rebalancing*, and are illustrated by the following exemplar. Here, Megan (osteopath) describes her approach to responding to an irritable baby who is a fussy breast feeder.

The [physical] stress point was right around the [baby's] gut, so that was the major thing I treated in the first session ... So that released and when I saw her the second time I couldn't feel that. I checked and it felt pretty good. I was really drawn

¹⁵² See Chapter 13.5 for an account of mother participants' views of their experiences of osteopathy.

to her liver yesterday; it felt like the fluid and the cranial [physiological] rhythm wasn't getting through like it should have been. It felt a bit hard in there so that was the main thing I worked on and I think that if the liver¹⁵³ is not functioning as well as it should, it's going to affect the digestive system (Megan, O4/10).

In this exemplar, physiological *change* is induced on a step-by-step basis according to physical findings, which are linked to knowledge regarding digestive system function and its potential impact on breastfeeding. Generally speaking, osteopaths articulate, in detail, how they promote *optimal breastfeeding* by facilitating specified physiological *changes* on the premise that such changes will enhance dyads' physical capacities to breastfeed. At the same time, it is evident from the data that they view breastfeeding as a sensitive personalised human behaviour and *positive change* of a psychosocial nature is also relevant and likely to be important. They are, however, generally less clear about identifying the precise therapeutic processes that they use to achieve a *change* in this dimension. Strategies involved are based more on influencing how a mother thinks and feels about her *breastfeeding struggle*. Typically, osteopath and mother take an open and shared critique of the breastfeeding situation, which encourages a positive shift in attitude. *Positive change* involves moving mothers from a situation in which they feel *disempowered* to feeling increasingly confident and able to care for their babies, and where possible, to improve their breastfeeding self-efficacy. The *change* processes of *empowerment* for mothers, discussed previously, also tend to follow a progressive sequential pathway whereby mothers gradually regain a sense of control over their breastfeeding decisions and actions, through understanding and skill development.

Regardless of the type of *change* processes involved, paediatric osteopaths see themselves as taking a *facilitator* role. *Change* is essentially encouraged or stimulated rather than imposed or forced. When interacting with mothers, osteopaths typically *facilitate positive changes* in breastfeeding postures through touch and advice that is suggestive rather than authoritative. In general, they defer to mothers in all discussion and activities that involve breastfeeding and care of the baby. In this way, mothers are encouraged to become active participants throughout the course of treatment. Osteopaths *facilitate change* of a psychosocial nature by engaging with mothers and involving them in problem-solving, decision-making, and the discovery of new and relevant knowledge. In a similar way, *positive change* at a physiological level is not forced on the physical structures nor is the baby a passive recipient of manual techniques. Paediatric osteopaths use manual techniques that are modelled upon the idea of working in harmony with the

¹⁵³ Osteopaths use manual techniques to influence the body's viscera or internal organs by influencing local muscular tensions, nerve pathways and circulation of body fluids.

body's physiological mechanisms. This idea is based on the fundamental osteopathic principle that the human body has an inherent capacity to self-heal and find physiological balance. The patient makes the *change*, not the osteopath. Osteopaths play an essential role in the *change* process, but only as a *facilitator*. This means contacting the tissues and initiating, guiding, allowing, releasing, and activating bodily processes. The level of direct action and involvement to bring about a *change*, however, varies according to different treatment approaches. When treating babies, osteopaths use predominantly gentle techniques, collectively referred to as 'indirect techniques' that are considered more suited to a baby's physiology. The proposed model for the underlying mechanism or *change* process of indirect techniques is described by Lauren, osteopath, in the following exemplar.

It [indirect technique] involves us [osteopaths] being physically involved with shifting or moving a body part and then in some way [being] involved in the change. We are sitting back and allowing a change process to occur and just support and augment or enhance that process. So it's quite a subtle way to treat and can often be a hard one to explain because it's not a concept in our current medical science model; that there's this capacity for change and there's a capacity to interact with that process of change (Lauren O2/10).

Change arises from the data as a central concept that underpins osteopathic treatment. It can occur at many levels and it is not always possible to predict how a *change*, even a seemingly small one, might affect an individual or have a more substantial flow-on effect. Whatever the level and nature of *changes*, in order to maximise their benefits, the osteopath must integrate them in a meaningful way.

12.3.3 Integrating

Integrating means "to bring together (parts) into a whole; to make up or complete as a whole" (Butler, 2009, p. 643). The emphasis of the transitional themes of the core category, thus far, has been on setting up, defining, and implementing change processes, *through the osteopathic therapeutic cycle*. Change is, however, a complex concept and is experienced and interpreted by participants in different ways. The osteopath and mother do not necessarily share the same meaning of the overall treatment experience, but as a whole concept, the core category has general applicability for dyads *struggling to breastfeed satisfactorily* and for the osteopaths who assist them. *Integrating* involves bringing together the various change processes and clinical ideas in a unified way that results in a meaningful experience for participants and ultimately derives a beneficial

outcome. In order to see how the parts or changes become *integrated* into a meaningful whole, the dimensions of change and their relationship to each other and transitions is considered in more depth.

Change is an essential characteristic of transitions but the two concepts are not synonymous. Transitions involve long-term adaptive processes and “are both a result of change, and result in change” in peoples’ lives (Meleis, Sawyer, Im, Hilfinger Messias, & Schaumacher, 2010b, p. 52). It is evident from the data that physical and psychological change, expressed in terms of quality, degrees of difference, and personalised experience, can occur in various ways. It can be perceived as subtle, accumulative, minor or profound. It is not limited to immediate events but can emerge over time and after the conclusion of the treatment session. The idea of physiological responses continuing, once manual therapy is completed has been discussed previously¹⁵⁴. This notion can be extended to include other therapeutic change processes, such as the mothers’ thoughts, feelings, and actions. The outcome of each change or response is individualised and can be difficult to predict because most changes interlink, influence each other, and require a period of processing before their ultimate effects are discernible.

In the current study, osteopaths typically take short and long-term views of the core problem and the core category. Initially, however, they tend to focus on facilitating incremental changes at physical and psychosocial levels according to their evaluation of the immediate situation, while simultaneously maintaining an awareness of the potential consequences into the future.

I mean my role is to make sure that they get back to health, as far as they can, in that treatment and that’s it really... I know it should be having a positive role in their [babies’] future [health] but I just take it treatment to treatment (Edward O 6/16).

In this exemplar, Edward (osteopath) describes his step-by-step approach to achieving positive or healthful changes while acknowledging a generic belief that this approach will also likely lead to long-term benefits. A similar view is generally expressed by osteopath participants who place more emphasis on immediate or future treatment effects at different times, depending on the situation. The general consensus is, however, that over time, incremental changes accrue to induce a more lasting change or transition process that is reflected by more purposeful adjustment to the challenges and activities of daily living. This gradual positive change process impacts in meaningful, functional, and health-

¹⁵⁴ See Chapter 10.4.3.

related ways on dyads' lives and reflects a transition experience that is, in this study, encapsulated by the notion of *Promoting optimal breastfeeding through the osteopathic therapeutic cycle*. It is also evident that, when responding to dyads *struggling to breastfeed satisfactorily* and taking a long-term perspective, paediatric osteopaths are also concerned with broader transitional concepts that relate to promoting mother-baby health and wellbeing. For example, they share a common belief in the potential for inducing life-long change through osteopathic treatment, in some situations. In most cases, this idea is based upon the principle of risk analysis and preventative medicine, which is particularly applicable to the situation of a growing developing baby within a family environment.

A mother's and baby's experiences of physiological and personal change, however, do not automatically result in a smooth transition to *optimal breastfeeding*. The situation is more complex; changes have different qualities and need to be integrated into a broader multidimensional concept of patient care. For example, *integrating* for osteopaths in this study, often involves referring dyads to other health professionals to provide specific services deemed to be particularly appropriate at that point in time¹⁵⁵. Changes that are thought to influence dyads' breastfeeding capabilities tend to be cumulative and require time before their impact can be determined. Smaller changes become strategically *integrated* into a more significant overarching beneficial change, which is typically reflected by a baby's settled behaviour and a mother's growing self-confidence. Osteopaths attempt to manage the changes they facilitate by observing and evaluating them, predicting how they might influence the *breastfeeding struggle*, prioritising next steps, and incorporating new strategies to enhance their effects. Many of the strategies for *integrating* treatment responses emphasise clinical reasoning and judgement and have been presented previously as the strategies *Drawing Conclusions*¹⁵⁶ and *Finishing Well*¹⁵⁷. *Integrating* thus also involves implementing different strategies in systematic, creative, and flexible ways in order to achieve a final beneficial outcome that can become incorporated into dyads' lives and ultimately lead to *optimal breastfeeding*. A common unifying thread that underlies the implementation and *integration* of these various strategies is the osteopaths' strategic use of time.

Osteopaths recognise the importance of time in how it influences therapeutic processes. They use and manage it in a various ways to enhance *integration* of treatment responses, changes, and ideas in order to arrive at a final purposeful therapeutic outcome. An initial

¹⁵⁵ See Chapter 11.4.1.2.

¹⁵⁶ See Chapter 9.4.2.

¹⁵⁷ See Chapter 10.4.3.

overarching consideration relates to the amount of time that osteopaths make available for each treatment session, compared for example, to a standard medical appointment. On the basis of observations and interviews, time spent during a typical 30-40 minute appointment is used efficiently without a sense of rushing. It is acknowledged as an important element of relationship building, which underpins and enhances the quality of practitioner-patient interaction at all levels. A common idea, expressed by osteopaths is that of working harmoniously with time, such as taking their time to potentiate interpersonal processes, physical interactions, and treatment responses. They discuss timing in terms of sequencing of manual techniques when explaining their clinical methods, thoughts and actions. They were observed to purposefully manage each session in order to allocate time for interacting with the baby or mother according to specific breastfeeding related problems and personal needs. They talk about the healing qualities of time. Intervals between treatment sessions were adjusted according to interpretations of mothers' psychological states, the baby's feeding behaviours, likely treatment effects and how the course of time might impact upon these factors. For example, osteopaths often finished a treatment session with a general comment regarding the need to wait and see how the baby responded. This idea is based upon the rationale that time might be required for physiological processes to re-adjust and the consequences of change to become evident. Time thus plays a role in feeding back information into the *osteopathic therapeutic cycle* and influencing future diagnostic and therapeutic decisions and actions.

12.4 INTEGRATING CENTRAL CONCEPTUAL ELEMENTS

The study's final substantive theory is generated through integration of the core category, *Promoting optimal breastfeeding through the osteopathic therapeutic cycle*, with other key conceptual findings. It offers a more summative and complete explanation of the study as a whole and is represented by Figure 8. The substantive theory's Inter-related conceptual findings consist of contextual determinants, the core problem, the core category and four categories and their strategies and sub-strategies. Undertaking the final integration is one of the key characteristics of grounded theory methodology¹⁵⁸. Corbin contends that the cues to theory building lie in the researcher's ability to gain insight from the data and "make the scheme work" (Corbin & Strauss, 2008, p. 274)¹⁵⁹. In order to illustrate how the resultant theory 'works', in a practical sense, in the situation of osteopaths treating babies with breastfeeding difficulties, its theoretical underpinnings are discussed as they apply to one specified clinical case and participant group. Comparisons are then made with other

¹⁵⁸ See Chapter 3.5.7.

¹⁵⁹ Credibility and trustworthiness of qualitative and grounded theory studies is discussed in Chapter 4.9.

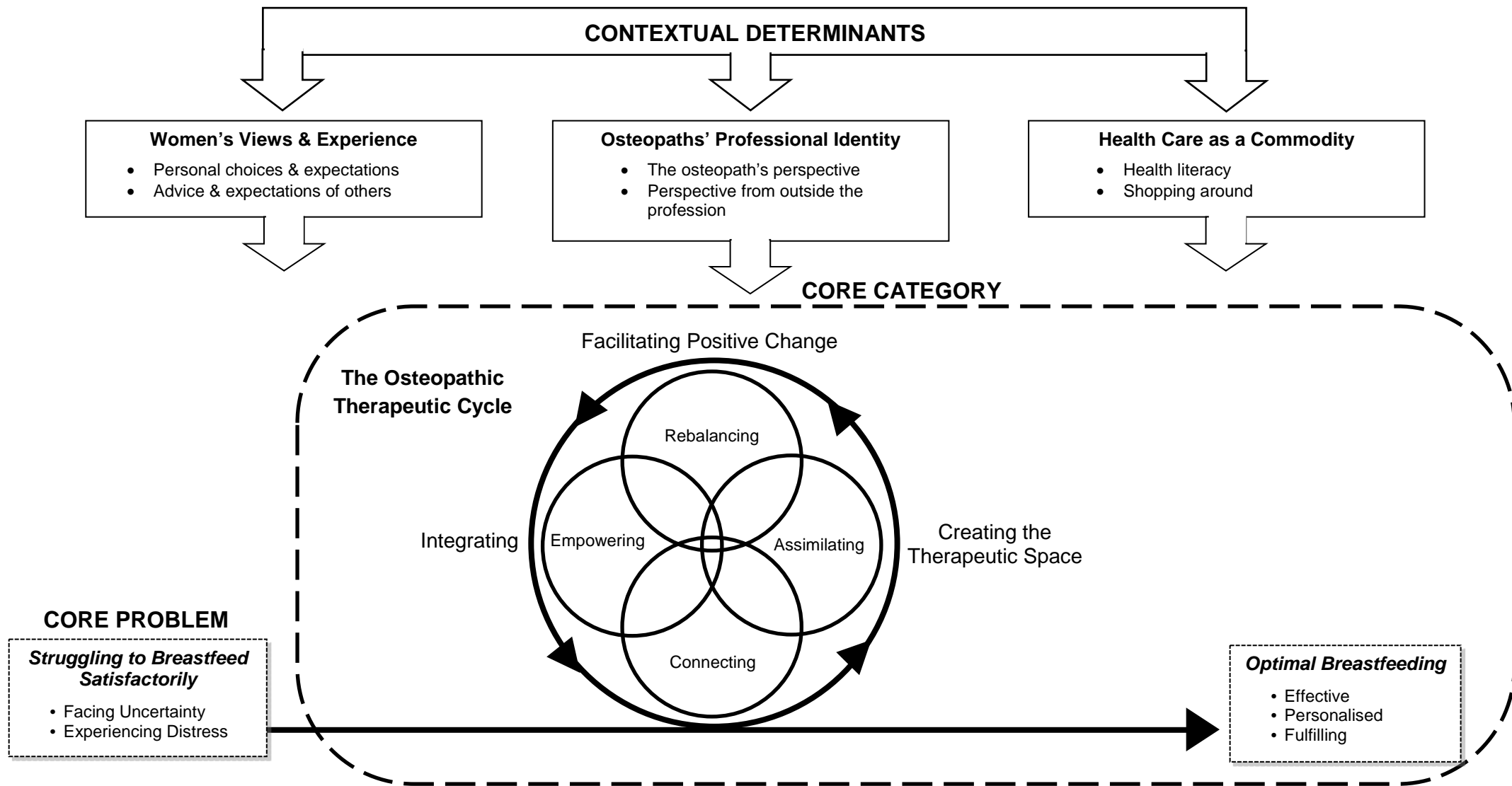


Figure 8: The substantive theory

cases to illuminate commonalities and differences and to show how the overarching theory can be applied in individual ways.

The exemplar case involves Vivienne, a 30 year-old first time mother of six-week old baby Amanda, who is treated by Tom (osteopath). Tom is in his fifth year of practice and thus represents one of the least experienced osteopaths in the study. Unlike the other three male osteopath participants, who are fathers; he has a history of limited personal experience with babies. He is, however, interested and comfortable with treating babies and enjoys paediatric practice. This is Vivienne and Amanda's third visit and, on this occasion, they are accompanied for the first time by father, Steve.

The obstetric history is complicated as labour commenced with Vivienne unaware that the baby was in a breech position. She experienced medical difficulties and the baby was delivered by an emergency caesarean section. Steve and Vivienne had planned, and were committed, to breastfeed. They come from a family background where breastfeeding is considered normative and they were aware of its health advantages. They describe the decision to breastfeed as a shared, easy and normal new parenting expectation. Elements of this contextual background are similarly reported by other mothers. Most had complicated births and describe feeling distressed and disappointed by perinatal events. All have supportive partners who play a key role in assisting and encouraging them to breastfeed. Unlike Vivienne, however, most women were more analytical regarding their decision-making around infant feeding, which was informed by a belief that breastfeeding was natural and the best option, but not necessarily normative and, at times, different to other family members' expectations.

Vivienne describes a scenario of confusion and uncertainty surrounding the birth. She left the hospital, however, believing that breastfeeding was progressing normally.

We didn't realise that there was a real [breastfeeding] problem ... I thought we were doing fairly well; just thought we'd fine tune it. Then they weighed her and found that she had lost a fair bit of weight (Vivienne, M 03/01).

Vivienne faces further uncertainty relating to breastfeeding when, at a follow-up domiciliary visit, the maternal child health nurse reports that baby Amanda has a dysfunctional suck. Vivienne, who was referred to Tom by a lactation consultant had no prior knowledge of osteopathy but expresses an open-minded view to complimentary therapies and reflects on her experiences of the health services made available to her on becoming a mother.

I don't really feel like it [osteopathy] should be something that's rightfully offered to everyone. You could seek it out if you want to. There's been so much government funded support of all kinds that I haven't really felt the whole experience to be financially a strain. Um, I can't really speak for anyone else but in my opinion if you felt that you needed it, you try to find a way (M 03/18).

This exemplar illustrates a common finding of the study; that women think about themselves as consumers of health services and osteopathy is situated within the private sector. While Vivienne accepts financial responsibility for osteopathic treatment, women participants have a range of views on the personal and social implications of the notion of *health-care as a commodity* and paediatric osteopaths demonstrate awareness of this contextual determinant's potential influence on their clinical practice. In the current case, Tom knows that he needs to earn Vivienne's trust and describes the most effective means to do this as achieving positive treatment results.

On the first two visits, Tom follows a course of action conceptualised as *the osteopathic therapeutic cycle* to get to know Vivienne and Amanda, define or diagnose their breastfeeding problem, and respond accordingly. He *creates a therapeutic space* by building interpersonal relationships through the strategies of *Connecting*. He gains knowledge by uncovering the nature of the clinical problem through *Focusing, Analysing* and *Validating* information; the strategies of *Assimilating*. He interprets examination findings according to what he feels in Amanda's body and which he believes are a result of forces sustained during her birth and he links physical findings, conceptually, to her suck dysfunction.

Amanda had that posterior drag through the head but she was also compressed down through the middle face into her anterior neck and chest. So that then held down the front [causing] a bit of restriction to her lifting her head up and getting the tongue on the roof of her mouth properly (O 3/03).

Before commencing treatment, Tom ensures that Vivienne understands and feels comfortable with his diagnostic analysis and intended treatment approach by using the strategies of *Forming an Alliance* and *Building Trust*. Vivienne states, "*He (Tom) explained sufficiently what he was doing. And I was comfortable with just kind of trusting to what he was doing* (Vivienne, M 3/11).

Like Vivienne, mothers generally describe osteopaths' interpretations of their birth histories and physical findings in the babies' bodies as insightful and believable. Typically,

they need to trust in osteopaths' integrity and knowledge because paediatric osteopathy is not well known to them or to significant others; a situation that includes health practitioners who are involved, at the same time, in their care. The contextual determinants of *Women's views and experiences* and *Osteopaths' professional identity* impact in various ways on how mothers and osteopaths articulate and define the core problem and how they form comfortable and cooperative practitioner-patient relationships.

On the third visit, Tom *re-connects* with Vivienne and Amanda by discussing their breastfeeding progress and develops an introductory relationship with father Steve, who has some understanding of the situation and paediatric osteopathy based on Vivienne's account of events and Amanda's responses. After some preliminary discussion, Steve was observed to place Amanda carefully onto the treatment table and, with Vivienne, sit close by her. Tom sits opposite them and places his hands lightly and deliberately on either side around her pelvis. He is still and maintains this hand contact while Amanda, who is awake and visibly content, wriggles and slowly uncurls to adopt a more symmetrical and relaxed position. Mother and father have relaxed facial expressions as they gaze at their baby and occasionally smile at her and each other. Overall, it is observed to be a calm, quiet, and intimate scene.

This part of *the osteopathic therapeutic cycle* involves the transitional theme of *Facilitating positive change*. Tom is applying manual therapy and draws on the strategies of *Rebalancing*, which are *Tuning-in and Releasing and Activating*. As Amanda lies on the table in her 'natural' twisted posture, Tom adopts a global manual treatment approach by applying one technique that appears to influence her body posture as a whole. He explains his thoughts and actions as follows.

Yes, well she (Amanda) had a little bit of a false midline ... her physical tissues were more comfortable off to that right side which is why she doesn't like turning her head to the left You're getting all the information coming into your hands; you just sense it, I suppose, and then they (babies) kind of rebalance themselves ... as things started moving back to a more normal position, she was more comfortable to adopt that easy straight position.

Tom chooses a subtle form of indirect manual technique to release abnormal physical tensions and achieve a state of improved physiological balance. He reasons that one technique or *therapeutic cycle* suffices for this particular session because a positive change has occurred, driven by the baby's self-adjusting postural mechanisms and visibly apparent. Throughout this process, a comfortable and attentive silence is maintained.

When the technique is finished, however, signalled by Tom removing his hand contact, the tempo of interaction shifts immediately from quiet to busy. Participants stand up, the baby is picked up, and an interactive discussion takes place about the current situation and future plans.

Positive changes of a less overt psychosocial nature are likely to have also taken place through the parents relaxing and acquiring a deeper understanding of Amanda's developmental changes. Parental awareness is reinforced through inclusion and the opportunity to observe Amanda's bodily responses and general demeanour, particularly when interacting with Tom. Vivienne states, "*I can see a visible difference in her as she's being treated. Like her jaw has certainly come out, she pokes her tongue out more easily (M3/15)*". Physical responses become linked logically through explanation and by signs of a stronger coordinated suck and overall improved breastfeeding self-efficacy. Vivienne's current approach to breastfeeding involves a complex mix of feeding strategies that she summarises as follows.

A typical feed for us at the moment is she goes on the breast for 20 minutes total; 10 minutes each side; then has a bottle. Then [she] goes back on the breast for another 10 minutes each side; just to try and give her a chance to do it herself first. And then, [I] give her some bottle and that seems to actually make her suck better. So she then goes back on me and sucks better and swallows better (M 3/02).

It is apparent that Vivienne and Amanda are working out breastfeeding together, each in her own way. Amanda's suck is improving and Vivienne is assuming control of a difficult breastfeeding situation. She is *empowered* by a growing sense of confidence and mastery of breastfeeding, which is encouraged by Tom. Steady progress in this dyad's breastfeeding capabilities is generally reported, which suggests that smaller positive changes accrue as one *therapeutic cycle* plays into the next cycle. Over time, sequential changes are *integrated* in a meaningful way that results in a smooth transition toward *optimal breastfeeding*.

For Vivienne and Amanda, the end goal of effective breastfeeding appears to be realistic and achievable. This case, however, represents one of a range of therapeutic approaches, treatment responses, and breastfeeding outcomes that were observed to take place throughout the conduct of the study. Not all babies were able to cooperate so well and osteopaths adjusted their therapeutic approaches accordingly. For example, mothers might be recruited to play a more active role in distracting or soothing the baby during treatment and osteopaths might need to adjust treatment positions and

expectations. The concept of *optimal breastfeeding* differs according to individual circumstance, which, in turn, influences treatment strategies and aims. For example, Tania (mother) first brings baby Charlie, aged 14 weeks to Julie (osteopath) because he is generally unsettled, a poor sleeper, and has fed exclusively from one breast because he refuses to feed from the other breast. She is frustrated by his behaviours but he is putting on weight and developing normally. Julie identifies significant somatic dysfunctions¹⁶⁰ in Charlie's body that restrict his neck mobility and deduces that these findings are implicated in his behaviour patterns. She focuses less on the specific breastfeeding problem and more on restoring normal physical function and helping Tania understand the postulated physical causes of Charlie's breast refusal and other difficult behaviours. Understanding assists Tania to accept and cope with their current breastfeeding relationship, which is personally frustrating but successfully meeting Charlie's nutritional needs. Tania expresses regret that she didn't seek osteopathic treatment earlier and we cannot know how new insights or *creating new meanings*¹⁶¹ might influence their future breastfeeding relationship, but Julie predicts the following outcome.

That his [Charlie's] general health will be improved by the structural [physical] changes and an understanding for the mum that it was OK to be going the way that she was going and there was a reason for it (Julie, O 1/12).

Promoting mothers' understandings of their breastfeeding situations and validating their struggles is a common therapeutic goal. Despite different breastfeeding difficulties and individual needs, paediatric osteopaths are able to respond satisfactorily by using a common schema; *the osteopathic therapeutic cycle*. Regardless of the final breastfeeding outcome; overall, each mother believed that she and her baby received some benefits through their interaction with the osteopath and would recommend osteopathy to other dyads with breastfeeding difficulties.

12.5 CONCLUSION

The core category, *Promoting optimal breastfeeding through the osteopathic therapeutic cycle* provides a conceptual framework that answers the initial research question, "How do paediatric osteopaths promote effective breastfeeding in mother and baby dyads with breastfeeding difficulties?" It provides an answer that encapsulates the study's key findings in an abstract format that is theoretical yet pragmatic and clinically relevant. Paediatric osteopaths' conceptualise a professional and individualised interpretation of *optimal breastfeeding* by taking a balanced view of the biological and psychosocial

¹⁶⁰ See Chapter 9.3 for a definition of somatic dysfunction.

¹⁶¹ See Chapter 9.4.2.1 for an explication of *Creating new meanings*, a sub-strategy of Assimilating.

influences that can impact on dyads' breastfeeding capabilities, experiences, health needs, and family situations. In order to *promote optimal breastfeeding*, osteopathic treatment follows a *therapeutic cycle* made up of three interlinking transitional themes; *Creating the therapeutic space*, *Facilitating positive change*, and *Integrating*. The first, *Creating the therapeutic space*, concerns clinical diagnosis and setting up a purposeful enabling environment. The second, *Facilitating positive change*, involves the application of osteopathic manual therapy and other therapeutic strategies to facilitate beneficial change in biological and psychosocial dimensions. The third, *Integrating*, draws the elements of change together in a cohesive way to feedback and influence the clinical situation in beneficial ways, and as a whole. Together, the three themes augment a progressive therapeutic change process or transition toward *optimal breastfeeding*.

As an overarching process, the core category is influenced by interplay between processes from within, which comprise the study's categories; *Connecting*, *Assimilating*, *Rebalancing*, and *Empowering*, and broader contextual determinants from without, which consist of *Women's views and experiences*, *Osteopaths' professional identity*, and *Health-care as a commodity*. Explaining the links between these key conceptual findings and the core category as the central organising theme, provides a unified account of the many interweaving and complex concepts and processes that underpin osteopathic paediatric practice in the situation of treating dyads *struggling to breastfeed satisfactorily*. Development of a final theoretical schema that explains paediatric osteopaths' therapeutic approaches across a range of individual circumstances and breastfeeding difficulties raises the overall findings to the level of a substantive theory.

CHAPTER THIRTEEN

DISCUSSION

13.1 INTRODUCTION

In this chapter, a discussion of the results of the study is presented. The chapter commences with a statement of the principal findings, which is followed by a synopsis of how they link back to original research aims. Discussion then focuses on the substantive theory, *Promoting optimal breastfeeding through the osteopathic therapeutic cycle*. The four categories, *Connecting*, *Assimilating*, *Rebalancing*, and *Empowering*, which represent the key conceptual processes that underpin the core category, are then discussed. This leads to a consideration of the distinctive practice knowledge and skills demonstrated by paediatric osteopaths in the situation of treating dyads with breastfeeding difficulties. As little research specific to the research topic is available, results are scrutinised by comparing them to the general osteopathic and relevant contemporary health care literature. New findings and understandings, attributed to the current study, are thus drawn out, examined in more depth, and viewed within a broader knowledge base.

13.2 PRINCIPAL FINDINGS

In the situation of responding to new mothers and babies who are *struggling to breastfeed satisfactorily*, paediatric osteopaths take a dynamic multi-dimensional integrative approach. They focus on understanding dyads, their breastfeeding problems, clinical histories, and unique personalised circumstances in order to make collaborative mother-baby-centred decisions, develop good practitioner-patient relationships, apply manual therapy to the baby, and build maternal confidence and breastfeeding-self-efficacy. Overall, they demonstrate clinical expertise by implementing and integrating a range of purposeful therapeutic strategies, encapsulated by the categories *Connecting*, *Assimilating*, *Rebalancing*, and *Empowering*, which are tailored to individual needs. Therapeutic strategies are underpinned by various forms of professional practice knowledge and skills that are organised into a systematic, yet flexible, progressive cyclic schema; conceptualised as *the osteopathic therapeutic cycle*. This dynamic, progressive cycle represents the fundamental transitional process for *promoting* the final therapeutic goal of *optimal breastfeeding*.

13.3 ADDRESSING THE RESEARCH AIMS

Three specific research aims were posed at the beginning of the study. The first relates to exploring mothers' experiences of encountering and coping with breastfeeding difficulties;

a perspective purported to be under-represented in the breastfeeding literature¹⁶². The final substantive theory addresses this aim by defining the core problem, *struggling to breastfeed satisfactorily*, explicating the contributing factors¹⁶³, and describing the trajectory of dyads' experiences and paediatric osteopaths' responses, over time, and throughout their interactions with each other. Findings emphasise the high levels of uncertainty and distress that many new mothers face when encountering breastfeeding difficulties, which paediatric osteopaths must take into account when analysing the clinical problem and ascertaining the best way to provide assistance. In addition, dyads' breastfeeding problems proved to be difficult to separate from other challenging obstetric and perinatal experiences. Paediatric osteopaths place high importance on uncovering the clinical and personal details of these related events because they are thought to contribute to the various breastfeeding problems and thus provide important diagnostic and management clues. One such notable concern is the relationship between birth trauma and breastfeeding difficulties. It was evident from the data, however, that mothers had little understanding of these potential inter-relationships, which were made apparent through the osteopath's explanation and therapeutic approach.

Similar concerns have been reported in the literature in the context of increasing intervention in labour and birth, medicalisation of midwifery practice (Thompson et al. 2011), and 'scientification' of breastfeeding (Craig & Dietsch, 2010, p. 162). These two Australian-based studies raise concerns about contemporary professional breastfeeding education and practice. Craig & Dietsch (2010) conducted a pilot study to investigate the perceived usefulness of a typical antenatal education strategy¹⁶⁴ for initiating breastfeeding, in a group of new mothers. They found that, when experiencing difficulties with breastfeeding initiation, participants' anxiety was related to the belief that they had not learnt how to breastfeed correctly or they were lacking in natural capabilities. No consideration was given to the potential negative consequences of their obstetric experiences such as delayed mother-baby contact due to birth complications or the effects of drugs used during labour on the newborn's feeding behaviours. On this basis, the authors argue that, in order to be fully informed, women should be educated about the physiological links between birth-related events and breastfeeding initiation. Thompson et al. (2011) conducted a review of Australian breastfeeding practice over the past 40 years¹⁶⁵ and concluded that increasing use of medical technology during birth and

¹⁶² See Chapter 1.6.

¹⁶³ See Chapter 7.2.

¹⁶⁴ See Chapter 2.8.1. Typical antenatal education programmes include information about correct positioning for breastfeeding initiation.

¹⁶⁵ See Chapter 2.8.1.

obstetric intervention had impacted negatively on modern breastfeeding practice and eroded women's instinctive nurturing behaviours. They contend that, in order to improve breastfeeding rates, health professionals should reflect on their roles as breastfeeding 'experts' and pay more attention to encouraging mothers' and babies' innate mammalian skills. It is noteworthy that mothers, in the current study, typically placed high value on the notion of breastfeeding as natural and an important element of their approach to motherhood; a view generally recognised and supported by paediatric osteopaths, and which might also reflect changing social attitudes toward contemporary parenting styles¹⁶⁶. Overall, mother participants' breastfeeding experiences, in this study, support the recent trend in the literature, of recognising the need for developing individualised breastfeeding strategies that promote breastfeeding self-efficacy, and that value dyads' instinctive and learnt breastfeeding behaviours¹⁶⁷ (Locke, 2009; Meedya et al., 2010).

The second aim of the study relates directly to the core category because it seeks understanding of the processes involved when paediatric osteopaths adopt a holistic approach and use manual therapy for the baby to promote effective breastfeeding. The notions of 'effective' breastfeeding used in the beginning of the study, when formulating the research question, has, as a result of data analysis, become superseded and subsumed within the broader concept of osteopaths *promoting 'optimal' breastfeeding*. This concept incorporates more than the notion of correct breastfeeding postures and coordinated infant sucking actions and recognises breastfeeding as a symbiotic partnership and meaningful human experience. Exploring the processes by which paediatric osteopaths identify, analyse and deal with the core problem has led to the development of the core process, *Promoting optimal breastfeeding through the osteopathic therapeutic cycle*. Conceptually, *the osteopathic therapeutic cycle* represents a generic mode or pattern of response adopted by paediatric osteopaths that accounts for clinical practice and combines a holistic patient-centred approach with more specific osteopathic technical and professional knowledge and skills. In-depth discussion of the core category follows in the next section of the chapter. The third aim relates to the purpose of generating a substantive theory of paediatric osteopathic practice in the situation of treating dyads with breastfeeding difficulties, which is now discussed.

13.4 THE SUBSTANTIVE THEORY

The study's substantive theory, presented in detail in the previous chapter, consists of a number of interlinking abstract concepts that contribute to the elements of structure and

¹⁶⁶ See Chapter 6.2.1.1.

¹⁶⁷ See Chapter 2.8.

process. Structure is the conditional context in which findings are situated (Strauss & Corbin, 1998, p. 123) and is made up of three key contextual determinants that concern broader contemporary social and professional influences that impact upon osteopathic treatment of babies with breastfeeding difficulties. Process relates to the study's categories, which interlink and inform the core category, Promoting *optimal breastfeeding through the osteopathic therapeutic cycle*, which, as the central explanatory concept, is generally representative of the substantive theory. Discussion is thus directed toward scrutinising the conceptual ideas contained in the core category and comparing them to relevant literature. As the substantive theory has a high level of abstraction, many of its concepts have relevance to other clinical contexts; however, in the main, it is applicable to the circumstances of paediatric osteopathic practice¹⁶⁸. No similar study or substantial research on the topic could be found in the literature, and only two related qualitative United Kingdom postgraduate research studies, were located (Barnes, 2004; Thomson, Petty, & Moore, 2014b). These studies, which used grounded theory methods, propose theoretical models of general osteopathic practice.

The first study, conducted by Barnes (2004), involved gathering and analysing data from semi-structured interviews and a focus group discussion, with experienced osteopaths, to explore the meaning of 'osteopathic care'. Described as an in-depth but small-scale study, results are presented as a theoretical model of five inter-related themes of 'osteopathic care' rather than a substantive theory. Four themes of care that focus on communication, understanding the patient, the therapeutic relationship, and action, were identified. These themes interlink and are organised in a circular way around the fifth, core theme; 'Care as the most beneficial outcome' (Barnes, 2004, p. 159). Here, 'the most beneficial outcome' is arrived at through patient consultation and professional judgement by taking into account all relevant factors; a finding that is consistent with the notion of paediatric osteopaths *promoting optimal breastfeeding* in the current study¹⁶⁹.

In the literature, much emphasis is placed on *optimal breastfeeding* in terms of outcomes that relate to rates, extent, exclusivity and duration of breastfeeding¹⁷⁰. From a health perspective, the World Health Organisation's (WHO) (2014a) recommendation of exclusive breastfeeding for the first six months is representative of *optimal* infant feeding¹⁷¹. In the current study, participants share a common motivation to breastfeed on the basis of its health benefits. They are familiar with the WHO recommendation, although

¹⁶⁸ See Chapter 3.5.1 for a definition of theory and the scope of a grounded theory.

¹⁶⁹ See Chapter 12.2.1 for discussion of the concept of *optimal breastfeeding* in the current study.

¹⁷⁰ See Chapter 2.2.

¹⁷¹ See Chapter 2.2.

osteopaths are more cognisant that it is informed by a well-substantiated research-base. Mothers and osteopaths discuss, and generally agree upon, the health-laden qualities of breast milk¹⁷², although its longer term benefits typically receive less attention. For a small group of mothers, the delivery of breast milk to the baby is seen as a priority and separated from the experience of feeding the baby at the breast. This idea has been discussed previously within the context of contemporary women's personal breastfeeding choices and expectations¹⁷³. For example, the practice of breast milk feeding with a bottle is a common finding of this study and has been reported as a growing phenomenon of more recent times (Thorley, 2011). In Australia, there is a high breastfeeding initiation rate; however the health benefits associated with *optimal breastfeeding* are more closely related to extent and duration, than initiation. Despite efforts to promote the WHO recommendation, a trend of early cessation of breastfeeding continues¹⁷⁴. Some authors contend that while breastfeeding is considered a biological norm; in developed countries, according to breastfeeding rates and outcomes, it is not a cultural norm (Hunt, 2006; Wolf, 2006), particularly for younger mothers (Noble-Carr & Bell, 2012). Others have drawn attention to the implications of the way language has been used in research texts to portray breastfeeding as an ideal infant feeding option rather than normative (Berry & Gribble, 2008; Ebert Wallace & Taylor, 2011). In an effort to improve breastfeeding support strategies, the personal meaning of the breastfeeding experience for new mothers has received growing research attention (Demirtas, 2012; Nelson, 2006; Sheehan et al., 2009). In these studies, a common conclusion is made; that women can only be appropriately supported to breastfeed when infant feeding is understood as an individual and socially contextualised experience. This view aligns with findings from the current study according to women's breastfeeding experiences and paediatric osteopaths' responses to dyads with breastfeeding difficulties. Overall, *optimal breastfeeding* is perceived as a relative, conceptually broad therapeutic goal that develops over time, according to individual dyads' preferences and health needs.

Returning to the core theme of osteopathic 'care as the most beneficial outcome', proposed by Barnes (2004); in a similar way, how paediatric osteopaths view the therapeutic goal of *optimal breastfeeding* is inextricably linked to the processes used to achieve this goal. The explicit links that osteopaths make between the five themes of care in Barnes' study and the interlinking nature of the four categories, *Connecting*, *Assimilating*, *Rebalancing*, and *Empowering*, which underpin *the osteopathic therapeutic cycle* in the current study, represent similar distinctive features of a holistic model that

¹⁷² See Chapter 2.4 for an account of the evidence relating to the health advantages of breast milk.

¹⁷³ See Chapter 6.2.1.1.

¹⁷⁴ See Chapter 2.2.

embraces patients' broader health needs. In order to *promote optimal breastfeeding*, paediatric osteopaths merge and balance a range of personal, patient-centred, scientific, and professional views, knowledge, and skills into a unified therapeutic approach. A similar individualised practice approach has been identified across other health disciplines, and described as practitioners' "internal frame of reference" (Chapparo & Ranka, 2008, p. 271). This idea is developed further in the second, recently completed, grounded theory doctoral study (Thomson et al., 2014b), which is now examined.

Thomson et al. (2014a) explored osteopaths' clinical decision-making and therapeutic approaches by collecting and analysing data from semi-structured interviews with experienced osteopaths and from video-recorded patient treatment sessions that were followed by video-prompted interviews. A constructivist approach (Charmaz, 2006) was used to generate a theory, based upon the idea that osteopaths' professional views and interactions with patients are informed by their 'conception of practice'; a term that relates to the lens through which a practitioner views the patient's problem and determines treatment goals and strategies (Thomson et al., 2014a, p. 2). The resultant substantive theory proposes that experienced osteopaths' 'conception of practice' lay on a continuum from 'technical rationality' at one extreme, to 'professional artistry' at the other. 'Technical rationality' is a term, first coined by Schön (1991, p. 22), which is used to describe professional practice that is characterised by rigorous technical problem solving, based on specialised scientific knowledge. It takes a traditional positivist perspective, in order to solve straightforward practice problems. In contrast, 'professional artistry' represents a more expansive interpretive or constructionist¹⁷⁵ paradigm that pays more attention to the complex and unpredictable nature of clinical practice and the need to draw upon different sources and types of knowledge to guide action (Thomson et al., 2014b, p. 4). Elements of Thomson et al.'s theory fit with findings from the current study on the basis that paediatric osteopaths demonstrate characteristics that align more closely with a 'professional artistry' conception of practice. Overall, they view *struggling to breastfeed satisfactorily* as a complex multi-layered biopsychosocial problem and thus respond by taking a dynamic multi-dimensional integrative therapeutic approach. A critique, however, of the notion of professional artistry as it applies to osteopaths in the current study, follows later in the chapter¹⁷⁶.

Overall, findings from the two grounded theory studies of general osteopathic practice presented here, and the current study, propose that, with the exception of a group of practitioners in Thomson et al.'s (2014a) study, who conceived a narrower form of

¹⁷⁵ See Chapter 3.3 for definitions of a constructionist epistemology and interpretive paradigm.

¹⁷⁶ See section 13. 5.

practice, described as 'technical rationality', osteopaths adopted a holistic approach by incorporating a range of epistemologies of knowledge, perspectives, and treatment strategies to inform their clinical practice. The theory derived from the current study however, has two distinctive characteristics. First, it incorporates patients' (mothers') perspectives of osteopathy and the clinical practice experience, into the data. Diverse perspectives add dimensional range to findings and can thus expand understanding of clinical practice processes¹⁷⁷. Second, the substantive theory of the current study relates to the situation of treating babies with breastfeeding difficulties. In comparison, a study of general osteopathic practice has, by nature, a broader theoretical range and perspective. Having a specific clinical focus enables deeper, more detailed exploration of a particular phenomenon; in this case, breastfeeding difficulties. Hence, the resultant substantive theory fits closely with everyday practice routines and interactions that occur between paediatric osteopaths and new mothers and young babies.

The notion of the *osteopathic therapeutic cycle* as a progressive feedback process that provides the means to solve complex breastfeeding problems fits with the literature relating to the clinical reasoning skills of health practitioners¹⁷⁸. For example, a similar cyclic hypothesis oriented approach has been reported by studies that have investigated the clinical reasoning of expert and novice physiotherapists in a range of clinical settings (Case, Harrison, & Roskell, 2000; Doody & McAteer, 2002; Edwards, Jones, & Carr, 2004; May, Greasley, Reeve, & Withers, 2008). Findings from these studies suggest that clinical reasoning in physiotherapy doesn't end with a diagnostic decision but continues with manual therapy treatment. Responses to treatment became another source of hypothesis evaluation, which further emphasises the dynamic cyclic nature of the ongoing reasoning process. This concept of clinical reasoning in physiotherapy fits with the notion of the *osteopathic therapeutic cycle* as a continuing and evolving clinical assessment and treatment process; however, there are significant differences.

Conceptually, the *osteopathic therapeutic cycle* is more than a clinical reasoning process, which relates more to thinking and the organisation of ideas and experiences to reach conclusions (Banning, 2008, p.178) rather than progressive interactive processes. Paediatric osteopaths' clinical reasoning aligns closely with the category, *Assimilating*, discussed later, which is an important component of practice that impacts upon their interactions with dyads¹⁷⁹. However, paediatric osteopathic professional practice as a

¹⁷⁷ See Chapter 4.9.1.2 for discussion of this research method, called triangulation, which strengthens the credibility of interpretations and findings.

¹⁷⁸ See section 13.4.2 for discussion of *Assimilating* in relation to clinical reasoning of health professionals in the wider literature.

¹⁷⁹ See section 13.4.2.

whole, involves multiple factors that go beyond the notion of reasoning, which is, primarily, a cognitive process. Such factors include reflection on prior clinical and personal experiences and values, professional judgement, and highly developed tactile skills, all of which impact upon interpersonal relationships with dyads, inter-professional relationships, and individual approaches to osteopathy. A number of these factors are thought to represent some of the more subtle, tacit processes of professional practice, commonly referred to as metacognition¹⁸⁰, and which tend to be merged seamlessly and intuitively into clinical practice. They are discussed later in the chapter, in the context of defining practice expertise¹⁸¹.

The core process, *promoting optimal breastfeeding through the osteopathic therapeutic cycle*, is described as a basic biopsychosocial process¹⁸² to reflect its conceptual depth and dimensional range, and, overall, the theory derived from the current study aligns with the biopsychosocial model¹⁸³. However, unlike a substantive theory, the 'biopsychosocial model' provides a more generalised conceptual framework, which can be applied to more diverse contexts. For example, Penney (2010) contends that a biopsychosocial model of pain relates particularly well to osteopathic practice, because pain is a common phenomenon experienced by patients, who seek osteopaths' services. In physiotherapy practice, Jones, Jensen, and Edwards (2008) situate their study of practitioners' clinical reasoning processes within a biopsychosocial framework¹⁸⁴. On the other hand, substantive or middle range theories are more concrete and limited in range¹⁸⁵ than a philosophy or conceptual model. Theory is defined by The Australian Oxford Dictionary as "a supposition or system of ideas explaining something, especially one based on general principles independent of the particular things to be explained" (Moore, 2004, p. 1338). The key defining element of a theory is thus its explanatory power and the specific purpose of the current study's thesis is to provide a well-substantiated theoretical schema that links concepts together to ultimately explain the processes involved when paediatric osteopaths treat dyads *struggling to breastfeed satisfactorily*. The core process, *Promoting optimal breastfeeding through the osteopathic therapeutic cycle*, essentially proposes a theoretical, yet, at the same time, pragmatic, procedural schema that draws together various conceptual diagnostic and therapeutic elements of practice into a

¹⁸⁰ See section 13.4.1 for a definition of the term, metacognition.

¹⁸¹ See section 13.5.

¹⁸² See Chapter 12.2.

¹⁸³ Engel (1977, 1980) first proposed the biopsychosocial model of medical practice as an alternative to, or broadening of, the traditional biomedical approach. It provides a framework for incorporating patient experiences of disease, disability, health, and wellbeing, as well as the practitioner-patient interaction, into a diagnosis and individualised treatment strategies and outcomes.

¹⁸⁴ See section 13.4.2.

¹⁸⁵ See Chapter 3.5.1 for a discussion of the meaning of theory in a grounded theory study.

cohesive systematic clinical framework. The schema rests upon the strategies and sub-strategies of four interlinking categories, which explain the complexities of treating dyads *struggling to breastfeed satisfactorily*. Discussion of each of the four interlinking categories is now presented.

13.4.1 Connecting

Connecting relates to the qualities of the osteopath-dyad therapeutic relationship. In general terms, the practitioner-patient relationship is acknowledged as a special type of interpersonal relationship that is critical to the therapeutic process (Bylund, Peterson, & Cameron, 2012). In nursing, it has been the subject of extensive research (McCann & Baker, 2001; Morse, 1992; Travelbee, 1971, Forchuk, 1993). One type of nurse-patient relationship that resonates with the osteopath-dyad relationship, in the current study, is similarly described as the “connected relationship”, which is characterised by qualities of openness, self-disclosure, trust, and friendliness (Morse, 1992). *Connected* relationships tend to develop and strengthen over time, as understanding of each other grows, in various ways. Understanding, for the paediatric osteopath, starts with *Forming an Alliance* by *establishing background* to get to know dyads at a personal level, their histories and breastfeeding difficulties, how their problems impact upon their lives, and what is important to them. The sub-strategies of *seeking affirmation, allaying anxiety, being empathetic and non-judgemental*¹⁸⁶ represent osteopaths’ attempts to understand dyads’ experiences of breastfeeding difficulties, from an insider perspective. They believe that seeing the person foremost, as well as the patient, better enables them to provide support and treatment strategies that match individual needs. “Attempting to understand” is similarly reported as an important strategy for developing nurse-patient relationships in McCann and Baker’s (2001, p. 532) study that explored how mental health nurses promoted wellness with young adults who were experiencing an early episode of psychotic illness. Here, the concept of developing interpersonal nurse-patient relationships is described as ‘mutual relating’ whereby the relationship is enhanced by the practitioner being open and prepared to discuss aspects of oneself, as deemed appropriate for the situation. Such strategies, based on the principle of reciprocity or self-disclosure, are strong motivators in human behaviour (Bylund et al., 2012, p. 265) and thus could be considered useful tools in the delivery of health care. For example, McCann and Baker (2001) describe ‘revealing oneself’ as a strategy of ‘mutual relating’ that nurses use to help put patients at ease and to avoid the perception of developing a one-sided relationship. The principles of this approach are similarly adopted by paediatric

¹⁸⁶ See Chapter 8, sections 8.4.1.2, 8.4.2.1, 8.4.2.2, and 8.4.3.1 respectively.

osteopaths' who articulate a humanistic understanding of women's *struggle to breastfeed satisfactorily* that is reinforced by sharing their own parenting and breastfeeding stories¹⁸⁷. They are aware that their life-views, which are shaped by personal and clinical experiences, influence their interaction with new mothers. Paediatric osteopaths use these strategies, however, in measured ways with awareness of how they might be influencing the therapeutic relationship. Typically, they believe that they do so in positive ways that enhance the quality of their *connection* with them.

Connecting, through relationship building, relies upon effective communication, in all its forms. One distinctive form of communication, used by paediatric osteopaths, is therapeutic touch; an idea that is developed further when discussing the category, *Rebalancing* and the application of manual therapy. In general, as interpersonal relationships are founded upon good communication, effective communication skills are acknowledged as a core competency of professional health care practice (Verma et al., 2006) and a defining characteristic of providing good patient care. When considering the dimensions of the practitioner-patient relationship, it can be difficult to separate out the processes of communicating, developing interpersonal relationships, and adopting a patient-centred approach to care because these elements overlap and influence each other. For example, sensitive empathic communication is consistently acknowledged as a high priority when interacting with new mothers when providing maternity care (Bick, 2010; Gramling, Hickman, & Bennett, 2004) and breastfeeding support (Graffy & Taylor, 2005; Nelson, 2006; Sheehan et al., 2009; Schmied et al., 2011). These studies report a common finding that women value professional care that is framed by a sensitive and personalised perspective. Similar findings have been reported in other health care settings by studies that have explored patients' views on the meaning of good patient-centred care¹⁸⁸. For example, two studies that investigated patients' perceptions of physiotherapy management of chronic low back pain (Cooper, Smith, & Hancock, 2008) and general musculoskeletal conditions (Kidd, Bond, & Bell, 2011) identified communication and an interactive practitioner-patient relationship as the most important dimensions of a patient-centred model of care. A similar idea is proposed by findings from McCann and Baker's (2001) study, which suggest that a particular type of "professional friendship" (p.533) can develop between practitioner and patient; one based on *trust* and *being non-judgemental* and *empathetic*. While the issue of practitioner-patient friendship did not specifically arise in the current study, the same qualities that underpin 'professional friendship', outlined above, relate to the strategies of *Connecting*.

¹⁸⁷ See Chapter 8.4.2.2.

¹⁸⁸ Patient-centred care relates also to the category, Empowering, and is discussed section 13.4.4.

13.4.2 Assimilating

Assimilating involves paediatric osteopaths taking a more focused critical view of each dyad's breastfeeding difficulties, obstetric history, and social situation in order to formulate a clinical diagnosis and make treatment plans. It fits with the notion of "problem setting" in professional practice, described by Schön (1991, p. 40) as naming the things that require attention, such as a baby's suck dysfunction, and framing the context in which they will be attended, such as the mother's health status or family circumstance. As *Assimilating* is premised on mental processes, it aligns closely with the concept of health practitioners' clinical reasoning. Traditionally, clinical reasoning emphasises analytic thinking and decision-making associated with clinical practice (Case et al., 2000; Doody & McAteer, 2002); processes that align with the strategies and sub-strategies of *Assimilating*. Clinical reasoning has been studied extensively in medicine (Schwartz & Elstein, 2008) and across a range of health disciplines, including osteopathy (Thomson, Petty, & Moore, 2014), occupational therapy (Chapparo & Ranka, 2008), physiotherapy (Jones et al., 2008), and nursing (Banning, 2008; Fonteyn & Ritter, 2008). Overall, the literature supports the notion that health practitioners employ two key forms of clinical reasoning called hypothetico-deductive reasoning and pattern recognition.

Hypothetico-deductive reasoning is a cyclic process that involves selective collection of patient information that is interpreted and analysed in terms of how it strengthens or weakens an initial diagnostic hypothesis, which can be modified accordingly (Schwartz & Elstein, 2008, p. 224). In pattern recognition, the practitioner associates and compares current patient problems with similar prior clinical situations and previously successful management strategies (May et al., 2008, p. 262). Studies have also been undertaken to investigate and compare the clinical reasoning skills of novice and expert practitioners (Case et al., 2000; Doody & McAteer, 2002; May et al., 2008; Schwartz & Elstein, 2008). A common finding is that while novice and expert practitioners use hypothetico-deductive reasoning, experts tend to draw more upon pattern recognition, which relates to experience and the ability to organise, retrieve, and utilise cumulative and various forms of knowledge. There is consensus also that clinical experience is important when defining practitioner expertise but only if associated with an ability and desire to reflect and learn from it. In the situation of responding to dyads *struggling to breastfeed satisfactorily*, it is evident that paediatric osteopaths use similar hypothetico-deductive and pattern recognition reasoning approaches to formulate their diagnoses and treatment plans and they move flexibly between these two approaches on the basis of experience, reflection, and clinical judgement.

Research in clinical reasoning has led also to an expanded notion of the concept by situating it within a biopsychosocial framework (Jones, Edwards, & Gifford, 2002; Jones et al., 2008). This approach involves a shift from diagnostic reasoning or clinical decision-making that is separated from the patient's experiences toward a more holistic view that takes into account the complex interplay of various reasoning strategies that occur on an ongoing basis throughout practitioner-patient interaction. While there are discipline-specific variations, the following definition draws together the common characteristics of clinical reasoning, from a biopsychosocial perspective, across the health professions.

Clinical reasoning is that process in which the therapist, interacting with the patient and significant others, structures meaning, goals, and health management strategies based on clinical data, client choices and professional judgment and knowledge (Jones et al., 2002, p. 2).

It can be seen that the definition, above, takes clinical reasoning from a predominantly cognitive process to 'structuring meaning' through a multi-layered process of acquiring and using a range of different types of knowledge. Such an approach requires practitioner self-awareness and reflection or "thinking about thinking" (Banning, 2008, p. 179); a form of higher order thinking also known as metacognition (Jones et al., 2008, p. 249).

In general, findings from the literature, pertaining to the clinical reasoning of expert practitioners, situated within a biopsychosocial model, fit well with the central idea and strategies of *Assimilating* in the current study¹⁸⁹. Here, paediatric osteopaths use a mix of deductive and inductive thinking processes to *assimilate* diverse forms of information in order to create a clinical diagnostic and treatment framework of understanding¹⁹⁰. In general, they share a common holistic mother-baby-centred approach when making a diagnosis and formulating treatment goals, which have two main foci of attention; the baby's physical body (*Rebalancing*) and the mother's personal wellbeing (*Empowering*); two foci that tend to become blended into the overall dynamic practice situation.

13.4.3 Rebalancing

Rebalancing relates to inducing a beneficial physical change in the baby's body; one that is directed toward an improved state of physiological *balance*, which can be expressed at physical and emotional levels. Although this change process is essentially brought about by the application of specific osteopathic manual techniques, it rests also upon osteopath-patient interaction, mediated through therapeutic touch, and as such, has a number of

¹⁸⁹ See section 13.5 for further discussion around the idea of professional expertise.

¹⁹⁰ See section 9.2 for a definition of *Assimilating* as a process of absorbing and constructing knowledge.

special humanistic features. Traditionally, manual therapy is grounded in biomedical sciences such as anatomy, biomechanics, and the rational application of technical manual skills¹⁹¹. While these elements are an important part of *Rebalancing*, in the current study, overall, this category expands understanding of manual therapy as more than a science-based technical skill. The use of touch during manual therapy and more broadly, from a therapeutic perspective, is a complex phenomenon. A consideration of how paediatric osteopaths incorporate therapeutic touch into their treatment sessions is presented, which is followed by discussion of relevant literature.

Paediatric osteopaths were observed to touch the mother and baby in different ways to convey messages as part of the process of developing interpersonal relationships (*Connecting*). For example, a hand on the mother's shoulder and cradling the baby impart humanistic messages of a reassuring nature. When applying manual therapy, however, they follow a particular and consistent approach. The osteopath positions mother and baby, becomes visibly calm and focused, meanwhile placing her hands carefully onto, around, or underneath the baby's body in a supportive way (*tuning-in*). This deliberate action is then followed by a period of quiet sustained attention, sometimes interposed with subtle slow manual adjustments (*releasing and activating*). A common manual therapy contact, for example, involved cradling the baby's head in a seemingly static holding position. At times, the osteopath was observed to apply a more specific technique by using her finger pads to touch a localised body tissue but invariably, appeared to wait for some form of subtle indication that the technique was completed (*finishing well*) before removing her hands. Throughout manual treatment, paediatric osteopaths' body language typically conveyed a sense of attunement to the baby's responses. Mothers watched the interaction intently and overall, expressed awareness that an exchange was taking place between osteopath and baby but that its form was difficult to see and understand, exactly¹⁹². Whenever the general tempo of interaction slowed and the baby relaxed, the mother also tended to relax¹⁹³ and some mothers appeared to become assimilated into the physiological experience¹⁹⁴.

Lederman (2005) maintains that how the manual therapist touches the patient and uses the hands during the application of manual techniques conveys the practitioner's intention, and for manual therapy to be successful, this intention must match the patient's condition (p.270). On this basis, he differentiates between two forms of therapeutic touch;

¹⁹¹ See section 10.3.

¹⁹² See exemplars from the data in Chapter 11.4.2.1 *Educating*.

¹⁹³ See Chapter 8.4.2.1 *Allaying anxiety* and 8.4.2.2 *Being Empathic*.

¹⁹⁴ See Chapter 11.4.2 *Involving*.

instrumental and expressive. Instrumental touch is used for more precise directed techniques such as examining, testing, or moving body structures, whereas expressive touch is less mechanical and more supportive in an emotional and humanistic sense. This idea of practitioners using different forms of touch according to their aims of inducing relaxation or making subtle fine physical adjustments to achieve a state of physiological *balance* fits well with the strategies of *Tuning-in*, *Releasing and Activating*, and *Finishing well*. It is also supported by what is known about touch as a primary human sense and form of communication. In their synthesis of the research literature pertaining to the communicative functions of touch, Hertenstein, Verkamp, Kerestes, and Holmes (2006, p. 6) point out that in evolutionary terms, touch precedes other forms of communication, is the most developed sensory modality at birth, and tactile stimulation is a fundamental human need for normal development. It is also considered central to the communication of attachment, particularly in relation to infant and maternal bonding (Montagu, 1986). One related example is the positive relationship between early mother and baby skin-to-skin touch and the development of a successful breastfeeding relationship (Moore et al., 2012)¹⁹⁵. Following a similar logic, Lederman (2005) argues that the relationship between touch and the psychological and psychosomatic effects of manual therapy originate from two primary sources: recognising touch as a basic human biologic need or process; and the individual's early life association that is made between touch (usually maternal) and a sense of wellbeing (p.299).

Osteopaths, Elkiss and Jerome (2012) offer a more scientific biomedical-based explanation for the health benefits associated with therapeutic touch as an important part of osteopathic treatment. They propose a biological systems-network approach that explains the link between touching the body and the potential to access and influence reciprocal anatomical and physiological interactions between the musculoskeletal, immune, nervous, and endocrine (MINE) systems. Hence touch is a potent agent of the MINE system, which acts as a 'super system' (p.516) that influences the body as a whole. Limited research relating to the effects of therapeutic touch in a clinical setting has been generated, which is generally suggestive of its health benefits. Examples include touch that is applied through infant massage (Bennett, Underdown, & Barlow, 2013; Chen, Sadakata, Ishida, Sekizuka, & Sayama, 2011; Lorenz, Moyse, & Surguy, 2005) and in a particular format called 'Therapeutic Touch', which has developed as an independent discipline applied, in the main, in nursing practice (Leskowitz, 2003; Monroe, 2009). Research pertaining to the underlying mechanisms and therapeutic use of touch is, however, incomplete and remains controversial (Ernst, 2007; Leskowitz, 2003).

¹⁹⁵ See Chapter 2.6.2 for further information relating to this topic.

In the current study, the more expressive form of therapeutic touch is less well articulated and tends to become absorbed into the overall concept of care and the development of practitioner-patient relationships. It could be argued that osteopaths have not paid attention to the less well-known therapeutic effects of human-to-human touch as an integral part of their manual techniques because they do not want to take manual therapy out of the realm of a biomedical framework; one that offers a more legitimate basis for using touch in a professional therapeutic way. Lederman (2005, p. 229), however, contends that the psychological responses associated with human touch can be an important treatment aim, not just a by-product of manual therapy and argues that there is a strong body of scientific evidence to explain the physiological mechanisms by which this process takes place. More recently, a discussion of the potency of touch in osteopathic treatment was presented by Elkiss and Jerome (2012) who propose that physical contact between osteopath and patient creates an interactive, complex, and dynamic partnership, “with emergent thoughts, feelings, and dialogue that are greater than the sum of the individual parts” (p. 515). Their idea that therapeutic touch involves a form of tactile conversation that deepens trust and the quality of interpersonal processes while enhancing physical treatment fits well with the overall concept of *Rebalancing* in the current study.

13.4.4 Empowering

Patient *empowerment* is a common therapeutic goal reported throughout the wider health care literature. It can, however, be difficult to define exactly and is perceived more in terms of a philosophy that guides behaviour (Feste & Anderson, 1995). In health care settings, this means practitioners applying the principles of patient autonomy and self-determination in pragmatic ways by adopting *empowerment*-orientated attitudes and strategies according to the clinical context (Gramling et al., 2004). In the situation of dyads *struggling to breastfeed satisfactorily*, paediatric osteopaths responses align with these general principles of patient *empowerment*, and also with related breastfeeding research, where maternal *empowerment* is expressed in particular ways. For example, paediatric osteopaths use *Empowering* strategies of *Supporting* and *Involving* and sub-strategies of *resourcing* and *educating* to promote maternal confidence and adjustment to motherhood¹⁹⁶. They fit also within a breastfeeding self-efficacy framework, which has been used widely in breastfeeding research to develop a breastfeeding self-efficacy measure (Creedy et al., 2003; Dennis, 2003) in order to explore specific interventions to support breastfeeding women (Kingston, Dennis, & Sword, 2007). In addition, studies that

¹⁹⁶ See Chapter 11.3.

explored mothers' perceptions of breastfeeding contend that breastfeeding success can have an *empowering* effect on some women (Barnes, 2013; Locklin & Naber, 1993), and particularly so, when associated with overcoming difficulties in the perinatal period. For example, Barnes (2013) found that, in a group of new mothers who had assisted conception, breastfeeding was viewed as a means of counteracting the medicalisation they underwent in order to conceive. In a similar way, mothers in the current study, who have had a complicated birth, tend to associate breastfeeding with personal agency and a means for regaining a sense of woman-centred control; a form of *empowerment*. A contrasting viewpoint, however, is that as contemporary society emphasises a moral imperative for women to breastfeed, feelings of breastfeeding failure can have significant negative psychological consequences (Crossley, 2009). This viewpoint resonates with some women's experiences of the core problem, *struggling to breastfeed satisfactorily*, in the current study, in terms of their feelings of being *disempowered*¹⁹⁷.

Overall, findings from the current study support the notion that individualised patient *empowerment* can be facilitated by practitioners' use of strategies that are founded upon a patient-centred approach (Aujoulat et al., 2007). Such an approach has been discussed previously, in relation to the category *Connecting*, and is a criterion of good professional practice, outlined in the "Code of Conduct for Registered Health Practitioners" (Osteopathy Board of Australia, 2013). In more recent times, the concept of patient-centred care has been studied, across a number of health disciplines, to determine what it is, exactly, and how it is practised. Particular attention has been paid to investigating the processes of mutual collaboration and negotiation that underpin the practitioner-patient relationship and the nature of *empowering*-orientated strategies (Mead & Bower, 2000; Wilson, 2008). As the biopsychosocial perspective has been increasingly integrated into health care, the notion of patient-centredness has moved toward increasing the patient's involvement in practitioner-patient interaction. This includes nursing (Lauver et al., 2002), physiotherapy (Cooper et al., 2008; Kidd et al., 2011), chiropractic (Miller & Gemmell, 2004), and osteopathy (Oliver Thomson, Nicola Petty, & Ann Moore, 2013) and is consistent with findings from the current study. Here, patient-centredness, relates to paediatric osteopaths understanding dyads as people, their social circumstances, individual *struggles to breastfeed satisfactorily*, and the deeper personal meanings of breastfeeding. In the study's final substantive theory, paediatric osteopaths' *empowering* strategies are linked to achieving the final personal goal of *optimal breastfeeding*, which is determined through consultation and negotiation but made, primarily, by mothers. A consistent guiding principle of patient *empowerment* is that treatment goals and outcomes

¹⁹⁷ See Chapter 11.2.

are not pre-determined by health providers but individually formulated through collaborative discussion (Aujoulat et al., 2007). Patient-centred and *empowering* approaches are thus closely associated but not necessarily the same, depending on the extent of patient involvement in key decision-making and therapeutic processes.

Personal *empowerment*, in terms of patients' decision-making and self-management capabilities, is discussed in the wider literature, also in association with the concept of health literacy; how patients access and use knowledge in ways that are meaningful to them¹⁹⁸. Health professionals are expected to provide health-related information for the purpose of increasing patients' knowledge of relevant issues and options; thereby enhancing their ability to make informed choices about their health management and ultimately improve health outcomes (Schiavo, 2007). However, the assumed benefits of health communication were not necessarily evident for mothers in the current study, even though they had, in general, high levels of health literacy¹⁹⁹. They typically reported feeling overwhelmed, frustrated, and confused by the plethora of breastfeeding and new mothering information made available to them that appeared, at times, to be contradictory, ambiguous, and ineffective²⁰⁰. This finding is supported by results from another study that investigated patients' perspectives of the doctor-patient relationship and information giving across a range of literacy levels (Shaw, Ibrahim, Reid, Ussher, & Rowlands, 2009). Results suggest that, irrespective of their health literacy skills, patients consistently have difficulty in accessing, understanding and using health information and they place high value on face-to-face discussion with health practitioners who have good interpersonal communication skills.

In principle, mothers in the current study, valued a critical evidence-informed approach to learning about and seeking breastfeeding strategies to assist them, and were interested in breastfeeding related information, acquired from a variety of sources. What was particularly useful to them, however, was the opportunity to ask questions and discuss information, concerns, and goals with an interested and supportive health practitioner; in this case the osteopath, who they believed had relevant, up to date, expert knowledge²⁰¹. Another criterion of 'good practice' for osteopaths (Osteopathy Board of Australia, 2013) relates to practising with an evidence-based approach²⁰². Osteopaths, in the current study, generally adopted a pragmatic evidence-informed approach, which was

¹⁹⁸ See Chapter 6.3.1 for a discussion of health literacy as a component of the contextual determinant, *Health Care as a Commodity*.

¹⁹⁹ See Chapter 6.3.1.

²⁰⁰ See Chapter 7.2.1.2.

²⁰¹ See Chapter 11.4.1, p 19

²⁰² Evidence-based medicine is defined as "the integration of best research evidence with clinical expertise and patient values" (Sackett, Straus, Richardson, Rosenberg, & Haynes, 2000, p. 1).

characterised by creating opportunities for shared critical discussion with mothers but only on the condition that mothers were interested in the particular topic and it was likely to be helpful or applicable to their needs. They typically prioritised strategies that emphasise and foster mother-led decision-making about caring for, and feeding, their babies, over giving advice based on best breastfeeding evidence. In addition, they were self-critical of their breastfeeding knowledge limitations, and valued personal breastfeeding experiences over theoretical knowledge. Wherever possible, they followed the mother's lead with the aim of *supporting* her to better explore her options²⁰³. When this type of patient-led approach and interactive discussion facilitates patient learning, it becomes a form of *educating*. Educational methods of this type, which are essentially patient-centred and based on experiential learning, are considered most likely to facilitate patient *empowerment* (Aujoulat et al., 2007; Feste & Anderson, 1995). Such methods enhance patient (and practitioner) understanding and the ability to reflect on experiences in order to seek, apply, and evaluate new resources. These learning outcomes are important to new mothers who want to make sense of their babies' behaviours, breastfeeding, and life circumstances.

Paediatric osteopaths typically take the notion of patient-centredness to a level where the focus shifts from a shared perspective toward greater opportunity for mother-led decision-making and change, which is of a more transformative nature. They take this approach because they are sensitive to the fundamental importance of maternal self-determination and breastfeeding self-efficacy for the health and well-being of mother and baby. They understand the need for personal agency when developing a maternal identity²⁰⁴ and coming to terms with, or overcoming, breastfeeding difficulties. Self-understanding assists mothers to make informed decisions about breastfeeding and take control over other aspects of new mothering and family life that are important to them²⁰⁵.

In summary, the substantive theory, *Promoting optimal breastfeeding through the osteopathic therapeutic cycle* is underpinned by four categories, *Connecting*, *Assimilating*, *Rebalancing* and *Empowering*, which have been defined and discussed in detail. Together, the four categories interlink closely to influence each other, and account for *the osteopathic therapeutic cycle's* simultaneous consistency and creative potential. Each cycle follows a similar pattern that begins with the theme of *Creating a therapeutic space* (*Connecting* and *Assimilating*), moves onto *Facilitating positive change* (*Rebalancing* and *Empowering*), followed by an *integrative process* (*Connecting* and *Assimilating*), which

²⁰³ See Chapter 11.4.1.

²⁰⁴ See Chapter 11.3.

²⁰⁵ See Chapter 11.2.

results in consequences or outcomes that lead to, and feed into, a new therapeutic cycle. At an initial visit, the categories tend to follow a more logical sequential pattern, as above, whereas during subsequent visits, while the basic cyclic process is repeated, more spontaneity might be required and categories move back and forth to influence each other. Hence, each cycle is unique; developing according to the flow of events, dyads' responses, and how the osteopath reflects upon and responds to the immediate and evolving situation.

13.5 EXPERTISE IN PAEDIATRIC OSTEOPATHIC PRACTICE

Discussion now takes place around the distinctive professional and personal attributes demonstrated by paediatric osteopaths. The impetus for such discussion relates to an unexpected finding of the study; one that is similarly recognised as a topic of interest in the contemporary health care literature. It relates to the concept of professional practice expertise, which is generally demonstrated by osteopath participants when responding to new mothers and young babies, in what is an inherently complex and unpredictable clinical practice situation. Expertise is characterised by osteopaths' practice knowledge, skill, sensitivity, and professional judgement in response to a range of diverse clinical breastfeeding problems and practice situations, which were, overall, dealt with effectively in a caring, competent, and professional manner. This finding relates also to another general finding that, regardless of individual breastfeeding outcomes, mothers were essentially satisfied with their experiences of osteopathy and believed that it could benefit other mothers in similar situations. The researcher is aware also that the study's substantive theory portrays an overwhelmingly positive view of paediatric osteopathic practice, which is not considered a common feature of clinical practice in general, and thus requires closer examination. Discussion of expertise in paediatric osteopathic practice begins with a statement that explains the researcher's interpretation of the concept, based upon analysis of data, before making comparisons with the literature.

Expert practice in the situation of responding to dyads *struggling to breastfeed satisfactorily*, rests upon paediatric osteopaths' abilities to blend personal and professional values and judgement with technical manual therapy skill and practice knowledge to assist dyads, in individualised ways, to achieve their end goal of *optimal breastfeeding*. It is founded upon their expressed interest in understanding dyads and their breastfeeding problems from a biomedical and social perspective²⁰⁶ and to organise and use different forms of knowledge and action, according to perceived need, at the time, and over a

²⁰⁶ See Chapter 9.2.

period of time²⁰⁷. They skilfully combine clinical reasoning, technical manual and interpersonal skills by moving between positivist (scientific) and interpretivist (psychosocial) paradigms, according to their reading of the practice situation. In other words, expertise, in a generic sense, lies in taking a disciplined yet dynamic and flexible multidimensional view of practice to apply a range of professional and personal knowledge and skills, wisely. Some of the distinctive features of expert practice that arise from the study are the quality of interpersonal osteopath-dyad relationships, osteopaths' judicious use of therapeutic touch, specific manual techniques, and time, and their open reflexive practice approach.

In the osteopathic technical and conceptual literature, the discipline is described frequently as a philosophy, science, and art (Cameron, 1998; Di Giovanna, Schiowitz, & Dowling, 2005; Parsons & Marcer, 2006; Stone, 1999; Ward, 2003) but what this means as a unified concept remains unclear. The elements of philosophy and science are generally well-articulated but the artistic component of professional practice has not been investigated or well defined. Traditionally, osteopaths draw upon a set of principles²⁰⁸ combined with scientifically based treatment models²⁰⁹ to ultimately inform clinical practice. When discussing their approach to assisting dyads with breastfeeding difficulties, paediatric osteopaths refer often to these principles and biomechanical, anatomical and physiological treatment models. They do not, however, discuss research pertaining to the social processes of clinical practice and the complexities of decision-making, interpersonal relationships, and practitioner-patient interaction. A similar situation has been articulated in the literature by (Schön, 1991), who, in his seminal book, *The Reflective Practitioner*, describes a gap between expert knowledge of the science-based health professions, and the complex demands of clinical practice. On this basis, he argues for a shift toward a new epistemology of practice called "reflection-in-action" (Schön, 1991, p. 49) in which technical problem solving is placed within a broader context of reflective enquiry. 'Reflection-in-action' is a complex concept that fits with the notion of 'professional artistry' in a health care setting, as proposed previously in Thomson et al's study²¹⁰. The more subtle elements of practitioner-patient interaction, have become more visible, in recent times, through investigation, across a range of health disciplines, into the complex phenomenon of expert practice or professional artistry; concepts that are closely linked but the distinction between them remains unclear (Chapparo & Ranka, 2008; Paterson & Higgs, 2008).

²⁰⁷ See Chapter 12.3.3 for discussion of osteopaths' strategic use of time to augment treatment results.

²⁰⁸ See Chapter 6. 2.2.

²⁰⁹ See Chapters 9.3 and 10.3 for a presentation of the background to some osteopathic treatment models, which are based primarily on the sciences of anatomy and physiology.

²¹⁰ See section 13.2.

Practice expertise has been investigated by studying and comparing the clinical reasoning skills of novice and expert practitioners across a range of health disciplines (Banning, 2008; Case et al., 2000; Chapparo & Ranka, 2008; Doody & McAteer, 2002; Jones et al., 2008; May et al., 2008; Schwartz & Elstein, 2008). Practitioner reflection, as discussed previously²¹¹, consistently emerges as a requisite feature of expert practice, and the notion of professional artistry is often attributed to a particular form of reasoning, called metacognition that is characterised by practitioner reflective self-awareness, intuition, and adopting a patient-centred approach (Banning, 2008; Fonteyn & Ritter, 2008; Jones et al., 2008). Banning (2008) summarises a number of other common attributes of expert practitioners by defining expertise in nursing as the ability “to undertake cognitive shortcuts during the thinking process but also to rely on schema, experience, and intuition (p. 182)”. This description of expertise fits well with paediatric osteopaths’ organisation of their clinical practice into the four categories that underpin *the osteopathic therapeutic cycle*. Intuition emerges from the data as a valuable form of practice knowledge that impacts upon their decisions and actions, particularly relating to what they feel or sense when interacting with dyads; such as sensing a baby’s responses to manual therapy. Treating the baby by blending scientific knowledge with honed tactile skills based upon thinking about what they are feeling and observing in the moment (“reflection-in-action”), while attending to maternal wellbeing within a dynamic clinical context, represents a form of practice mastery or artistry; depending on how one perceives these concepts. The traditional idea of an artist, such as a painter, sculptor or musician, is someone who has much technical skill that is used for creative purpose in which the end result is something that is significant and other than ordinary. It is evident from the data, however, that paediatric osteopaths view *Promoting optimal breastfeeding through the osteopathic therapeutic cycle* in terms of good professional practice, grounded in expert skill and knowledge, rather than artistry. An observer or investigator, who uncovers the processes of expert clinical practice, however, might interpret their findings in a more theoretical light and conceptualise the processes involved as a form of professional artistry.

Such a theoretical model of practitioner expertise has been developed from a synthesis of the literature that relates to the conceptualisation of expert practice and professional artistry in the health professions (Paterson & Higgs, 2008). The proposed model, called “professional practice judgement artistry (PPJA)”, combines four practice dimensions; professionalism, multifaceted judgement, practice artistry, and reflexivity. Each dimension is complex but some of their underpinning elements, which are purported to be generally applicable across a range of health disciplines, align with similar findings from the current

²¹¹ See section 13.4.2 *Assimilating*.

study. These elements relate to practitioners' having a strong professional identity, attunement (being in tune with people), passion, and heightened self-awareness.

A distinguishing attribute of paediatric osteopaths is their strong sense of professional identity. Despite osteopathy, as a health profession, and more specifically, paediatric osteopathy, being relatively unknown and poorly understood²¹², osteopath participants demonstrate confidence and commitment to paediatric practice and, as a matter of routine, adopt strategies to manage patients' and other health practitioners' (mis)perceptions concerning their clinical work. This attribute links to their commitment to osteopathic paediatric practice, which for some, is expressed as a sense of passion. Commitment is evidenced by accounts of their pursuit of a career in paediatrics without a clearly defined professional educational pathway. It is expressed also as a sense of belief in osteopathy and the benefits it can offer to the very young and their families²¹³. Paediatric osteopaths' ability to attune to dyads' *struggling to breastfeed satisfactorily*, physically and emotionally, and to recognise and respond in sensitive ways to individual cues, needs, and circumstances is evident throughout the data and likely to be associated with their personal and professional motivation and ideology. Finally, paediatric osteopaths have a heightened self-awareness of how they might be influencing a vulnerable patient group. They recognise their breastfeeding knowledge limitations and are careful not to impose personal and professional breastfeeding and parenting views. They rather adopt a collaborative mother-baby-led approach that is centred on balancing dyads' individual, immediate, and long-term health goals and needs.

13.6 CONCLUSION

Completion of the study has led to the development of a substantive theory, which is refined, has conceptual depth, and has addressed, in detail, the three original research aims, outlined in Chapter One. Overall, paediatric osteopaths demonstrate practice expertise by attending to the interplay between various biological, psychological, and social elements that influence clinical evaluation and diagnosis, practitioner-patient interaction, a dyad's breastfeeding experiences, and health outcomes. The substantive theory of paediatric osteopathic practice has a number of features in common with current research that highlights the evolving nature of contemporary health care practice, based upon an appreciation of its multi-dimensional nature, and the challenges faced by practitioners when dealing with each dynamic and unique practice situation. Responding to dyads *struggling to breastfeed satisfactorily* is perceived as an inherently complex, yet

²¹² See Chapter 6.2.2 *Osteopaths' Professional Identity*.

²¹³ See Chapter 6.2.2.1 *The Osteopaths' Perspective*.

rewarding area of practice that rests upon osteopathic principles and a disciplined systematic, yet flexible, individualised practice approach. Some of the significant generic aspects of osteopathic practice found in the data, which have been similarly reported in the wider clinical literature and discussed in this chapter; include exploration of practitioner-patient relationships, patient-centred care and empowerment, clinical reasoning, and the notions of practice expertise and professional artistry. While many similarities, relating to these practice concepts, are apparent across different disciplines, manual therapy of the baby represents the distinctive treatment tool used by paediatric osteopaths and warrants particular attention. It emerges from data as the category, *Rebalancing*, which portrays manual treatment in a less mechanistic and more holistic light; as a collaborative interactive activity that involves gentle manual techniques that work in harmony with the baby's body to facilitate physiological balance and thus normalise function. Other features of osteopathic manual therapy that relate to the study include the strategic use of time, therapeutic touch, technical skill, and clinical judgement.

Overall, study findings give a positive account of osteopathic treatment of babies and uphold it as a potentially helpful intervention for dyads with breastfeeding difficulties. This finding is linked to the personal and professional traits of osteopath participants, which reflect the attributes of expert practitioners. In general, paediatric osteopaths are confident and committed to their work, and receptive to dyads' cues and needs. They are able to meet the complex and changing demands of paediatric practice and manage difficult situations, such as responding to a crying baby or distressed mother, by following a systematic yet flexible schema. The schema functions as a progressive therapeutic cycle that is underpinned by a range of therapeutic strategies, which osteopaths implement on the basis of reflection and clinical judgement.

CHAPTER FOURTEEN

CONCLUSION

14.1 INTRODUCTION

In this final chapter of the thesis, the study's strengths and limitations are examined, which is followed by discussion of the implications of study findings for general and paediatric osteopathic practice, education, and research. A final concluding statement is then made.

14.2 STRENGTHS AND LIMITATIONS OF THE STUDY

A qualitative grounded theory study design was chosen for the research project because it was considered most appropriate for exploring the research question, "How do paediatric osteopaths promote effective breastfeeding in mother and baby dyads with breastfeeding difficulties?" It also met the aim of developing a substantive theory to explain the processes involved; however, like all research, it has particular strengths and weaknesses. Acknowledging and uncovering these aspects of the study is important when evaluating results and their contribution to knowledge.

14.2.1 Strengths of the study

In the first instance, attention to aligning and making explicit the study's constructionist epistemology, theoretical perspective of interpretivism and symbolic interactionism, and Corbin and Strauss's (2008) version of grounded theory methodology and methods is strength of the study. From this point, determining a grounded theory study's strengths tend to relate to issues concerning its overall 'quality'. Quality relates to issues of academic rigour and trustworthiness, which have been examined in Chapter Four²¹⁴. According to Charmaz (2006, p. 18), quality starts with the depth and scope of the data, acquired by entering research participants' worlds and understanding their lives and perspectives. This study generated rich data with a range of views and experiences, drawn from clinical observations and interviews with two specific participant groups and sampling continued until saturation. From a clinical perspective, a more pragmatic approach to ascertaining quality in a grounded theory study arises as a result of the need to deliver effective and evidence-informed patient care. In this situation, quality relates to a consideration of how the research methods were used to produce findings that give a meaningful and accurate account of the phenomenon of interest, in the clinical setting. One of the proposed strengths of a grounded theory study is that it provides a package of research methods that build quality into the research process (Elliott & Lazenbatt, 2005). Implicit in this idea is the notion of methodological consistency (Morse et al., 2002). It is

²¹⁴ See Chapter 4.9.

for this reason that the researcher faithfully employed the techniques and procedures of Corbin and Strauss's (2008) grounded theory methods and provided a robust audit trail to enable the reader to follow the analytic process in order to have confidence in the results. Attention was paid to visibility of data collection and analysis procedures. As analysis proceeded, theoretical sampling and memo writing became particularly important to add conceptual density to categories, test ideas, and gain insights into some of the more tacit processes of clinical practice; processes that paediatric osteopaths use but which can be difficult to articulate.

Overall, the researcher spent 12 months in the field gathering and analysing data and interacting with it over an extended period of time (four years) to develop categories with high levels of abstraction and dimensional range. Regular meetings with research supervisors and presentation of research material to colleagues provided opportunity for discussion, critique, and reflection, all of which assisted with auditing the research process. A common idea concerning the quality of a grounded theory study is that it is best judged by those who read and respond to it; by following the researcher's data and analysis to make their own conclusions (Chiovitti & Piran, 2003; Cooney, 2011). When attempting to define a 'quality study', Corbin (2008, p. 302) places more emphasis on how the methods are used as tools to produce research that has depth, is creative, stimulating, and interesting. Overall a plausible and coherent theory of paediatric osteopathic practice in the situation of assisting dyads with breastfeeding difficulties was generated. The final substantive theory, however, has a number of limitations.

14.2.2 Limitations of the study

The first limitation relates to the general design of a qualitative study in that the results arise from a prescribed context; in this instance, paediatric osteopathic practice in metropolitan Melbourne and in the situation of treating dyads with breastfeeding difficulties. Findings pertain to the experiences, views, and actions of paediatric osteopaths and mothers and babies, which are interpreted by the researcher whose assumptions and expectations will have some influence on the final analysis²¹⁵. The value of a substantive grounded theory is its ability to address specific issues relating to the clinical setting from which data was derived and, therefore, it cannot be assumed to be generalised (Petty, Thomson, & Stew, 2012). There is, however, some contention regarding the notion of generalisability, which traditionally represents a canon of quantitative research (Snowden & Martin, 2010). Rather than generalisability, findings from qualitative studies are discussed as being potentially transferable to other similar

²¹⁵ See Chapter 4.4 for an account of the researcher's assumptions and expectations.

situations and are evaluated in terms of trustworthiness²¹⁶. They are also recognised and valued more for the purpose of gaining insight into clinical practice, rather than description and measurement (Morse & Field, 1995). This is particularly relevant when very limited literature is available in the area of interest; as is the case in the current study. Strauss and Corbin (1998) contend, however, that raising the level of abstraction of a grounded theory study through systematic and widespread theoretical sampling will elevate its generalisability in terms of explanatory power and precision, and that it can be generalisable in the sense that it might have meaning for other populations in similar circumstances and thus have “predictive ability” (p. 267).

The second limitation relates to the two participant groups, osteopaths and dyads, and some restrictions posed by the inclusion criteria. While both groups demonstrated variety, they tended to be homogenous in some respects. Mother participants shared a common socio-demographic and educational background²¹⁷ and a trend toward older maternal age. This means that the breastfeeding experiences of younger women and women from lower socio-economic or non-English speaking backgrounds were not represented. To avoid any sense of pressure on new mothers, who are generally recognised as a vulnerable social group, recruitment occurred primarily through indirect means by displaying Research Information Pamphlets²¹⁸ in osteopaths' clinics. This might have meant that only highly motivated breastfeeding mothers, interested in the research topic, chose to participate. It is also likely that this group of mothers might be particularly receptive to osteopathy as a new treatment approach. Additionally, mothers generally reported positive experiences of osteopathic treatment. It is possible that mothers who had negative experiences of osteopathy might have chosen not to return for further treatment and were thus less likely to participate in the study, and their accounts were missing from the data. Overall, limitations concerning diversity of mother participants on the basis of age, culture, education, and social circumstance could have been addressed by using more expansive recruitment methods. For example, this might involve providing study information pamphlets to women who attend larger public health care institutions for pre-natal and obstetric care or specialty outpatient breastfeeding clinics. Reducing the financial costs of osteopathic treatment for some families might be another strategy to encourage participation of a wider social group of breastfeeding women. In a similar way, expanding participation criteria to include not only healthy term babies, but also premature babies or babies with special needs could add another perspective to the data. Osteopath participants were informally classified by their peers as paediatric practitioners because of

²¹⁶ See Chapter 4.9 for a detailed account of the concept of Trustworthiness.

²¹⁷ See Chapter 5.2.

²¹⁸ See Appendix F.

their interest and experience in this patient-base. Hence findings cannot be generalised to osteopathic practice as a whole. While these limitations might have narrowed the breadth of human experiences and interaction associated with the research topic, nevertheless they tend to more accurately reflect the everyday circumstances of paediatric osteopathic practice in the prescribed situation, and did not interfere with the collection of rich and diverse data.

The final limitation relates to practical issues and time constraints associated with completing a doctoral thesis. In particular, concurrent data collection and analysis took place over a 12-month timeframe and involved time spent travelling to participants' homes for interviews and to 12 different geographically located clinics to deliver documents, gain access, and conduct observations and interviews. Recruitment of dyads took time and osteopaths had busy treatment schedules. One interview was conducted with each participant and while follow-up interviews might have added a longitudinal perspective, they were not conducted for two reasons. First, the limitations of time and second, rich sources of diverse data were made available from observations and interviews such that data saturation was achieved and categories were able to be conceptually well developed. The data did not indicate that a series of observations or interviews was needed. However, in a larger scale study, collecting data at the beginning and end of a course of treatment might be a worthwhile consideration.

14.3 IMPLICATIONS OF THE STUDY FINDINGS FOR OSTEOPATHY

The study findings have implications for osteopathic practice in general, in the field of paediatrics, and more specifically, in the situation of assisting dyads with breastfeeding difficulties. They also have implications for osteopathic education and research. For convenience, the three elements of professional practice, education, and research are discussed separately; however, it is evident that they interlink and inform each other closely.

14.3.1 Implications for paediatric osteopathic practice

The theory derived from the current study, *Promoting optimal breastfeeding through the osteopathic therapeutic cycle*, is, to the researcher's knowledge, the first theory of paediatric osteopathic practice. It is also one of a very limited number of studies that proposes a substantive theory of osteopathic practice. It specifically adds to osteopathic practice knowledge by including the patient's (breastfeeding mother's) perspective of osteopathy.

One of the purposes of theorising is to create knowledge that can build on, extend, or modify existing theories (Strauss & Corbin, 1998, p. 24). Hence, the first implication is that the current substantive theory represents a beginning to the development of a theory of osteopathic practice. Although it pertains to paediatric practice and the situation of responding to dyads *struggling to breastfeed satisfactorily*; it emphasises also the complex and dynamic health care environment in which osteopaths must function, regardless of the specific clinical context. It is evident from contemporary qualitative studies of health care practice, discussed previously, that this situation is widespread across a number of disciplines. The literature emphasises the evolving roles and professional expectations of health practitioners who must use a range of clinical reasoning knowledge, skills, and judgement to provide evidence-informed, patient-centred care in dynamic practice situations. Trede, Higgs, Jones, and Edwards (2003) summarise this concept by describing the dual roles of health practitioners as moving between being “scientific technicians” and “humanistic patient advocates” (p. 2).

A substantive theory, grounded in data from paediatric osteopathic clinical practice, is timely for a number of reasons. First, although there is widespread acknowledgement in the conceptual literature that osteopathy is underpinned by scientific knowledge, critical thinking and technical skill, research into these and other more tacit elements of professional practice such as interpersonal and communication processes, is limited. Osteopathic practice, in general, incorporates biological, psychological and social domains and one of the challenges facing the profession is the development of a well-substantiated theoretical basis that explains the complex array of phenomena that influence clinical practice and patient health outcomes. A theory is thus a practical tool for guiding practice and ultimately improving interventions and the delivery of health care. *The osteopathic therapeutic cycle* represents an abstraction that has generic dimensions that can be potentially applied to a range of clinical situations in paediatric practice and also in general osteopathic practice, and which can be studied, tested and further refined according to new insights and research outcomes.

The second reason why a grounded theory of paediatric osteopathic practice is timely concerns ‘Paediatrics’ as an emerging specialised area of osteopathic clinical practice that has not yet been defined by the profession. Study findings highlight the ambiguity surrounding paediatric practice in terms of the knowledge and skill sets required to deal competently with this patient population, and in particular, new mothers and infants. Findings emphasise also paediatric osteopaths’ use of particular manual techniques that are gentle and seem to be well suited to babies. In addition, building therapeutic

relationships, based upon taking an internal view of dyads' breastfeeding problems and social circumstances, is an important element of paediatric practice. Overall, study findings highlight the level of practice expertise demonstrated by paediatric osteopaths, who claim to have learnt their professional skills through common self-directed learning pathways that focus on manual skill development, mentorship from other more experienced practitioners, and reflection of relevant personal and clinical experiences. This type of informal learning approach raises a number of questions about paediatric osteopathic education, which are addressed in the following section.

14.3.2 Implications for breastfeeding

Breastfeeding research continues to report on the positive impact of breastfeeding on the health and wellbeing of mothers and babies, in the short and long-term. Despite this knowledge, duration of breastfeeding continues to decline in the postnatal period, particularly on discharge from hospital, and falls short of recommended breastfeeding targets²¹⁹. Women in the current study, represent a group of well-informed new mothers who want to follow contemporary evidence-informed breastfeeding guidelines but have difficulty translating this information into practice. Their experiences of *Struggling to breastfeed satisfactorily*²²⁰ resonate with the literature that has identified a number of common barriers to breastfeeding²²¹. Brodribb (2011) discusses these barriers and the recommended strategies to improve the flow of best breastfeeding practice along a research-to-practice pipeline. On this basis, collaborative care for breastfeeding dyads across the health professions and complex multi-strategy interventions to assist mothers to overcome breastfeeding difficulties, are recommended (Brodribb, 2011; Demirtas, 2012; Dyson et al., 2006; Renfrew et al., 2012), and that such strategies should span the antenatal, and extended postnatal periods (Meedya et al., 2010; Pannu et al., 2011). Findings that relate to paediatric osteopaths' therapeutic approach to assisting dyads with breastfeeding difficulties fit with this premise.

Paediatric osteopaths *promote optimal breastfeeding* through a range of strategies that broadly focus on two aspects; promoting breastfeeding self-efficacy and providing a form of social support. Their therapeutic approach incorporates building good therapeutic relationships (*Connecting*), analysing breastfeeding problems (*Assimilating*), *rebalancing* the baby's body, and *empowering* mothers to enhance breastfeeding confidence and self-efficacy, as well as dyads' overall health and wellbeing. Here is a potentially useful intervention that, for many health professionals, represents a new approach to an old

²¹⁹ See Chapter 2.2.

²²⁰ See Chapter 7.2.1 and 7.2.2

²²¹ See Chapter 2.7.

problem. As little is generally known about osteopathic treatment of babies with breastfeeding difficulties, it is anticipated that access to the study's research outcomes will make paediatric clinical practice more comprehensible and visible to health professional and lay audiences. Ultimately, it is hoped that insight into paediatric osteopathy will translate into improved inter-professional relationships and opportunities for collaboration when sourcing and providing timely and appropriate professional breastfeeding support.

14.3.3 Implications for osteopathic education

The study's grounded theory of paediatric osteopathic practice aligns with the contemporary trend of shifting health care practice toward a biopsychosocial framework. Historically, osteopathic education (and research), like physiotherapy (Jones et al., 2002; Trede et al., 2003), has emphasised biomedical sciences, the physical body, and technical manual examination and treatment procedures and skills rather than psychosocial assessment and management, and the development of critical thinking, reflective, intuitive, and interpersonal communication skills. Findings from the study and the wider literature suggest that the latter skill set, otherwise collectively known as metacognitive skills, represent essential components of expert practice that enable practitioners to blend various forms of knowledge in order to deal with the unpredictable dynamic clinic environment. Schön (1991) describes the expert or reflective practitioner as someone who becomes a researcher in the practice context; who "is not dependent on categories of established theory and technique, but constructs a new theory of the unique case" (p. 68). This idea represents an important change in perspective relating to professional education. In this case, practice informs theory rather than the other way round. Gaining insight into osteopaths' therapeutic approaches in the everyday circumstances of their professional practice provides a valuable form of theoretical practice knowledge and helps to close the gap between theory and practice (Mann, Gordon, & MacLeod, 2009). Mann et al's. (2009) systematic review of 29 studies that investigated reflective health care practice reports on a generic growing interest in this topic with a view to implementing educational strategies that promote reflective practice. Results suggest that practitioner reflection is an important part of health care practice that seems to be amenable to development. However, understanding of this complex phenomenon and appropriate educational strategies is still in its early stages and requires ongoing investigation.

Insight into osteopathic clinical expertise in general, provides valuable information for advancing the profession. More specifically, in the field of paediatrics, it raises questions about what types of specialised professional knowledge and skills are required, how they

are learnt, and if, and how, they can be taught. Such insight would prove valuable to enhancing their development through targeted educational strategies. Current educational trends in osteopathic paediatric practice, evident in the data, are consistent with the notion of practitioners acquiring expert practice knowledge and skill through reflection on personal and clinical experiences and informal mentorship arrangements. As osteopathy in the field of paediatrics grows, this self-directed educational approach is not only unlikely to be sustainable but raises important questions about professional practice standards and safe-guards. If osteopathy is to be considered a consistently safe and good treatment option for breastfeeding difficulties, further questions arise concerning the setting up and maintenance of quality professional educational programs, specific to this patient population. If the current trend of paediatrics being perceived by members of the profession as a specialised area of osteopathic practice continues, then more efficient, relevant, and systematic educational methods and programs, such as the development of a post-graduate diploma, are required to prepare osteopaths for the demands of paediatric practice.

14.3.4 Implications for future research

An outcome of this study is that, as well as the grounded theory of *Promoting optimal breastfeeding through the osteopathic therapeutic cycle*, a number of potential areas for future study have emerged from data and through discussion. Overall, further research of an exploratory nature is recommended to build on the findings from the current study in order to uncover and better understand the processes of paediatric osteopathic practice in a range of clinical contexts. Although *the osteopathic therapeutic cycle* was developed from data taken from the inherently complicated and unpredictable circumstances of paediatric practice, and in the situation of *struggling to breastfeed satisfactorily*, the researcher contends that the schema is likely to be applicable to other osteopathic practice situations. Conceptually, the idea of an *osteopathic therapeutic cycle* potentially fits with a number of different clinical problems and practitioner therapeutic approaches because it can account for a blending of knowledge and skill sets that range from a technical rational perspective to a more humanistic and socially grounded view. Further grounded theory research is, however, required to substantiate or test this claim.

To date, the few studies that have explored osteopaths' therapeutic approaches have involved experienced practitioners. Limited information is available concerning the thoughts, actions, and perspectives of novice osteopaths; in general practice, and in more specialised fields such as paediatrics. Such knowledge has proved helpful for professional education and practice in other disciplines and clinical situations, like physiotherapy,

(Case et al., 2000; Doody & McAteer, 2002; May et al., 2008) and would likely be relevant to osteopathy for a number of reasons. It would add depth to current understandings of practice expertise, through self-development or specialised educational pathways, and shed light on the transition from novice to expert practitioner with a view to enhancing this process. In addition, patients' perspectives of osteopathic practice, which are largely missing from the literature, would be helpful for better defining a patient-centred approach and providing osteopathic care that aligns with patients' views and needs.

In the specific circumstances of investigating osteopathy as an effective intervention for *promoting optimal breastfeeding*, further research in the form of a clinical trial or mixed quantitative and qualitative methods is recommended, to study more closely the relationship between paediatric osteopathic treatment, specific breastfeeding strategies, and positive breastfeeding outcomes. In addition, as study findings support the notion, reported in other studies (Creedy et al., 2003; Kingston et al., 2007), that osteopaths' therapeutic goals and strategies align with a breastfeeding self-efficacy framework, the researcher proposes that the breastfeeding self-efficacy scale would be a useful measure suited to such research. Such a line of enquiry could ultimately lead to the development of clinical guidelines for an osteopathic intervention to promote breastfeeding.

Other areas of research interest pertain to exploring, in more depth, three unexpected findings that were identified as important elements of the study's theory of paediatric osteopathic practice, which have been largely overlooked in the literature. The first relates to the importance of sensitive interpersonal processes and effective communication skills (*Connecting*) in paediatric practice, which is founded upon practitioner attunement to mother and baby, as individuals, and as an interdependent functional unit. The second concerns the different forms of therapeutic touch that play a part in osteopath-dyad interactions and manual therapy intervention (*Rebalancing*). The third pertains to the role of time and timing in patient-osteopath interaction, which impacts across all categories. A consistent and distinctive feature of each practice visit was the taking of time to allow dyads to feel comfortable, gather relevant information, and for close interpersonal and physical interaction. When combined, these three practice elements potentiate a form of humanistic care that enhances manual treatment and other therapeutic responses, and which ultimately facilitate a beneficial transitional change experience; factors that are often missing in busy, less personalised, health clinics.

14.4 CONCLUDING STATEMENT

The study's theory, *Promoting Optimal Breastfeeding through the Osteopathic Therapeutic Cycle*, uncovers the range and depth of physical, technical, cognitive, interpersonal, intuitive, and reflective processes that paediatric osteopaths use in practice. These processes are organised into therapeutic strategies that underpin a progressive integrative cyclic schema, which represents the functional knowledge used by paediatric osteopaths to understand and solve complex individualised breastfeeding problems. The theory explains also, the broader social and professional healthcare conditions that influence osteopath-dyad relationships and interactions. Overall, it shifts paediatric osteopathy from a predominantly narrow biomedically-influenced discourse toward a broader, more reflective one that operates within a range of paradigms, knowledge and skill sets. In general, it stands for a practice approach that follows a transitional wellness orientation. Less emphasis is placed on particular problems faced by breastfeeding dyads and more on finding and facilitating a satisfactory solution that is encapsulated by the notion of *promoting optimal breastfeeding*. A wellness orientation is characterised also by osteopaths consistently taking a collaborative, personalised, positive, and pragmatic therapeutic approach. When applying manual therapy, they use particular gentle techniques that work harmoniously with the baby's body to facilitate physiological balance and normalise function. Taking such a sensitive and reflexive interactive approach is satisfying for patients and osteopaths, and likely to be associated with osteopath participants' strong sense of professional identity and purpose. Finally, the study's theory presents osteopathy as a potentially useful intervention to assist breastfeeding dyads. It also provides a holistic framework and guidance for osteopaths involved in paediatric practice that can make a valuable contribution to the wellbeing of mothers and babies.

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INFORMATION FOR OSTEOPATH PARTICIPANTS INVOLVED IN THE STUDY TITLED:

“Osteopathic care of babies with breastfeeding difficulties”.

Osteopaths, with at least five years of clinical experience, who treat babies and children ('paediatric osteopaths'), are invited to participate in this qualitative study which explores how osteopaths promote effective breastfeeding.

This project is being conducted by Denise Cornall, an osteopath and lecturer in the Osteopathy program at Victoria University, who is currently undertaking PhD studies at Victoria University. The research project is under the supervision of Professor Terence McCann and Dr Mary Carolan from the Faculty of Health, Engineering and Science.

Project explanation

Breastfeeding is an important and complex health issue, influenced by many factors. It offers significant health benefits for both mother and baby, and the community. The World Health Organisation (WHO) recommends exclusive breastfeeding for the first six months of life, with introduction of other foods and continued breastfeeding thereafter. Current Australian breastfeeding rates fall short of the WHO recommendation, particularly in relation to how long a baby continues to be breastfed. Although natural, breastfeeding difficulties are common and women need support in a variety of ways, in their decisions and efforts to breastfeed. Following discharge from hospital, breastfeeding education and practical advice is provided mainly by lactation consultants and maternal child health nurses.

Osteopathy is also a therapy to promote breastfeeding, and is an area where little prior research has been undertaken. Osteopaths evaluate the physical strains in the baby's body which could be contributing to their breastfeeding difficulties. They then apply manual therapy to enhance the baby's sucking actions necessary for effective breastfeeding, and to promote general relaxation and well-being. This qualitative study will involve observations of osteopaths, in their clinics, treating babies with breastfeeding difficulties. In-depth interviews with osteopaths and mothers will also take place. Information gathered will be analysed using Grounded Theory methods. The study aims to gain increased understanding of breastfeeding difficulties and osteopathy's role in promoting effective breastfeeding. It is hoped that this knowledge will assist osteopaths and other health professionals in providing improved health care for breastfeeding women and babies.

How can I be involved?

You can be involved by displaying 'Study Information Pamphlets' in the waiting room of your clinic. Once a mother has read the pamphlet, had an opportunity for discussion with the researcher and agreed to participate; the researcher will phone you. You will be invited to continue participation by:

- Allowing the researcher to observe the treatment session of the mother and baby with breastfeeding difficulties. The researcher will not play an active role, as she wants to allow the session to proceed in a natural way.
- Taking part in an interview with the researcher (approximately one-hour duration) at a time and place of your choice.

- Note: Interviews with the mother will take place at a later date.

How will this project be conducted?

- Interviews will be open and provide a means for you to express your views in your own words.
- You will be asked about your thoughts regarding the processes and actions that took place during the treatment session.
- During her interview, the mother will be asked about her experiences of breastfeeding difficulties and osteopathic treatment.
- Interviews will be audio-recorded and transcribed verbatim (written out) for later analysis. The researcher will audio-record her observations of the treatment session shortly after its conclusion, which will also be transcribed for later analysis.

Confidentiality

Audio recordings and interview transcripts will only be made available to the identified members of the research project. They will be kept in a locked cabinet and stored for at least five years, after which time they will be destroyed. You, the mother, and baby will be given pseudonyms (other names) to protect your privacy and no one will be able to be identified in any publications or presentations.

How will the information I give be used?

Three different methods of data collection will be used: observations; interviews with osteopaths; and interviews with mothers. The information gathered will be analysed systematically by grounded theory methods, which are well-known in health-related qualitative research. It is anticipated that the results of the study will be published in relevant professional journals.

What are the potential gains or risks of participating in this project?

There are no direct benefits to you from participating in the study. The knowledge gained from the study will benefit the profession by adding to the osteopathic research base.

Participation is voluntary and you are free to withdraw at any time without judgement or penalty.

Contact details

For further information about your participation in this project please contact:

Denise Cornall (student researcher)	03 9919 1150
Prof Terence McCann (Principal supervisor)	03 9919 2325
Dr Mary Carolan (Co-supervisor)	03 9919 2252

Thank you for your time and we look forward to your participation.

If you have any concerns about the study, please contact the Secretary, Victoria University Human Research Ethics Committee, Victoria University, PO Box 14428, Melbourne, VIC, 8001 phone (03) 9919 4781.



**INFORMATION FOR MOTHER
PARTICIPANTS
INVOLVED IN THE STUDY TITLED:**

“Osteopathic care of babies with breastfeeding difficulties”.

Breastfeeding mothers and babies are invited to take part in this study if they are experiencing any breastfeeding difficulties; and are considering, or currently receiving, osteopathic treatment to assist with these problems.

Babies must be normal term (at least 37-week s at birth) infants and not have had osteopathic treatment for breastfeeding difficulties before.

This project is being conducted by Denise Cornall, an osteopath and lecturer in the Osteopathy program at Victoria University, who is currently undertaking PhD studies at Victoria University. The research project is under the supervision of Professor Terence McCann and Dr Mary Carolan from the Faculty of Health, Engineering and Science.

Project explanation

Breastfeeding provides important health benefits for a mother and her baby. Although natural, breastfeeding difficulties are common, and women often require support in their efforts to breastfeed. Following discharge from hospital, breastfeeding education and practical advice is provided mainly by lactation consultants and maternal child health nurses. Osteopathy is also a therapy to promote breastfeeding, and is an area where little prior research has been undertaken. Osteopaths evaluate the physical strains in the baby's body which could be contributing to their breastfeeding difficulties. They then apply manual therapy to enhance the baby's sucking actions necessary for effective breastfeeding, and to promote general relaxation and well-being. This qualitative study will involve observations of osteopaths, in their clinics, treating babies with breastfeeding difficulties. In-depth interviews with osteopaths and mothers will also take place. The information gathered will be analysed in order to gain an increased understanding of breastfeeding difficulties and osteopathy's role in promoting effective breastfeeding. It is hoped that this knowledge will assist osteopaths and other health professionals in providing improved health care for breastfeeding women and babies.

How can I be involved?

Once you have read the 'Study Information Pamphlet', had all your questions answered by the researcher and made an appointment for your baby with the osteopath, you can participate in the following ways:

*Consent to the researcher observing your baby's osteopathic treatment session. Please note that the research is additional and quite separate from the normal osteopathic treatment that is provided. The researcher will not play an active role as she wants the session to proceed in a natural way.

*Consent to the researcher being present during breastfeeding.

*Take part in an interview with the researcher (approximately one-hour duration) at a time and place of your choice.

How will this project be conducted?

- Interviews will be open and provide a means for you to express your views in your own words.

- You will be asked about your experiences of breastfeeding difficulties and osteopathic treatment of your baby.
- During his/her interview, the osteopath will be asked about the thoughts and actions that took place during the treatment session.
- Interviews will be audio-recorded and written out for later analysis. The researcher will audio-record her observations of the treatment session shortly after its conclusion, which will also be written out for later analysis.

Confidentiality

Audio recordings and interview transcripts will only be made available to the identified members of the research project. They will be kept in a locked cabinet and stored for at least five years, after which they will be destroyed. You, your baby, and the osteopath will be given pseudonyms (other names) to protect your privacy and no one will be able to be identified in any publications or presentations.

How will the information I give be used?

Three different methods of collecting information will be used: observations; interviews with osteopaths; and interviews with mothers. This information will be analysed by qualitative research methods and it is anticipated that the results of the study will be published in relevant professional journals.

What are the potential gains or risks of participating in this project?

There is a slight risk that discussions about breastfeeding difficulties could lead to some discomfort. If this happens, the researcher can offer initial support. The interview will stop, allowing you time to settle and decide if you wish to continue. If necessary, you might be referred to a psychologist at Victoria University, at no cost, for advice and referral for further help. While there are no direct benefits to you from participating in the study, there is some evidence that research participants can find it helpful to talk about their experiences.

Participation is voluntary and you are free to withdraw at any time without judgement or penalty.

Contact details

For further information about your participation in this project please contact:

Denise Cornall (student researcher)	03 9919 1150
Prof Terence McCann (Principal supervisor)	03 9919 2325
Dr Mary Carolan (Co-supervisor)	03 9919 2252

Thank you for your time and we look forward to your participation.

If you have any concerns about the study, please contact the Secretary, Victoria University Human Research Ethics Committee, Victoria University, PO Box 14428, Melbourne, VIC, 8001
phone (03) 9919 4781.

APPENDIX C



**VICTORIA
UNIVERSITY**

**A NEW
SCHOOL OF
THOUGHT**

**Consent Form for Osteopath
Participants Involved in the study titled:
"Osteopathic care of babies with breastfeeding difficulties".**

CERTIFICATION BY PAEDIATRIC OSTEOPATH

I,

of

.....

certify that I am at least 18 years old and that I am voluntarily giving my consent to participate in the above study being conducted at Victoria University by: Denise Cornall, Prof. Terence McCann, & Dr Mary Carolan. I consent to: (Please circle your response)

* The researcher observing a treatment session of a mother and baby participant

YES NO

* Take part in an interview with the researcher (approximately one-hour duration) at a time and place of my choice

YES NO

I certify that the objectives of the study, together with any risks and safeguards associated with the procedures listed hereunder to be carried out in the study, have been fully explained to me, and I understand that participation in this study is voluntary.

I certify that I have had the opportunity to have any questions answered and that I understand that I can withdraw from this study at any time and that this withdrawal will not jeopardise me in any way.

I have been informed that the information I provide will be kept confidential.

Signed:

Witness other than the researcher:

Date:

.....

Any queries about your participation in this project may be directed to the principal researcher (Prof. Terence McCann on 9919 2325). If you have any concerns about the way you have been treated, you may contact the Secretary, University Human Research Ethics Committee, Victoria University, PO Box 14428 MCMC, Melbourne, 8001 (telephone no: 03-9688 4710).

APPENDIX D



**VICTORIA
UNIVERSITY**

**A NEW
SCHOOL OF
THOUGHT**

Consent Form for Mother

Participants Involved in the study titled:

"Osteopathic care of babies with breastfeeding difficulties".

CERTIFICATION BY PAEDIATRIC OSTEOPATH

I,

of

.....

certify that I am at least 18 years old and that I am voluntarily giving my consent to participate in the above study being conducted at Victoria University by: Denise Cornall, Prof. Terence McCann, & Dr Mary Carolan. I consent to: (Please circle your response)

* The researcher observing a treatment session of a mother and baby participant

YES NO

* Take part in an interview with the researcher (approximately one-hour duration) at a time and place of my choice

YES NO

I certify that the objectives of the study, together with any risks and safeguards associated with the procedures listed hereunder to be carried out in the study, have been fully explained to me, and I understand that participation in this study is voluntary.

I certify that I have had the opportunity to have any questions answered and that I understand that I can withdraw from this study at any time and that this withdrawal will not jeopardise me in any way.

I have been informed that the information I provide will be kept confidential.

Signed:

Witness other than the researcher:

Date:

.....

Any queries about your participation in this project may be directed to the principal researcher (Prof. Terence McCann on 9919 2325). If you have any concerns about the way you have been treated, you may contact the Secretary, University Human Research Ethics Committee, Victoria University, PO Box 14428 MCMC, Melbourne, 8001 (telephone no: 03-9688 4710).

APPENDIX E



Denise Cornall is an osteopath and lecturer at Victoria University. She has a special interest in osteopathic treatment of babies and children.

Terence McCann is Professor of research in nursing at the School of Nursing & Midwifery, Victoria University.

Dr Mary Carolan is a midwife & senior lecturer in midwifery at the School of Nursing & Midwifery, Victoria University.

If you would like to participate, or find out more about the study, please:

Let the clinic receptionist know

OR

Contact Denise Cornall.

Telephone (03) 9919 1150 or 0438 344433.

The study is conducted with approval of the Victoria University Human Research Ethics Committee. If you have any concerns about the study, please contact the Secretary, Victoria University Ethics Committee, Victoria University, PO Box 14428, Melbourne, VIC, 8001. Telephone (03) 9919 4781.

Osteopathic Care of Babies with Breastfeeding Difficulties

A study conducted by Denise Cornall as part of her PhD studies undertaken at Victoria University and supervise by Professor Terence McCann and Dr Mary Carolan

Breastfeeding mothers and babies.....



You are invited to take part in this study if you are experiencing any breastfeeding difficulties; and are considering, or currently receiving, osteopathic treatment to assist with these difficulties.

Thankyou for considering participation in this study

What is the study about?

This study aims to explore how breastfeeding difficulties affect mother and baby, and how osteopathic treatment promotes effective breastfeeding. It will involve observations of a paediatric osteopath treating a baby with breastfeeding difficulties, followed by separate interviews with the osteopath and mother. It is hoped that the knowledge gained from the study will lead to improved health care for breastfeeding women and their babies.

What does 'breastfeeding difficulties' mean?

Breastfeeding success involves a special partnership between you and your baby. It relies on positioning skills, and your baby's sucking ability, which in turn stimulates your milk supply. A breakdown at any point in this cycle could lead to problems for you, such as sore nipples and concerns about milk supply, as well as an unsettled baby, all of which can be particularly stressful at this time of adjustment for you and your family. While most difficulties are overcome with practical advice and practice, your baby might not respond to these strategies alone and you might consider seeking the help of an osteopath.

What does 'osteopathic care' involve?

Osteopaths evaluate your baby's body for physical strains, possibly due to a difficult birth, which could be contributing to his/her unsettled behaviour and breastfeeding problems. Osteopathic treatment involves gentle manual therapy to assist your baby's sucking actions and promote general relaxation and well-being.

How can I be involved?

If your baby is a normal, term (at least 37 weeks) infant at birth and you are experiencing any breastfeeding difficulties, you can participate by:

- Consenting to the researcher observing your baby's osteopathic treatment session.
- Taking part in an interview with the researcher (about one-hour) at a time and place of your choice.

How will the information I give be used?

During the interview, you will be asked about your breastfeeding experiences and the osteopathic treatment. The interview will be audio-recorded and written out at a later time.

All the information gathered will be analysed by well known research methods. The study outcomes will be written up as part of a PhD thesis and published in professional journals.

Are there any risks or benefits if I agree to take part?

- The research is quite separate from the normal osteopathic treatment that is provided.
- There is no direct benefit to you in participating in the study.
- There is some evidence that you could find it helpful to talk about your experiences.
- On the other hand, there is a slight risk that talking about sensitive issues could cause some discomfort. If this happens, the researcher can offer support and refer you, if necessary, to another agency for help.

How is my privacy protected?

All information gathered from observations and interviews will remain confidential and available only to the members of the research project. You and your baby will be given another name so that you will be unable to be identified in any way in research publications or presentations.

You are free to withdraw from the study at any time without judgement or penalty.

APPENDIX F

AID MEMOIRE, INTERVIEW WITH OSTEOPATHS

INTRODUCTION

Define our professional relationship & my role as **researcher**.

"I want to learn about **what you think & do** from a fresh, open and new perspective".

Free to not answer any question, Free to withdraw at any time

DEMOGRAPHIC QUESTIONS

BEGIN AUDIO-RECORDING

What lead you to treat babies and children in your practice?

When you meet a mother and baby for the first time, what do you do?

BREASTFEEDING

What are your views on breastfeeding?

In what way, if any, have these views been influenced by your own parenting experiences?

What are your thoughts on the osteopath's role in general terms, for promoting BF?

ASSESSMENT

What do you think is going on here with this mother and baby?

What influenced your decisions about the nature of the problem?

How did you decide the best way to proceed during the session?

TREATMENT

What sort of things influenced how you treated the baby?

Were there any factors that constrained the way you responded to the baby?

Were there any factors that constrained the way you responded to the mother?

Why did you choose those treatment approaches/techniques?

GENERAL

What do you foresee as the general outcome for this mother and baby?

What are your thoughts on how mother and baby interacted?

What factors influenced your decisions concerning the broad management goals?

LINK TO OBSERVATIONS

During the treatment session, I noticed at this point....., you did/said..... Could you tell me why/how..... you did/said this? What were you hoping to achieve?

CONCLUSION

Is there anything else that you would like to like to add?

DEBRIEF

Thankyou for your help

Explain what I will be doing with the information

APPENDIX G

AID MEMOIRE, INTERVIEW WITH MOTHER

INTRODUCTION

Recognise the challenging time of early motherhood. My role as researcher- to explore and learn about all the issues from your viewpoint.

Free to not answer any question, Free to withdraw at any time

DEMOGRAPHIC- purpose to provide a context only

BEGIN AUDIO-RECORDING

How are you both? What is the current situation with Baby and BF?

PRELIMINARY

What led you to bring Baby to see the osteopath?

What sort of BF difficulties did you have?

Were you experiencing any other difficulties?

What sort of help had you already had before seeing the osteopath?

How were you feeling about taking Baby to the osteopath on the first visit?

CONSULTATION

What happened during your treatment session?

How did you feel about all the questions that the osteopath asked?

Did the osteopath explain clearly what she thought was going on? Did you understand what she said?

What do you think the osteopath was doing when she put her hands on Baby?

How did you find Baby responded to the osteopath?

How did you feel at the end of the visit?

GENERAL

Did the osteopathic treatment help with your breastfeeding difficulties?

Did anything unexpected happen during the visit? Were you concerned at any time?

How did your partner/family feel about you and Baby seeing the osteopath?

Based on your experiences, what would you recommend other women with BF difficulties do?

LINK TO OBSERVATIONS

During the treatment session, I noticed at this point....., you did/said..... Could you tell me why/how..... you did/said this?

CONCLUSION

Is there anything else that you would like to like to add?

DEBRIEF

Thankyou for your help. Offer encouragement & recognise mother's efforts

Explain what I will be doing with the information

Wind down by lighter chat about baby

APPENDIX H

AID MEMOIRE, OBSERVATION OF TREATMENT SESSION

Dyad Number: Date: Time (start) (finish)

WHO was present (pseudonyms)

SETTING

- Clinic in general
- Treatment room

OSTEOPATH'S PURPOSE & GOALS (how they were determined, expressed, clarified)

MOTHER'S PURPOSE & GOALS (how they were determined, expressed, clarified)

INTERACTION (verbal, actions, expressions, attention, responses)

- Mother & Baby
- Mother and Osteopath
- Osteopath & Baby

KEY MOMENTS

- Changes (pace, mood, attention)
- Expressions (body & face)
- Actions
- Language

NOTES