

**Fussy, unsettled and irritable infants
- the mothers' voice**

How can you support me if you don't understand me?

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A research project submitted in partial fulfilment of the
requirements for the degree of
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ABSTRACT

Background: Osteopathic literature on the topic of infant health is from a clinical stand point and lacks supportive research. This project is a first step towards extending this literature by exploring the mothers' point of view.

Objective: To identify and describe factors which mothers associate with their infant's *fussiness, unsettledness or irritability*.

Methods: The qualitative research design employed in this project was descriptive phenomenology. Participants were recruited through purposeful sampling and consisted of five mothers of *fussy, unsettled or irritable* infants aged between six and twelve months. Face to face interviews were aimed at exploring the mothers' experiences from pregnancy till the infant was the age of six months. Colaizzi's method of analysis was employed to provide a narrative account of the participants' experience.

Results: The focus of the project shifted from factors which cause infant *fussiness, unsettledness or irritability* to factors which influence infant demeanour. Three themes emerged that described this phenomenon: (1) **The effect of understanding on support**, (2) **The emotional link between mother and infant** and (3) **The mother's search to understand and care for her infant**.

Conclusions: Understanding a mother's situation is essential for health practitioners to provide her with the appropriate support that she needs to care for her infant.

DECLARATION



Name of candidate: Amanda Maria Viedma-Dodd

This research project is submitted in partial fulfilment for the requirements for the Unitec degree of Master of Osteopathy.

The regulations for the degree are set out in the Master of Osteopathy Programme Schedule and are elaborated in the course handbook.

Candidate's declaration

I confirm that:

This research project represents my own work;

The contribution of any supervisors and others to the research and to the research project was consistent with the Unitec Code of Supervision.

Candidate:

(Amanda Viedma-Dodd)

Date:

Supervisors' declaration

I confirm that, to the best of my knowledge:

The research was carried out and prepared under my direct supervision;

Except where otherwise approved by the Board of Postgraduate Studies of Unitec, the research was conducted in accordance with the degree regulations and programme rules;

The contribution made to the research by me, by other members of the supervisory team, by other members of staff of Unitec and by others was consistent with the Unitec code of supervision.

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LIST OF ABBREVIATIONS

GOR	Gastro-oesophageal reflux
GORD	Gastro-oesophageal reflux disease
OCF	Osteopathy in the cranial field
Plunket	The Royal New Zealand Plunket Society
PRM	Primary respiratory mechanism
TMBT	Transient mechanical birth trauma
WHO	World Health Organisation

KEY TO TRANSCRIPTS

Participant quotes are *italicised* and referenced with the participant's pseudonym and transcript page number. Symbols used are as follows:

...	Omission of dialogue
...//...	A large break in the quoted dialogue
[<i>Text</i>]	Text is added or altered for clarification

CHAPTER ONE:
Introducing the project

The current chapter will introduce the topic under investigation, provide the background and rationale for the project as well as briefly describe the method. Chapter Two presents and discusses major findings from the review of literature surrounding infant health and motherhood. Chapter Three will describe the phenomenological philosophy and method and Chapter Four will detail the manner in which the method is utilised in this project. Chapter Five portrays the mothers' voice in describing the phenomena of a *fussy, unsettled and irritable* infant. Chapter Six will further discuss the themes with respect to current literature. Finally, Chapter Seven evaluates the project and outlines the implications for health practitioners.

INTRODUCTION TO THE TOPIC

“Many problems experienced by infants ... originate in birth trauma” and birth trauma “can play an important part in determining our general health” (Turney, 2002). Osteopathic students commonly encounter literature that refers to the detrimental effects of a traumatic birth. However, literature on this topic to date in New Zealand is based on the clinical expertise of osteopaths. Three issues arise from such literature:

1. There is little research to support their claims
2. The findings are solely from the point of view of the osteopath
3. Their knowledge is based on the small proportion of infants who receive osteopathic care

This project is a first step towards extending the current literature on infant health by exploring the mothers' point of view. The project identified parameters of infant health by exploring the mothers' experience of 'difficult' infants as well as their beliefs with respect to factors which influence infant health. The researcher used a phenomenological method in which five mothers were interviewed. The interview transcripts were used to identify common areas of infant health concerns and the words mothers used to convey them.

The Aim

The aim of this project was to describe mothers' accounts of their infant's health and related factors during their first six months of life where the mother had experienced what she described as a *fussy, unsettled or irritable* infant.

PROFESSIONAL AND PERSONAL BACKGROUND

My interest in osteopathy as a form of treatment for infants was sparked during my undergraduate course. During a clinic visit I observed the gratitude of an exhausted young mother to her osteopath. Her four week old infant was finally feeding well and thriving after treatment received at the clinic a week prior; the outlook was good. I was intrigued by the method of treatment. Moreover, I was intrigued by the way the treatment affected the mother and her relationship with her infant.

I have little first hand knowledge regarding infants and motherhood; I am the youngest of three sisters, none of my friends are mothers and I have no children of my own. My knowledge on infants and motherhood was initially based solely on the information which was made accessible to me through literature. I found this unsatisfactory. Reading the text on infant health and parenting did not compare to the glimpse of motherhood I observed in the clinic that day. I felt a need for greater insight. I wanted to relate to mothers whose children I treated without the experience of having children of my own.

I went into this project with an inquisitive mind. It is my attempt to understand as best I can how mothers feel when they have *fussy, unsettled or irritable* infants. In doing so I hope that it will provide other practitioners in a similar situation the same insight.

RATIONALE

This project was an exploration of infant health and related factors as described by mothers. It is the first step required to establish etiological factors which contribute to *fussiness, unsettledness or irritability* in infants. The data collected from the mothers in this project allowed common themes to be established with regards to factors which they believe contributed to their infant's temperament. The results from this exploratory project can later be used as variables in quantitative studies. If a cross sectional survey is carried out in future, the prevalence for particular health concerns will be able to be established for different populations of infants.

THE METHOD

A qualitative method is appropriate for this research project. Firstly, there is little research done into this area of health and therefore an exploratory study is required prior to focusing on one topic. Secondly, the goal of this project is to assess the

mothers' beliefs regarding infant health and this can only be achieved if a two way interchange between participant and researcher is available. Thus a descriptive phenomenological method will be employed using Colaizzi's method of analysis. The methodology will be described in detail in Chapter Three and its application to the project will be described in Chapter Four.

CHAPTER TWO:
Review of the literature

This chapter is a summary of the key literature which surrounds the topic of infant health from the perspective of mothers. Literature was sought from osteopathic texts and published articles accessed through the electronic database, PubMed. Initial searching focused on previous measures of infant health which, apart from objective facts and figures, were rather lacking. At this early stage, literature on pregnancy and birth trauma was also sought as they are, according to osteopaths, related to infant health. Later, through interviewing participants and analysing data, new factors arose which led to a review of further literature. Background literature for the project is presented in this chapter and literature related specifically to the themes, is presented in Chapter Six, **The Discussion**.

The background literature reviewed in this chapter is presented as follows: factors regarding infant health, factors surrounding motherhood, birth trauma, and a review on osteopathy and infants.

INFANT HEALTH

Health is defined in the World Health Organisation constitution of 1948 as:

“A state of complete physical, social and mental well-being and not merely the absence of disease or infirmity” (Nutbeam, 1998)

Previous studies on ‘infant health’ have focused on the objective findings of medical practitioners such as Apgar scores¹ (Casey, McIntire, & Leveno, 2001; K. B. Nelson & Ellenberg, 1981), blood cord pH, birth weight (Raio et al., 2003; Walsh, 2004) and number of medical visits (Hannah et al., 2002). These tools measure only the physical aspect of infant health. However, the World Health Organisation’s (WHO) definition of health also encompasses social and mental well-being. Mothers have the potential to account for all aspects of infant health, including physical, social and mental wellness, and therefore their view complements that of the WHO. This holistic view of health forms the basis for this project.

¹ Apgar scores are given to newborns at 1, 5 and 10 minutes after birth and are based on five factors: appearance, pulse, grimace, activity and respiration. They provide a method of evaluating infants rapidly so that delivery room personnel can act accordingly. Attempts to extrapolate these findings to future infant health have been inconclusive (Baskett, 2000).

Mothers Perspective

Mothers are primarily responsible for their children's well-being. They are often the first to notice health changes in their children and decide when to seek help. Previous research has used objective measures of infant health such as Apgar scores in newborns or number of medical visits. Despite the lack of mothers' input in current research, its use in everyday interactions with health professionals makes it central to this project. A study conducted by McCormick & Brooks-Gunn (1999) which investigated maternal recall of events in infancy, found that mothers were accurate at recounting the medical history of their infant up to 8 years following the events. Their study specifically investigated maternal recall of birth weight, gestational age, and hospitalisations in infancy. Due to these findings and since mothers were interviewed within the first year following delivery, accuracy in this project is expected to be satisfactory.

Fussy, Unsettled and Irritable

Fussy, unsettled and irritable are all terms used to indicate infant distress of varying degrees. They have been used in many studies with often strikingly different meanings. The table below (Table 1) details some of the ways in which these words have been used in previous studies. It is important to note that the definitions are from the perspective of health practitioners and researchers. In comparison, this project will explore the mothers' experience and thus use their own definitions as detailed in the section **The Mothers & their Infants, Part I** (p.33).

Term	Author	Use
<i>Unsettled</i>	Don, McMahon, & Rossiter (2002)	Behaviour such as crying, <i>fussing</i> , <i>irritability</i> , ‘colic’ and restlessness
	McMahon, Barnett, Kowalenk, Tennant, & Don (2001)	Behaviour including irregularity of feeding or sleeping, a tendency to <i>fussing</i> , crying and negative mood, “temperamentally difficult”
<i>Fussy</i>	Cirgin Ellett (2003)	Describes an infant who is not settled, yet is not crying continuously either A mature form of distress that arises as an infant develops the ability regulate their behaviour
	Helseth & Begnum (2002)	Used synonymously with crying
	Henry (2004)	Used to describe gastro-oesophageal disease
	Lucas & St James–Roberts (1998)	A baby who is <i>unsettled</i> and <i>irritable</i> and may be vocalising but not continuously crying
	Soltis (2004)	Used to describe “noncry” sounds
	Wessel, Cobb, Jackson, Harris, & Detwiler (1954)	Used to describe colic
<i>Irritable</i>	Helseth & Begnum (2002)	Hypersensitive
	Henry (2004)	Used to describe gastro-oesophageal disease
	Keefe, Barbosa, Froese-Fretz, Kotzer, & Lobo (2005)	Used to describe infants as sensitive and easily overstimulated by noisy environments. They suggest that a disturbed sleep pattern is responsible for their excessive crying
	Pauli-Pott, Becker, Mertesacker, & Beckmann (2000)	Describes an infant who cries often and is <i>irritable</i> with a low distress threshold
	Wessel et al. (1954)	Used to describe colic

Figure 1: Previous use of the terms *fussy*, *unsettled* and *irritable*.

Colic

It is reported that five to twenty-five percent of infants suffer from colic (Cirgin Ellett, 2003; Ellett, Schuff, & Davis, 2005; Roberts, Ostapchuk, & O'Brien, 2004). The commonly cited definition of colic is known as “Wessel et al.’s rule of three” in which he states that a *fussy* infant is:

“A young infant, otherwise healthy and well-fed, has paroxysms of *irritability, fussing* or crying for a total of more than 3 hours a day and occurring on more than 3 days in any 1 one week and lasting for more than 3 weeks”.

(Wessel et al., 1954, p. 425-426)

It is important to note that Wessel et al. used the above parameters to define fussy infants, not colicky infants, as it is commonly stated (Helseth & Begnum, 2002). In fact, Wessel et al. note that only 25 of the 48 “fussy” infants would be considered colicky by paediatricians.

It is evident from the literature that colic is a diagnosis of infant behaviour, based on the definition of *fussy* infants proposed by Wessel et al., and has no bearing on the cause. Actually, the cause of colic remains unknown and as such there are many theories which explain this phenomenon. These include: allergy or intolerance to cow’s milk, immaturity of gastrointestinal tract, immaturity of central nervous system, infant temperament and problems with parent infant interaction (Cirgin Ellett, 2003; Pauli-Pott et al., 2000). Roberts et al. (2004) state that the most likely explanation is that the excessive crying experienced as colic is within the normal distribution of crying infants. Throughout the literature reviewed on colic there is both support and contradiction for the above concepts and the results are inconclusive. It is likely that colic is a multifactorial problem with an influence from one or more of the above.

Helseth & Begnum (2002) conducted an exploratory study in which parents and nurses identified three categories of cries. They proposed aetiologies for each as follows:

1. The **intense cry** was described as attacks of hysterical, inconsolable crying in which parents and nurses assumed the infant was in pain. This was identified as ‘real’ colic and assumed to be due to a physiological cause such as gastrointestinal immaturity.
2. The **non-specific fussing and crying** was described as persistent, qualitatively normal and incomprehensible. This cry was explained by infant and mother issues such as, temperament and maternal competence.
3. Parent identified **feeding-related fussing and crying** was explained by technical feeding problems.

It must be emphasised that Helseth & Begnum’s (2002) study established aetiological factors through thoughtful reasoning based on the findings of a small sample and has

yet to be validated by a larger study. However, this article currently provides health practitioners with a guide to questioning and managing complaints of excessive infant crying.

Only five percent of infants present with colic which is deemed to have an organic cause, and medical treatment is available only to this small group (Roberts et al., 2004). In cases where there is found to be no organic cause management of colic is aimed at the parents. It is thought that eliminating an organic cause and a diagnosis of colic is enough to relieve parents (Roberts et al., 2004). Furthermore, understanding, support and guidance may provide parents with a better coping mechanism and thus decrease the amount of infant crying (Cirgin Ellett, 2003; Helseth, 2002; Roberts et al., 2004). Despite support, mothers who care for colicky infants report a time of exhaustion, frustration, inadequacy and isolation; several authors claim there is little more health practitioners can do until a cure for colic is found (Cirgin Ellett & Swenson, 2004; Ellett et al., 2005; Roberts et al., 2004).

Reflux

According to Douglas (2005) it has become common for an infant who cries excessively and vomits to be labelled as having reflux. She further states that there is no evidence to support this in an infant younger than four months of age. The confusion may lie in the differentiation between physiological gastro-oesophageal reflux (GOR) and gastro-oesophageal reflux disease (GORD). GOR is common in infants and affects 40-60 percent of those aged between one and four months (Henry, 2004). GOR is the regurgitation of gastric contents. It is not associated with any complications and the infant is generally content and thriving. These infants are known as “happy spitters” (Henry, 2004). GOR is thought to be caused by immaturity of the oesophagus (Cezard, 2004). In contrast, infants with GORD present with crying and *fussing* during feeds, *irritability* after feeds, vomiting, weight loss and respiratory symptoms (Henry, 2004). Diagnosis is based on patient history and physical examination and other causes must be ruled out. Treatment for GORD is graded according to severity and ranges from changing feeding habits and administering medication, to surgery.

The review of literature regarding infant health revealed that all previous research identified on the topic lacked a holistic approach, with only objective measures being

investigated. The lack of an overall assessment of infant health is a gap in the literature which this project aims to fill. Literature gathered on this topic was from the perspective of health care providers and researchers; the mothers' voice was lacking. This is despite the fact that mothers were found to provide an accurate account of their infants' medical history even years later. The terms *fussy*, *unsettled* and *irritable* were found to have an array of different meanings in the literature. This project will define these terms from the mothers' perspective. Colic and reflux were identified as two relatively common infant maladies which have little hope for cure and a profound effect on both infant and mother.

MOTHERHOOD

As this study relies on the mothers' experience of infant health, there are factors regarding maternal coping abilities and maternal satisfaction which are relevant for review; these factors include maternal experience, stress, support, fatigue, and the mothers' response to infant behaviour.

Maternal Experience

One of the key factors contributing to maternal experience is the number of children she has raised. According to the literature, first and second time mothers have equally trying times, while women with three or more infants show higher satisfaction and lower stress.

First-time mothers

Several qualitative studies have outlined the sense of 'lack of preparedness' which first-time mothers experience. This phenomenon was described by one author as the 'conspiracy of silence'. In this study mothers described that no one prepared them for the sleeplessness, the 24 hour care and the hard work involved in motherhood (McVeigh, 1997). George (2005) found that mothers felt prepared for the pregnancy and delivery but lacked knowledge about what to expect in the postpartum period. Mothers reported being unprepared for the role change, overwhelmed by the responsibility and suffering from an unexpected depth of fatigue.

Second-time mothers

The birth of a second child is equally overwhelming and offers unique challenges for mothers. O'Reilly (2004) utilised a phenomenological method to describe the transition into second-time motherhood. The initial transition period was found to be easier the second time around because the mothers had prior knowledge of infant care and greater confidence in their mothering ability. However, there was additional demand placed on the mothers due to having another child to care for. Second-time mothers required support in the form of childcare from partners, family and friends. Developing a sleep routine which accommodated the needs of the infant, the sibling and the mother was essential. The mothers in O'Reilly's study also reported much concern over the developing relationships between herself and each child, the father and each child as well as between the children. It was evident that the focus for second-time mothers shifted from the infant to the family.

All mothers

There are several studies which investigated both first and second time mothers. A common theme of such literature is that maternal role competence is similar for both groups because each group faces individual challenges. Mercer & Ferketich (1995), who investigated experienced and inexperienced mothers, found that each new mother-infant relationship represents an individual process of maternal role attainment. That is, previous experience in mothering was not an advantage with respect to maternal role competence. However, Grace (1993) noted that maternal satisfaction, although similar for first and second-time mothers, was greater for mothers of more than two children who reported greater satisfaction in their role as mothers.. These findings indicate that although maternal role competence is not related to parity, maternal satisfaction is greater for mothers of more than one child.

Stress and Support

Parenting stress results when there is a discrepancy between the demand of a situation and the available resources. The perception of a *fussy-difficult* infant, caretaking hassles, feeding and sleeping difficulties, as well as excessive crying are reported to add to maternal stress (Ostberg & Hagekull, 2000). Stress has negative effects on the mother, the infant, and their interactions (Sepa, Frodi, & Ludvigsson, 2004). In situations where

the mother has good social support, the negative impact of stress can be minimised. This is because social support increases the mother's personal resources thereby decreasing the gap between demand and available resources (Crnic & Booth, 1991; Sepa et al., 2004). According to Kahn (as cited in M. Tarkka & Paunonen, 1996), social support is a human interaction which has one of the following: admiration and respect, reinforcement and feedback, or aid in the form of objects, money or time. Tarkka & Paunonen (1996) assert that a mother can cope better with any given situation if they have support, hence support contributes to a more positive experience of motherhood.

Support is a complex theme which varies from mother to mother; good advice and reassurance can be uplifting and encouraging while conflicting advice can be demoralising. During the postpartum period mothers draw on the knowledge of people who are more experienced to gain information on child care. They may call on paediatricians, midwives, their mothers or friends with children (Barclay, Everitt, Rogan, Schmied, & Wyllie, 1997; Borjesson, Paperin, & Lindell, 2004; Warren, 2005). This expert advice is especially utilised by mothers in the early postpartum period and forms a base or guide for their parenting (Miller, 2003). However, George (2005) noted that during the postpartum period there was an abundance of advice from numerous sources which was often conflicting and confusing for the mother. Another study found that mothers felt intimidated by the competence of midwives and that this prevented the mother from developing her own method of child care (Barclay et al., 1997).

Mothers seek support in the form of affirmation for their mothering skills from their partner, their mother, a female relative or friend. The same support people also offer emotional support, aid with child care or housework, and support in decision making (M. T. Tarkka, 2003). This particular network of support has been found to be especially important in the development of maternal self confidence with respect to infant care (Warren, 2005).

In McVeigh (1997), mothers reported that partners provided shared responsibility, support and confidence. Many mothers described how their partners encouraged them to become independent by suggesting they ignore others' conflicting advice (McVeigh, 1997). Another study conveyed the loneliness associated with a lack of partner support in which the father worked long hours or failed to acknowledge the new demands placed on the mother (Barclay et al., 1997). It is apparent from the literature that support is closely related to maternal mood and satisfaction.

Fatigue

Current literature details that postpartum fatigue is common and can last well beyond the previously believed six week postnatal period (McQueen & Mander, 2003). Mothers describe postnatal fatigue as overwhelming, unrelenting and unbearable (McQueen & Mander, 2003; McVeigh, 1997; Troy, 2003). A concept analysis on the use of the term fatigue resulted in the following definition: “fatigue is a subjective, unpleasant symptom which incorporates total body feelings ranging from tiredness to exhaustion creating an unrelenting overall condition which interferes with individuals’ ability to function to their normal capacity” (Ream & Richardson, 1996, p. 527).

Causes of postpartum fatigue are thought to include length of labour, delivery type, breastfeeding difficulties, poor infant sleep patterns, infant care responsibilities, managing multiple roles and having more than one child under five (Dennis & Ross, 2005; Troy, 2003). The relationship between these causative factors and the level of fatigue is complex. One study found that multigravidae mothers reported lower levels of fatigue in comparison to primigravidae despite having more household demands. The authors hypothesise that stresses associated with maternal role attainment create increased sleep disturbance and fatigue in primigravidae (Waters & Lee, 1996). Whatever the cause of postnatal fatigue the result is the same, maternal irritability, loss of concentration and possibly depression (Dennis & Ross, 2005; McVeigh, 1997).

Mothers’ Response to Infant Behaviour

Mothers employ problem solving skills to interpret behaviour and make decisions about health issues for their children (Gross & Howard, 2001; Sullivan, 1997). Decisions regarding maternal care and health care for infants are based on the available social support, practitioner attitude, previous experience and perceived seriousness of the situation (Gross & Howard, 2001). According to several authors decision making is a stepwise procedure which includes: identifying and naming a problem, planning for and implementing a solution and evaluating the outcome (Gross & Howard, 2001; Pridham & Chang, 1991).

Literature on the topic reports that mothers are able to identify a change in infant behaviour and implement a series of procedures to sooth an infant but have difficulties in naming a problem and evaluating the adequacy of their actions (Pridham & Chang, 1991; Sullivan, 1997). In Sullivan (1997), mothers reported that when an unknown

problem presented itself they would take action to soothe the infant with the use of learnt procedures while trying to understand the cause. Mothers continue this process until both infant and mother are comforted. Sullivan asserts that the cause often remains unknown and so the efficacy of the mother's actions remains largely unappreciated.

Literature regarding maternal issues revealed that the experience of motherhood is similar for both first-time and second-time mothers; this is in contrast to mothers of more than one child, who experience less stress and more satisfaction. Maternal stress was found to be greater for mothers of *fussy-difficult* infants and minimised with good social support. Fatigue, another factor related to motherhood, was reported to be worse when feeding difficulties and poor infant sleep patterns were present. The literature revealed that mothers place great importance on identifying a cause for their infants' altered behaviour. However, when the cause was unknown, they were able to soothe their infants through implementing a series of learnt procedures. The review on issues surrounding motherhood details that infant factors have a close relationship with maternal stress and fatigue.

BIRTH TRAUMA

Birth trauma has been linked, by osteopaths, to adversities in the wellbeing of children and is thus under consideration in the literature review. In the broadest sense, birth trauma is an event during labour or delivery which involves psychological or physical injury to either the mother or the infant (Beck, 2004). While Beck's definition describes an event, many authors have used the term to describe a physical injury occurring as a result of labour or delivery (Pressler & Hepworth, 2000).

Mothers Birth Experience

The experience of childbirth is different for mothers and clinicians. Some mothers have reported that doctors were focused solely on the outcome of a live infant without being aware of the mothers difficulties (Beck, 2004). There are many factors which contribute to a mother's experience during birth. These include: infant complications, obstetric interventions, lack of support structures and previous experience and expectations. A

phenomenological study by Beck (2004) investigated the mothers' experience of traumatic births. Beck's analysis revealed four themes:

1. Lack of care for the mother
2. Lack of communication with the mother
3. The feeling of helplessness
4. The feeling that the birth of the infant was at the cost of the mother

This study suggests that a mother can have a negative birth experience despite having a delivery which is regarded by doctors as being routine; as Beck (2004) surmises, the quality of "birth is in the eye of the beholder".

Physical Infant Birth Trauma

Pressler & Hepworth (2000) found that there were no criteria for grading the degree of "foetal mechanical birth trauma". The researchers suggest two levels of birth trauma: major birth trauma and transient mechanical birth trauma (TMBT). Major birth trauma includes central nervous system injuries, muscle damage, bone fractures and lacerations. Major birth trauma is known to be a risk factor of infant mortality and morbidity. TMBT includes moulding, cephalohematoma, subconjunctival haemorrhage, body bruising, facial bruising, petechiae, forceps marks and diminished arm movements. While medical practitioners note TMBT as insignificant, Pressler & Hepworth suggest that it may influence infant well-being. Their study indicates that there is a broad spectrum of birth trauma from the commonly insignificant to the more severe forms.

It is evident from the literature that the term birth trauma is ambiguous and varies from author to author, depending on their area of expertise. Beck (2004) revealed incongruence between the mothers' view, with respect to the event of birth trauma, and that of clinicians. Pressler & Hepworth (2000) propose that there is a range of severity with regard to physical infant birth trauma. Osteopaths view infant birth trauma as a physical outcome resulting from birth; this and the theory of osteopathic treatment is detailed below.

OSTEOPATHY AND INFANTS

It is an osteopathic belief that for infants birth can be stressful and result in structural strain (Frymann, 1966; Hayden, 2000; Lloyd, 2002). This may occur when the labour is too long or too short, if ventouse or forceps are used, or the delivery is a caesarean section. Symptoms may include *unsettledness*, *irritability*, sleeping difficulties or excessive crying (Lloyd, 2002). Other factors which are thought to affect healthy growth of infants include: the mothers health before the birth, trauma and emotional health during pregnancy, the infants gestational age, and pain relief during labour (Hayden, 2000).

Osteopathy in the cranial field (OCF) is a treatment that is, according to Lloyd (2002), gentle and beneficial for many childhood conditions. Treatment is based on the theory that a stressful birth causes retained moulding of the infants' head which creates strain between the cranial bones. This moulding affects the primary respiratory mechanism (PRM) which is an inherent rhythmical movement of the bones of the skull, the meninges, the brain, the spinal cord, the cerebrospinal fluid and the sacrum. Proper PRM function is believed essential to health (Lloyd, 2002). Proponents of OCF claim that gentle manipulation re-establishes motion and subsequently improves blood flow and drainage, ultimately allowing healing to occur in a cranial strain (Carruthers, 1997).

A survey carried out in Nelson, New Zealand, investigated the type of childhood problems which presented to one osteopathic clinic (Carruthers, 1997). Presenting complaints which were found in infancy included sleep problems, constant crying, colic, windy, *irritability*, reflux and feeding difficulties (Carruthers, 1997). Another survey by the same author was aimed at establishing treatment efficacy. This survey found that 33% of parents felt osteopathy had helped their infant's symptoms to some extent and 53% felt that they were helped a lot (Carruthers, 1998). This study utilised a small sample from only one osteopathic clinic and the results are published only in the author's patient pamphlet. These results are exploratory and a larger multi centre study is necessary to investigate efficacy of treatment further.

It is important to note that Hayden's book (2000) and Lloyd's article (2002) are based on osteopathic theory. Their writing is based on their experience as students and practitioners of osteopathy and writings handed down by over a century of osteopaths. There has been little research into the PRM and OCF and that which is available is not definitive or harmonious.

In summary of this chapter, the literature review revealed that infant health is a phenomenon which is commonly investigated through a quantitative process. Authors reduce the complex philosophy of health to measurable indices such as Apgar scores and health practitioner visits. This is inconsistent with a holistic view on health which accounts for social and mental well-being as well as the physical aspects. The present project aimed to address this gap in the literature by exploring holistic infant health.

Previous studies from the perspective of mothers on the topic of infant health have focused on the effect of infant health issues, such as colic or reflux, on them as mothers. They do not provide information on the infant or factors which contribute to their demeanour. This project proposed to assess the mothers' beliefs with respect to infant health. The findings expand and complement current literature and allow health practitioners an insight into the concerns of mothers. Once mothers' concerns regarding infant health are identified, health practitioners can act to resolve them through additional support or research as necessary.

CHAPTER THREE:
The research method

The current chapter details the theoretical aspects of the research method. It will commence with a generalised review of qualitative methods and then focus on the method of choice, descriptive phenomenology. Phenomenology will be discussed as both a philosophy and a method. Colaizzi's method of research will be described, with a focus on his method of analysis. The chapter finishes with the question of rigour in qualitative methods. The manner in which these theoretical aspects are applied to this project are detailed in Chapter Four, **Undertaking the project**.

QUALITATIVE METHODS

A qualitative method was appropriate for this investigation of infant health from the perspective of mothers. Firstly, there is little research done into this area of health and therefore an exploratory study was required prior to focusing on one topic. Secondly, the goal of this project was to assess the mothers' beliefs regarding infant health and this could only be achieved if a two way interchange between participant and researcher was available. Lastly, the philosophy of this method is consistent with the osteopathic principles.

The topic of this research arose from a lack of supportive literature for osteopathic theories regarding infant health. Due to this lack of literature, a quantitative study would not be suitable as any hypothesis generated would have no grounding. A qualitative study is suited to exploring topics for which little is known (Morse & Field, 1995).

Due to the mothers experience being the focus of this project, a qualitative study with data collected through an interview process was most appropriate. This approach allowed the mothers beliefs to be communicated. Other methods may have restricted the data through imposing assumptions based on current osteopathic literature without regarding the mothers' viewpoint.

Osteopaths place great emphasis on the person as a whole and the many factors which contribute to a person's health. Research into the osteopathic profession should take this view of health into account to maintain clinical relevance. As McKibbin & Gadd (2004) note, qualitative studies are embraced by professions that deal "with the patient as much more of a whole person rather than basic scientific facts and numbers".

PHENOMENOLOGY

Phenomenology is considered both a philosophy and a qualitative research method. The philosophy or methodology is a way of thinking while the method is any one of the many procedures which can be used to carry out research (Caelli, 2001). These two concepts are entwined, as the method should reflect the philosophy and the philosophy is “accessible only through its method” (Oiler Boyd, 2001a, p.95). Phenomenological research which fails to consider the underlying philosophy may contain methodological confusion such as incongruence between method, findings and discussion. This would ultimately impact the study’s quality and rigour (Lopez & Willis, 2004; Lowes & Prowse, 2001; Oiler Boyd, 2001b; Sadala & Adorno, 2002).

The Philosophy

Descriptive phenomenology was the method employed for this retrospective study into the mothers’ perspective of infant health. This qualitative method is founded on Husserl’s philosophical ideas which assume that experience, as perceived by human consciousness, is valuable to scientific study (Lopez & Willis, 2004). Added to this is the assumption that any phenomenon has an essential structure which is present irrespective of the individual who is experiencing it. This essential structure can be found when studying the facts which are encountered by those who have experienced it (Beck, 2004). The use of phenomenological reduction, or bracketing, as a method to limit the impact of the researcher on the topic is in line with this methodology (Lopez & Willis, 2004). The method of bracketing will be described later in this chapter when discussing rigour in qualitative research. The aim of phenomenology is to describe experience directly without care for cause and effect relationships (Oiler Boyd, 2001a).

The Method

According to Giorgi there are three necessary constructs which must be considered in a descriptive method which is founded on Husserlian phenomenology (Kleiman, 2004). Firstly, there is a requirement for concrete description of the phenomenon which is made possible through willing and able participants and a good interview process. Secondly, analysis should be conducted with a phenomenological attitude, which involves an awareness of presumptions and an open attitude about the phenomenon presented in the data. Lastly is the discovery of the essential meaning of a phenomenon.

This is defined as the meaning which if removed has an impact on the phenomenon. The result of a descriptive phenomenological study is a description of everyday experience and an understanding of its essential structure.

COLAIZZI'S METHOD

Colaizzi (1978) provides a guide for implementing phenomenological descriptive research. His method remains true to the phenomenological philosophical background and strives to remain with the experience of the participants without imposition from the researcher or the process. Colaizzi (1978) portrays descriptive methods as flexible, free processes which are shaped by the individual phenomenon as well as the aims and objectives of the researcher. The theoretical process is outlined below and its application is outlined in Chapter Four: **Undertaking the project.**

Participant Selection

The first step in studying a phenomenon is to gather participants who have experienced it. Another criterion for participant selection is the ability to communicate their experience verbally. There are a number of perspectives from which an experience can be viewed (Oiler Boyd, 2001b). In the case of infant health this may include: osteopaths, paediatricians, parents, fathers or mothers. Mothers have been selected for this project because, as the literature review demonstrated, their perspective was lacking in current academic writing.

Data Collection

Colaizzi suggests interviews as an appropriate form of data collection. He states that interview questions should be based on presuppositions regarding the phenomenon. These presuppositions are founded on practical knowledge and available literature. However, an interview should be structured and carried out so that data regarding the phenomenon is obtained with the least restriction or influence from the researcher. It must be remembered that the role of the researcher who utilises a descriptive phenomenological approach is to identify the essence of the participants' experience, not to prove or deny a hypothesis. The result of this process is a narrative account of participant knowledge and experience (Lopez & Willis, 2004).

Data Analysis

Data analysis in the Colaizzi method is based on a seven step procedure. This forms a guide rather than a strict protocol and can be adapted “in whatever ways seem appropriate” (Colaizzi, 1978, p. 59) The result of employing this seven step method is a rich and exhaustive description of the phenomena which should be accurate and valid.

Step 1. Read and understand each transcript. This is to familiarise the researcher with the content and context of the transcript. Undertaking the interview and personally transcribing also aids this familiarisation process.

Step 2. Extract significant statements about the topic. The most significant statements or phrases regarding the phenomenon are extracted from the transcript. Phrases which have identifying features are reshaped into a more generalised statement and repeated statements are removed.

Step 3. Formulate meanings for the above statements. The meanings are to be sought from the statements extracted in Step 2. They will be formulated from the data and must represent the data. In order that the meanings exclusively relate to the phenomenon under investigation there should be no imposition from other sources. Being aware of and putting aside researcher presuppositions is especially vital in this step so that participant misinterpretation is avoided.

Step 4. Organise meanings into clusters of themes. This is where the meanings from all participants are merged into themes which are common to all experiences. These themes are then related back to the original transcripts in order to validate them. Colaizzi highlights that themes may appear contradictory but should not be disregarded because “what is logically inexplicable may be existentially real and valid” (p. 61).

Step 5. Exhaustively describe the investigated topic. All themes, clusters and formulated meanings are brought together into a description of the phenomenon. This incorporates all aspects of the experience and describes the overall structure.

Step 6. Describe the fundamental structure of the phenomenon. The phenomenon is unequivocally described in a statement that identifies the

fundamental structure. Although similar to Step 5, the resulting statement is succinct in comparison.

Step 7. Return to the participants. This final validating step assures that the full description of the phenomenon is correct and true to the experience. It can be achieved either by returning to the primary transcripts, the original participants or other subjects who have experienced this phenomenon.

(Colaizzi, 1978; Sanders, 2003)

RIGOUR IN QUALITATIVE METHODS

To achieve rigour or trustworthiness, in qualitative research one must be explicitly systematic throughout the process. This can be achieved through utilising any of a number of operational techniques. Such operational techniques include purposeful sampling, bracketing, testing the themes, triangulation, providing an audit trail and a 'thick' description, and returning to the participants (Tuckett, 2005). Operational methods have been devised to limit the influence of the researcher and where this is not possible, to make clear the researcher's influence on the study. Exposing the researcher's involvement allows readers to judge the study's merits and applicability. The theory of operational methods will be described in this chapter while the methods employed in this project will be detailed in Chapter Four.

One of the first steps in undertaking research is selection of participants. According to Patton (1999), rigour in sample selection involves selecting participants who will provide information which is relevant to the purpose of the project which can be achieved through carrying out preliminary assessment of their suitability prior to selection. This method provides a clear limit to the extrapolation of findings and avoids incorrect generalisation to a wider population.

Colaizzi (1978) states that researchers utilising descriptive phenomenology should lay their presumptions aside while analysing data. This process was termed bracketing by Husserl. There is much debate regarding this concept, specifically its meaning and its undertaking (LeVasseur, 2003). Throughout the study, presuppositions are identified and laid aside to minimise researcher influence on the data and so allow phenomena to be described as they exist (Maggs-Rapport, 2001). LeVasseur (2003) argues that

bracketing should be regarded as a state of curiosity where the researcher queries previous knowledge and acknowledges a lack of understanding of the phenomenon.

Another method which can be utilised during the process of data analysis is “testing rival explanations”. According to Patton (1999), this process involves (i) reorganising data to expose alternate findings, (ii) investigating other possibilities by assessing their presence in the data, and (iii) weighing up the support for one theme against another. It is important to include alternate themes tested in the report so that readers can ascertain the integrity of the findings. Testing other possibilities is closely related to finding “negative cases”; the search for apparently opposite cases can shape, broaden, change or cast doubt on the common findings (Patton, 1999). These two processes, “testing rival explanations” and finding “negative cases”, will ensure that the findings generated are those which are most highly represented in the data.

Triangulation is the confirmation of findings through combining multiple methods, observers, or sources of data. Their use limits methodological error, errors of analysis, or respondent error, respectively. The aim of this method is not merely reproduction of findings but a broadened insight into the phenomenon under investigation. Triangulation is ideal for strengthening qualitative findings, however Patton (1999) notes that the method is often impractical for a researcher with limited time and resources.

“Thick description” relates to the depth of description regarding the sample, the method and the findings. It is thought that if sufficient detail is provided to the readers, they can better ascertain the relevance of the project to their needs (Tuckett, 2005). The concept of “thick description” is similar to that of providing an audit trail, except that an audit trail should provide details of the researcher’s internal thought processes (Koch & Harrington, 1998). The aim of both methods is to provide the audience with enough detail to ascertain the projects rigour.

Returning to the participants at the completion of data analysis is another method used to promote rigour in qualitative research. This process allows either the original participants or other people who have shared in the experience of the phenomenon to endorse the findings or comment on any discrepancy (Donalek, 2004). Colaizzi asserts that the same outcome can be achieved by returning to the original transcripts (Colaizzi, 1978).

In summary, a qualitative method is appropriate for this research project because (i) the project is exploratory, (ii) the focus is the experience of mothers, and (iii) the philosophical foundation is consistent with that of osteopathy. This chapter also described the theory of descriptive phenomenology with specific mention of the Colaizzi method of analysis. Methods of maintaining rigour in qualitative methods were also examined. The overall theoretical guide provided in this chapter is recognised as a flexible process which is tailored to the intended purpose of this project. The manner in which the theory is applied to this project is discussed in the subsequent chapter, **Undertaking the project.**

CHAPTER FOUR:
Undertaking the project

Chapter Four moves from the theory of descriptive phenomenology to its practical application. The current chapter will discuss the research process in its entirety: from gaining ethics approval, to participant selection, the interview process, and the development of themes. The chapter ends with a discussion of measures related to achieving trustworthiness in this project.

ETHICAL CONSIDERATIONS

Ethical approval for this research project was sought and gained from the Unitec Research Ethics Committee on the 6th of April 2005. This was approved for the period between the 6th of April 2005 and the 1st of February 2006 (See Appendix A for a copy of the approval letter).

Participation was informed and voluntary. Participants were informed about the project and their role within it and informed consent was acknowledged by signing a consent form (see Appendices B and C for the information sheet and consent form). Information gained throughout the project was anonymous and confidential as all mothers chose a pseudonym for themselves and their infants. Printed data was kept in a secure location and electronic data was password protected.

There was a concern that during the interview process participants may recall an unpleasant or traumatic experience. The researcher was aware of this possibility and actively sought to minimise the potential harm. In the event that emotional or psychological discomfort was recognized by the researcher, cessation of the interview and referral to an appropriate person would be recommended. However, these measures were not required during the undertaking of this project. No other people were at risk during this project, including the infant, healthcare providers, other maternal support services, the investigator and Unitec.

PARTICIPANT SELECTION

Participants were gathered through a purposeful sampling method (Kleiman, 2004). This sampling method ensured that participants had experienced the phenomenon which was necessary for the production of informative data. Five mothers were sought. This small number of participants can usually provide a rich and exhaustive description of the phenomenon. One review on phenomenology stipulates that the sample size

usually ranges from one participant to a maximum of ten (Kleiman, 2004). This sample size was sufficient for the researcher to note repetition of common subjects between the participants which indicated that further recruitment was not necessary and data collection was complete.

The sample was obtained through a combination of advertisements and word of mouth. Advertisements were displayed at an **Osteopathic Clinic** and a **Plunket Centre** located in the same suburb in Auckland. The advertisement sought mothers of *fussy, unsettled or irritable* infants of 6 to 12 months (See Appendix D for a copy of the advertisement). Three mothers responded to the advertisements. Subsequently, word of mouth was utilised to gain a further two participants.

Interested mothers were contacted by phone. The project was explained in full and assessment of participant eligibility was carried out in accordance with the following criteria:

Inclusion Criteria:

1. The mother recognizes her infant as *fussy, unsettled or irritable*.
2. The infant is between the ages of 6 months and 12 months old.
3. Willingness of the mother to communicate her experience.

Exclusion Criteria:

1. Chronic serious illness of mother or infant. Although these mothers have experiences of value to researchers this project is aimed at investigating lesser complaints.
2. Recent hospitalisation of either the mother or the baby, other than maternal obstetric procedures.
3. English must be the mother's primary language as the project involves an in-depth interview.

The mothers were offered a meeting with the researcher prior to deciding on whether to participate in this project. However, all agreed to participate via phone and an interview date was set. Participation was confirmed through the signing of a consent form prior the interview (see Appendix C).

THE MOTHERS (SAMPLE CHARACTERISTICS)

The purposive sample consisted of 5 mothers who described their infants as *fussy, unsettled or irritable*. Three participants were recruited through the adverts in the osteopathic clinic while the other two were recruited through word of mouth. The mothers were educated women of European descent in their twenties and thirties. Their children ranged in age between 6 months and 12 months and for most this was their first child. For one couple the infant in question was their second child and for another it was the mother's first born however, the partner had previous experience in fathering. All participating mothers had partners.

THE INTERVIEW PROCESS

Participants selected the time and location of the interview. Three participants were met at their homes, one at her workplace and one at a friend's house. Two infants were present and involved in their mothers' interviews.

The interviews were loosely structured and flexible; guided by the aim of identifying the mothers concerns regarding their infant's health. The opening question was: "what makes you describe your infant as fussy, unsettled or irritable?" This was followed by: "can you describe what your infant was like in those first six months?" Topics identified in the literature review were raised by the researcher if they had not previously been discussed. These included questions regarding infant feeding, infant sleeping, pregnancy, delivery and support (See Appendix E for the researcher's interview guide). The focus throughout the interview was identifying the mothers' beliefs with regard to factors influencing her infant's health. Once a mother commenced to repeat her main themes and ceased to present new material, the researcher would summarise her main points and add "is there anything else you can think of that you believe may have affected your infant's health?" Interviews lasted on average 45 minutes.

The digital recordings were transcribed within a short period of conducting the interviews. Transcripts were anonymous through the use of pseudonyms and the omission of any identifying features such as partners' names or locations. Irrelevant conversation was omitted from the transcripts and recorded as such. Any sections which were of poor sound quality or of questionable accuracy were highlighted. Each participant was posted a copy of their transcript and invited to make alterations or

comments. At this time participants were reminded of their right to withdraw from the project within two weeks of receiving their transcript.

DEVELOPING THE THEMES

Familiarisation with the data was achieved through personally conducting and transcribing all interviews. Also, once all interviews were completed, transcripts were read individually to gain an overall impression of the mothers' experiences. Transcripts were then examined with the objective of extracting significant statements which were those relating to infant health. These statements were then scrutinised for validity, consistency and strength. Statements which incorporated identifiable features were reshaped into generic statements and duplicate statements within each transcript were omitted. Subsequently, meaning was attributed to each phrase and common meanings grouped to form themes. Chapter Five will describe these themes through the mother's voice and Chapter Six will discuss them further with respect to the literature.

MAINTAINING RIGOUR

Techniques employed to maintain the project's trustworthiness included purposeful sampling, bracketing, testing the themes, and returning to the transcripts. These were carried out as follows:

Purposeful sampling was carried out through assessment of the mother's suitability prior to undertaking the interviews. This ensured that the data obtained was in accordance with the purpose of the project.

Researcher presuppositions were based on the osteopathic literature encountered throughout five years of study in the field. The researcher went into the project with an inquisitive mind by querying her previous knowledge, especially statements of facts that lacked supportive evidence. Due to the researcher's lack of personal experience on the phenomenon, it is mainly the presuppositions of the profession which were set aside during the process of interviews and data analysis. The process of becoming aware of presuppositions indicates that the findings should represent the experience of the participants with minimal influence from the researcher.

Once initial themes were generated, **testing of the themes** was carried out by investigating other thematic possibilities which included aspects of pregnancy and birth.

These lesser themes were inconsistently present in the project with mention in only some of the mothers' transcripts. Data analysis was carried out on three separate occasions over a period of months and on each separate occasion the process of investigating other possibilities was carried out. The re-testing of themes and revisiting of data resulted in strengthening the findings of the project.

When Colaizzi's final step of **returning to the participants** was carried out, the major themes which developed from the analysis process were found to be represented in all the mothers' original transcripts. Although participants were not involved in the validation process, informal feedback from other mothers of *fussy, unsettled or irritable* infants provided verification of the findings.

This chapter outlined how the project was carried out in accordance with the theory presented in Chapter Three. It also described its design to provide a trustworthy representation of infant health from the perspective of mothers. Prior to presenting the results in Chapter Five, the next section will introduce the mothers and their infants.

The mothers & their infants

Part I

Sam & baby Fi

Sam, although identifying Fi as appropriate for this project, did not *like any of [my] words* (p.12) and preferred to describe her baby as inconsolable. Incessant, inconsolable crying was the main concern, with feeding and sleeping difficulties being secondary to the fact. Health practitioners used the terms reflux and colic as possible explanations for the crying.

During the later stages of pregnancy, Sam experienced emotional stress which *clouded everything* (p.10). Fi was nine days overdue. The labour was long due to Fi's asymmetrical presentation. However, Sam delivered vaginally with no drug relief. Sam's partner was home from work for the first postnatal week which was described as *magic* (p.12). Sam had support from her partner, her paediatrician, her parents, some friends, her osteopath and La Leche league. However she felt negative pressure from other family, friends and Plunket.

Jan & baby Jon

Jan described Jon as a *fussy, unsettled* baby, *very difficult* (p.1) and *anxious* (p.9). Jon had episodes of inconsolable crying. He did not sleep well and had a constant need to be held. He was diagnosed with colic.

The pregnancy was described as *horrid* (p.3). Jan experienced a lot of anxiety over a threatened miscarriage. Jon was three and a half weeks premature and born vaginally. In the postnatal period Jan found the constant stream of visitors very unsettling and she believes it interrupted her initial bonding with Jon. Jan had support from her midwife, maternity health, her paediatrician, Plunket and the La Leche League. However, she lacked family support. Jan made special mention about the benefits of learning to identify Jon's needs.

Sue & baby Amy

Sue described Amy as *unsettled* and *irritable*. Amy needed to be held all the time and she wouldn't sleep on her own because she would scream incessantly when left alone. Reflux was thought a possible causative factor.

Sue had a premature rupture of membranes with a latency of two weeks till delivery. Amy was born vaginally four weeks premature and spent her first week in the neonatal unit. This was a difficult time for Sue as *this is not how it is supposed to be* (p.18). She had support from her partner but their extended family lived out of town. She found an after hours clinic unhelpful and unsympathetic while her personal general practitioner and her osteopath were more understanding.

Jo & baby Mia

Jo described Mia as *fussy, unsettled* and *very whingy* (p.1). Mia didn't sleep well, she was a difficult feeder and when she would cry Jo could not comfort her. During breastfeeding attempts, Jo and Mia *were just completely anxious* (p.6). Jo *hated being pregnant* (p.4) because she found it very restrictive. Mia was 10 days overdue and she required ventouse assistance. Her birth was described as *traumatic*. The first few weeks were *stressful* (p.7). Jo found her partner, her female relatives and midwife extremely supportive. Plunket offered assistance initially but later Jo felt negative pressure regarding their parenting advice. Jo did not find La Leche League helpful. She made special mention about the difficulties in getting to know Mia and questioned whether Mia's behaviour was fed from her own personality.

Meg & baby Ana

Meg described Ana as *fussy, irritable* and *unsettled* because Ana had trouble getting to sleep without being held and she was *hopeless at breastfeeding* (p.17). Ana was diagnosed with colic and reflux.

Meg was *nervous* (p.9) during her pregnancy as she had a history of previous miscarriages. Ana was born via caesarean section due to deep transverse arrest. Meg described this experience as *horrific* (p.14). She felt supported by her partner, her midwife and Plunket. She found the diagnosis of colic dismissive because the general practitioner did not follow it up with an offer of support. Meg also sought help from an osteopath, a naturopath and a homeopath with little success. Establishing a routine helped Meg cope with the situation.

CHAPTER FIVE:
The mothers' voice

Now that the mothers and infants have been introduced, we move to the results of the analytical process outlined in Chapter Four. This chapter includes an introduction to the themes and outlines the development of the project's original aim. Then the themes are presented utilising the mother's voice to provide a full description of the phenomenon. These themes will be further discussed with relation to the literature in Chapter Six and their relevance to the health profession will be explored in Chapter Seven. Links between the themes will emerge in the following section and these will be further developed in Chapter Six, **The Discussion**.

INTRODUCTION TO THE THEMES

The focus of this project shifted from factors which cause infant *fussiness, unsettledness and irritability* to factors which influence infant demeanour. The original aim of this project was to establish the mothers' view point with respect to factors affecting their infants' health. In the attempt to soothe their inconsolable infants the mothers had naturally asked themselves the question: what is the cause of my infant's *fussiness, unsettledness or irritability*? These mothers, like health care providers, had been unable to ascertain a definite cause. "*We spent hours trying to rack our brain of ... what had happened, what had changed? ... We just could not come up with anything*" (Sue, p.2). While mothers could not identify a particular cause, all were able to ascertain factors which indirectly influenced their infants' demeanour. These factors have become the focus of this project. This section is divided according to the three common themes which arose from the analysis of data as outlined in the preceding chapter.

The first theme, **The effect of understanding on support**, illustrates the importance of listening to mothers so that the support offered is appropriate to each individual. When mothers were provided with adequate support they were better able to cope with the demands of mothering. They were able to respond to their infants' demands more effectively and thus diminish their infant's *fussiness, unsettledness and irritability*.

The second theme, **The emotional link between mother and infant**, describes the inseparable nature of a mother and her infant due to the merging of their emotional and physical demeanours. This link was evident to the mothers as an ongoing factor in their relationship with their infant. Some mothers utilised this link as a conscious method of soothing their infant.

Theme three, **The mother's search to understand and care for her infant**, details the mother's belief that her lack of experience or her choice of mothering technique may influence her infant's demeanour which leads to a search for external help. This process allowed them to find methods which soothed their infants to some extent. Although no 'cure' was found, mothers were secure in the fact that it was not their parenting method that was the cause of their infant's *fussiness, unsettledness or irritability*.

Theme One: *The effect of understanding on support*

“I didn’t feel supported because people didn’t know how exhausting it is to have a baby cry, cry and cry. And their babies didn’t do it.” (Sam, p.4)

“The effect of understanding on support”, is a theme which is common to all first-time mothers in this project. When a lack of understanding was present, support would be absent or unhelpful. When understanding was gained, support was not only appropriate but also helpful.

Lacking understanding

Sam, the mother quoted above, reported a lack of support due to the widespread lack of understanding for her situation. Other mothers also described a lack of understanding due to family and friends’ failure to see the demands placed upon them when caring for their *fussy, unsettled or irritable* infants. Two reasons for the lack of understanding were present in the data (i) absence of the ‘support’ person, and (ii) absence of the ‘support’ person’s interest.

We [have] both got family in [the city] which just wanted to stay away and give us time with the baby. [When,] they would have been welcome.” (Jan, p.6).

“We had so many visitors coming through ... constant, everyday ... / ... visitors who wanted to give a gift, which was lovely, and hold the baby and then at the same time go.”
(Jan, p.4 & 7)

“My mum and dad came to stay in this tiny little house and my sister came up to stay ... It was too much because they weren’t understanding that I was knackered. And it was all, it was all about them seeing the baby and it felt like ‘what about me?’... I have just had a caesarean, and I was recovering from that, and I was absolutely tired, and she wasn’t sleeping... it was all about them seeing the baby ... They are not into getting up at the night time, like they would get up early, like 6 or whatever, but I had been up all night anyway.” (Meg, p.16)

In these situations, those who ought to have provided the mother with support failed to gain an appreciation for her situation. These mothers demonstrated an element of

resentment for the fact that those close to them were failing to understand their situation. Without understanding, there were instances of inappropriate and unhelpful support.

“Plunket, I found that frustrating too because, I kept being told the same thing ... [and I would tell them] ‘this is my fifth phone call and that process has not worked’. It isn’t, I am not asking them to solve the issue for me, just perhaps suggest something different. (Jo, p.19)

“Everyone was like ‘she will grow out of it’. You know, that is just soul destroying when you are tired beyond anything you have known your whole life. And people say ‘oh she will grow out of it in six weeks’... Well I remember thinking, when she was two weeks, ‘how am I going to do this every night until she is six weeks?’ You know, to me that was like a lifetime away. (Meg, p.18)

Having understanding

Understanding was reached by sharing in the mother’s experience. In accordance with “lack of understanding”, understanding was gained by either (i) the presence of a support person spending time with the mother and infant or (ii) the presence of the support person’s interest for example, listening to the mother express her concerns. In this manner, support people gained an appreciation for the mother’s situation.

Mothers reported on the benefits which were gained from the understanding of others:

Appreciation for the mothers’ efforts: Appreciation, as detailed in the literature review, is one form of social support. One mother described a situation where obtaining appreciation from her parents gave her great relief, “we spent an evening with my parents and [they] said ‘now we see how hard it is for you’.” (Sam, p.4)

Advice becomes appropriate and helpful: Mothers reported the benefits of advice and support given by people who took time to understand their situation.

“The midwives at [the hospital] were completely overwhelmed with patient to staff ratio. Every time there was a birth, two of them had to go. They literally, latch and then go. ...//... [My midwife] admitted me to the maternity ward where I was successful, they were really good. ... You need someone to stay with you, you need someone to be with you the whole time you are breastfeeding.” (Jo, p.6)

“Plunket were great, I went along to the family centre and ... I would get a sleep. Because I was absolutely exhausted, you know, only getting maybe two hours of sleep a night. And I would go to Plunket centre for the whole day and maybe get two, two hour sleeps, and they would look after her. And just watch how I fed her and things like that.”

(Meg, p.4)

The second-time mother

The one second-time mother in the project was the only one who did not raise support as an issue. The following was her response to this topic when raised by the researcher.

“We don’t have a lot of family in [town] so I didn’t have a lot of support, like from our family and things, but my husband is really great with both [my son] and Amy. So I don’t think, really, that I could have asked for any more. I don’t think that I would have needed to ask for any more support... In myself, I sort of felt like knew what, I really should have known what I was doing. Probably more in terms of getting more things done around the house, like you know, doing the housework, doing the washing and things like, that would have been good. But in terms of looking after her, I guess I was just focused more in making sure my children were happy, or just attend to their needs rather than actually doing anything else.” (Sue, p.16)

The support Sue describes as lacking is in the form of child care and chores. As detailed in the literature review, this is common amongst mothers with more than one infant. However, this lack of support, unlike that reported by first-time mothers, was not linked to influencing infant demeanour.

Theme Two: *The emotional link between mother and infant*

“But it was hard to know what came first. Was I tense and that made my baby tense ... or was it just her crying incessantly without an end that made me tense? Can you separate them? ... All intertwined huh?” (Sam, p.7)

Another common theme which arose from all the mothers’ narratives was the unity of their emotional status with that of their infants. Mothers noted that when they were unwell or upset, their infants were simultaneously *fussy, unsettled or irritable*. This is important as it indicates an immediate link between the mother’s wellbeing and that of her infant.

“I [had] huge negative vibes ... I am sure she picked up on that, and that did not help her relax.” (Sam, p.6)

“Well I had taken her to the doctor, where I was treated like an absolutely neurotic mother who couldn’t handle her crying baby. It was really, really degrading and I found it extremely upsetting. It made me even more [angry], which probably didn’t help Amy, that I was so upset about it.” (Sue, p.3)

“I really believe in that. That if you are stressed or unhappy or even unwell that your baby will pick up on that, or even your children pick up on that, and react to that.” (Sue, p.20)

The above excerpts describe situations in which mothers were upset by the people around them which in turn impacted negatively on their infants. This project also provided examples of women influencing their infants positively. However, a mother’s ability to utilise her emotional link as a means to soothe her infant was a skill that required development. Learning to positively influence her infant was a process which began with the mother discovering her emotional link with her child.

“I was on the phone with mum saying, ‘I have had it up to here with him, I am just so angry with him’. I was talking and was really upset, crying myself, holding him, pacing up and down. He was crying and the more I let it all out to mum, the more he got anxious ... and I remember mum saying, ‘Jan you have to get off the phone, you have to try and calm him down, put him in the bouncer to try and calm him down’ and once I,

like, she actually had to say that for me to get off and do that ... and I realised that once I did that, I softened him and [worked] really hard to calm him down and I managed it. But I think it was at that time when I realised that [my] feelings and how I react to them definitely interfere with [him].” (Jan, p.9)

Mothers then had to consciously strive to keep control of their emotions in order to soothe their infant. Some mothers eventually became experienced at utilising the emotional link to settle their infant on an everyday basis.

“I can remember, I had to really step back and take a deep breath to calm myself down, and remind myself to be the bigger, better person ... so now I guide him ... on what to do ... to calm himself down, trying to take deep breaths. I know he doesn't necessarily understand what I am saying, but I know for me, it is reminding me what I have got to do ... but I think that was most helpful.” (Jan, p.8)

Some mothers in this project discovered this emotional link on their own, while other mothers were facilitated in this process by outsiders who helped them recognise their connection with and influence on their child. For example, a mother who sought help from a naturopath was advised to utilise the emotional link as part of her infant's healing process. This gave the mother an ongoing tool to enhance her role as primary caregiver for her child.

“She said to me that whenever I could, I should just sing that I am a good enough mum to myself. And she said to sing it so then it would go right deep down and relax me. So part of her method of healing [my infant] was to help me relax” (Sam, p.7)

The importance of the emotional link was emphasised by the need to find parenting techniques which suited the mother as well as her child. One mother described how the act of breastfeeding was “stressful” and how she and her infant were “like an elastic band waiting to snap” (Jo, p.6). Ultimately, she decided that the stress of breastfeeding was more detrimental to her infant than the effects of not being breastfed. She found that once she stopped breastfeeding, her infant's temperament changed for the better as did their relationship.

“I do think that your mood and your temperament does rub off a bit on your child ... that for me was evidenced by the breastfeeding thing ... The moment that whole process ended ... I relaxed, and so she relaxed. So there is evidence of that for me anyway, I

could see it. ... / / ... I was relieved when I ended it. I felt guilty but ... we just got along so much better when we stopped. It really did improve. It improved a hundred fold in our relationship.” (J0, p. 14 ↔ 13)

This scenario illustrates the strong emotional link which the mothers in this project reported as having with their infants.

Theme Three:

The mother's search to understand and care for her infant

"It is sort of hard to know if that is just the process of becoming a mother and a new baby and just getting to know each other." (Jo, p.3)

All mothers in this project queried whether their infants' *fussing, unsettledness or irritability* was related to their parenting methods. Mothers identified two key aspects to their parenting skills (i) understanding what their child needed and (ii) responding appropriately.

Understanding her infant

Even the most experienced mother in this project reported the difficulties of understanding her infant's needs.

"She was my second baby. I was, like, trying to recognise all the signs of her being tired or being hungry. All those sorts of things that are really hard the first time round and you think, 'oh yeah I'll have this sussed the second time' but I would put her to bed and she would just scream." (Sue, p.2)

Some mothers reported that learning their infants behaviours and signals required effort.

"Being a first time mother, I can't really stand being at home. So I used to go out a lot and just take him out. So I think that was really unsettling for him. ... I realised that at home I picked up some of his patterns." (Jan, p.4)

For one mother the benefit of understanding her infant's behaviour was striking.

"When she was really tiny, day time [sleeping] was a problem. And that was actually my fault. Because ... I have worked with babies, I have nieces and nephews coming out my ears, I have had a lot to do with babies, I have lived with them and I missed all the sleeping signs. How funny is that? And other than the obvious ones like when she was yawning or rubbing her eyes, there were other signs that you don't actually, that you don't understand. I went to Plunket ... I attended a sleeping talk that they had, and they showed this fantastic video, ... [it] was fantastic because it really identified, not just the eye rubbing and the yawning, it identified signs before they even get to that point. ... So

once I identified, once I saw them and recognised them ... daytime sleeping suddenly became a very easy thing, very achievable.” (Jo, p.9)

The above illustrates how a mother was able to influence one part of her infant's behaviour. The benefits of understanding were not as significant for other mothers in this study. This was due to the fact that infants remained inconsolable despite their mother's best efforts at understanding their needs. The ongoing nature of the infants *fussiness, unsettledness or irritability* despite all efforts, meant that mothers moved on to query their own behaviour.

Mothers queried their parenting techniques

“Especially when I am choosing to parent her very differently from my friends, and there is all that pressure like, feeling like ... I am doing something wrong therefore she is like this.” (Sam, p.11)

There are numerous philosophies or methods which can be utilised to care for an infant. Each mother in this project had to sort through an array of information, recommendations and advice, before choosing their own parenting technique.

“[Plunket's] methods of settling I found really difficult to do. So that is when I decided to try [a book] ... it was more comfortable, their style of parenting.” (Jan, p.7)

In the absence of a method where both mother and infant were content, the mother decided upon a technique which helped her cope as best she could.

“[Staff at the Plunket Centre] were really good in giving me advice ... [it] has been the absolute best bit of information that I have had in this whole thing, getting her into a routine. And she really responded to that ... it still didn't make her sleep the night, but at least there was sort of a coping mechanism during the day.” (Meg, p.4)

When a parenting method was inappropriate, mothers kept searching for other means to soothe their infants.

“I went through a whole process, and none of these things seemed to have made any difference. I called Plunketline a lot. Trying to get them to help me find methods I could use” (Jo, p.10)

“She would fall asleep only if there was excessive movement. So I would take her for a walk. Like if I just lay her down she would not sleep at all. So we went for a walk and at one point just, with her crying so much, and me wanting to be a good mum and calm her down. At one point the only thing that would calm her was me jogging on the spot ... You can picture that, it was just ludicrous. And I am like, ‘why did I think of it?’ because now this is my only solution, in fact, that would just calm her... So just we just did everything in terms of jiggling and jogging and just to, kind of help her relax” (Sam, p.8)

To think they had exhausted all parenting methods without success, gave mothers a sense of failure. It was therefore important for mothers to be able to explore other options for helping their infant, as this allowed for continued hope in their own mothering abilities. Four of the five mothers reached a stage where their focus shifted from their mothering ability to the possibility that there could be something wrong with their infant, this led to seeking advice from other sources.

Mothers sought advice from other sources

“I had to do something else for her” (Sue, p.8)

In this project it was found that when most mothers exhausted their personal resources they sought help. All mothers sought advice regarding parenting techniques from female friends, relatives, midwives, Plunket (The Royal New Zealand Plunket Society) and La Leche League.

“My midwife was great and she, I would text her a lot and she would sort of suggest different things” (Meg, p.4)

“I also did go to Plunket a bit in the beginning ... It was when I had problems settling him that I went to La Leche” (Jan, p.7)

“I have a supportive mother in law and quite a supportive mother ... and a sister who has had three children, who had her third baby probably three or four months before Mia. So yeah I definitely had the support there. And I am not afraid to pick up a phone, like Plunket got a lot of phone calls from me especially over sleeping issues. And I must say, with the whole breastfeeding thing, I was very unimpressed by La Leche League, you know, I just yeah I wasn't impressed with them at all, but my midwife was great.” (Jo, p.8)

When their infant failed to show improvement with the use of new parenting techniques, four mothers shifted their focus from self-scrutiny to querying their infants' health. One mother described the situation which led her to take her infant to an after hours clinic:

"I thought, 'this is ridiculous, you know, there has got to be something wrong, she is not sleeping'. I could see she was incredibly tired and I thought I just had to do something. (Sue, p.6)

Four mothers took their infants to at least one health care provider with regard to their *fussiness, unsettledness or irritability*. They first went to their health care provider of choice, for some it was their general practitioner, for others their osteopath. No relief arose from these initial consultations and this resulted in two outcomes:

One mother found **comfort in the diagnosis** of colic and the paediatrician's explanation of the problem. *"The doctor said that he had an immature digestive system"* (Jan, p.2). She then soothed her baby by whichever means possible. *"I heard with a child who has colic, that if I sit there and help, things like the 5s's. ... Swinging, shushing, on the side, stomach, swaying, sucking. And that is what we did."* (Jan, p.6)

The other three mothers sought further help from other practitioners.

"I went back to my own GP and ... the doctor couldn't find anything. And I thought 'well this, this is just crazy she isn't happy I need to do something more about this'. Because it was heartbreaking, because you know she was normally a happy little baby. So it was through my antenatal group ... a lot of them had taken their baby to see a cranial osteopath and I had never really considered it before then and talking to them and telling to them about what she was like, they were like 'why don't you take her to the osteopath' and so I thought 'oh yeah that would be good' ... // ... I mean my GP is great... he is really good, but I just felt that I had to do something else for her... I was just open to anyone at that stage." (Sue, p.3 & 8)

"I took her to osteos, a naturopath. I tried all the homeopathic stuff as well." (Meg, p.4)

"[My midwife] wanted us to go see a paediatrician but we're, we are trying to be as natural as possible. So we took the long route, so we went to a cranial osteopath ... And we, my doctor is also a homeopath, so then we had a homeopathic treatment." (Sam, p.2)

For one mother the result of the treatment sought from her homeopath was striking “*we had a homeopathic treatment and that worked like a miracle. It was stunning*” (Sam, p.2). In contrast the three mothers who sought osteopathic treatment, found it difficult to assess the outcome of treatment because there was no striking difference in their infant’s behaviour. Despite this, these mothers appreciated the effort osteopath put into finding the cause of the *fussiness, unsettledness or irritability* and they found that treatment helped.

“I am quite a firm believer in the medical system and in the biology of the body and all the things that go with it but I think when it comes to your children you really need that whole holistic you know, and because children can’t talk I just think that it is really beneficial to be able to you know, I just found that the osteopath communicated with her whereas a doctor you know will just look.” (Sue, p.8)

“The osteo was good in that he was trying to figure out like look big picture and figure out the whole thing. Why was she getting a sore tummy, what was causing it, you know and he did his cranial stuff and she was really relaxed and calm when she was getting that and she did, she was settled for a few days after each session but it didn’t really do anything you know it didn’t help her sleep, that is what I wanted. So that was good, but everyone else was like she will grow out of it.” (Meg, p.18)

In conclusion, **The mother’s search to understand and care for her infant** describes the mother’s sequential search for something which would soothe her *fussy, unsettled or irritable infant*. This process commenced with searching within a mother’s own knowledge and led to seeking help from traditional and alternative healthcare providers.

SUMMARY OF THE THEMES

This chapter portrayed the mother's voice in describing factors which influence her infant's demeanour. The first factor described the importance of listening to mothers and understanding their situation in order to provide the support they needed to care for their infant. Secondly, emotion was found to be an immediate link between the mother's and infant's demeanour. The third factor identified was founded on the mother's belief that her mothering ability could account for her infant's *fussiness, unsettledness or irritability*; this led to a search to understand and care for her infant which ranged from seeking new mothering techniques to seeking advice from alternative healthcare providers, when they have exhausted all other options. These factors are closely related and this will be discussed in the next chapter.

CHAPTER SIX:
Discussion

While Chapter Five discussed the themes from the mothers' perspective, this chapter presents and discusses the themes with respect to current literature. Each theme will be described individually and the connections between themes will be explored. Other factors which arose throughout the literature review, but were found lacking in the mothers accounts, will also be discussed.

SUPPORT

The effect of understanding on support

Mothers in this project sought support from their partners, mothers, sisters, friends and midwives. This is consistent with the findings of previous studies. Understanding the mother's individual situation was the biggest determinant of whether advice was appropriate and supportive. In fact, understanding in itself was found to be helpful to mothers because when others shared their experience, mothers felt validated in their own.

A qualitative study, "Living and coping with excessive infantile crying" by Long and Johnson (2000), also identified the need for understanding. The authors found that parents in their study required health professionals to believe their story and this was achieved not just by verbal confirmation, but also a visible commitment to trying to understand their case. When practitioners did so, they gained trust and established a rapport and so became sources of support for the parents (Long & Johnson, 2000).

The effect of understanding on support may appear unrelated to infant temperament however, there were two ways by which understanding and good support were linked to infant *fussiness, unsettledness and irritability*:

Appropriate advice on mothering techniques helped the mother attain an effective form of parenting technique, the ability to care better for her infant or a method by which she could cope better. This is closely related to **The mothers search to understand and care for her infant**.

Validation, appreciation and affirmation are forms of support which can greatly affect maternal self confidence with respect to child care. This is closely related to **The emotional link between mother and infant**.

The fathers' role

In the literature explored, the partner's role was reported to be one which: (i) when present provided mothers with shared responsibility, emotional support and confidence, (ii) when absent resulted in the mother feeling isolated (Barclay et al., 1997; McVeigh, 1997). While the father's role in providing emotional support was apparent in the subtext of the interviews, the mothers in this project only made special mention to the fathers' shared responsibility with respect to childcare.

Times of shared responsibility:

"We just had to carry her and feeding was dreadful because she would scream whenever I offered my breast for her to drink from and so whenever my husband was around he would carry her and that would calm her down a bit more." (Sam, p.1)

"It helped because it was a Saturday and [my partner] was home. Because, I had the support of him and he was being really good at holding Amy ... we could take turns at doing that." (Sue, p.9)

Times of being on their own:

"Days on my own when I have [my older son] and Amy, and trying to keep them both happy was just, just really, really hard. I couldn't get anything done." (Sue, p.9)

"I mean there [have] been a lot of bad days. I have just cried, and cried, and cried the whole day long. Probably days when I have been here on my own... I can't get her to sleep during the day... Just absolutely exhausted and no one here to help me, my family isn't here, [my partner] was at work and just thinking 'oh my god how much longer is this going to go on'." (Meg, p.5)

Partner's availability

All mothers commented on their partners' availability: *"fathers aren't around as much"*, *"my husband was out"*, *"when he was around"*, *"when he was at work"* and *"when I was alone"*.

Shared responsibility of care was more significant to the mothers in this study than confidence or emotional support. Most techniques which mothers employed to soothe their infants required their full attention, for example, *jiggling*, *jogging*, *swinging*, *massage* or

constant contact. Thus, shared care would be important because of the high demands placed on the mothers by their *fussy, unsettled or irritable* infants. Fatigue has been identified in the literature as being higher for mothers of colicky infants. Thus, the presence of a father to share the load of care would help them.

Emotional support and confidence from fathers were not reported by the mothers in this project. However, it was apparent that these were available because all mothers used the term “*we*” throughout their discussion: *we tried lots of things, everything that we would try, we spent hours trying to rack our brain, we would really try something, and we had issues with her*. Furthermore, no mothers in this study reported on marital strain which has been associated with the stress of caring for a child with colic (Ellett et al., 2005).

Although the mothers in this study did not highlight the father’s role when discussing factors related to influencing their infant’s *fussiness, unsettledness and irritability*, their presence was highly valued and of great support to the mothers.

The role of support in the mothers search to understand and care for her infant

All mothers in this project described their **search to understand and care for their infant** as a series of trial and error attempts. They sought help from many different sources in order to find a mothering technique which they felt worked for them. They sought advice from midwives, paediatricians, Plunket, La Leche League and coffee groups. It appears that these mothers were unprepared for the role of motherhood, and that may be the case as numerous studies report on the lack the preparedness which new mothers encounter (George, 2005; McVeigh, 1997; A. M. Nelson, 2003). However, the number of organisations these mothers sought help from may not signify a lack of preparedness but, on the contrary, resourcefulness. These mothers took the initiative to seek help, and keep seeking help until they found the method which suited their situation. No one person or organisation can provide all mothers with *the* method which suits her and her infant, for each dyad is unique. Following is a discussion on the support services utilised by the mothers.

Antenatal classes are probably the first place where parents learn the basics of infant care. However, as one mother reports, advice given during antenatal classes are not entirely taken on board.

“I didn’t have a clue. I mean I probably got told them when I was pregnant but you don’t listen to any of that I was focusing on the birth. They probably mentioned it at antenatal classes but I never listened.” (Meg, p.17)

As mothers have the huge hurdle of birth to cross before mothering techniques will have any application, they are sometimes unable to fully appreciate the advice. Postnatal advice may be the answer for these mothers for whom antenatal advice was redundant.

The way in which postnatal advice is delivered to mothers in New Zealand has changed since my mother had children. Postnatal advice used to be achieved through the hospital system, where mothers would stay for up to ten days post-partum. The nurses would be available for any questions the mother had, at any time, and mothers learnt how to care for their infants basic needs. Personal communication with a few mothers of that time suggests that this was a great way to convey the information which they needed to care for their children. One of those mothers asserts that the old method of in-hospital postnatal advice was very effective; even though at the time she was considered “noncompliant” because she refused to give her daughter complimentary formula (Dawson, N., personal communication, March 6th, 2006). Nowadays, mothers spend as little time as possible in hospitals, which have become places for acute patients only. Postnatal support has been placed in the hands of the community and support in this form is gained from Plunket², La Leche and coffee groups:

Plunket

In the community, Plunket has taken up the role of providing new mothers with postnatal advice. Some mothers found advice given by these sources very helpful:

“Plunket were great, ... they were really good in giving me advice on, only feed her three hourly, wrap her up, when she cries go in and stick her dummy in, but don’t pick her up. She needs to learn how to go to sleep. She needs to learn how to associate bed with sleep. So we had that whole retraining thing and we, and that has worked really well, that is

² The Royal New Zealand Plunket Society is a non-profit organisation which provides well child and family health services. The organisation is formed by health professionals and volunteers and their aim is to support families with young children by providing appropriate clinical and support programmes. (The Royal New Zealand Plunket Society)

that has been the absolute best bit of information that I have had in this whole thing is getting her into a routine.” (Meg, p.4)

However, two mothers reported as follows:

“I mean Plunket, I went to the family centre where they, I went and I was beside myself. I went because I heard they make you a cup of tea and you can talk to them. And they said oh she doesn’t have colic the problem is that you are not putting her to sleep and letting her cry to sleep. So they were the messages I got from Plunket like, you aren’t doing it right. Like actually she is just tired so that, I. The worst thing about being a parent is that everyone feels like they can tell you what you are doing right and what you are doing wrong yeah that, and because we are doing (she faded of)” (Sam, p.14)

“Plunket, I found that frustrating too because I kept being told the same thing. Leave her in a room, let her scream for a while, she is not going to harm herself, she has got a bad habit. And I would go I know she has a bad habit and I am telling you this I my fifth phone call and that process has not worked. It isn’t, I am not asking them to solve the issues for me just perhaps suggest something different.” (Jo, p.20)

It is interesting that all three comments on Plunket were in regards to sleeping. All three mothers were advised on using the same method. One mother thought it was the best advice possible, while the other two found the advice rigid and were frustrated when Plunket were “unable” to suggest any other method. They also felt ignored because their views on parenting weren’t respected and their previous efforts had not been acknowledged. This emphasises the need for mothers to feel understood.

La Leche League

La Leche League is run by mothers and has been set up to help breastfeeding mothers. They offer a network of support to help mothers find confidence in breastfeeding and parenting. Mothers in this project, in general, found that they gained helpful information and support from this organisation. However, one distraught mother found that trying to talk to a mother, who had children of her own, screaming in the background, was too difficult. When she looked back on the incident, she believed she should have called another time, or a different contact within the organisation, as she would have liked their advice and support. Her reason for not doing so was that she *“was so angry and annoyed, and put off, and just frustrated, and fed up with the whole bloody thing”* (Jo, p.8). This

comment did not stem from the lack of understanding of the mother on the other end of the line as for this particular mother this “difficult” phone call was the last straw in a long line of problems. Her situation outlines the importance of gaining the mothers perspective prior to offering them support. This could be achieved by asking yourself if you are both in a position where advice can be given and received in the manner in which it is intended. Unfortunately, there is no one perfect way because it is individual to the mother.

Coffee groups

A common occurrence now is the concept of a ‘coffee group’ which often stems from antenatal classes. Coffee groups are a group of mothers (or parents) who meet on a regular basis to provide a support network for each other. One mother in this study described how the coffee group was her only escape from the house.

“Like I would go to coffee group because it didn’t matter if she screamed but if I was to, if we went to friends or something like that and she missed a sleep or missed the opportunity to go into her own bed it would be an absolute disaster the rest of the day. So in the end I just didn’t bother, people would come to me.” (Meg, p.7)

The difficulty lies when one mother feels her method is not supported by others in her network.

“Especially when I am choosing to parent her very differently from my friends and there is all that pressure like feeling like what I am, I am doing something wrong therefore she is like this.” (Sam, p.11)

The above mother’s situation illustrates the importance of establishing antenatal classes, coffee groups and support networks around the values which are important to the mother. There are already some examples of this such as, an antenatal class centred on homebirths. This is a common value for the mothers who attend, and thus the support they gain from such a group may be more applicable to their own situation.

It is clear, even from this small sample of mothers, that the support and advice which mothers need is individual. So perhaps mothers may feel unprepared for their mothering role, but it is not for any one mother, organisation or professional to tell

them how to do it. It is the mother's journey to find her own way through motherhood and it is the role of a good support person to provide mothers with options.

THE NOT-YET-UNDERSTOOD EMOTIONAL LINK

The mothers in this project reported an immediate link between their physical and emotional wellbeing and that of their infant. **The emotional link between mother and infant** is an integral part of this project's findings because it forms the connection between the other two themes and infant demeanour. Essentially, successful parenting and good support lead to maternal self-confidence and maternal role satisfaction which in turn influences infant demeanour: *happy mother equals happy baby*. There is little research into this emotional link reported by the mothers in this project, below is a discussion on the relevant literature.

Infant's influence on the mother

The transition to motherhood is a highly emotive time for women. Some of the feelings that mothers report at this time are isolation, confusion, guilt and resentment. These negative emotions are reported to be exacerbated by caring for a "difficult" infant and it is recommended that women in this situation require additional practical and emotional support (Barclay et al., 1997). Previous literature on mothers of colicky infants has detailed how they report feelings of anger, frustration, worry, guilt, helplessness, hopelessness, isolation, nervousness and rejection as a result of their infants' excessive crying and *fussing* behaviour (Cirgin Ellett & Swenson, 2004; Helseth, 2002; Pauli-Pott et al., 2000). This literature provides no indication on the time period for the generation of these emotions. Does it relate to an immediate effect, or is it the constant nature of caring for a colicky infant? Regardless, these reported feelings exhibit the link between infant and mother reported by the participants in this project.

Mother's influence on the infant

Mothers in this project reported on their emotional and physical influence on their infant's *fussiness, unsettledness and irritability*. There is little research on this topic, the few articles available are from the view of psychologists and psychoanalysts and relates specifically to the emotional aspect. Based on this literature, the link may be explained through the following process: maternal anxiety may lead to a change in a mothers

behaviour, where she is less sensitive to her infants needs and when she fails to respond in an appropriate time and manner, the duration of *fussiness, irritability or unsettledness* is greater (Helseth & Begnum, 2002; Hiscock & Jordan, 2004; Kivijarvi, Raiha, Virtanen, Lertola, & Piha, 2004). As with the literature on **the infant's influence on the mother**, there is no time period provided in the literature for this process also, the literature sourced is specific to the effect of maternal anxiety.

Oneness

Rather than one affecting the other as described above, there is a theory proposed by some psychoanalysts that mother and infant are as one. Terms such as symbiosis, undifferentiated, merged and boundary-less are used to describe the relationship between mother and infant. Initially it was proposed that this was a phase in the emotional development of an infant however, Pine (2004) suggests that instead, oneness is present during “certain highly significant moments”. Pine describes one of these moments:

“... Nursing seemed capable of producing experiences of oneness for the infant. Cradled in the mother's arms, molded to her body, sucking from her, the infant moves progressively from ravenous hunger to satiation and drowsiness, and, with that, body tonus relaxes and the infant “melts” into the mother's body. Perhaps there are other such moments—being carried and moving in synchrony with the mother, or mutual gaze and cooing.”
(p.516, Pine, 2004)

Pine's theory of “moments of oneness” appears to fit with the experience of the mothers in this project. It was moments like being carried and talking soothingly to their infants, which some mothers used to describe their emotional link with their infant. Pine (2004) asserts that these moments of oneness are part of the normal development process present in the first few months of life. He also acknowledges that when the mother and infant experience something fraught with anxiety or ambivalence, the handling of her infant will alter and affect the infant.

Silverman (2005), acknowledges that mothers believe they are as one with infants but disputes the validity of their claims. She suggests moments of oneness form part of a maladaptive interaction between mother and infant and asserts that intrusive and over-attentive mothers limit an infant's formation of self. If Silverman is correct in her

assertion, she offers no cause for this mal-adaptation and no help to offer these mothers.

Due to the abstract nature of this concept and the difficulties in interpreting what the inarticulate infant's experience, articles on this topic are purely speculative. Although there is little literature regarding the nature of the emotional link between mother and infant, the mediator for it, or the long term effect of it, there is evidence that some link exists. What is not in question within the literature review is the mothers' belief that they and their infants are inextricably linked.

The mother's application of the emotional link

Although the presence of a link between infant and mother is reported in the literature, the immediate effect described by these mothers is not reported and neither is the way in which mothers learned to use it to their advantage. Current literature lacks research on the mother's view on factors affecting infant demeanour. Previous studies which have identified the emotional effect which colic has on mothers, have not queried whether the opposite occurs, as this was not the focus of their investigations. Even in this project, the mothers were matter of fact about this emotional link, which they believe to be true. Only two mothers described the process of learning to apply this link to their daily care-giving methods. One was supported by a homeopath in this endeavour. The other, once realising the link, took time and concentrated efforts to successfully use herself as a mediator to soothe her infant.

It is interesting to note that only one of the four mothers had help in understanding and utilising this link. There may be three reasons for this failure to pass on this knowledge.

This link is not common to all mothers. As this study does not involve mothers of *non-fussy, unsettled and irritable* infants, it is unknown whether the emotional link is significantly present in the wider population of mothers.

The link is present in the wider population and (i) other mothers and health professionals may **assume this link is known** or (ii) professionals utilising a method of evidence based practice, may **feel unwilling** to discuss the emotional link due to a lack of supportive literature.

Some mothers in this study would have benefited from the guidance of others with respect to understanding and applying this link. This relates back to understanding a mother's situation and providing her the best advice and support for her situation.

THE MOTHER'S NEED TO DO SOMETHING ELSE

The **mother's search to understand and care for her infant** has been well documented in previous literature (George, 2005; Keefe & Froese-Fretz, 1991; Long & Johnson, 2000; Sullivan, 1997). Sullivan (1997) used phrases like "learning the baby" and "trying to figure it out" to describe a systematic thinking process by which a mother attempts to soothe her infant. "The method of identifying problems continued indefinitely until babies were comforted and mothers were satisfied" (p.24, Sullivan, 1997). Sullivan's findings are similar to those identified in this project, specifically the process of **searching to understand and care for her infant**. However, this is the point where Sullivan's findings and that of this project part. Sullivan's sample was drawn from a general population of mothers, while the mothers in this project were specifically contending with *inconsolable* infants. Despite the mothers' best attempts, their infants were never satisfied and their *need to do something else* extended this process of "learning the baby" to seeking external help. This help was sought from people far removed from the mothers initial support networks. The mother's focus shifted from her own need to "learn the baby" to questioning her infant's physical health.

Another study investigated the effect of colic on mothers (Keefe & Froese-Fretz, 1991). Similar to the data found in this project, Keefe & Froese-Fretz (1991) found that infant signals were difficult to interpret and that when mothers were unable to identify the cause of their infant's problem they became insecure about their mothering capability. They also found that mothers "searched for effective interventions" which reportedly was limited to reading books and asking questions. Similar to Sullivan (1997), Keefe & Froese-Fretz's study did not describe the mothers strong need to seek external help from either primary or alternative health care providers.

The mothers in this project also reported visiting numerous alternative health care practitioners. Through their *need to do something else* they consciously left their comfort zone by seeking help from health practitioners they would otherwise not consider using. This trend was also identified in Long and Johnson (2000) who named their similar theme "search for a diagnosis". They noted that as the mothers attended numerous

medical consultations which gave infants no relief, it became clear that “traditional medicine held no solution, or even a convincing explanation for the crying, parents would often turn to alternative therapies.” (p.34, Long & Johnson, 2000)

Long and Johnson (2000) described a mother who after visiting an osteopath was unable to ascertain whether the treatment actually altered the infants behaviour, although it seemed to help. Both the mother in Long and Johnson, and those in this project, queried whether they were just coping better with time and it wasn't the osteopathic treatment at all. This trend is in contrast to that Carruthers (1998), where he found that 53% of mothers felt that treatment helped their infants symptoms a lot. This difference is an indication that further research should be carried out with respect to the effect of osteopathic treatment on infants.

INFLUENCING INFANT DEMEANOUR

It must be noted that mothers and health practitioners were unable to cure the infants' *fussiness, unsettledness or irritability*. However, the themes outlined in this project provided mothers with the ability to soothe their infants to some extent through: (i) good support, (ii) proper application of the emotional link, and (iii) appropriate parenting techniques. The fact that the themes did not cure but aided slightly, may be explained by the use of Helseth & Begnum's (2002) proposed aetiologies for infant crying. Perhaps mothers in this study were able to soothe their infant's **non-specific fussing and crying** and **feeding-related fussing and crying** but were unable to soothe **intense crying** which was thought to be 'real' colic and therefore due to a physiological cause such as gastrointestinal immaturity.

OTHER ISSUES FOR DISCUSSION

The following section covers topics which were not present in the data significantly enough to become themes but were found relevant to the topic through the literature review. Topics include fatigue, pregnancy and birth. This section will also discuss postnatal distress.

Fatigue

Maternal fatigue was identified in the literature review as a common occurrence in the post-partum period and was linked to maternal irritability and loss of concentration. Fatigue is even more pronounced in mothers of colicky infants (Ellett et al., 2005; Helseth, 2002; Helseth & Begnum, 2002; Troy, 2003). This issue was not raised by the mothers in this project. There were two instances where mothers described being fatigued but this was not associated with any adverse effect on the infant, which was the topic at hand. The importance was placed on their infants and not on themselves. As one mother told an after hours clinic *"I can handle having no sleep but she can't... I want you to focus on my baby"* (Sue, p.6). It may be that mothers see fatigue as a part of motherhood and therefore an unchangeable factor. Troy (2003), explains that evidence-based interventions for fatigue are few; apart from suggesting the side-lying position for breastfeeding mothers.

Pregnancy

Maternal stress during pregnancy has been reported to effect infant crying behaviour (Canivet, Ostergren, Rosen, Jakobsson, & Hagander, 2005; Hayden, 2000). However, a recent investigation into the effect of pregnancy adversities on infant crying and colic, disputes this because they found no relationship between maternal stress, alcohol consumption or smoking cigarettes during pregnancy and infant crying (St James-Roberts & Conroy, 2005). The same study did, on the other hand, identify an association between maternal anxiety at 37 weeks gestation and increased crying of the infant at 12 weeks of age.

Four mothers in this project reported periods of emotional stress and anxiety during their pregnancy and the other *"hated being pregnant"*. However, only one mother associated this with influencing her infant's demeanour, *"I believe that if I had of relaxed during the pregnancy I think that she would have been a more chilled out baby"* (Meg, p.19). The only incident of physical stress during pregnancy was a premature rupture of membranes for one mother which meant her infant was not delivered till two weeks after her waters broke. This also was not stated to be relevant to her infant's *fussiness, unsettledness or irritability*.

The osteopathic belief that emotional health during pregnancy is related to infant adversities may be supported by the mothers' reports however, it is not a considered a

major concern for most mothers in this project. Perhaps mothers did not consider emotional stress during pregnancy a causative factor because the concept seemed far removed from their infant's demeanour. As the one mother who thought emotional health during pregnancy affected her infant's demeanour said, "*It would be interesting if I have another baby because I am sure that I would be more calm during the pregnancy ... I think that that was a huge influence on her health.*" (Meg, p.19) This would be an area for future study.

Birth

Four infants were born vaginally and one was born via caesarean section. One of the vaginal deliveries was *a very long labour*, another was *very quick*, and another required ventouse extraction. Four of the five mothers had what osteopaths may call a stressful birth which could lead to structural strain. However, only two mothers associated their infant's *fussiness, unsettledness or irritability* with their birth.

One study investigating excessive infant crying found no correlation between delivery complications (a non-defined parameter) and infant crying. However, a link between a mother's negative experience of delivery and severe infant colic was recognised (Räihä, Lehtonen, Huhtala, Saleva, & Korvenranta, 2002). Another, more recent, study on the effect of childbirth adversities on infant crying and colic, established increased infant crying in the presence of the following factors: second stage of labour greater than an hour, Syntocinon acceleration, use of analgesia, and abnormal foetal heart rate (St James-Roberts & Conroy, 2005). These effects had a cumulative effect in that when all four factors were present, 10 out of 13 infants suffered from severe colic.

There is literature to support (i) emotional and (ii) physical links between childbirth and excessive infant crying and in this project, the two mothers who associated birth as relevant to their infants' demeanour, could fit into either category because: (i) both reported negative birth experiences, one was described as *traumatic*, the other as *horrific* and both (ii) required intervention (caesarean section and ventouse extraction). The mother who had the caesarean section proposed the way in which her infant was effected, "*she didn't have to work to be born; she didn't get squished out in the natural processes of what goes on*" (Meg, p.19). However, there is no link between caesarean sections and infant demeanour in the literature reviewed.

Postnatal distress

“It is an inability to cope with [the] constant demands [of childcare] that often signals the beginning of postnatal distress.” (p.1, Goss, 1998)

As the infants in this study remain inconsolable, despite their mother’s best efforts, this may suggest that the mothers were not coping with the demands of motherhood. Previous literature has associated unsettled infant behaviour with maternal mood state (McMahon et al., 2001) and therefore postnatal distress deserves a mention in this discussion. Postnatal distress is a term used by Goss (1998) to encompass: baby blues, postnatal depression and postnatal psychosis. These three distinctive forms of postnatal distress range in severity and occurrence.

Postnatal depression occurs in ten to fifteen percent of mothers and is characterised by a deep cycle of depression. It presents as a change in personality and behaviour, and an inability to cope with the demands of motherhood. Mothers become anxious and exhausted. Diagnosis is difficult because of the many ways in which postnatal depression can present, symptoms may be hidden or the mothers do not identify the symptoms as abnormal.

The mothers in this study have discussed issues surrounding anxiety as well as difficulties with coping and although we can not rule out any influence from postnatal depression, mothers in this study did not raise this as an issue.

In summary of this chapter, the themes **The effect of understanding on support** and **The mothers search to understand and care for her infant** have been previously identified in literature. The main difference between the previous findings and those identified in this project is that the mothers in this project associated these themes as having an impact on their infant’s demeanour. This was thought to occur, at least in part, due to **The emotional link between mother and infant**. This theme, although represented in previous literature, has a slight variation in this project as it portrayed an immediate link with an immediate effect as opposed to a longer term association between mother and infant.

The next chapter deals with the project’s limitations, applications and areas for future study. However prior to that, an update on the mothers is provided which details the

mothers' progression past their infant's period of *fussiness, unsettledness and irritability*, which was the scope of this project.

The mothers & their infants

Part II

Sam & baby Fi

"We had a homeopathic treatment and that worked like a miracle. It was stunning ... Like that weekend Fi just slept and slept ... she's been so much more of a joy especially with the contrast. So from 2 1/2 months she has been really well and healthy ... On her fifth month she was grizzly. She just, we couldn't put her down again. And I am kind of thrown back to the early days. Not crying, just grizzly, just like "aaggh". And then ... two days before she turned six months, two teeth appeared and she has been a happy baby again." (p.2)

Jan & baby Jon

"It was really at six months that I realised that 'oh we haven't had any of those crying sessions for a while'. They would happen every so often, and I just realised maybe they have stopped ... [It was] a progression" (p.7)

Sue & baby Amy

"It was only really for a couple of months, probably. It started when she was about two months old and lasted for a couple of months till she settled down again, as I would put it." (p.1) *"Yeah so that change was pretty gradual, and she just began to settle down, just began to sleep in her own bed, [I would] be able to put her to bed when she was tired."*

(p.3)

Jo & baby Mia

"She still [will cry for no reason at all] now. Like, I will get her from day care, for instance, put her in the car she is very, very happy to see me, and halfway home all she starts doing is yelling." (p.13) ... *"I think she has got better, she did seem to grow out of it, and she is quite happy now, but she gets grumpy really quickly"* (p.3)

Meg & baby Ana

"As it was going on, I was getting more confidence with it and sort of just dealing with it. And then as she got older it did get better. You know like during the day she is a great baby. During the day now, but just at nights we still have the 'I don't want to go to sleep' issue." (p.5) *"It had been hard ... I would say it has only been until recently that I enjoyed being, having a baby. Because up to now it has been really challenging, it hasn't been what I expected it to be."* (p.16)

CHAPTER SEVEN:
Conclusions

This chapter will detail the project's attributes and propose topics for future study. The project will conclude with the relevance of key findings to the osteopathic profession.

PROJECT ATTRIBUTES AND LIMITATIONS

This project provides a rich description of factors which mothers believe influence their infants' demeanour. These factors are specific to these mothers of *fussy, unsettled and irritable* infants and therefore are limited to mothers and infants in a similar context. It should be possible for the reader to ascertain the findings applicability to their situation. The small sample size may have allowed common themes to emerge however, a greater sample size may allow for further themes to become evident.

The sampling method while valid, may have led to a biased population of participants. All respondents to the adverts were from the osteopathic practice and not the Plunket centre. Then a snowball method was used to gain more participants. This may have led to a disproportionate representation of mothers who support alternative medicines. Additionally, four of the five mothers were first-time mothers which could reflect the theory that first time mothers tend to report infant *fussing, unsettledness or irritability* more than experienced mothers (Cirgin Ellett, 2003). Another reason could be that the busy schedule of juggling more than one child did not allow experienced mothers the time to partake in this project. These group characteristics should be taken into account when assessing the findings applicability.

FUTURE RESEARCH

This project was an exploratory one and therefore numerous studies could stem from its findings:

The fathers' experience of *fussy, unsettled and irritable* infants should be investigated because at least one theme in this study, **the search to understand and care for her infant**, was identified as a common process for both mothers and father. Although this is reported to be a common theme for parents, the fathers experience should be investigated to verify whether this is true.

The purpose of this project was to provide support for osteopathic literature which associated difficulties in pregnancy, labour and delivery with infant problems such as colic and reflux. At the time when this project commenced, a lack in background

literature meant that a larger survey study which could address these issues was not possible. A large quantitative study on a broad population of New Zealand infants would be useful to ascertain the incidence of *fussiness, unsettledness or irritability* and their correlation with diagnoses of colic and reflux. It is evident from this study that the mothers view on factors associated with infant *fussiness, unsettledness and irritability* is somewhat different from that of osteopaths, for example, with respect to emotional health during pregnancy. Based on the findings from this study and current literature, it would be beneficial for a large quantitative survey to include investigation into both 'objective' factors such as, mode of delivery, and 'subjective' factors such as, birth experience. This would provide an overall view on factors previously, but inconsistently, associated with infant crying and colic.

The trend identified in this project where mothers seek help from alternative practitioners when they exhausted all other options, is a trend which was minimally represented in the literature. In this trend, many mothers sought advice from alternative health providers to settle their *fussy, unsettled or irritable* infant only when they exhausted all their resources and still "*needed to do something else*". It would be valuable for osteopaths to investigate this finding by looking into the factors which influence parents in their decision to seek osteopathic treatment for their infant. In doing so, osteopaths will be able to better understand their patients and thus tailor information to address the parents concerns regarding osteopathic treatment.

Another question which arose from this project is the efficacy of osteopathic treatment in regard to treating infant *fussiness, unsettledness or irritability*. Two mothers stated that while they had found that osteopathic treatment helped, they were unsure whether their infant's symptoms had improved. This finding was also identified in the literature, and therefore needs to be investigated. If the symptoms did not improve, what effect did the treatment have that made it helpful to mothers? It would be valuable to investigate this topic from the experience of both mothers and osteopaths as this would ascertain whether they share common goals of treatment.

IMPLICATIONS FOR HEALTH PRACTITIONERS

Each theme identified in this project has an implication for the health profession. Although the following is directed at the osteopathic fields, the findings can be tailored to other health professionals in a similar manner.

Firstly, the inseparable nature of mother and infant through **the emotional link** is valuable knowledge for practitioners. On the basis of this finding it may be advisable that where appropriate, not only should *fussy, unsettled or irritable* infants be treated but also the mothers. Through treating the mother and aiding in her recovery from childbirth she may be better able to cope and respond to her infant and thus keep her infant at ease.

Secondly, in order to help mothers in their **search to understand and care for her infant**, they require health practitioners to provide them with options. When mothers present to an osteopath with a *fussy, unsettled or irritable* infant, it may be a good opportunity to assess whether the mother has these options available to her. Osteopaths could help mothers who lack options by knowing and passing on information on the local support organisations for mothers and the role each one plays.

Thirdly, it is evident from the analysis of the data that understanding is a key factor in helping mothers of *fussy, unsettled and irritable* infants. Prior to giving mothers advice or support, health practitioners should take time to understand her situation. Health practitioners are able to appropriately advise mothers of *fussy, unsettled or irritable* infants once they understand:

1. How a mother is coping
2. The previous measures which she has tried
3. The support structures the mother has at her disposal

Through practical experience with appropriate support, mothers are able to better understand, care for and cope with their infants. At this point in time, this approach appears to be the most suitable to helping *fussy, unsettled and irritable* infants.

CONCLUDING STATEMENT

The mothers in this study described *fussy, unsettled and irritable* infants who were inconsolable despite their best efforts to soothe them. Support, maternal emotional state, and parenting techniques were the factors which mothers associated with influencing their infant's demeanour. However, these infants remained inconsolable which led mothers to seek advice from health professionals who they would otherwise not consider. Health practitioners must understand the situation of these mothers who have tried everything, exhausted all options, and left their comfort zones in order to be at their clinic. This understanding is particularly important because there is no known aetiology or cure for *fussiness, unsettledness and irritability*. Given this situation, listening to and understanding the mother is the best way for practitioners to help these infants.

APPENDICES

APPENDIX A: UREC APPROVAL LETTER



phone +64 9 849 4180 fax +64 9 815 2901 web www.unitec.ac.nz
address Carrington Rd, Mt Albert, Private Bag 92025, Auckland, New Zealand

Amanda Viedma
2/37 Hakanoa Street
Grey Lynn
AUCKLAND

11th April 2005

Dear Amanda

Your file number for this application: **2004.342**
Title: **Infant Health: an exploratory study from the viewpoint of mothers**

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

Start date: 6th April 2005
Finish date: 01 February 2006

Please note that:

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

This letter has been copied to the Principal Supervisor for Unitec student research projects, and additionally to the Board of Postgraduate Studies for postgraduate student research (where applicable).

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

Yours sincerely

A handwritten signature in cursive script that reads 'Annette Jones'.

Dr Andrew Stewart
Deputy Chair, UREC

RMO ref#: 560

Cc: Elizabeth Niven

APPENDIX B: INFORMATION SHEET



PARTICIPANT INFORMATION SHEET

Infant Health: an exploratory project from the viewpoint of mothers.

About this research:

You are invited to take part in a project which examines the health of *fussy, unsettled or irritable*, infants in the first six months of their life. We are interested in researching this topic from the perspective of mothers as they are ultimately responsible for their infant's health.

If you and your baby have not had any major surgery or chronic illness we would like your participation. Your involvement in this project will help establish common maternal infant health concerns.

The results of this project will help future mothers as well as health care providers by increasing their knowledge of infant health, and gaining a little more understanding of your experience.

The Researcher:

Amanda Viedma, Masters of Osteopathy Student, Unitec.

This project is being supervised by Dr. Elizabeth Niven, Unitec.

Taking part in the project

This project will investigate your experience of infant health; how you define *fussiness, unsettledness or irritability* and what you believe contributes to your baby's health. This will be done through an in-depth interview. You will be interviewed by Amanda and this will take at most an hour and a half. The interview will take place in your home, or other place of your choice.

Information

During the interview open questions will be asked about your infants' general health. All information conveyed during the interview will be confidential and anonymous. A copy of the transcript will be posted to you as soon as possible after the interview; you are able to comment on the transcript. You are able to withdraw from the project up to two weeks following the interview. The information will have all identifying factors removed and will be presented within the context of a larger group of data.

Any concerns

If you have any further questions or concerns please feel free to contact me directly on (09) 378 8373, 025 6688 599 or amandaviedma@clear.net.nz.

If you so wish you may also contact my principal supervisor Dr. Elizabeth Niven on (09) 815 4321 ext 8320

Thank you for reading the information sheet – please keep it for your records.

This study has been approved by the Unitec Research Ethics Committee from 6 April 2005 to 1 February 2006. If you have any complaints or reservations about the ethical conduct of this research, you may contact the Committee through the Secretary (ph: 09 815-4321 ext 8041). Any issues you raise will be treated in confidence and investigated fully, and you will be informed of the outcome.

APPENDIX C: CONSENT FORM



PARTICIPANT CONSENT FORM

Infant Health: an exploratory project from the viewpoint of mothers.

This research project will investigate the health of *fussy, irritable or unsettled* infants. The research is being done by Amanda Viedma a Masters of Osteopathy student at Unitec, and is supervised by Elizabeth Niven.

Name of Participant: _____

I have seen the Information Sheet dated _____ for people taking part in the exploratory project on infant health from the viewpoint of mothers. I have had the opportunity to read the information sheet and to discuss the project with Amanda and I am satisfied with the explanations I have been given. I understand that I may seek further information if I wish. I understand that taking part in this project is my choice and that I may withdraw from the project at any time up until 2 weeks after the final interview is completed.

I understand that I can withdraw from the interview at any time.

I understand that my participation in this project is confidential and that no material that could identify me will be used in any reports on this project.

I have had enough time to consider whether I want to take part.

I know whom to contact if I have any questions or concerns about the project.

The principal researcher for the infant health project is Amanda Viedma, and she is contactable by phone on 378 8373 or 025 6688 599, or by email, amandaviedma@clear.net.nz.

Participant signature _____ **Date:** _____ 2005

Project explained by _____

Signature _____ **Date:** _____ 2005

Thank you for participating in this research.

Please keep a copy for your records.

This study has been approved by the Unitec Research Ethics Committee from 6 April 2005 to 1 February 2006. If you have any complaints or reservations about the ethical conduct of this research, you may contact the Committee through the Secretary (ph: 09 815-4321 ext 8041). Any issues you raise will be treated in confidence and investigated fully, and you will be informed of the outcome.

APPENDIX D: ADVERTISEMENT

Seeking mothers to help
in a study about infant health.



We are looking for participants for a study on infant health.

DO YOU FIT THESE CRITERIA:

1. Is your baby irritable, fussy or unsettled?
2. Is your baby between the ages of 6 - 12 months?
3. Would you like to share your experience of infant health?

If you are interested in participating
please contact the researcher:



Amanda Viedma
Ph. 378 8373
amandaviedma@clear.net.nz

APPENDIX E: INTERVIEW GUIDE

Fussy, unsettled or irritable?

Explain information sheet and get consent form signed.

This is an interview on (date) at (time)

Between Amanda and (Participant)

The chosen pseudonyms are ____ for the mother and ____ for her baby

Do you describe (Baby) as F, U or I?

What makes you describe (Baby) as F, U or I?

This project is specific for the first six months so thinking about baby's first 6 months ...

What was (Baby) like during that time?

Can you think about a time when Baby was particularly F, U or I?

Can you give me a specific/typical example of ...?

Pregnancy

Delivery

Support

Feeding

Sleeping

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