Host: From the studios of Queen Mary University, London, this is Health Psychology Matters!

Hello and welcome to Health Psychology Matters, the podcast series of the Journal of Health Psychology. I’m Dr David Marks, editor of the Journal of Health Psychology and I will be talking to a range of people throughout the series. The Journal of Health Psychology is a leading international peer review journal that supports and helps to shape research in health psychology from around the world. It’s a platform for traditional empirical analyses, as well as more qualitative or critically oriented approaches. It also addresses the social contexts in which psychological and health processes are embedded. The journal is now in its 17th year and is published by Sage Publications eight times a year.

Coming up on the podcast today we’ll talk with one of the authors of some recent groundbreaking work about ‘risk taking while driving in adolescents’ and then later we’ll talk to the lead researcher of a new research review on ‘assisted home births’.

But first, since this is our very first podcast, I want to take a minute or two to tell you what this is all about.

The idea for each podcast is to select two recent papers published in the Journal of Health Psychology and highlight the work by interviewing the authors. What we want to do is to produce a podcast that brings you the latest in exceptional research but does so in a way that is accessible and has real world relevance to your life and awareness of the role of psychology in health and healthcare.

We’re aiming the podcast series to a broad audience; under graduate students, graduate students, researchers, clinicians, journalists, policy makers and basically anyone interested in behaviour and health.

I’ve asked the guests to speak in plain English and to explain their work in an engaging fashion.

Now, before we get started, some recognition is due – I want to thank Baxter Stone for donating the music that you’ll hear throughout the podcast series. You can hear more of Baxter’s music at Baxter Stone Music on My Space. I also warmly thank Mile End Films, Queen Mary University and, lastly, Kerry Barner, Senior Publishing Editor, Social Sciences at Sage Publications, for her enthusiasm for this podcast series and her great support.
Firstly, I would like to welcome Dr Robert Ruiter of Maastricht University, the Netherlands. Robert is one of the authors, with Hans Feenstra and Gerjo Kok, of a paper entitled ‘Go fast; reaction time differences between adults and adolescents in evaluating risky traffic situations’. Hello Robert, welcome to this podcast!

Respondent: Hello. Thank you.

Host: Your paper begins with the worrying statistic that in the Netherlands and other western countries, adolescents aged 15-24 comprise only 12% of the population, while they account for a disproportionate 21% of the fatal injuries in traffic. One possible explanation might be that adolescents have slower reactions in risky situations – would you like to expand on this a little bit?

Respondent: The study looks into decision making in adolescents and there are some nice recent findings that show that adolescents are in fact very good at reasoning, they have good reasoning skills, they perform to the level of adults already at the age of 12/13 years. Our sample demonstrated the fact that they are perfectly able to tell you what it risky and what is not but still, they are involved in a lot of risky behaviour – for example, if you think about unsafe sex, the use of drugs and also speeding and other traffic related risky behaviour. So it seems to be the case that all kind of safety campaigns have reached a limit in effectiveness, so they’re looking for new ways to motivate young people to act in less risky ways. And this came to us by research in the field of [4.47] psychology, showing that adolescents simply miss the experience and expertise to come quickly to a safe decision and so what we tried to find here is evidence for the hypothesis that they are simply slower in responding to risky decision making considerations or risky actions or whatever, than adults.

Host: Very interesting. Your study employed a measurement called the ‘Choice Reaction Time’ (or CRT), can you tell our listeners what the CRT is?

Respondent: The Choice Reaction Time (or CRT) is simply a task in which people are asked to make a decision and it’s the speed of making that choice between two or more options you’ve measured … this measure is done in milliseconds … and the responses in the CRT are, by definition, slower than in a Single Response Time task, in which people respond to a single stimulus or it only has a single response.

Host: Now what was the setting that you used and who were your research participants?
Respondent: Okay, the study is part of a successfully completed [5.50] project by the first author, Hans Feenstra, and he went with four laptops to a field hockey club in the Hague and asked young males, 14-18 years of age, to get their fathers or their trainers or coaches to participate in the study and he was able to include 52 participants in one afternoon – it was well enough.

Host: Excellent. So what did you find? Who was faster; the adolescents or the adults?

Respondent: Adults. The adults were faster in responding both to risky actions – we gave them a risky decision making situation, which we asked ‘do you think it’s a good idea, for example, to go cycling at night without having a working headlight on your bike?’, ‘would about go on a moped without wearing a helmet?’ and we gave them safe actions, to decide on those safe actions – for example, ‘is it a good idea to have both hands on the steering wheel?’ and they simply had to make a choice, yes or no. And what we saw is that adults are faster both in responding to these risky actions and also in responding to the safe actions and they were faster than adolescents. And what we find here is evidence for the hypothesis that adults just simply rely more on [7.09] based intuition, whereas adolescents seem to rely more on the conscious deliberation or reasoning of the pros and cons of each behaviour and therefore they are slower than adults.

Host: But youngsters, in fact, when they get the question, for example, ‘is it a good example to set your hair on fire?’, for example, something like that – an adult person would immediately respond out of intuition, ‘no, that’s not a good idea, that’s a bad idea’, whereas adolescents seem to have some kind of reasoning on that question, that says ‘okay, it depends’, it just makes them slower in responding to this action. So they might be more attracted to risk but in terms of decision making they act slower.

Respondent: Well I think the first implication is a very important one and that’s why we were very happy that this paper got published in the Journal of Health Psychology, is that the ‘adolescents; risky decision making’ literature is referring to a paper presented at a conference by [8.20] and colleagues and they say here that adolescents are slower in responding to risky situations than adults but that’s the only evidence that there is and, in fact, in all recent papers in his literature they make reference to that conference paper and now we were able to publish this study in the Journal of Health Psychology. So that’s the first important objective we reached … published peer review, that shows that adolescents are indeed slower than adults. Secondly, this paper supported the idea that adolescent decision making is different than that of adults and it has very
important implications for the way we should develop our interventions. For example, in this case, you can see the different decision making in adolescents and we should think of other ways to motivate them or to make them act less risky in certain situations - for example, in this case, by improving the decision making process, by making it faster – and you could think, for example, of risk detection training, where you teach young people to look at, through all kinds of educational interfaces, how to detect risks, to make them faster and act on that decision - that’s the second important objective we reached I think.

Host: What are your plans, Rob, for further research on this topic?

Respondent: Well, this study sits in a larger resource line in which we aim to identify all kind of cognitive mechanisms that explain adolescents’ risky decision making and in particular we are interested in the role of basic cognitive processes, also called ‘executive control functions’, that help us in regulating our behaviour in such a way that we reach important life goals, such as graduating successfully from school or acting safe in traffic but also maintaining help in reaching those large goals – so it’s basic cognitive functions, for example, planning, risk detection, response in [addition 10.15] and mentalising, so that you foresee certain events, so you can develop already an effective response in advance.

And together with my colleagues in the department here at Maastricht but also the University of [10.25] in Belgium and the Institute of Mobility, we’re looking at these aspects – so what are the basic cognitive mechanisms driving adolescent decision making, with a specific focus there on ‘traffic safety’ – we use a large driving simulator to do these kinds of studies, in which we measure these basic cognitive processes and we relate them to their driving in the simulator and the extent to which this driving results in accidents, etc. dependent on their cognitive functioning.

Host: Well thank you very much indeed, Robert, for participating in this podcast and I’m sure your work will be of great importance in the future. Thank you very much.

Respondent: Pleasure, thank you, bye-bye.

Host: Now I’d like to introduce Judy Slome Cohain, a master of midwifery in private practice as a home birth midwife in Israel – hello Judy, welcome to the podcast!

Respondent: Hi David!

Host: Today we are discussing your recent editorial published in the Journal of Health Psychology, entitled ‘Alligators, hospital birth and other urban legends’ - why is it that over 99% of people in every westernised country are convinced that attended home birth for low risk women is more dangerous and has worse outcomes than hospital birth?
Respondent: It’s pretty simple actually, all you have to do is quote ‘follow the money’, by which I mean figure out who profits from hospital birth; hospitals, hospital administrators, hospital suppliers, drug companies, insurance companies and some lawyers all profit greatly from hospital births, their livelihoods depend on it. This trend started after World War II, when many hospitals were built and hospital beds had to be filled and since then birth is the most common reason for hospitalisation. Since many people depend on those profits, governments support it. Even the most idealistic journals have difficulty publishing research that contradicts their sponsors, so there’s an incentive for business to support home birth, home birth uses very few pharmaceuticals and doesn’t require insurance, so business sells the myth of hospital births but you can never fool everyone because if you think about it momentarily, it’s immediately obvious that healthy mothers and their vulnerable newborns shouldn’t be exposed to the dangers of bacteria found in hospitals, for example.

People are convinced mostly because the media is very consistent about demonising home birth. Often the media uses single home birth outcomes to demonise home birth. Again, if you think about it, the same outcome might be much more common at hospital birth but you have to think about it because that’s rarely pointed out. If hospitals had the function under the magnifying glass but home birth functions, there wouldn’t be a single hospital open for birth. Whenever an epidemic kills newborns in a nursery or another mother bleeds to death from an unnecessary cesarean, the media never leads with the headline, ‘have your baby at home; shut down hospital birth!’ [laughs]. So that is my answer.

Host: So we’re dealing here with what we could call an ‘urban legend’, is that right?

Respondent: Yeah!

Host: You mentioned, for example, ‘our human propensity to gossip’ – could you say a little more about this?

Respondent: Oh, gossip is a useful way to get expert advice but you have to ask an expert; if you ask a person whose attended hospital and home birth you’ll get expert advice – in order to be an expert of birth, that someone will have to have at least seen or at least been at a single planned home birth; seeing one planned home birth is enough for anyone to get it. The problem today is so few doctors and midwives have ever been present at even a single planned home birth, so they have no idea why it works so well and then it’s like people exchange gossip about birth and they’re likely to get uninformed gossip, comparable to the myth that the world is flat, because so few people have the [14.47].
Host: And you also mention ‘the human tendency to follow the crowd’ – how does that fit?

Respondent: Well, following the crowd in public is the glue that keeps our society together, that makes it function but conformity in public is not needed for certain private functions; people don’t conform in how they behave in the bedroom or the bathroom and birth also works better behind closed doors because, like those other functions, birth requires shutting down the cortex (so the thinking part of the brain) and allowing the body to function instinctually but for the sake of profit hospitals have now used the human tendency to follow the crowd, to herd women into giving birth in public, something no other animal, let alone mammal, would choose to do. In the case of hospital birth, the result of following the crowd is known. If you follow the crowd and have a hospital birth, one out of five you’re going to end up with caesarean surgery that you didn't need. In the case of birth, following the crowd results in worse outcomes for the mother and baby but better profits for business, institutions, the media and the government.

Host: Now, you also mention ‘irrational hope’ but what do you mean by that?

Respondent: Well there’s a quote, ‘there’s a close distinction between hope and optimism’ – hope and optimism are actually good characteristics and they say that people who live into their 90s have irrational hope and optimism but that quality is still alterius in young women giving birth if it means that she’s making rational choices based mostly on hope – for example, a good example is; women who’ve had a caesarean on their first birth and now she’s pregnant again and she says she doesn’t want another caesarean, she wants to deliver naturally – if she looks into the matter it often turns out that the local hospital hardly ever offers natural birth after caesarean and if she goes there, 95% she’ll have repeat caesarean, yet often women go to the hospital, they go to the hospital with the irrational hope, even though from the outset her chances of [17.07] is only five percent. Or another example is epidural anaesthesia; it’s well know that it only works 85% of the time, 15% of the time the woman gets no anaesthetic help from it – but for women who’ve had it and it didn't work, unfortunately there are women who have a migraine headache for a week after, from the epidural, it’s irrational to hope that epidural anaesthesia will work on the next birth, rather than seeking out a more effective, safer method of pain relief! So in many cases in birth, making a rational decision has better outcomes than irrational hope but it requires reading and decision making.

Host: Your analysis suggests that planned home birth with experienced, trained attendants has the best outcomes for both mother and newborn for low risk pregnancy – can you tell us more about this analysis please, Judy?

Respondent: The evidence is not largely spread because it’s only spread by people who have two qualities; one, they have to either have had a home birth themselves or attended or even just observed one, a planned home birth
and two, they have to be willing to oppose the status quo, there’s no research supporting hospital birth is safer than planned home birth. *All* research – and I don’t use that easily, the word ‘all’ – that concludes that hospital birth is safer than home birth always includes unattended birth, unplanned home birth, premature home birth and then in the summary or abstract they forget to include that they included such births – unscrupulous research is included in their samples to discredit home birth and then the media runs with it, with headlines saying ‘home birth is not safe!’, without pointing out that they’re talking about women delivering premature babies at home alone, some of who were denied access to abortion and didn't want the baby in the first place!

All the research that *excludes* these unplanned home births, shows planned home birth to be safer! Everything that’s needed to make birth safe can be brought to the home, with a midwife and a small birthing bag – my birthing bags weigh less than five kilos – technology, surgery, electronic monitors, IVs, vacuums, forceps; none of it has been shown to improve birth outcomes. The rate of cerebral palsy is exactly, exactly the same as it was one hundred years ago, in 1912, despite or perhaps because of the high rate of caesarean surgery and electronic monitoring.

Host: Pretty amazing statistics there. Judy, you’ve recently been working on the issue of ‘collusion versus empowerment in hospital care’, can you tell our listeners something about your understanding of this issue?

Respondent: Well, I think I’d like to order the dangers of hospital birth, so I’ve pointed out the most obvious danger is the fine bacteria in the large hospital staff. The next most obvious danger is the increased level of adrenaline when you’re in the hospital, which opposes the birth process. And the third well documented danger is the frequent use of unnecessary interventions to speed up the process – speeding up the process is good business practice because it increases your turnover but all these methods of speeding it up have serious dangers to the mother and baby, such as rupturing membranes, vaginal checks, pitocin inductions, pitocin augmentation, IVs, forceps, vacuum, epidurals, electronic monitoring and episiotomy.

But on top of those three there’s a fourth less obvious danger and that’s collusion among the hospital workers – at home birth the doctor or midwife work alone and have complete accountability, they’re *guests* in the woman’s home and the woman expects respect and truthfulness from her guests but in hospital those qualities will get you fired – any staff member who refuses to lie to women to protect other workers won’t last long. Whatever happens, the hospital workers are bound to a vow of silence or even worse, lying to the patient about what happened when there was malpractice and this certainly decreases the level of accountability in hospital birth, which is reflected in hospital outcomes.
Host: Well thank you Judy for your really interesting discussion about some of the myths about home births, we look forward to reading more of your papers in future. Thank you very much indeed for your participation in this podcast.

Respondent: And thank you very much.

Host: Health Psychology Matters is a production of the Journal of Health Psychology and Sage Publications, you can subscribe through iTunes or access the series from the web page of the journal, please send us an email at jhpeditor@gmail.com or follow us on Twitter @ Newhealthpsych (all one word). Thank you very much for your attention.

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