AN INVESTIGATION OF PATIENT EXPERIENCES OF
TREATMENT IN THE CRANIAL FIELD OF OSTEOPATHY

Dionne Greene

A thesis submitted in partial fulfilment of the requirements for the degree of Master of Osteopathy, Unitec New Zealand, 2009
DECLARATION

Name of candidate: Dionne Greene

This Thesis/Dissertation/Research Project entitled An Investigation of Patient Experiences of Treatment in the Cranial Field of Osteopathy is submitted in partial fulfillment for the requirements for the Unitec degree of Master of Osteopathy

CANDIDATE’S DECLARATION

I confirm that:

☐ This Thesis/Dissertation/Research Project represents my own work;

☐ The contribution of supervisors and others to this work was consistent with the Unitec Regulations and Policies.

☐ Research for this work has been conducted in accordance with the Unitec Research Ethics Committee Policy and Procedures, and has fulfilled any requirements set for this project by the Unitec Research Ethics Committee.

Research Ethics Committee Approval Number: 2007.733

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

Student number: 1117605
ABSTRACT

There is a wealth of information available in print and other forms of media about osteopathy in general. Significantly less information exists about osteopathy in the cranial field (OCF), and still less information is available surrounding the experience of treatment by OCF. This study helps to fill this deficiency identified in the research literature and possibly further inform the practice of OCF.

This is a hermeneutic phenomenological study informed by the work of van Manen (1997), reflecting the need for research of a qualitative nature in the field of osteopathy. Interviews were conducted with five people, referred by several practitioners of osteopathy, who had experienced treatment in OCF. These interviews were then transcribed and analysed. It was discovered that there were common threads of experience for all the participants. Thematic analysis of the data revealed two prominent themes. The first ‘The appearance of health’ explored aspects of the therapeutic relationship, its interaction with the participant’s own innate healing ability and the resulting reports of improved health. The second theme ‘Sensations that signal change’ illuminated the participants’ more esoteric descriptions of the experience of OCF, including physical and emotional sensations.

These findings are discussed alongside past and current osteopathic literature. Implications for both the osteopathic profession and health profession in general are explored along with suggestions for further research possibilities.
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CHAPTER ONE – INTRODUCTION AND BACKGROUND

“Like being held in the palm of a hand and gently rocked by the life force.”
“I just lay there as he put his hands on my head, but when I got up it felt like there was more wind in my sails”…

(Kern, 2001, p. 153)

Introduction

Chapter One introduces the research topic: An investigation of patient experiences of treatment in the cranial field of osteopathy. My personal background is outlined including the experiences that brought about the choice of research topic. A brief overview of the history and philosophy of osteopathy is given, followed by an introduction to and summary of the evolution of thought that lead to the development of osteopathy in the cranial field (OCF). The chapter concludes with an overview of the chapters to follow.

Personal background

My fascination with osteopathy in the cranial field began in 2001 after the birth of my son the year before. For the first 18 months of his life he woke 4-5 times through the night and as a result we were both struggling. I was exhausted and battling with post-natal depression. At the time I was studying herbal medicine and one of the visiting tutors was an osteopath. This was my first introduction to the existence of osteopathy and soon afterwards both my son and I received treatment by OCF. Within a week my little one was sleeping through the night and my mood was rapidly lifting. Subsequently, I enrolled in the Unitec osteopathy course with the express wish to study OCF.

In the years since then I have had regular treatment by OCF involving many and varied physical, cognitive, emotional and spiritual experiences which intrigued me
and challenged my understanding of hands-on healing. My experience of OCF as a patient always leaves me feeling in a state of bliss and at times I have felt at one with the practitioner, as though physical boundaries dissolve and there is no skin and bone to hold my form.

After three years of study at Unitec it came time to consider a research topic for the masters programme. The task of choosing a research topic that would hold my interest for two years was daunting at first. My initial attraction to the study of osteopathy had been due to my experiences of treatment by OCF and the lack of teaching on the subject at the undergraduate level had been disappointing. With this in mind I thought that it would be both advantageous and exciting to be able to combine my passion for OCF with the in-depth study required to produce a masters thesis. A number of students in previous years had elected to research aspects of OCF using the method of hermeneutic phenomenology and two specific examples (Cardy, 2004; McFarlane, 2006) were particularly inspiring to me. Family, friends and like-minded students who were also passionate about OCF had recounted experiences of treatment similar to my own. I began to wonder if there was a commonality to these experiences. Thus the research question became, ‘What is the ‘lived experience’ of patients who undergo treatment by OCF?’ This question was continually referred to in the initial stages while developing the overall plan for this research.

**The history and philosophy of osteopathy**

*Early history*

Osteopathy was named and developed in the United States of America in the 1850’s, by a Christian minister and medical doctor named Andrew Taylor Still. Still wrote; “...the mechanical principles on which osteopathy are based are as old as the universe” (1910, p. 10). The medical profession at this time was employing procedures and therapies that were often more harmful than helpful: unsanitary surgical procedures and the use of arsenic and opium as therapeutic agents for example. Still was dissatisfied with this current medical system, which he believed
lacked efficacy, was morally corrupt and treated only the outward signs of disease, rather than the root cause (Still, 1910). Osteopathy was developed as an alternative to this system and as outlined by Kuchera and Kuchera (1991), was guided by the following principles:

1. Structure governs function; this implies that structural integrity is needed for correct function, and conversely that a loss of function results in a loss of structure.
2. The ‘body’ is one functioning unit; all structures and functions are interrelated and consequently what happens to one part has implications for the entire body.
3. The ‘body’ has an inherent ability to heal itself; the process of homeostasis allows the body to adjust to stressors such as injury, cold, gravity, microbes for example and to allow moment by moment fine-tuning in structure and function. (p. 2)

In allowing the underlying osteopathic philosophy to inform the interpretation of these principles, the osteopath’s role is clearly one of assisting the natural intelligence of the body to correct its structural and functional imbalances. However, there is a trend among some of today’s osteopaths to apply these principles in reductionist terms, working with the purely physiological and observable, and dismissing the non-material or spiritual aspects of osteopathy so central to Still’s philosophy. Others, both those who use a biomechanical approach and those using OCF, manage to incorporate Still’s holistic ideas into their treatment regime. A brief overview of Still’s original philosophy is given in the following section.

**Osteopathic philosophy**

A philosophy is a set of guiding principles or concepts fundamental to a particular sphere of knowledge (Teichman & Evans, 1991). In early osteopathic texts there are several recurring concepts relating to the fore-mentioned principles that give clarity to the original philosophy behind them. These include the concepts of health
and spirit, which will be explored as key examples of early osteopathic ideas.

**Health**

While orthodox medicine endeavours to diagnose and treat dysfunction, osteopathy seeks to find and engage the health of the patient. This is one of the basic tenets of osteopathy and is stated by Still (1899): “To find health should be the object of the doctor. Anyone can find disease” (p. 28).

Health is difficult to define, and there is no one accepted definition. According to the World Health Organisation (1948-2009) “Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”. Therefore treatment to improve the health of an individual can never be confined to just one domain. Within an osteopathic context the use of the word health appears to be twofold. Firstly, health is that which is present when the processes of homeostasis allow each part of the whole to work in synchronization. This is illustrated in the following quote from Still (1908), “What is harmony but health? It takes harmony of every nerve, vein and artery in every part of the body” (p. 248). Furthermore, Still declared that the body contained all remedies necessary to regulate, adjust and heal itself; contained within the blood, fascia, lymphatics and, the highest known element, the cerebrospinal fluid (Sutherland, 1990).

Secondly, there is a more esoteric description of health, held by many osteopaths. Still (1892) implies that there is no division between the natural world and health: “Nature is Health” (p. 22). In this sense health is not only present within us, but extends beyond our physical boundaries and is all around us. It is mystical, non-material and inexplicable in a western orthodox sense. This is a view reiterated nearly a century later by Becker (2001) who in his book ‘Life in Motion’, offers the following insight into health from his osteopathic perspective.

It is extremely difficult to find words to express health. Health is a word with an unknown meaning…/ /… We can’t prove that we’re healthy; we can’t
prove that we register health. However, health in the broadest sense, “Health” with a capital “H”, is something. It’s the very reason we’re all here... I mean on earth. We’re here because we have Health. (p. 219)

Health in this sense, Health with a capital H, is that which is at the very core of our being, untouchable and unchanged even in the disorder of disease, present at conception and transcendent even in death (Jealous, 2003). Health from this point of view illustrates a belief in the existence of an inseparable relationship between humanity and the source of all life. Masiello (1999) points out that:

The osteopathic philosophy is a vitalist philosophy. From the vitalist perspective a living thing is not just a complex pattern of organization where each element of that pattern is itself nonliving. From the vitalist perspective, a living thing is not alive because something called life emerges when nonliving elements are combined in a certain way. Vitalism maintains that there is in living things the presence of an entity or organizing principle that imparts powers not possessed by inanimate objects and which is not reducible to the mere sum of the parts of the living system. The vital entity or principle that animates an organism is called Life. Life is made up of living substance and Life is capable of an existence apart from the organism. (p. 23)

This leads to the consideration of this vital entity or Spirit in osteopathic thinking and its obvious relationship with Health.

**Spirit**

The word spirit is derived from the Latin *spiritus*, meaning breath (Piles, 1990). “The human spirit is the essential life-force that undergirds, motivates, and vitalises human existence” (Swinton, 2001, p. 14). The concept of ‘spirit’ appears to be part of traditional osteopathic terminology and this is unsurprising given Still’s origins and influences. In his book *The Philosophy and Mechanical Principles of Osteopathy* (1892), Still began with the words “I quote no authors but God and
experience...” (p. 9). Therefore for many practitioners, osteopathy from its inception
cannot be separated from the Divine.

Still (1908) reminds us, “You should ever remember that Osteopathy is confined to
the immutable laws of nature and an unerring Deity who is its Author’’ (p. 295). Still
believed that the osteopath’s role was to adjust the body’s structure to allow
‘God and Nature’ to heal disease. In doing so the ‘spirit’ was liberated to aid the
body to heal. One contemporary author, Lee (2005), discusses the role of spirit in
osteopathy and examines the use of the word in the writing of A. T. Still. The words
Spirit, Health and Nature seem intimately entwined and are often used
interchangeably. Lee (2005) gives the following summary of what he believes were
Still’s views of the mechanism of spirit in osteopathy.

Still believed that healing originates from within the individual because of the
fulfilment of spirit’s potential to create form and function (Lee, 2005). Some
development from the original design of the form, resulting from trauma or disease,
interferes with spirits’ ability to accomplish this fulfilment, and this condition
requires some assistance from the outside to correct. Restoring the distortion of the
structure towards normal liberates spirit to reassume its role of providing health (p.
61).

Still, and many of the prominent osteopaths who followed, including those
specialising in OCF, (for example, Sutherland, Becker and Jealous), make reference
to a divine being (Lee, 2005). Spirit infuses all aspects of their thinking, and while
they may employ different metaphors they are all essentially describing the same
vital force. One of the most important metaphors in OCF, the ‘Breath of Life’
(Sutherland, 1990), is an example of the continuing importance of spirit in
osteopathy. This will be further explored in the following section.

**Osteopathy in the cranial field (OCF)**

The development of OCF began in 1899 with Sutherland’s observation that the
bevelled edges of the sutures of the human skull were similar in shape to the gills of a fish, and thus suggestive of a breathing mechanism. He then spent many years exploring and experimenting with this concept, and developed the system of treatment now known as OCF. Sutherland’s philosophy evolved over decades, with his emphasis shifting from the osteology of the cranium, to the reciprocal tension membrane, the fluctuation of the cerebro-spinal fluid, and finally in the later stages of his life to the ‘Breath of Life’. According to Sutherland, the ‘Breath of Life’ is contained in the cerebrospinal fluid and is “that mysterious spark which cannot be explained but is none the less present” (Magoun, 1976, p. 15). The ‘Breath of Life’ is a fundamental principle of OCF, borrowed directly from Genesis; “The Lord God formed the man from the soil of the ground and breathed into his nostrils the breath of life” (Genesis 2:7). This phrase was claimed for osteopathy by Sutherland long after Still’s death. Sutherland, however, always maintained that the concepts of OCF were in no way separate from, but merely an extension of Still’s own osteopathy (Handoll, 2000). Sutherland’s ‘Breath of Life’ was therefore a reconnection of osteopathy with its lost roots. He referred to the ‘Breath of Life’ as a direct manifestation of the Divine and from this point of view, treatment by OCF could be perceived as a direct engagement with the Deity.

Many osteopaths choose to treat either partly or wholly using OCF, which often involves the palpation of what Sutherland referred to as the ‘Primary Respiratory Mechanism’ (PRM) (Magoun, 1976; Sutherland, 1990; Sills 2004). Handoll (2000) asserts that the PRM is concerned with the following five phenomena.

1. The inherent motility of the brain and spinal cord.
2. The fluctuation of the cerebrospinal fluid.
3. The mobility of the intracranial and intraspinal membranes.
4. The articular mobility of the cranial bones.
5. The involuntary mobility of the sacrum between the ilia. (p.18)

Sutherland was first to recognize these phenomena, and after decades devoted to their study, first published his findings in a seminal text: “The Cranial Bowl” in 1939, followed by his definitive work “Teachings in the Science of Osteopathy” in
1990. These phenomena represent the original cranial concept, and essentially describe the mechanistic, anatomical and physiological qualities of the PRM. The PRM is expressed in every cell of the body and is a manifestation of vital force, or what Sutherland (1990) referred to as the ‘Breath of Life’. Students of Sutherland, including Becker and Jealous have further added to and refined the practice of OCF. The discipline of OCF encompasses various treatment models, and cannot be described as a single technique. No matter which model a practitioner chooses to work with, OCF essentially involves connection with the patient’s inherent healing mechanism to bring about healing.

The sparseness of directly relevant literature led to the exploratory nature of this study. Researchers have investigated various aspects of OCF; for instance its effects on body structure and a range of disease states (Frymann, 1966; Hanten, Olson, Hodson, Imler, Knab, & Magee 1999; Joyce & Clark, 1996). The relationship between the ‘Primary Respiratory Mechanism’ and numerous aspects of physiology, including the parasympathetic and sympathetic nervous systems (McPartland & Mein, 1997), circulation, heart rate, breathing (Richards, McMillin, Mein & Nelson, 2001) and the phenomenon known as the Traube-Hering-Mayer oscillation (Nelson, Sergueef, Lipinski, Chapman & Glonek, 2001) have also been explored. However, the predominance of empirical methods in OCF research makes the translation of findings into a human dimension difficult. Notable studies using the tradition of phenomenology have been undertaken at Unitec, including work by Cardy (2004), Mitchell (2005) and McFarlane (2006). These studies and any that are to follow are of prime importance to bridge a gap between scientific and philosophical interpretations. The literature review that follows will discuss the existing research in further detail.

Summary of chapters

Chapter One has introduced the dissertation, including the background to the study and a statement of the research question. The subsequent chapters provide specific information about this research. Chapter Two will present an overview of the
literature on OCF including evidence for the cranial rhythm, reliability of assessment of the cranial rhythm, evidence of the clinical effectiveness of OCF and the phenomena of OCF. In Chapter Three, qualitative research will be introduced along with the rationale for the choice of hermeneutic phenomenology as the research method for this dissertation. The philosophical underpinnings of hermeneutic phenomenology will be discussed, along with the work of van Manen (1997), whose approach and methods of analysis informed the research methodology. In Chapter Four the research design for the study is presented, including information on the ethical considerations and the approval process, recruitment of participants and data collection. Van Manen’s (1997) six steps used in the analysis and interpretation of the data are also discussed. Chapter Five expounds the data obtained from the interviews carried out with participants who had experienced treatment by OCF, and the central themes that emerged from them. These themes are ‘The appearance of health’ and ‘Sensations that signal change’ have been identified as recurring throughout the interview transcripts. They are discussed with reference to the literature and the philosophical underpinnings of osteopathy. Chapter Six presents the limitations of the study and an evaluation of the overall research process. Potential research questions arising from the research are offered and discussed and an overview of the preceding chapters is provided along with concluding remarks.

Summary

This chapter has provided a brief overview of the research question and my background. Furthermore it introduces some of the concepts of osteopathy in general and OCF specifically. It concludes with a summary of those chapters to come. The following chapter will review the current research literature.
CHAPTER TWO – LITERATURE REVIEW

Introduction

This chapter summarises the existing research literature about OCF. It is intended to both paint a picture of the current knowledge of OCF as it stands in 2009 and illustrate the lack of research addressing patient experience of OCF in the existing literature.

Literature background

A literature search using the databases MEDLINE, EBSCO-CINAHL and MANTIS (Manual Alternative and Natural Therapy Index System), with the key words osteopathic medicine, cranial osteopathy, primary respiratory mechanism and cranial rhythmic impulse failed to return any research directly related to the experiences of the patient in relation to OCF. Although the concept of OCF has been explored for more than a century, the body of literature that accompanies it is sparse. OCF research can mostly be placed into the broad themes of evidence for the cranial rhythm (physiology), the reliability of its assessment (clinical/palpation/diagnosis), its clinical efficacy or effectiveness and research on the phenomenon of OCF.

Evidence for the cranial rhythm

The Cranial Rhythmic Impulse (CRI) refers to the cyclic fluctuations of the cerebrospinal fluid, occurring at a rate of approximately 10-14 times per minute (Magoun, 1976). The CRI can be defined as “a palpable, rhythmic fluctuation”, perceived while palpating the head (McPartland & Mein, 1997, p. 40). The amplitude, rate and quality of this rhythm are said to provide information about the health of a patient, and thus can be used in both diagnosis and treatment (Upledger & Vredevoogd, 1983; McPartland & Mein, 1997).
Many explanations have been offered to explain the source of the CRI. Sutherland (1939) suggested that the cranial motion, resulting in the CRI, was due to the rhythmic contraction/relaxation of the ventricles of the brain. Upledger and Vredevoogd (1983) presented a possible hypothesis on the underlying physiology of the CRI, known as the ‘pressurestat’ model. They proposed that cerebrospinal fluid (CSF) is produced intermittently and drives the motility of the brain and cranium. Norton (1991) initially proposed that the combined respiratory and cardiovascular rhythms of both the examiner and the subject were responsible for the CRI; however subsequently he concluded that there was no correlation. In the paper ‘Entrainment and the Cranial Rhythmic Impulse’, McPartland and Mein (1997), identified the various theories that had been put forward to explain the origin of the CRI, and presented a hypothesis popular at the time of publication.

We hypothesize that the CRI is the perception of entrainment, a palpable harmonic frequency of multiple biological oscillators. These oscillators include cardiac pulse and variability in heart rate, Traube-Hering modulation, diaphragmatic excursion, contractile lymphatic vessels, and CSF production by the choroid plexus, pulsating glial cells, electrical fields generated by cortical neurons, cortical oxidative metabolism, and probably many other oscillators. (p. 42)

A number of authors, including Ferguson (2003) and Nelson, et al. (2001) have found evidence to conclude that the CRI is a consequence of normal physical factors. Ferguson (2003), in a review titled ‘A review of the physiology of cranial osteopathy’, looked at over a hundred different papers spanning the years 1902-2002 and concluded that “there is evidence of movement between and compliance of cranial bones, and there is evidence that arterial vaso-motion occurs at rates usually associated with CRI” (p. 81). However, this proposed correlation between the CRI rate and cranial vaso-motion, does not suggest that circulatory function is responsible for the CRI. This is because the CRI is the manifestation in the cranium of the PRM, which is palpable throughout the body (Magoun, 1976; Upledger & Vredevoogd, 1983).
Several researchers have related the CRI to the phenomenon known as the Traube-Hering-Mayer oscillation (Nelson et al., 2001; Sergueef, 2001). The Traube-Hering-Mayer oscillation refers to a whole-body phenomenon related to “blood pressure, heart rate, cardiac contractility, pulmonary blood flow and movement of the cerebrospinal fluid, and peripheral blood flow, including venous volume and thermal regulation” (Nelson et al., 2001, p. 163), identified in the late 19th century, and named for those who first observed it. In a study examining the relationship between the cranial rhythmic impulse and the Traube-Hering-Mayer oscillation, by comparing the use of laser-Doppler flowmetry and palpation, Nelson et al. (2001), discovered that the two phenomena closely approximate each other. They were however unable to conclude that the oscillation gives rise to the CRI, and along with the above presented theories this remains just one of the possible sources of the CRI.

Reliability of assessment of the cranial rhythm

An ongoing theme in the literature is evaluation of the validity of cranial rhythm assessment. Palpation of CRI is reliant on detecting the minute movements between the cranial bones, the sacrum, and the rhythmic fluctuation of CSF. These movements are detected via the palpation of tension of the dural membranes, the falx cerebri and the tentorum cerebelli (Upledger and Vredevoogd, 1983). Studies of inter-examiner reliability in assessing the CRI have shown poor outcomes (Ferguson, 2003).

An early interexaminer reliability study undertaken by Upledger and Vredevoogd (1983) found an acceptable degree of inter-examiner reliability; however a number of limitations identified in the study (none of the participants used were classified as having normal craniosacral movement) make the outcomes of limited use and subsequent studies failed to reach the same conclusions. In a noteworthy article published in Physical Therapy, Wirth-Pattullo and Hayes (1994) investigated the reliability of measurement of craniosacral motion by physical therapists with
expertise in craniosacral therapy. They concluded that the reliability achieved was “unacceptable for clinical decision making” (p. 916). Similar findings of poor interrater reliability were found in research conducted by Rogers, Witt, Gross, Hacke and Genova (1998), Drengler and King (1998), and Moran and Gibbons (2001). Hartman and Norton (2002) reviewed the fore-mentioned studies, and concluded that interrater reliability associated with OCF research was close to zero and similarly poor rates of intrarater reliability of practitioners has been found by Wilk and Vivian (2000). Improvements in design of these later studies consistently produce findings that indicate consistency of assessment of the cranial rhythm is unreliable.

Evidence for the clinical effectiveness of OCF

Another theme of the literature concerns the clinical efficacy of OCF, including both positive and negative outcomes. Assessment of both the quality and rate of fluctuation of CSF is thought to be an important diagnostic tool in assessing an individual’s state of health (Brooks, 2002). A number of studies have endeavoured to establish a link between CRI dysfunction and poor health outcomes (Frymann, 1966; Upledger, 1977); however, these studies used cross-sectional design and subjective methods, lacking both validity and reliability.

Greenman and McPartland (1995) documented considerable iatrogenesis from OCF. They list such effects as “emotional swings, psychiatric disturbances, and nausea, vomiting, diarrhoea and cardiac palpitations” (p. 8). These effects were however observed in patients with previous traumatic brain injury, which is one of the contraindications to OCF. After reviewing a series of cases, of ‘normal’ patients, adverse effects as a result of cranial manipulation were catalogued by McPartland (1996). These include “depression, confusion, headaches, diplopia, vertigo, nausea, vomiting, loss of consciousness, trigeminal nerve damage, hypopituitarism, brainstem dysfunction, opisthotonus, assorted seizures and possible miscarriage of a 12 week pregnancy” (p. 2). While the incidence of adverse reaction to treatment was not specified, the author indicates that the rate is
low and that OCF is “probably one of the safest treatment modalities in existence today” (McPartland, 1996, p. 8).

Evidence of iatrogenesis from OCF indicates that OCF does indeed induce physiological change. A 2001 pilot study by Richards et al. focused on how one specific cranial technique affected sympathetic nervous system physiology. The results suggest that there is indeed an effect, with changes seen in circulation, skin temperature, heart rate and breathing rate (p. 34), however due to the variability of the outcomes, the data cannot be generalized. Several studies have attempted to establish a connection between cranial rhythm dysfunction and poor health (Frymann 1966; Upledger 1977). The cross sectional design employed by both Frymann (1966) and Upledger (1977) may well have provided some evidence of association, however the researchers in both cases failed to describe key attributes, for example population characteristics. The use of subjective methods to classify cranial restriction added to the lack of both validity and reliability of their outcomes.

Evidence of both iatrogenesis and sympathetic affects from OCF gives weight to the hypothesis that OCF has a physiological affect. The small number and variable quality of the research to date makes it difficult to make a conclusive statement as to the cause of these effects.

The phenomenon of OCF

The yet unpublished work by Cardy (2004), explored the nature and philosophy of osteopaths’ experience of the ‘Breath of Life’ in the Cranial Field of Osteopathy by conducting interviews with osteopathic practitioners about their experiences, beliefs, theories and accounts of OCF. It was found that practitioners of OCF form a relationship with the ‘Breath of Life’, which evolves during their practice life.

Mitchell (2005) investigated osteopaths’ interactions with the body-psyches of their patients, and discovered that the stories patients related of their illnesses and
injuries had a psychosocial context. Furthermore, osteopathic practitioners were able to palpate and treat the physical manifestations of these psychosocial symptoms.

In a recent study, McFarlane (2006) considered the role of practitioner ‘intention’ in OCF using semi-structured interviews to question patients on their impressions, thoughts and feelings after either an ‘intention’ session or ‘non-intention’ session. Findings indicated that there is indeed variation of patient perception and experience of treatment, with modification of practitioner intent, and thus provide direct examples of patient experiences of OCF. Curtiss (2006) further explored the concept of intention using phenomenological methods to examine the ideas, attitudes and uses of intention by practitioners of OCF. The interview material collected was used to give depth to the meaning of intention within the practice of OCF.

With the exception of the studies by Cardy (2004), Mitchell (2005), McFarlane (2006), and Curtiss (2006), much of the research is of a quantitative nature. While certain aspects of osteopathy lend themselves to research by quantitative methods, OCF is difficult to measure with quantitative tools. The quantitative tools that researchers have at their disposal at present, for example, the use of lasers to gauge movement at the sutures of the cranial bones, are not sensitive enough to measure this aspect of the phenomenon. Opening the cerebrospinal circulatory system to measure would upset the delicate hydrodynamic state in which it normally exists (Magoun, 1976). Some aspects of OCF are clearly better approached using qualitative research methods. “What we need to do is to begin to expand our understanding of science and empirical evidence to include methods and ways of looking at the world which will not overlook the spiritual dimension of the person” (Swinton, 2001, p. 13).

Using quantitative methods, Engel (2006) investigated the effect that treatment by OCF has on the patient’s state of consciousness by administration of a cranial fluid technique (working to influence the flow of CSF) compared to non-osteopathic
touch. Measures were made using the ‘Phenomenology of Consciousness Inventory’ (PCI), which included variables such as time sense, state of awareness and sense of joy. It was concluded that there was indeed a distinct change in consciousness as a result of the administration of a cranial fluid technique as compared to non-specific touch. Engel points out that this research lack power due to the limited number of participants used however the findings provide insight into the effects on mind and body during treatment by OCF. Exploration using the qualitative research method of phenomenology may provide a further dimension to the Engel’s findings and give weight to the assertion that treatment by OCF effects more than just the physical body. While there may be a legitimate separation of the mind and body for academic exploration, they are not in fact independent variables. Engel’s research will be revisited in Chapter five, ‘Interpretation and Discussion’.

In the public health sector there is a drive toward research for evidence-based practice and objective quantitative research in order to demonstrate clinical effects of treatments. This type of research is isolated from practical experience in the field and research findings are not necessarily easily transferable to clinical settings. There is a push for osteopaths and other health professions to use evidence-based research in their practices (Hansen, Mior & Mootz, 2000), but there is also a need for research of a qualitative nature, in inform practitioners of their patients’ ‘lived experience’. “The structural organization of life can often be studied by dissection after death, but vital processes can only be explored in living beings” (Selye, 1956, cited in Magoun, 1976, p. 25). Qualitative research has the potential to enrich the practitioner’s knowledge of a phenomenon, and begin to capture the essence of what that phenomenon is.

Several areas for future research were recognized in the literature, including the patient’s experiences of OCF and how long after treatment these experiences can continue to occur. Anecdotal evidence suggests that the therapeutic process can continue for approximately 2-4 days. Information gathered from this research may help to give weight to this assertion and increase osteopaths’ understanding of the holistic experience of their patients. It may be advantageous for osteopaths working
in the field of OCF to have a well-rounded understanding of the experience and philosophy of OCF. To illuminate greater understanding of the lived experience of patients undergoing treatment by OCF and to contribute to the growing body of knowledge pertaining to OCF, this study investigated the lived experience of a sample of patients undergoing treatment by OCF. The objectives were to:

1. Seek information on the experiences of a small group patients who have received treatment in OCF.
2. Discover the nature and extent of experiences perceived by a small group of patients having received treatment in OCF.
3. Identify common themes among these experiences.
4. Investigate a putative link between these experiences and the documented academic literature.

Summary

This chapter has presented the OCF research to date and identified a gap in the literature, which involves the description of the experience of treatment by OCF. The gap recognized in this literature review supports the aims and objectives of this study.
CHAPTER THREE – METHODOLOGY

Introduction

In this chapter an overview of qualitative research will be given. The rationale for the choice of hermeneutic phenomenology as the research method for this study and its philosophical underpinnings will be discussed. The work of van Manen (1997) whose approach and methods of analysis informed the method of this research will then be discussed. Finally the question of rigor and credibility of qualitative research will be addressed.

Qualitative research

Laverty (2003) compares quantitative research; that which emphasises prediction, control and measurement, with qualitative research; that which emphasises discovery, description and meaning. Historically, research topics that could not be explained objectively held no place in the realms of science (Streubert & Carpenter, 1999). In more recent times however there has been a move to include not only the traditional quantitative methods needed to provide such objectivity, but also a more humanistic approach. This is particularly important when researching topics that involve human interaction or experience. Consequently there has been an upsurge in the use of qualitative research methodologies including ethnography, grounded theory and hermeneutic phenomenology (Denzin & Lincoln, 1998). These methods are often employed when the subject of research is sparsely represented in the research literature or has been poorly examined in the past (Morse & Field, 1996).

There are a number of features that are common within the qualitative methodologies. “Qualitative research involves broadly stated questions about human experiences and realities, studied through sustained contact with people in
their natural environments, generating rich, descriptive data that helps us to understand their experiences and attitudes” (Dingwall, Murphy, Watson, Greatbatch & Parker, 1998, p. 111). It does not seek to prove causal relationships, but instead uses such methods as in-depth interviews to discover people’s feelings and experiences from their own point of view. However, the specific type of question that each paradigm considers appropriate to elicit the data varies. Grounded theory, for example, is focused on key social processes and structures. Ethnography looks for meanings that are important to specific cultures. Phenomenology on the other hand, seeks to describe and understand individuals’ lived experience of a phenomenon (Polit & Beck, 2004). Data are then presented in the form of comments and statements rather than as statistics, as would be the case with quantitative research (Rees, 1997).

Osteopaths have an expanding role in the treatment of the population’s health and well-being, and claim that their treatment is ‘holistic’ in nature. From its earliest inception, osteopathy has been concerned with the whole. A. T. Still (1892) never actually used the word holism, but he did euphemistically speak of the concept by using such phrases as “connected oneness” (p. 76), “one common whole” (p. 120), and “the body functioning united” (p. 231). Webster’s Third New International Dictionary (2003) defines “holism” as “the philosophic theory first formulated in 1925, by Jan C. Smuts that the determining factors in nature are wholes (as organisms) which are irreducible to the sum of their parts” (p. 867). Morse and Field (1996) say that qualitative research is a holistic approach to research that does not reduce participants to functioning parts. Thus a holistic research paradigm is an appropriate choice to explore the osteopathic phenomenon on OCF, by asking, “What does it mean and how does it feel to experience OCF?”

**Phenomenology and hermeneutic phenomenology**

Among those methods that lie within the qualitative paradigm is the field of phenomenology. This method seeks to allow participants to describe their ‘lived experience’ of a given phenomenon. “Phenomenology is both a philosophy and an
approach to enquiry that seeks truth and logic through critical and intuitive thinking about human existence” (Omery, 1983). Within the roots of phenomenology are the ideas of epistemology or “how do we know?” and ontology or “what is being?” (Cohen & Omery, 1994). The philosophy of phenomenology, as described by Husserl (1859-1938) and Heidegger (1889-1976), upholds these concepts, as well as the transcendental and eidetic (descriptive) and hermeneutic (interpretive) ideologies (Cohen, 1987; Cohen & Omery, 1994). There are subtle differences between the two viewpoints of Husserl and Heidegger however, which has resulted in two clearly distinct research traditions (Laverty, 2003).

Husserlian phenomenology is primarily interested in the nature of knowing and focuses on the experience itself. Proponents of Husserlian phenomenology, for example Van Kaam (1966) and Colaizzi (1978), seek to separate the given phenomenon from one’s own beliefs and experiences by ‘bracketing’ or holding back pre-conceived and pre-learnt feelings, traditions, beliefs and ideas, and thus uncovering the essence of the experience (Cohen & Omery, 1994; Gearing, 2004). Hermeneutic phenomenology on the other hand does not seek to set aside biases and assumptions, but sees them as embedded and essential to the interpretive process (Polkinghorne, 1983; van Manen, 1997). The researcher therefore acknowledges his or her previous social, historical and cultural experiences of the phenomenon under study and how they may influence the research process, but does not seek to suspend or eliminate them. Instead the researcher endeavours to use their unique perspective to reflect and interpret the emerging data (Koch, 1996).

Hermeneutic phenomenology employs the concept of the hermeneutic circle; a metaphor to show how, during interpretation of the data, there is dynamic movement between the parts and the whole of the text. The researcher moves in and out of an imaginary circle, connecting with the parts, then the whole, and then the parts once more, each time taking increasing understanding with them. Therefore the hermeneutic circle refers to the idea that one’s understanding of a phenomenon, as a whole is determined with reference to the individual parts, and one’s understanding of each individual part by reference to the whole (van Manen,
Thus, interpretation must be found within the context it is viewed and this context is continually changing throughout the research process. The hermeneutic circle and other concepts of Heidegger’s phenomenology, inform van Manen’s method of analysis, and were used as a framework for the interpretation and analysis of this research.

“Phenomenology is a human science, which strives to interpret and understand rather than simply explain and observe; hermeneutics is concerned with the description and interpretation of experience” (Morse & Field, 1996, p. 56). Application of these two approaches together provides a unique means to search for meaning in research. Other research designs were considered. For example an alternative method of seeking the desired information would have been a quantitative survey of patients of OCF. However, as Byrne (2004) explains, responses to surveys may not give sufficient depth of information of the respondents underlying attitudes and opinions. The qualitative method known as grounded theory was also considered. Grounded theory is a method of qualitative research that requires the researcher to strive to understand a particular research situation. Using observation, conversation and interviews the researcher sets out to find a theory that accounts for what is occurring in the given situation as the researcher sees it (Glaser, 1995). In other words the aim is to discover the theory implicit in the data. Phenomenology on the other hand aims to describe the ‘lived experience’ of the participants without necessarily being able to explain it fully. It was therefore deemed appropriate to use phenomenological method to gather descriptions of treatment by OCF in order that common experiences may be identified. While these descriptions, along with my own experiences of treatment by OCF, may often be ‘ineffable’, the data gathered may possibly give further explanation as to how OCF works and add to the limited existing literature. Thus a brief appraisal of other research traditions and their approaches to research questions showed that phenomenology was the appropriate choice of method for this research project.
Van Manen’s approach to phenomenological research

This section outlines the philosophical underpinnings to method when using hermeneutic phenomenology. Van Manen suggests an approach to research in relation to interpretive or hermeneutic phenomenology, in which the researcher acknowledges his or her previous experience, knowledge and beliefs, and how these may influence the researcher in all phases of data collection, analysis and interpretation. Furthermore, van Manen suggests a six step ‘methodical structure’ (1997, p. 30) for hermeneutic phenomenological research. These six steps are outlined below and provide a framework for the research method as a whole. Consideration is then also given to his methods for isolating the prominent themes contained in the data. The application of these six steps and the isolation of thematic statements in this research are further discussed in terms of application within this study in the chapter that follows.

Van Manen’s six components of phenomenological research

The six steps outlined by van Manen (1997) were selected to provide the framework for this research, as they were seen as sufficiently broad to allow flexibility in emphasising or minimising one step or another, depending on the emergent data. Step one ‘Turning to the nature of lived experience’ in essence involves formulating a research question. Step two ‘Investigating experience as we live it’ is concerned with the methods employed to investigate the lived experience in question, for example, using in-depth interviews for data collection. Van Manen (1997) suggests that lived experience must be investigated as opposed to simply learning about it through books, journals, discussions and other second-hand accounts and therefore in-depth interviews are an appropriate way of examining people’s unique experiences. In step three ‘Reflecting on the essential themes which characterise the phenomenon’ the emphasis is on the analysis process itself, by reflecting on the themes identified from the interviews and endeavouring to capture the essential meaning or essence of the lived experience in question. Van Manen (1997) points out that there is “a distinction between appearance and essence” (p. 31), that which
we tend to see as everyday and that which is obscure; and phenomenological research allows this to be brought into focus. Step four ‘Describing the phenomenon in the art of writing and rewriting’ is another important part of the research process; in particular the analytic phase. Through the process of writing, the intention is to make visible the feelings, thoughts and attitudes of the participants. The writing of phenomenological description “strives for precision and exactness by aiming for interpretive descriptions that exact fullness and completeness of detail, and that explore to a degree of perfection, the fundamental nature of the notion being addressed in the text” (van Manen, 1997, p.17). When considering step five ‘Maintaining a strong and orientated relation to the phenomenon’ the researcher must strive to remain focussed on the research question at hand.

To establish a strong relation with a certain question, phenomenon, or notion, the researcher cannot afford to adopt an attitude of so-called scientific disinterestedness. To be orientated to an object means that we are animated by the object in a full and human sense. (van Manen, 1997, p. 33)

Finally in step six ‘Balancing the research context by considering the parts and the whole’ the researcher is asked to “constantly measure the overall design of the study/text, against the significance that the parts must play in the total textual structure” (1997, p. 33). While these steps are sequential there is a back and forth movement between the steps throughout the research process. An unfolding and infolding occurs as the data is read and re-read, considered and re-considered, examined and re-examined. There is no beginning or end, no top or bottom to this circular process.

**Van Manen’s method for isolating thematic statements**

Thematic analysis, as described by Arminio and Hultgren (2002) is an “unloosening that occurs only as the researcher spends a great deal of time seeking to understand the text” (p. 456). In order to attribute meaning to the data, van Manen (1997) suggests three methods for isolating thematic statements. These methods are the
detailed reading approach, the selective or highlighting approach and the holistic reading approach. In the detailed reading approach, van Manen (1997) proposes that the researcher looks at each sentence or group of sentences while asking, “What does this sentence, or sentence cluster, reveal about the phenomenon?” (p. 93). The selective or highlighting approach asks which statement is most revealing about the phenomenon in question. In the third approach, the holistic reading approach, van Manen suggests looking at the text as a whole and asking which notable phrase captures the fundamental meaning of the text? These themes are then used as a framework around which to create a text, which aims to capture the essential meanings of the phenomenon that have become evident within the data. All three approaches were employed during the data analysis of this research.

The question of rigor and credibility in qualitative research

Qualitative research is an umbrella term that covers a number of research traditions including hermeneutic phenomenology. Previously, empirical methods of research have been perceived as the ‘gold standard’ and more reputable than qualitative methods (Hicks, 2004). Although qualitative methods of research are by no means new, they have in the past been challenged as lacking both credibility and rigor or trustworthiness (Sandelowski, 1993; Tobin & Begley, 2004). Therefore, when undertaking a research project using qualitative methods it is essential to demonstrate a high standard of academic integrity and rigor.

According to Koch (1996) one way of ensuring rigour within qualitative research is the demonstration of the researcher’s understanding of alternative research approaches and how the choice of each may affect the research process. Each research tradition has its own unique approach and consequently its own unique criteria for rigor (Koch, 1995). In the case of hermeneutic phenomenology, it is critical to detail the “multiple stages of interpretation that allow patterns to emerge, the discussion of how interpretations arise from the data, and the interpretive process itself” (Laverty, 2003, p. 23).
Credibility is defined as “the quality or power of inspiring belief” (Merriam-Webster Online Dictionary, 2008). Koch and Harrington (1998), use the words believable and plausible synonymously with rigor. Therefore, it is fair to say that the concepts of rigor and credibility have much overlap. According to Stark (2007):

A study is credible when it presents such faithful descriptions or interpretations of a human experience that the people having that experience would immediately recognize those descriptions or interpretations as their own. A study is also credible when other people can recognize the experience when confronted with it after having only read about it in a study. (p. 307)

The use of data excerpts to illustrate the themes and the comparison of others interpretations of the phenomena of OCF add credibility to this research. Another way of strengthening the trustworthiness, according to Koch (1994), is by the researcher establishing an audit trail describing and justifying all the steps undertaken in the research process. Documentation of such procedures as the recruitment of participants, the interview process and the development of themes, add to the trustworthiness of the research. Such an audit trail has been provided and the reader is referred to the following chapter, which outlines the methods followed during collection and examination of the data for this research.

**Summary**

In summary, this chapter has discussed qualitative research in general and explored the basics of phenomenology and its philosophical origins. Van Manen’s six components of phenomenological research and three methods of isolating thematic statements were then outlined, followed by a short discussion of credibility and rigor within qualitative research. The following chapter will outline the methods used in this study.
CHAPTER FOUR – METHOD

Introduction

A research method can be described as the steps; procedures and strategies used in gathering and analysing research data to give the final account. In this chapter the research method for the study is presented. Included is information on the process of gaining ethical approval and how ethical procedures were then followed when interacting with the participants. The recruitment of participants, data collection and the methods used in the analysis and interpretations of the data are also discussed. Van Manen’s (1997) suggested framework for hermeneutic phenomenological study and isolation of thematic statements is used to structure this discussion. The preliminary descriptive analysis of the text and the analytical process of developing the themes that emerged from the interviews are outlined.

Ethical issues

Ethics approval from the Unitec Research Ethics Committee was obtained before recruiting any participants for this research (Appendix A). Participants were provided with a plain language information sheet (Appendix B) outlining the research, which included the contact details of my thesis supervisors and the ethics committee. My own phone number was also included should the participants have needed to contact me after the interview. All participants were fully informed about the purposes, benefits and potential risks of the study. This consent process (participant consent form, Appendix C) included explanations of the interview process, the potential topics to be explored and the assurance of anonymity and confidentiality. The data collected were kept confidential, real names were not used and any identifying details were removed. Pseudonyms are used throughout when talking about both the referring osteopaths and the participants themselves. Participants are identified by age and gender only on both the interview transcription and in the excerpts of data used in this document.
As the information sought was of a personal nature, there was a possible risk of participant distress, in recalling an unpleasant event, for example. Every effort was made to ensure that the participants were not put at risk of emotional harm and they were assured that they could cease the interview at any time. As a health professional I am skilled in monitoring and assessing patient responses and therefore was competent to recognise and respond to any distress that may have been exhibited by a participant. No such situation arose during data collection.

**Participant recruitment**

Several recruitment strategies were undertaken to find potential participants for this research including purposive sample of osteopaths who practice OCF who were then asked to refer appropriate patients (Appendix B). Subsequently other participants were found through “snowball sampling” from colleagues, friends and family of these initial referrals who were also receiving treatment from the same practitioners.

Initially the participants were recruited from two busy osteopathic practices in Auckland. The osteopath was provided with an information sheet (Appendix D) outlining the research question and procedures and was asked to identify possible participants. These people were then provided with a participant information sheet and permission for their phone number to be given to the researcher was sought. The potential participant was then contacted and their possible involvement in the research was discussed and any of their immediate questions were answered. A time and place to conduct the interview was arranged.

From these initial contacts, additional participants were suggested. The process of word-of-mouth referral from participant to participant is known as snowball sampling (Patton, 2002).

An adequate sample is important in all types of research. In phenomenological research is it usual to use small numbers, as the goal is to achieve a rich
understanding of a specific lived experience, rather than to produce findings that can be generalised. Morse and Field (1996), suggest that a sample size of 10 or less is appropriate for such research, and that data should be collected until no new information emerges. A sample of five interview participants was anticipated to be likely to provide sufficient data and in fact this proved to be the case.

**Data collection**

Data collection for the study was through single in-depth interviews with five participants who had experienced treatment by OCF. In-depth, semi-structured interviews are a useful way to gather stories and obtain a person’s account of a given experience. Qualitative interviews offer the possibility of altering one’s line of enquiry, following up interesting responses and investigating underlying experiences in a way that postal and self-administered questionnaire for example could not (Robson, 1993). The intimacy that in-depth interview can create is valuable when endeavouring to learn about little known phenomena.

Interviews for this study were of a conversational nature, with open-ended questions in order to guide, but not direct participant responses, and allow the interviewee to express their values, beliefs, understandings, experiences and opinions (Byrne, 2004). Participants were encouraged to elaborate on their responses to some questions and to further expand and clarify these responses. This allowed flexibility in gathering information from the participants (Polit & Beck, 2004). The aim was to elucidate the participants’ perceptions of treatment in OCF, without imposing any personal assumptions. At times this was challenging, as having experienced vivid sensations during treatment by OCF, I had to be mindful that I didn’t influence the participants’ responses to questions by my own bias. Awareness of this possible bias meant that emphasis was maintained on topics that the participants’ considered important, not those that I may have had an express interest in.

The interviews took place in the participants’ homes and took an average of 40
minutes to complete. The interview questions focussed primarily on the participants’ experiences of treatment using OCF, including intra-treatment, immediately post treatment and delayed treatment experiences. As the material gathered was reliant on the memory and critical reflection of the participants, the interviews were carried out as soon as was practical after the participants OCF treatment. Three interviews were conducted within 24 hours of treatment, however in the case of two participants several weeks lapsed between their last treatment and the interview. Data were captured using a tape recorder and subsequently transcribed and analysed by the researcher.

The following questions are examples of the primary interview questions used in the interviews.

* Tell me about your experience of OCF?

Further questions that were used as prompts were:

* Can you tell me more about that?
* How did that make you feel?
* What happened next?
* What are you additional experiences of OCF?
  (For example, physical, cognitive, visual, spiritual, emotional)
* How did you feel after treatment?
* How did you feel 2 days after treatment?

**Data recording, storage and management**

All information was collected using pseudonyms to minimize the possibility of identifying the individuals involved in the study. The researcher carried out transcription of the interviews. Consent forms and transcripts of the interviews were stored separately, kept secure at all times, and will be destroyed after five years, as per Unitec policy. Computer files are stored in password protected files that only the researcher has access to.
Development and recognition of important themes and concepts start as soon as the collection of data commences (Polit & Beck, 2004). Immediately after each interview was completed, the recording was played and re-played, reflective notes were made and the interview was transcribed verbatim. It was important to transcribe as soon as possible following the interview while the ambience of the encounter was still fresh. Once the interview was transcribed, any identifying characteristics relating to either the participants or the osteopath they attended were changed. Notes were made on the participant’s general demeanour, body language, and tone of voice, laughing, crying, as well as my own feelings about their accounts. Notes on each participant were attached to their interview transcript. A copy of the transcript was then sent via post to the participant to ensure an accurate representation of their interview had been recorded.

**Data collection, analysis and interpretation - The place of the researcher's personal experience**

Van Manen (1997) suggests that it is necessary for the researcher to acknowledge his or her previous experience, knowledge and beliefs, and how these may influence the researcher in all phases of data collection, analysis and interpretation. In other words, the interpretation of the participants’ words is a function of the background, training and beliefs of the researcher involved. In order for such influences to be revealed, I was interviewed by a colleague. This interview exposed a greater awareness of my own experience of treatment by OCF, including preconceived notions, opinions, and expectations. A journal of personal reflections on the interview as well as my thoughts throughout the study period was also kept in order to illuminate my own experiences of treatment by OCF. While these observations are not data in the usual sense, they have been of value in the process of interpretation and discussion of the participant data. These notes were invaluable as a reminder of earlier thought processes, initial impressions of concepts and participants and as a cue to the continued evolution of thought involved in producing this research document.
1. Turning to the nature of lived experience

As mentioned in Chapter One under ‘personal background’ (p. 4), the research question was developed principally out of my attraction to OCF and influenced by the work of previous students of osteopathy; Cardy (2004) and McFarlane (2006). In the concluding chapter of her dissertation, Cardy (2004) suggests that there was further scope for research in exploring the ‘Breath of Life’ experience from the patient’s perspective, rather than the practitioner’s, as she had. This research has not sought specifically to illuminate the patient’s experience of the ‘Breath of Life’, but the experience of treatment by OCF in its entirety. The research question became, ‘What is the ‘lived experience’ of patients who undergo treatment in OCF?’ Throughout the research process this question was continually referred back to in order to ensure that the methods continued to be appropriate to answer it.

2. Investigating experience as we live it

The data collection method employed to investigate the lived experience of treatment by OCF was semi-structured, in-depth interviews, tape-recorded and subsequently transcribed. Interviews allowed the participants and the researcher to re-live the participants’ original experiences as they related them. The participants were asked to describe their experience of treatment by OCF in their own words, and these narratives were expected to add depth and breadth to the current understanding of OCF as a whole.

3. Reflecting on the essential themes which characterise the phenomenon

In order to reflect on the essential themes it was necessary to first identify the themes and sub-themes that were prominent in the data. During the interview I sought to recognise significant themes in the participant responses and encourage elaboration on these points in order to ensure sufficient data was collected for analysis. The reflective notes taken both during and immediately after the interview,
assisted in subsequent analysis and influenced the direction of the following interviews. After each interview the recording was transcribed verbatim and then analysed by identifying common themes and assigning meaning to these experiences (Polkinghorne, 1983). This was achieved with immersion in the data, reading and re-reading the transcripts, and moving between transcripts looking for common meanings the experience had for the group of participants. Statements, words and phrases that were felt to be of significance were selected while reading and re-reading the data; and these formed the early themes and sub-themes. This process will be further detailed later in this chapter under the heading ‘Isolating thematic statements’. Tabulated examples of this process are provided as Appendices E and F.

4. **Describing the phenomena in the art of writing and rewriting**

As the cycles of writing and re-writing continued during this research process, there was constant revising and refining of thought. Ideas that were formed during data collection and transcription became clarified during writing and re-writing, and in reading and re-reading. Constant questioning and reflection of the emerging themes allows a deeper understanding of the lived experience.

5. **Maintaining a strong and orientated relation to the phenomenon**

During the sometimes-laborious task of interview transcription and analysis, my genuine interest in the subject at hand was advantageous to the continuation of work. It was often easy to become immersed in the stories of the participants and become distracted from the study as a whole. To avoid being sidetracked it was necessary to have ongoing systems, for example a journal of reflections, which was used to refocus attention on the research question. Frequent contact with colleagues and supervisors in order to reflect on the research process was essential to maintain concentration on the task at hand.
6. Balancing the research context by considering the parts and the whole

Although analysis began with the five interviews, the ‘parts’, reflection allowed these stories to be gathered together as a ‘whole’. Reading the interview transcripts, considering one’s understanding of the whole, writing about the phenomenon, scrutinising the parts again, writing some more before once again considering one’s position, was a process that continued throughout the production of this dissertation.

Isolating thematic statements

Van Manen (1997) maintains that themes can be isolated in several ways. The detailed reading approach asks what each sentence or group of sentences reveals about the phenomenon; the selective approach which asks what is essential or revealed in the text and the holistic approach which asks what phrase captures the meaning of the text. This meaning is then construed to be a theme. These methods are briefly outlined previously in chapter four of this dissertation. Initially the detailed reading approach was chosen, but in using all three it was discovered that each approach elicited different information.

The detailed reading approach

In this method, van Manen (1997, p.93) proposes that the researcher looks at each sentence or group of sentences while asking, “What does this sentence, or sentence cluster, reveal about the phenomenon or experience being described”? Reading and re-reading the transcripts and identifying key words and concepts that appeared in particular sentences or groups of sentences, and then grouping these together was the first method of analysis. Appendix E is an example of the key words and concepts that resulted from using this process in the initial analysis of the transcripts of Maggie’s and Vanessa’s interviews.
The selective or highlighting approach

This approach was used in the second stage of analysis and in asking which statements were most revealing about the phenomenon in question. These statements were then highlighted, copied and tabulated. (Throughout the text the participants’ voice will be represented using italics). Below is an example of such a statement.

*I actually felt energy through my left leg. Because that’s normally dead and I don’t feel energy going through it. But I did feel it when she worked on it. There is just a sort of tingling… and it’s just like I can feel the energy flowing through it.* (Debbie, lines 66-67)

In the initial analysis, this quote was highlighted and became linked with the key words (felt energy/ normally don’t feel energy/energy flowing through it), which lead to the concept ‘Energy movement’, the sub-theme ‘A sort of tingling’ and the theme ‘Sensations that signal change’. Further examples of the use of the selective highlighting approach can be seen in appendix F, using statements from Nadia and Jennifer that along with similar statements from the other three participants’, formed the basis of the first theme ‘The appearance of health’.

The holistic reading approach

The third approach van Manen suggests for isolating thematic statements is the holistic reading approach. This method was employed a number of times and involves looking at the text as a whole and asking which notable phrase captures the fundamental meaning of the text? The theme ‘Finding health’ encompassed many of the concepts that were revealed in the data, including physical, emotional and spiritual experiences. When searching for the inherent themes in the data, the following quote from Nadia was found to describe a move toward health from a spiritual/emotional point of view.

*Those treatments woke me up. Woke me up… like my soul… my essence… had been walled up in a cave and now this treatment… or this person… somehow that primal part of me that I had abandoned… that was frozen… lost … was somehow found. Found and acknowledged…* (Nadia, lines 180-182)
An improvement in health appeared to be shared by all of the participants in the study. There was great variation in how this was manifested and while a number of the participants had obvious improvement in their physical health, others described dramatic changes in the emotional or spiritual realm. These accounts were grouped together under the sub-theme ‘A move toward health’.

The development of themes and sub-themes - The first stage of analysis

Originally each interview was analysed separately using the detailed reading approach. Key words, phrases and ideas were grouped together and then concepts were developed from these groups by reading and re-reading the data, and spending considerable time dwelling on the meanings emerging from the text. An example of a comment from Maggie in reference to her first experience of OCF is given below:

… she said that when I went home I’d probably find that I would be very sore for a few days. My muscles would be very sore. And I must admit I walked out of the place thinking ohhhhh yeah…. She didn’t do anything. (Maggie, lines10-11)

The key words were identified, as She didn’t do anything. The possible concepts related to these key words were ‘layers of meaning, several truths, uncertainty, felt nothing/experienced something’. Similar ideas within each interview, including the following quote, were grouped together before identifying several passages that gave an overall impression of the interview.

I love it. It’s very relaxing. She moves very gently. Nothing… you wouldn’t think she was doing anything. I feel like she’s doing something. But I don’t know. I sort of feel a whole movement in my head. It’s only a gentle movement. (Maggie, lines 213-215)

The process of identifying similar concepts was repeated with each of the five interview transcripts. Those key words and concepts that were found to be common between the interview transcripts were then grouped together. Nadia’s recollection of her first osteopathic treatment reflected those of Maggie, and these were grouped together with similar thoughts from all participants under the concept ‘felt
nothing/experienced something’.

I left ...calm... At the time I attributed that to the talking though... not so much the treatment, but now looking back that might not have been quite the case. He just talked to me in such a way that like I said I finally felt hope. But his hands... when he put his hands on I didn’t feel like he was doing anything. He was just holding my head. It was nice... but I remember thinking afterward that he hadn’t really done any treatment as such. He didn’t even feel like he moved his hands. But I really wanted to go back even so. There was something going on. (Nadia, lines 16-23)

Other illustrations of these early phases of analysis are shown in appendix E, using Vanessa and Maggie, and the concept of energy movement as an example. Their experiences differed in many respects, with Maggie almost exclusively describing energy movement from a physical point of view. Vanessa on the other hand seemed to experience energy from what she described as more energetic perspective. This process of analysis was undertaken using the interview transcripts of all five participants and identified a number of key concepts (see Appendix E for examples of this process), which were then used as the basis of development of subsequent sub-themes and themes.

The second level of analysis - moving from key words and concepts to sub-themes and themes

The development of sub-themes and themes, while distinct from the initial approach, shared many similarities. Significant statements were highlighted, copied and tabulated with the emphasis shifting from the identification of key words to the identification of themes from the early concepts. Gathering the transcripts from all five participants together, and examining them as whole, allowed statements to be grouped into similar categories. At this stage, the sub-themes and themes were by no means concrete; changing many times before those presented below became clarified. Appendix F illustrates the process of grouping early concepts within the theme ‘The appearance of health’. They formed the sub-themes of ‘The therapeutic relationship’, ‘The inherent healing mechanism’ and ‘Finding health’.
Summary

This chapter has outlined the research method used in this research. It began by detailing the processes of gaining ethical approval, recruiting participants and collecting, analysing and interpreting data. Van Manen’s (1997) suggested framework for phenomenological study and isolation of thematic statements were then reviewed. The chapter concluded with a summary of the development of sub-themes and themes. An interpretation and discussion of those key themes identified follows in Chapter five.
CHAPTER FIVE – INTERPRETATION AND DISCUSSION

Introduction

This chapter presents the data and the central themes that emerged from interviews carried out with five women who were receiving treatment by OCF. Maggie, Nadia, Jennifer, Debbie and Vanessa were women whose ages ranged between 35-75 years. They had sought osteopathic treatment for various conditions including endometriosis, facial neuralgia, headache and back pain from two female and two male practitioners of OCF. A more detailed explanation of each participant’s presentation is given on page 39.

The themes of ‘The appearance of health’ and ‘Sensations that signal change’ have been identified as recurring throughout the interview transcripts and will be discussed with reference to the literature and the philosophical underpinnings of osteopathy. The boundaries between the two are not well defined as they share a number of common elements that weave and interconnect.

This chapter is divided into two sections according to the two major themes identified and then further divided into their sub-themes. The first theme ‘The appearance of health’ contains three sub-themes; ‘The therapeutic relationship’, ‘The inherent healing mechanism’ and ‘A move toward health’. ‘The appearance of health’, offers an examination of the association between the osteopath, the participant, their own innate healing ability and possibly all-powerful animating ‘something else’. Finally the ensuing improvements in health after OCF treatment are explored.

The second theme ‘Sensations that signal change’ presents descriptions of the feelings that occur during OCF treatment. These sensations are wide ranging and include the physical, emotional and spiritual. This theme is made up of the sub-themes ‘A sort of tingling’ and ‘A sense of the ineffable’.
Throughout this interpretation and discussion it must always be remembered that the participants bring their own unique history to the treatment room. Korr (1974) suggests that the unique set of circumstances that a person brings with them has an influence on their health and thus how the person will consequently respond to OCF. This view is reiterated by McFarlane (2006) who concluded that the story that emerged during the interviews that she conducted “altered depending on the space in which the participants entered the treatment room” (p. 41). While the participants in this research were not questioned specifically about their backgrounds or the events currently unfolding in their lives, the interview process inevitably gave insight.

Maggie for example described herself as a very practical person for whom things have to be proved. She presented to the osteopath with chronic lower back pain sustained in a childhood injury more than 50 years earlier. Maggie’s descriptions of her experience of OCF were predominantly physical accounts.

Vanessa on the other hand worked was a ‘healer’ and suggested that for her it’s a spiritual connection: between practitioner and client. Vanessa’s descriptions contained many esoteric descriptions that seemed to be reflective of both her occupation and outlook on life. She was attending the osteopath for both physical (knee injury) and emotional (childhood abuse) reasons and reported that both aspects of her health were improving.

Debbie was also seeing the osteopath for a number of reasons. Recently she had slipped down a two metre bank and injured her lower back and pelvis. This coupled with long term endometriosis meant that the symptoms of this complaint had been aggravated.

Nadia went to see the osteopath specifically in relation to long term depression. She had no physical complaints at the time but did report an improvement in both mental and physical well being.
Having exhausted conventional medical interventions for facial neuralgia, Jennifer sought help from an osteopath. As well as a great improvement in this condition, a long term back problem was also attended and resolved successfully.

In the section below, the themes and sub-themes identified are explored and interpreted.

**The appearance of health**

Theme one draws attention to the participants’ experience of moving from a relative state of ill-health to improved health during their treatments by OCF. The first sub-theme ‘The therapeutic relationship’ highlights the role the participants see the osteopath as having in this change in their health. Sub-theme two ‘The inherent healing mechanism’ acknowledges the possible influence of ‘something else’ in the healing process and establishes the interaction between this ‘something else’, the participant’s own innate healing ability and the osteopath. Finally, sub-theme three ‘A move toward health’ gives examples of how the participants’ health improved during treatment by OCF from a physical, spiritual and emotional point of view. Together these sub themes describe how the participants re-discover health.

**The therapeutic relationship**

As mentioned above ‘The therapeutic relationship’ is part of the ‘The appearance of health’ theme and introduces the reader to how the participants view the osteopath and their role in assisting them to improved health. The theme begins by examining the relationship that exists between the participant and the osteopath.

The participants appear to see the osteopath’s function as co-ordinating the healing process in order to assist their own innate healing ability. In other words, the practitioner simply acts as a facilitator to awaken and encourage this inherent system to find the health within the body. All interviewees recount varying
experiences that can be interpreted as illustrations of this process in action. One example comes from Nadia, who describes a movement from the chaos of ‘disease’ to the order of ‘health’. She uses the analogy of an airport arrival/departure board.

*Cranial osteopathy... seems to put me back together. It gets all the fragments, muddled up from the stress of life, and arranges them back perfectly. You know those boards at the airport... that show the arrivals and departures... they click across all the letters of the alphabet, but finally fall into the right sequence to make sense. Maybe at some point when we are really healthy all our words are spelt right automatically. But slowly they get confused and the words are mis-spelt or have letters missing. The osteopath puts his hands on and all those letters fall back into place... Fly back even...* (Nadia, lines 88-100)

Nadia appears to be conveying the belief that the osteopath somehow supports her body to become whole once more by performing some intricate process that may be comparable to a spell check. This allows the repair of any damage that she sees has been done to her health as a result of everyday living to be repaired. Although Nadia does not necessarily understand what is happening she does imply that treatment by OCF provides the right conditions for her body to achieve an improved state of health. She appears to recognise that there is something out of sequence in her body, which she equates with ill health. Of course this infers that there is indeed a correct sequence that correlates to an optimum state of health. If we continue with the analogy of health being related to a particular sequence of letters, this inference immediately raises a number of questions. Is there a point in our lives in which the sequence is perfect? What causes the sequence to become confused? Can treatment by OCF influence this confusion? Possible answers can only be speculated on; however Blechschmidt (2004), whose work is influential in the biodynamic view of OCF, suggests that there is indeed a time when an individual’s pattern of health is perfect:

The perfection of the embryo is part of our make-up throughout our lives. In order to adapt to external stressors, such as trauma or emotional stress, the body may adopt a new, less than perfect pattern, which allows it to continue functioning, all be it at a less than optimal pattern. (Blechschmidt, 2004, p. 68)
Therefore, the perfection that is found in the embryo may serve as a blueprint for the correct sequence for health. The self-healing mechanism need only follow a path back to this perfection to find health.

Several of the participants suggest that all osteopaths are not created equal.

I felt with the first practitioner it felt like it was quicker. It felt like the symptoms diminished more. With the second one it felt like it was getting better but it was slower... They were both very different and I liked both of them...but one felt like they had more... at the time... more was happening within my body perhaps. (Jennifer, lines 13-15)

Jennifer comments that the difference she felt between the two practitioners was in the speed with which her health improved. She also notes that her state of health at each time was possibly different and this may have had some bearing on the experience. Vanessa also suggests that there is a variation in the skill of individual practitioners.

I've had some really good practitioners and some not so good practitioners... As soon as I had had work from her that was it, there’s no way I would go anywhere else. (Vanessa, lines 9-10)

Vanessa does not elaborate on exactly what makes one practitioner better than another, only that she recognised when she had found the right one. Unlike Vanessa, Nadia did not have to try a number of different osteopaths to find the right one for her. The relationship that the participant formed with the osteopath they attended seemed to be influenced by the unique set of circumstances they brought with them to the treatment room. Nadia for example had seen numerous doctors without positive result. She said of her first contact:

I wasn’t looking for another doctor. I needed looking after. (Nadia, line 4)

The relationship that Nadia formed with the first practitioner was instant. Nadia describes feeling like a connection was being formed even before treatment commenced that supported her and gave her hope.
The osteopath that I saw was about the same age as me, and so, so gentle. I just felt looked after... he nurtured me... I felt like there was hope. Before he even put his hands on me really. He took a very detailed case history and that made me feel like he was really wanting to find out just where the problem started. About all sorts of things that nobody had asked me before. Things about my birth and childhood accidents and illnesses... what jobs I'd done in the past... hobbies... friends... all sort of things. Building up a picture of me that wasn't just me at the moment I came to him. (Nadia, lines 5-8)

A number of elements seem to combine to give Nadia a sense of connection to this particular osteopath. He was of a similar age, took a detailed case history and showed an interest in all aspects of her life. This demonstrates both professionalism and caring, leading to an overall feeling of reassurance. The osteopath provided Nadia with just what she was seeking and consequently she returned despite admitting that she felt as if no actual treatment had taken place during that first OCF session. She goes on to say:

Well... each osteopath is different... and I'm different with each osteopath. I think that first practitioner was incredible. Maybe it was because he brought me out of a state of such... turmoil... woke me up. I was just so grateful. (Nadia, lines 257-258)

Here Nadia points out that each interaction is unique, depending not only on the osteopath she is seeing, but also on her own state of being. This mirrors Jennifer’s earlier statement, which suggests that her health status had an influence on the experience of treatment. In this instance, Nadia describes her state as one of turmoil that the practitioner was able to somehow alleviate, making the interaction all the more significant. Nadia is thankful to be released from her turmoil and attributes this directly to the osteopath.

Jennifer was also impressed by the thoroughness of the osteopath that she saw, and his approach may have contributed to her ability to relax immediately.

The practitioner was very professional. Went through a detailed history, which I quite liked. And did a complete check up...quite medically sound. Checked out all my vertebrae even though I wasn’t going to get manipulated or anything. That felt really good. And then I lay down and it felt ... really peaceful and relaxing. And I did feel changes in my body. I went into a
really, really deep relaxation and I really didn’t want it to stop. It felt lovely. (Jennifer, lines 22-25)

Perhaps the fact that Jennifer is herself a health professional, led her to have certain expectations of treatment. By taking a detailed case history and checking all her vertebrae, the osteopath demonstrates the professionalism that Jennifer required. Once convinced she is in safe hands, she appears to be able to relax.

Maggie however, was more sceptical. Although willing to try anything after years of lower back pain, she had reservations when she first visited her osteopath.

I thought ahhhh yes well... that won’t make me sore. Well I must admit, the next day and for three days I could hardly walk. My muscles were sooo sore. And she said I would be. So of course I thought oh ok then. She... she knew what she was talking about so I went back...I’m a very practical person. Things have to be proved to me. And I think that right from the beginning she proved it to me. And because I had my doubts when I walked out that first time. I nearly wasn’t going to go back. But she just proved it to me. She told me exactly what was going to happen to me. And it did. (Maggie, lines 17-20)

Maggie describes a feeling that the practitioner was doing nothing in her first treatment. She was incredulous when the osteopath suggested that she would be sore the next day. Maggie needed proof that the osteopath knew what she was doing and that the treatment was working. Her practical nature demanded concrete evidence. This was provided soon after in the form of muscular aches and pains. Once convinced of the osteopath’s effectiveness, she needed no more proof and was completely willing to trust.

In the passage below, Maggie conveys an admiration of her osteopath while acknowledging her limitations.

I totally and utterly believe in her. She’s got very, very special hands. And this is a girl that works with horses and mucks out and... she doesn’t do anything special to look after her hands. There’s something about her. Well... that’s what I feel. There’s something. She has a gift... I don’t quite know. I think she’s brilliant. Ummm... I’ll tell you...she doesn’t necessarily have a great rapport with people. (Maggie, lines 224-227)
Maggie appears to attribute the practitioner’s brilliance to some innate quality in her *special hands*, whilst she acknowledges the osteopath’s fallibility in terms of her lack of rapport and on occasion lack of attentiveness.

_Some days I do feel… she has a lack of concentration. Just occasionally… and she’s not in tune with me. And I don’t feel I’ve had the effect. But that doesn’t happen very often. But I feel her lack of concentration. It’s funny isn’t it, because even though it still works to a certain extent, I don’t feel that effectiveness…_ (Maggie, lines 232-235)

Over time Maggie has developed the ability to recognise or appreciate the subtleties of treatment by OCF. Upon completion of her first treatment she reports being unconvinced that anything has occurred. However she is clearly able to distinguish between the practitioner’s attention and inattention.

McFarlane (2006) found that practitioners’ intention did indeed have an effect on the experience of treatment by OCF. Conceivably, this lack of intention could correlate with a lack of attention, giving weight to McFarlane’s assertion that the osteopath’s focus is of importance. Maggie certainly conveys a belief that an absence of concentration has an influence on the effectiveness of treatment. As the relationship between Maggie and her osteopath develops the contact becomes more familiar and some degree of the therapeutic effect is lost. Their osteopathic relationship has remained and developed into a strong and cherished friendship, spanning two decades. It is clear that Maggie benefited from treatment by OCF.

Debbie is also delighted with the change that she sees her osteopath has brought about in her health and also suggests that her osteopath has *got something extra* in terms of healing ability.

_She has been the one that has actually taken it from where I couldn’t bear body weight and I would just get these shooting pains that would go from my knee, down into my foot and right deep into my hip, to being able to dance and walk and run and act like a normal person again. It’s unbelievable._ (Debbie, lines 33-36)

What Debbie describes is a fairly dramatic change in health. She reports both an
increased ability to perform everyday tasks, and to do those things that make one happy, such as dancing. These things give Debbie a feeling that the osteopath had helped her regain a sense of normality.

The development of a positive therapeutic relationship appears to be dependent on the osteopath demonstrating those attributes important to the person being treated. Professionalism and caring are two of the main attributes identified as important to the participants in this research.

Lee-Treweek (2002) used the practice of OCF to explore the concept of ‘Trust in complementary medicine’. She suggests that trust is a form of faith and goes on to point out how important this is in the case of OCF. Whilst describing the treatment as “deeply relaxing” many patients also reported “they could not detect anything happening”. Faith or trust in the osteopath was instant for some (Nadia) and grew over time for others (Maggie). In complete contrast to her initial scepticism, Maggie developed a strong belief in her osteopath. But was this complete trust she developed in her and the something extra that Debbie suggests her osteopath possessed justified?

“Patients assign power to the practitioner whether the practitioner wants it or not” (Greene & Goodrich-Dunn, 2004, p. 17). Osteopathic philosophy would suggest that they act merely as a kind of conduit that allows the ‘Breath of Life’ to do its work through the participants’ own means (Sutherland, 1990). At this point it is unclear as to exactly what role the osteopath plays in the improvements the participants report. Cardy (2004) seems to suggest there is a collaboration between the practitioner and the body’s own ability to heal, when she states that the ‘Breath of Life’ “is the intelligence assisting the healing process” (p. 20). Jealous (2003), Becker (2001) and Sutherland (1990) tend to downplay the role of the osteopath. They imply that the osteopath may order the treatment, but a higher Intelligence is that which carries it out (Brooks, 2002). This concept will be further explored in the following sub-theme, which considers the collaboration between the osteopath and the participant’s innate healing ability.
The inherent healing mechanism

Within osteopathic literature there is often reference to the inherent healing mechanism. Still (1892) uses the terms ‘Great Architect’ and ‘Master Mechanic’ to describe the notion and states “First, there is the material body; second, the spiritual being; third, a being of mind which is far superior to all vial motions and material forms, whose duty is to wisely manage this great engine of life” (p. 16). Brooks (2002) employs the phrases the ‘Primary Physician’ and the ‘physician within’ and Jealous (2003) ‘the other pair of hands’. Magoun (1976) also suggests that healing must be guided by and directed by a supreme being. These terms along with the ‘Breath of Life’ seem to overlap and along with the phase ‘something else’ are used interchangeably in the remainder of this document.

According to Brooks (1997), the ‘Primary Physician’ “works according to its plan, and it has only one goal – health” (p.144). During analysis of the interview data it became clear that there were many examples from the narratives that could be interpreted as evidence of the ‘Primary Physician’ at work. The participants’ narratives seem to confirm the osteopathic view that a ‘Primary Physician’ is functioning to find health during treatment by OCF. The sub-theme ‘Inherent Healing Mechanism’ resulted from several participants’ observations that even though the osteopath appeared to be doing nothing, they were aware of something happening. This functional paradox is prevalent throughout.

You wouldn’t think she was doing anything. I feel like she’s doing something. But I don’t know. I sort of feel a whole movement in my head. (Maggie, lines 213-214)

There is a sense of conflict in Maggie’s words as she struggles to make sense of what is happening. Nadia echoes this sentiment.

When he put his hands on I didn’t feel like he was doing anything. He was just holding my head. It was nice... but I remember thinking afterward that he hadn’t really done any treatment as such. He didn’t even feel like he moved his hands. But I really wanted to go back even so. There was
Nadia’s description indicates that treatment was indeed pleasant, but does not feel that this necessarily translates into effectiveness. However, even though she reports that she cannot feel any physical movement from the practitioner’s hands there is a feeling that something is happening, and this prompts a desire to return.

Jennifer describes an instance in which the body appears to be reorganizing itself and making adjustments to regain health. She used the words *realigned* and *rebalanced* to describe her experience.

> *It felt like my brain was rebalancing or something… something was happening inside my brain. I sort of felt like it was like the two hemispheres of the brain of were sort of being realigned or getting rebalanced. And it felt… and then sort of got into my whole body was getting more balanced.* (Jennifer, lines 50-54)

Once again Jennifer’s comment reflects her own health background. She is familiar with the anatomy of the brain and translates her experience into anatomical language. Jennifer makes it clear that the balance extends to her entire body, not just where the sensation originates. This rebalance may be seen as the process of unifying those ‘parts’ of the body that have become disengaged from the ‘whole’ (Handoll, 2000) and has similarities to the earlier quote from Nadia describing the letters of the alphabet falling *into the right sequence*. A self-regulating, self-healing capacity is one of the basic principles upon which osteopathy is based (Kuchera & Kuchera, 1991). In order for the body to maintain homeostasis or balance it must continually be making adjustments; at a cellular level, an organ level, at a systems level which ultimately affects the whole. Rebalancing is a word also used by Cardy (2004) in association with the self-healing mechanism. She infers that the osteopath is a catalyst for the body’s own attempt at the process of healing and makes a distinction between the practitioners’ role of assistant and the body’s inherent healing mechanism as the primary driver of health.

Several of the participant’s described feelings of extreme tiredness immediately after treatment or in the few days following treatment. In some cases this was
surprising as the treatment experience had been very gentle or even imperceptible as illustrated by the examples below from Maggie and Nadia.

"And she said that when I went home I’d probably find that I would be very sore for a few days. My muscles would be very sore. And I must admit I walked out of the place thinking ohhhhh yeah…. She didn’t do anything. I felt she hadn’t done anything." (Maggie, lines 9-12)

"By the next day it was apparent that I had been very wrong in my thought that I wasn’t getting so sort of treatment. I was very, very tired. To the bone tired." (Nadia, lines 26-27)

Vanessa also related a feeling of tremendous tiredness, and commented that her level of exhaustion afterward seemed to be related to the severity of her presenting problem. Perhaps the energy needed for healing is reduced as the body moves closer to an ideal state of health. When Ward (1997) states that “under optimal conditions, the body, mind, and spirit work to maintain health and heal” (p. 5), there is a suggestion that the personal history of the participant will have some bearing on their ability to express their self-healing capacity. The following narrative from Vanessa suggests that there may be some truth to this assertion. She describes her first treatment by OCF and explains what the after effects of treatment can be like, when one’s health is less than optimal.

"When I was in Christchurch I remember the first time I went to an osteopath there and afterward I felt like I had been run over by a truck. What I would notice was that each time I went for a treatment, the energy would leave but it would take less time to recover." (Vanessa, lines 221-224)

This seems to indicate that profound healing can occur not only at the time of treatment but for some days afterward and that there is a definite relationship, at least in Vanessa’s case, between the participants presenting state of health and the post treatment experience. The osteopath often appears quite passive in the process, which gives weight to the involvement of the inherent healing mechanism.

Maggie suggested the idea that the body was continuing to heal itself after treatment.
I usually go and try and lie down. Sometimes I’m fine, but sometimes I just feel… I just have that feeling that perhaps I should go and lie down. Just, you know, I don’t know why I feel that… but it makes you want to do that. To protect your self I think. Because I feel good, and something is happening. (Maggie, lines 181-185)

She seems to indicate that sometimes her body needs further rest after the treatment to allow the effects to continue. On these occasions she listens to the feeling and lies down for a period. The following comment by Jennifer also implies that healing continues.

I know that after sessions I just want to sleep and sleep and sleep. If I went say at mid-day I would just like to come home and sleep or lie down for a couple of hours afterwards. I think maybe it’s because I run… I feel like at times I run on nervous energy, I’m busy busy busy. And that that’s put me in a state of deep relaxation, so it’s a way of my body trying to heal… or repair it self. (Jennifer, lines 101-107)

She also describes a feeling that she needs to rest after treatment and recognises that treatment has enabled her to switch from a condition of prolonged tension to a more relaxed state. Furthermore she acknowledges the need to find respite from her busy life, in order that healing is able to take place.

The experience that the effects of treatment continued for some time after the session was common to all the participants interviewed in the study. A number of them reported needing to rest immediately post treatment and feeling tired for several days afterward. Treatment effects varied depending on the state of health the participants presented with. They tended to build over consecutive treatments, with several participants suggesting they felt nothing during the first treatment, but over time progressed to feeling a myriad of sensations and ultimately experiencing what may be seen as ‘A move toward health’.

I’m not actually sure when the first time was that I felt something. I think in the first session I was just so shut down…half dead really. No vitality at all. And maybe that’s why nothing registered. But steadily I have become more aware of sensations during treatment. (Nadia line 34-46)

Nadia seems to substantiate the suggestion that the participants’ state of health has
an influence on the experience of treatment by OCF. In this case, Nadia wonders if the reason she had not felt anything during treatment, was that she had such poor energy. She confirms that her ability to perceive treatment effects has grown over time.

Does osteopathic treatment serve to trigger or remind the body of its own internal medic? Perhaps once initiated healing continues unaided for a time after treatment has ceased. Becker (2001) suggests that this may indeed be the case when he says “all the corrections in any form of treatment always take place after you do the work” (p. 19). The belief that the body has a self-healing capacity is not unique to osteopathy and can be traced back to Hippocrates (470-410BC). He theorized that each person exhibited a predominant humor or temperament that dictated how that person responded to his or her environment, and this included his or her ability to ward off disease (Debus, 1968). Still (1908) stated “all remedies necessary to health exist in the human body” (p. 88). The osteopath acts to assist the body to access these remedies and thus achieve an improved state of health. This is reflected in the view of Florence Nightingale, who believed that the work of a nurse was to create the optimum environment for the body to heal itself. In Nightingale’s Notes on Nursing (1860/1969) cited in Macrae (2001) she stated “Nature [i.e., the manifestation of God] alone cures… and what nursing has to do is to put the patient in the best condition for nature to act upon him” (p. 133).

Humanity’s current position in relation to nature, in the Western World at least, is often one of separateness. When Still developed the practice of osteopathy on the frontier of America in 1874, a time when life and one’s very survival would have been very much influenced by the length of the days and the changing of the seasons, this separation between human and nature may not have been so apparent. Much of contemporary civilisation is largely unaware of the rhythms that dominated earlier human existence, and remain disconnected from them. In modern day society it could be said that many people are in a constant state of stress, which may be hard to disengage from without outside intervention (Lee, 2005). In this case that outside intervention is in the form of the osteopath. Once in a state of
relaxation or parasympathetic dominance, the body may be able to access its innate healing mechanism more readily (Ward, 1997). Perhaps this shift merely represents a change in body physiology that allows more efficient delivery of nutrients and removal of waste products from a compromised area of the body. From a purely structural point of view Lee (2005) uses an example of musculoskeletal injury in which heightened sympathetic input produces a “diminished blood supply” and the “potential to reduce health” (p. 25). He goes on to say that as the parasympathetic nervous system becomes predominate, “the sympathetic output also normalises and the vascular delivery of nutrient to end organs resumes a normal pace” (p. 26).

**A move toward health**

Initially the data were separated into passages that described a move toward physical, emotional or spiritual health. However, it became clear that there were very few participant narratives that could be clearly separated into one group or another. Furthermore, these categories are artificial and directly oppose osteopathic philosophy and the concept of holism by emphasising the Cartesian split between mind and body. Passages that describe advancement toward physical, emotional and spiritual health have thus been included together under the sub-theme ‘A move toward health’.

Debbie reflected on the change that OCF has brought about in her ability to carry out not just the tasks of everyday living, but the activities that add joy to living, such as dancing. The improvement she described in her physical health is dramatic.

*Dance and do anything, yeah. Gardening. Kneeling down, getting into my cupboards in the kitchen. All those sort of things that when I first moved in here it was a real struggle to unpack my house. I just didn’t have the mobility in my body. It was really hard even climbing in and out of the car.* (Debbie, lines 132-133)

Debbie reinforces the improvement the OCF has had to her health when she reported the cessation of medication from the time she began treatment by OCF to the time of the interview.
I went from taking Synflex\(^1\) twice a day and it would have been about 900mgs Gabapentin\(^2\) in a day, down to half of that. And then from that I’ve halved it again. And then I was able to stretch it out to two days…of this… you know… 20 percent dosage, and then three days. And then now I’m completely off my medication. (Debbie, lines 137-140).

She does not seek to understand or explain how this was achieved but says:

You can’t understand you just have to accept that sometimes some things are beyond our brain’s capacity. You just accept. (Debbie, line 142)

At least for some of the participants there was a willingness to have faith and no need to be able to understand how things worked, why tissues were moving, what the practitioner was doing. Debbie was willing to accept that some things are beyond our understanding. She appeared to embrace the ‘something else’ that she accepted was part of the treatment process. Others were not so willing to trust, at least initially. Maggie says that she needed proof. In this respect Maggie almost appears to contradict herself, when she reports that she needed proof, after stating earlier that she was always willing to try anything. At the end of the first treatment she was convinced that the osteopath had done nothing, but the next day had her proof in the form of extreme muscle soreness. Nadia also recounts that her first experience, while valuable, also felt like no treatment had taken place. She experiences the same apparent contradiction when she then acknowledges that in that first treatment something had indeed changed.

The rational mind may struggle to explain the paradox of nothing happening/something happening. Conceivably treatment was always taking place, despite the perception that nothing was happening. Perhaps the participants learnt how to perceive it, or learnt at least how to accept it. Cardy (2004) points out that not only can the experience of the emergence of health be “mysterious and unfathomable for the rational mind” (p. 74) it is also very difficult to then describe such an experience. Among the participants of this study, there was a diversity of

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1 Synflex, also know as Naproxen is a non-steroidal anti-inflammatory drug commonly used to alleviate moderate to severe pain, fever, inflammation and stiffness. (Carruthers et al, 2000).

2 Gabapentin (Gabapentin is a medication originally developed for the treatment of epilepsy, and now widely used to relieve pain, especially that of neuropathic origin (Carruthers et al, 2000).
ability to express the experience of OCF. Maggie also expressed the fact that her condition improved over time.

*I had an incredible improvement and then it was maintenance.* (Maggie, line 114)

She went onto say that the treatment outcomes also changed.

*I was sore. All my muscles. She said she couldn’t really work on my...my bones I suppose... until she had released all the muscles. It took about four treatments before she had released the muscles and I was starting to feel loose. For those first few treatments I always had muscular soreness... until it didn’t happen anymore.* (Maggie, lines 176-179)

Unlike Debbie and Maggie whose improvements are mostly described as physical, Jennifer and Nadia both reported an improvement in their emotional state. This may be reflective of both personality and background.

*I felt that my umm... anxiety was more manageable. Because I can get quite anxious. And I just think I had a pervading sense of being calmer. I just think the coping was better... my coping was better.* (Jennifer, lines 112-113)

Jennifer, for example, describes herself as being an anxious person and therefore being able to decrease her anxiety enabled her to cope much better. The following example from Nadia also relates to an emotional aspect of health.

*I always feel like I am gaining mental clarity... or emotional balance... that’s what I mean about it always being the same. That aspect is always the same. I get rebalanced.* (Nadia, lines 41-43)

Possibly the words *emotional balance* used by Nadia is equivalent to Jennifer’s *sense of being calmer*.

In summary the theme, ‘The appearance of health’, explored the inter-relationship between the participant, the practitioner and the inherent healing mechanism or ‘Primary Physician’. Health was shown to be a complex concept, with improvement of health being unique to each participant. Further analysis uncovered
that although a number of the participants describe a feeling that the practitioner is
doing nothing, they nevertheless acknowledge that something is happening. Naturally this presents a paradox to the patient, who must either strive to understand
this elusive process or find a way of accepting it without necessarily understanding it. There are many unanswered questions. If the practitioner is not doing anything, what or who is the doer? How can one be sure that treatment is in fact happening? That the sensations are real? Our western, rational view would suggest that doing nothing/ feeling something is not possible. Yet the feeling of being healed without
being treated is strong. If the participant cannot explain or understand the process, there has to be a level of trust in the practitioner. It appears reasonable to hypothesize that ‘The appearance of health’ is in fact the result of collaboration between the osteopath, the patient and the ‘Primary Physician’.

In addition, theme one showed that the participants experience a journey from a
relative unawareness of their state of health and the healing process during the
initial few treatments, to a refinement of perception in later sessions. There must
have been an awareness of illness or poor health initially for them to seek
osteopathic treatment, however there appears to be a changing perception of the
body: a change in state of mind and being over time. In a process that mirrors that
of the practitioners’ evolution of perception of the ‘Breath of Life’ (Cardy, 2004), a
number of the participants also exhibited an evolution in perceptual clarity. In her
first consultation, Nadia admitted she did not feel like she was being treated, but
subsequently describes a multitude of sensations. Maggie’s experience was much
the same. These observations will be further explored in the following theme
‘Sensations that signal change’, which is concerned with the experience of changes
in perception.

**Sensations that Signal Change**

The second theme ‘Sensations that signal change’ examines examples from the
participants’ narratives that relate to physical sensations as well as spiritual or
emotional experiences. This theme was divided into the sub-themes ‘A sort of
tingling’ and ‘A sense of the ineffable’. Once more there was significant overlap between the sub-themes and the division is purely for the purpose of the explication of the theme.

**A sort of tingling**

This first sub-theme concerns the physical sensations that the participants experience, both during and after treatment. Lederman (2005) points out that the experience of treatment will depend upon “the individual’s cultural and social background, past experiences, feelings at the time and nature of the patient therapist relationship” (p. 273).

All of the participants reported instances where they experienced the sensation of energy movement. From a physical point of view this energy movement was perceived in the varied forms of temperature change, tingling and twitches. Debbie gave an account of her experience of energy movement, which was accompanied by the sensation of tingling. She notes that the feeling was not necessarily in the area where the osteopath was thought to be working.

*There is just a sort of tingling… and it’s just like I can feel the energy flowing through it. She can be working on a completely different part of my body, but I can still feel the energy tracking down through there. Definitely a tingling…* (Debbie, lines 69-71)

Both the source and the site of this energy are perplexing. It is also difficult to know exactly what the word tingling means in this context. Is the feeling related to the nervous system, or perhaps the circulatory system? Several of the participants describe the character of energy movement as linear. Debbie for example uses the word *tracking* in association with tingling. Nadia in the following passage also reports energy running in straight lines. Therefore tissues with a linear nature, such as nerves or blood and lymphatic vessels, must be considered as possible sources of these feelings.

*I have had feelings on energy running in straight lines. Usually down my legs. Often it happens in a rush with no warning, like a dam has broken. And*
sometimes it’s… there’s a warning first… It’s like the mud pools at Rotorua. Little air bubbles tell you that something’s happening. I feel like something is happening… simmering. And then it just pops. I’m not sure if that is quite right, but then the energy is able to move. That feeling of energy may only last a few seconds… or it can last the whole treatment. When it happens I know that I will feel more alive afterward. (Nadia, lines 52-59)

Communicating the complexity of a phenomenon such as the experience of OCF is often difficult. A number of the participants tended to employ metaphors to describe what they felt could be happening. Metaphor is the application of a name or description to something, to which it is imaginative but not literally applicable. The metaphors used in osteopathy are “multidimensional matrices of meaning whose depth at first glance are not obvious” (Massiello, 1999, p. 35). Using metaphor to describe aspects of OCF is a common practice and extends too many of the comments made by the participants in this research. Often the participants liken their experiences to objects or happenings that others may have understanding of. Nadia’s quote above, describing the experience of energy movement is one such example. Nadia’s experience of energy movement differed with each session and reinforced the recurring observation by the participants that each OCF treatment was unique. Often there is no warning of the sudden rush of energy she describes. At other times there were physical clues that something was about to happen. Sometimes the feeling lasted just a short while and on occasion throughout the entire treatment. However, when it did happen there was a reported increase in vitality post treatment.

Maggie expressed a similar feeling, but in her case the sudden removal of the impediment to energy flow, was likened to a blood rush to the head.

I can just feel my whole brain clear. Blood rush to my head? I don’t know. That’s just like what it feels like. Like I have had a total blockage… not total of course because I’m still here. And suddenly I just feel I can just think clearly and move clearly… quite different. And energy I suppose. A certain energy goes into you. (Maggie, lines 256-260)

A sudden release of energy gives the impression that initially there must have been something blocking it. Once this obstruction had been removed she then noticed a
marked difference in her both her clarity of thinking and her ability to move.

Muscles twitches were also a common experience among the participants and are described in the following account from Maggie.

*I became very aware of my legs. And this happened on a regular basis when I went to Kate. When she started treatment my legs would jump like I had fleas. All over my legs would twitch. Little twitches right down. It was just like there were fleas jumping on my legs. That would last quite awhile. Sometimes 10 minutes. 5 minutes. Like a little twitch. I never used to get it originally... it was something that happened later on in treatments, then I used to get it quite regularly, when she first started the treatment. It was like little nerve twitches right down my leg. It was like something had been released and my legs were coming alive. Very strong.* (Maggie, lines 261-268)

Debbie tells of a sudden energy transfer in the form of muscle spasm and suggests that the release could possibly have an emotional origin.

*I didn’t actually feel the bone untwisting but when things release in me it’s like a muscle spasm in some part, and I think, oh yes something has just let go. And it’s not necessarily a physical thing. Sometimes I think it could be emotional stuff.* (Debbie, lines 168-171)

In addition she goes on to describe another example, this time a more isolated twitch, which resulted in a reduction in pain.

*I think my body did twitch. But for me it was just like... you know if you stretch a rubber band and you just let it go? That’s what it felt like. And afterwards the pain had decreased each time. Significantly.* (Debbie, lines 174-176)

Each of the examples from Nadia, Maggie and Debbie above, describe a sudden release of energy. All three depict differing physical sensations of energy movement, and all three then imply a positive change in their well-being as a result. Nadia felt *more alive*; Maggie noticed that she could then *think clearly and move clearly* and Debbie reported a decrease in pain. However, Vanessa inferred that her legs could actually lose energy during treatment, and is one of the few instances
where a participant reports an unpleasant feeling associated with treatment by OCF.

*I feel I lose my legs. If I was to walk I would not feel very steady on my legs. I know they are there, but energetically they have left.* (Vanessa, lines 83-84)

Another shared experience of OCF treatment among the participants was the sensation of temperature change. Several of the women reported feeling energy in the form of heat, both at the site of the osteopath’s hands and at other sites where they felt that the treatment was also taking place.

*Ummm… warmth… sometimes where the osteopath’s hands are… sometimes elsewhere. In areas he isn’t actually touching, but I guess he is still working on.* (Nadia, lines 47-48)

Nadia mirrors Debbie’s previous statement that the awareness of a particular sensation can be located quite separate from the osteopath’s hands. The participants in McFarlane’s (2006) study also reported that there was a sense of ‘communication’ extending beyond the area that the osteopath was treating. McFarlane (2006) points out “osteopathically, the cause of the symptom picture is frequently distant to the symptomatic site” (p. 44). From the practitioner perspective Cardy (2004) says that in her study, at least one of the osteopaths involved reported being “aware of changes in tissues distant from the actual position of her hands” (p. 64) during treatment.

Tingling, heat and energy all feature in one of Vanessa’s descriptions.

*Oh and heat. I might feel stuff shifting somewhere in my body… I might feel tingling going down my legs. Tingling or energy moving around my body. Pulsing.* (Vanessa, lines 136-137)

The presence of a feeling of pulsing tends to suggest an involvement with the vascular system. Perhaps the heat experienced was as a result of an increased vascular perfusion.

*It was like that congestion went away. It felt like it was flowing better… the blood supply or something was flowing better around the pelvic area. And*
there was heat… quite a lot of heat that I experienced. (Jennifer, lines 75-78)

Jennifer certainly seems to suggest this when she explains her experience of increased temperature from a physiological perspective, and suggests the possibility that the heat is due to increased blood flow to the area being treated. Nadia also suggests a relationship between the feeling of warmth and the circulatory system.

Warmth… sometimes where the osteopath’s hands are… sometimes elsewhere. In areas he isn’t actually touching, but I guess he is still working on. Sometimes that heat then turns cold… I guess the blood is coming to the area and then evaporating away. (Nadia, line 39-41)

Not all the participants shared this particular view however. Maggie implied that the source of this heat was due to a special ability that the osteopath possessed which allowed her to transfer warmth from her hands during treatment.

I might experience feelings of warmth. Her hands are incredible. Her hands are instantly hot. She has amazing hands. (Maggie, lines 172-173)

A comment such as this from Maggie is curious. She makes it clear early in the interview that her practical nature means she does not seek out experiences that are out of the orthodox. However, once the ability of the osteopath has been proved to her she seems very willing to believe that this person may have some extra-ordinary healing ability. This perspective seems to be shared by Debbie, who did not exactly attribute the source of the energy to the practitioner, but suggested that the practitioner had the ability to act as a kind of channel for some omnipresent universal energy.

Yeah it (the energy) is coming through her. From where I don’t know. It’s probably all around us. (Debbie, lines 96-97)

Energy movement, in the following example, in contrast to Vanessa’s earlier account of losing her legs, seems to be ‘life giving’ to Debbie’s injured limb when the osteopath worked on it.

I actually felt energy through my left leg. Because that’s normally dead and I don’t feel energy going through it. But I did feel it when she worked on it.
Debbie equates a lack of energy in her leg to an absence of life, saying that without energy running through it, the limb is *normally dead*.

The examples of energy movement above have been predominantly about physical sensation. However, there are many instances where the passages do not easily fall into one category or another, so it seems reasonable to conclude that there is a strong link between the physical and the emotional/spiritual. Osteopathy is a health system that seeks to treat the body as a whole. When contacting one part of the system that comprises the human being, one is inevitably touching the whole.

The following description from Maggie, of a wave like sensation during treatment, clearly comprised both physical and emotional elements. On a physical level she feels an undulation that encompasses her whole body.

* I really felt like my whole body was just waving along. (Maggie, lines 74-75)

However, from an emotional point of view the experience was obviously calming, nurturing or as she put it *soothing*.

* I didn’t just feel them I think I could see them when I think about it... Yes... just visually I could just see these waves. And they were very soothing waves. They weren’t scary waves or anything. They were very soothing and they were just ... you know, floating along there quite nicely and... I must admit it was quite an experience. (Maggie, lines 26-30)

OCF has a broad physiological effect which maybe due to treatment or contact with the cranium at the level of bones, membranes, CNS and CSF (Handoll, 2000). Handoll goes on to remind us that palpation of the CSF has a wave like swelling and receding quality that extends from the cranium to the pelvis. While we can only speculate to the origin of the waves Maggie describes, OCF as a holistic treatment system works on the patient as an indivisible whole. Therefore the treatment affects, in this case the feeling of waves, may be discernable throughout the body.
There are a number of OCF treatment philosophies and methods, and individual practitioners are free to interpret and apply the teachings of osteopathy in whatever way they deem fit. Therefore, the experience of OCF may depend just as much on the participating osteopath’s philosophy and treatment approach, as the participant’s personal history and views. The exact background of the osteopaths who were involved in this research was not explored; therefore comment of the possible physiological effects produced by specific techniques or approaches would be pure conjecture. Nevertheless it must be pointed out here that there are definite links between certain areas of the brain and a number of the experiences reported by the participants in this study. Initially this research was envisaged as an all-encompassing account of the experiences of OCF alongside the biological processes that may account for them. However it soon became clear that this subject is beyond the scope of this study and is more fully explored by authors such as Pert (1997) and Engel (2006).

In the following sub-theme, instances of sensations of energy from a predominantly spiritual or emotional perspective are explored.

**A sense of the ineffable**

The second sub-theme in ‘Sensations that signal change’ documents the participants’ perceptions of treatment in relation to the less tangible realm of the spiritual or emotional. All the participants report various feelings of connection between themselves, the osteopath and the universe as a whole. They go to explain how these feelings give them a sense of peace, relaxation and improved vitality. The exploration of this sub-theme begins with a comment from Nadia, whose narrative often centred on the spiritual or emotional aspects of the experience of OCF. Nadia’s description of one of her early treatments exemplifies the profound impact that OCF can have.

*Those treatments woke me up. Woke me up... like my soul... my essence... had been walled up in a cave and now this treatment... or this person... somehow that primal part of me that I had abandoned... that was frozen...*
Nadia describes being roused from ‘sleep’ by the osteopath and the result is a re-connection with a part of her that had been isolated. She may or may not have been aware of this isolation, but treatment by OCF seemed to allow her to focus inward and discover her ‘soul’ or ‘essence’ once more. Although Nadia does not specifically use the word connection in this passage, what she describes is indeed a re-acquaintance or re-connection with something she had lost. Connection is however a word used frequently by the participants and reflects a relationship between not only the participant and the practitioner, but with something extra.

I think in all non-orthodox healing there is a spiritual element. And you know the healer, the practitioner… you have to have a connection to something extra. (Debbie, line 93-94)

Debbie states early on in her interview that she has always sought alternative ways of healing, and therefore she possibly has a more ‘open’ view of potential outcomes of treatment. Debbie’s reflections are helpful in illustrating this common thread of connection evident in all the narratives.

Self-help and alternative care stuff you have to have a belief that it’s going to work. If you are just totally anti it, its just going to come against a… a block wall. And bounce off. So there has to be that openness or receptiveness for it. (Debbie, lines 50-53)

She emphasizes that she believes that all alternative health care contains a spiritual component, and then goes on to imply that in her view there is also an element of faith involved in the interaction. Often this concept is hard to verbalise, as Jennifer’s comments also show.

I’m not really sure… because… it’s hard to. I think it comes from both (the osteopath and spirit). But I think there’s a spirit… there must be something… there feels like there is some sort of other element as well. (Jennifer, lines 95-97)

Vanessa also views treatment as having a spiritual component.
Sometimes I’ll get memories based in the past. But sometimes it’s more on a spiritual connected level. Meaning I will get an image of a person and I will see an energetic connection. And that gives me a really deep insight into what’s going on. Not a premonition… but an insight. Something I hadn’t actually got before. So for me it’s a spiritual connection. Between practitioner and client. (Vanessa, lines 42-45)

This is a perspective also shared by Nadia.

_I don’t believe in God as such, but I do believe in some supreme energy…. Some vital, universal, all-encompassing source of energy… Something that is in everyone and everything. Maybe the osteopath has a way of tapping into that energy. I know that the sense of peace that I feel is kind of because I feel so connected._ (Nadia, lines 145-149)

The importance of this statement is that Nadia not only appears to be conscious of an all-encompassing energy source but also that the osteopath and herself were somehow connected to it. This is significant because it indicates that she believes that the osteopath is able to engage with the source of the energy as well as her.

She goes on to say:

_I think when I was really depressed, those first few times going to the osteopath was spiritual…. I got woken up and reintroduced to the fact that I was alive and interacting with … Everything._ (Nadia, lines 228-229)

Further she implies that for her this particular spiritual experience was linked with a feeling of present moment awareness.

_Yes it is a spiritual experience. I just feel … a sense of being very much present in the moment. I feel… very aware of … yes… the present. No concern or thought of the past… about anything that has come before… and no thought about the future. I’m not worrying about anything that is to come. Just content and very aware of the here and now… And I never want to get out of that state._ (Nadia, lines 232-236)

When Nadia is immersed in this state of present moment awareness and all her worries are suspended, she appears to be in a place of great peace. Nadia’s description parallels the views of prominent Sioux medicine man Black Elk (1863-1950) when he says:

_The first peace, which is most important, is that which comes within the souls of people when they realise their relationship, their oneness with the universe..._
and all its powers, and when they realise that at the centre of the universe
dwells the Great Spirit, and this centre is really everywhere, it is within each
of us. (Neihardt, 1961, p. 45)

That which constitutes a spiritual experience may vary significantly between
participants depending on their background. None of the participants described
having an affiliation to any specific religious organisation. Maggie when asked if
OCF ever provided her with an experience she would consider spiritual, states
I don't go searching for that. Yet others did express a connection with the spiritual.
Jennifer speaks of a spiritual belief. Nadia says she does not believe in God as such,
but rather in an encompassing source of energy.

So what exactly is meant by the term spirituality? “Spirituality is the specific way
in which individuals and communities respond to the experience of spirit”
(Swinton, 2001, p. 14). However, it appears that it means different things to
different people and this leads to a certain diffuseness of definition. Barnum (1998)
describes spirituality as a concept with numerous meanings, interpreted and applied
by Christianity, Buddhism, Islam, Humanism and the New Age. Spirituality is
different from religion, although religion may include aspects of spirituality.
Historically, spirituality and religion have been viewed by many cultures, both
ancient and modern, as closely linked to health, both physical and psychological
(Thoresen, Harris & Oman, 2001).

Brooks (2000) gives the following interpretation of the position of Still and
Sutherland with regards to spirituality.

Both men expressed their firm belief that there is a vital, universal, divine
force that pervades and governs the nature of things. Neither one of them
personally maintained any connection with an organised religion, but each
perceived himself and everyone else as spiritual beings…. Scientific
reasoning and spirituality were seen as a seamless whole. (p. 11)
An apparent change in state of consciousness or awareness was common among the participants. It appears reasonable to suggest a link between the altered state of consciousness that Engel (2006) refers to in his study ‘A cranial state of mind’ and the experience of inner peace and serenity expressed by several of the participants. Engel puts forward that treatment by OCF can result in deep relaxation; an improvement of awareness of the body, an altered state of consciousness which enables the patient to view worries and problems from a different perspective, and an overall shift of consciousness towards calmness and clarity. McFarlane (2006) found that participants in her study reported a feeling of relaxation in both the ‘real’ and ‘sham’ OCF treatments suggesting that possibly the mere act of lying still in a quiet room and being touched in a therapeutic way may be responsible for the feeling of relaxation. However, she goes onto suggest that in the ‘real’ sessions this relaxation was reported as having a different quality. As the only difference between the ‘real’ and ‘sham’ sessions was in the intention of the osteopath to provide treatment, intention is likely to be responsible for this different quality. While it is unclear to the extent that OCF is responsible for inducing feelings of relaxation they are however a prominent feature of the narratives, as illustrated by the following description from Jennifer, who refers to a state of deep relaxation that she wishes to remain in.

I was sort of aware of the time... but I didn’t want it to stop. It was a lovely state to be in. Sort of going to sleep but not going to sleep. Just feeling very calm and went... sort of into a deeper state of consciousness (Jennifer, lines 41-42)

Debbie identified an uplifting change in her state, but implies that this does not happen during every treatment.

Last week or the week before I was just totally relaxed and went off into a trance like state. It was wonderful. (Debbie, lines 108-109)

Nadia says:

I know that the sense of peace that I feel is kind of because I feel so connected. Not just to the osteopath. Though I do feel connected to him... like his hands and my head don’t really have a boundary. But I feel more than that... like I am connected to the room and the building and the spaces
Nadia described feeling connected in several ways; firstly to the treating practitioner and secondly to the immediate space and thirdly to the cosmos as a whole. She implies a disappearance of boundaries, not only between patient and practitioner, but also in a larger sense. These comments imply a momentary absence of separateness or a least the perception of lack of separateness. They parallel the findings of McFarlane (2006) who observed that the participants in her study experienced a greater connection between mind and body after treatment by OCF. Cardy (2004) also reported that for treating osteopaths “refined perceptual capacity leads to the experience of connectedness and the disappearance of boundaries” (p. 67). Further she describes one practitioner’s view of this disappearance of boundaries as seeing the whole in several ways, “in terms of tissues not being discernible; in terms of the extensiveness of affected organisational levels, and in terms of the whole person, the whole body-mind-spirit-unity in context, even extending to the whole universe” (p. 64). It seems reasonable to construe that the experiences that osteopaths report while treating by OCF, have some relationship to those experiences reported by patient’s being treated.

Oschman (2003) describes how touch may bring about this feeling of connectedness: “In essence, when you touch a human body, you are touching a continuously interconnected system, composed of virtually all of the molecules in the body linked together in an intricate web work” (p. 48). Within the osteopathic profession itself there are those who expound the idea that this interconnected system extends beyond our physical boundaries. Fulford (1996) refers to a distribution of forces that extends well beyond the patient’s body. Becker (2001) further clarifies this view, alluding to a reorganising of the room itself during treatment. The biodynamic view of osteopathy talks about four zones or spaces of energy (Jealous, 2003). Zones A-D, which extend from within the boundaries of the skin, the space immediately around the body, the room and off to the horizon. The actual experience of treatment described above seems to mirror this idea.
The word numinous, from the Latin meaning God, could be used to describe an experience that is mysterious or ineffable (Merriam-Webster Online Dictionary, 2009). Otto (1970) states that numinous refers to: “a moment of deeply-felt religious experience” (p. 8), evoking a deep feeling of immense beauty or awe. As Einstein stated “The most beautiful and profound emotion we can experience is the sensation of the mystical. It is the power of all true science” (cited in Lipton, 2008, p. 153). There is an air of mystery that surrounds the experience of OCF. Often it seems that this mystery is beyond the power of words to sufficiently describe. Ordinary language and rational concepts fail to do the experience justice. Possibly the fear of being seen to stray outside the confines of established academic thinking has prevented so called mystical experiences of OCF from being openly discussed. Perhaps when people are unable to rationalise such experiences they dismiss them as being all in their imagination. Of course, it is not always necessary or desirable to be able to rationalise every experience. People who are capable of suspending rational thought may be able to gain some sense of the ineffable. Negative capability is a phrase coined by the Romantic poet Keats (1917): “Negative Capability that is when man is capable of being in uncertainties, mysteries, doubts, without any irritable reaching after fact and reason” (cited in Roberts, 2009). When one remains within the tight confines of intentional thought, there may be a barrier to truly seeing the essence of an object or experience. The ability to abandon such confines, the ability to be in mystery without need of rational explanation may be essential to the authenticity of experience of OCF.

Handoll (2000) indicates that in order to be aware of a deeper reality; it is essential to be open-minded. Lee (2005) speaks of having the ability to move away from the realms of conventional thinking and being able to regard new thoughts, or revisit previous conceptions from a new perspective. A. T. Still had the courage to step beyond the mainstream thinking and convention of his time and is often talked of as a mystic (Paulus, 2009). The term “mystic” is derived from the Latin mysticus (Webster online dictionary, 2009), which means hidden and is often used in reference to one whose ideas are out of step with their time. Sutherland followed suit, at times being dismissed by the osteopathic establishment as an eccentric.
The findings of Cardy (2004) and McFarlane (2006)

Many of the findings prominent in the work of Cardy (2004) and McFarlane (2006) are relevant to this research. Reference to these two authors has been made throughout this document and summarised and discussed further here for completeness.

Cardy (2004)

Theme one of this research, ‘The appearance of health’, explores the collaboration between the osteopath, the participant and the participant’s own innate healing ability. The influence of ‘something else’ or ‘The Breath of Life’ is also examined. It was found that there is a complex interaction between the fore-mentioned elements that makes up the experience of treatment by OCF. Although the research conducted by Cardy (2004) examined the experience of the ‘Breath of Life’ from a practitioner perspective, the findings are pertinent to those that emerged from this research. Cardy (2004) expresses the view that the osteopath’s role is one of catalyst for the body’s own healing ability and that the ‘Breath of Life’ assists this inherent healing ability. She states: ‘All practitioners expressed the view that holistic osteopathy is not concerned with identifying disease states or pathologies but acknowledges a living mechanism that is capable of restoring Health, and that the purpose of osteopathic treatment is to support this self-healing mechanism’ (p. 41). Therefore she concludes that the osteopath appears to have a role as a facilitator of the patient’s self-healing mechanism and is assisted by the ‘Breath of Life’.

The osteopaths in Cardy’s study along with the participants in the current research convey a feeling that the experience of treatment by OCF is often mysterious and inexplicable. Despite this fact, the experiences expressed are very similar. At some point both practitioner’s and patients of OCF seem to ‘surrender’ to the process and
relinquish the need to explain exactly what is happening. The act of ‘surrender’ in turn appears to lead to a heightened ability to sense changes taking place during treatment. The evolution of perception is a feature of the experience of the practitioners interviewed by Cardy as well as the participants in the current research. Cardy (2004) states that there are “issues of maturation and readiness” (p. 49) that a practitioner continually progresses through in order to perceive the ‘Breath of Life’. These issues included “Building more confidence in the system of osteopathy” (p. 51) being willing to “Step into a place of not knowing” (p. 53), acknowledging that there was “Somebody else at work” (p. 56) and finally “Learning to listen” (p. 58). Cardy states; “Opening up to something bigger, other or new requires letting go of the familiar, letting go of what appears to be known, safe and solid” (p. 54). The participants in the study followed a similar process whereby they gained confidence in the practitioner’s ability - either because of the way the osteopath related to them or through the experience of improved health after treatment – and were then willing to ‘let go’ or trust in the treatment process. Possibly during the act of ‘surrender’ the participants were able to enter a more relaxed state of being that further enhanced the treatment affect and their ability to perceive this affect. Many of the participants reported feeling like nothing was happening in their initial treatments but they became increasingly aware of physical and emotional sensations as time progressed, indicating an evolution of receptivity that parallels the experience of the practitioners in Cardy’s research.

This increased receptivity seems to lead to feelings of connectedness and the disappearance of boundaries. Once more the experience is common for both participants and practitioners of OCF. Nadia says:

*I know that the sense of peace that I feel is kind of because I feel so connected. Not just to the osteopath. Though I do feel connected to him... like his hands and my head don’t really have a boundary. But I feel more than that... like I am connected to the room and the building and the spaces in-between... right off to the horizon. I feel like I belong...to the universe and everything in it.* (Nadia, lines, 149-153)

This quote is directly comparable to the following words from a practitioner of OCF
What we’re talking about, there is no sense of one tissue being separate from another…it’s about seeing the whole, you know the person as a whole, and the person within the whole of their environment, and on and on, this planet, universe and so on (I1p5F) (Cardy, 2006, p. 64).

Both Nadia and the practitioner describe a feeling of continuity between the body and that beyond its boundaries. Therefore, it can be reasonably concluded that there are in fact parallels between the experience of the ‘Breath of Life’ by practitioners of OCF and patients of OCF.

**McFarlane (2006)**

McFarlane’s (2006) main themes all have relevance to this research. Her first theme “Before: The participants stories” introduced the idea that the participants backgrounds and current life situation have influence on how they experience treatment. McFarlane states that the participant’s history “consequently shapes the future, and colours the palette for future experiences of health and illness. Embedded in this history are the participant’s values, culture, and beliefs. “Previous experiences of health and illness play a role in the history of who that person is” (p. 65). It was also clear from the narratives collected in the current research that the participants’ background and personality had an impact on how they described their experience. Maggie, a matter-of-fact person who did not go looking for the spiritual, described her experience almost exclusively in terms of physical sensations and outcomes. In comparison, Vanessa, an alternative healer, depicted OCF on a more energetic level.

You work through that issue and you go into a place of that higher energy…blissful state. (Vanessa, lines, 195-196)

In her second theme ‘During: A little window of time’, McFarlane (2006) concentrates on the events occurring during the participants’ OCF sessions. This
theme included the sub-themes of ‘Some form of communication [was] happening’, ‘Relaxation’, ‘A neutral place of exchange’ and ‘Surrender’. Each participant experienced two different treatment sessions, one involving the practitioner’s clear intention to treat and the other a ‘sham’ or non-intention session. It was found that independent of the type of session, the participants reported experiencing the feeling that some form of communication was occurring between themselves and the practitioner. This communication resulted in a sense of connection, a word used frequently by the participants in the current study to describe aspects of their experience. Several of the participants in the current research suggested that this connection was possible because of a unique ability possessed by the practitioner involved. For example Maggie said:

*There’s something about her. Well… that’s what I feel. There’s something. She has a gift…* (Maggie, line 225)

McFarlane’s participants implied a similar feeling and she concluded that the connection formed between the practitioner and the patient was because of the “finding, seeing, and feeling, that the practitioner was able to do through her touch” (2006, p. 43).

Furthermore this communication was enhanced by the state of relaxation that they found during this ‘little window of time’, which may have resulted in part from the treatment setting. As discussed in ‘The inherent healing mechanism’ (p. 50), part of the osteopath’s role in healing may be to provide an environment in which the patient can relax. McFarlane (2006) says that “the ‘conversation’ that occurred between the participants and the practitioner was enhanced throughout the session by the relative ‘silence’ maintained by the practitioner” (p. 45). Even though both the intention and non-intention sessions in McFarlane’s research resulted in a feeling of relaxation, the quality of the relaxation experienced in the intention session enabled the participant and osteopath to reach a ‘neutral place of exchange’. This suggests that the change that occurs during treatment cannot be attributed to the setting alone. As McFarlane points out, the only difference between the two sessions is the intent of the osteopath and there is a difference between “the
relaxation gained from having had a lie down for 20 minutes from the experience obtained from having had the practitioner working with diagnostic and therapeutic intention” (McFarlane, 2006, p. 72). This suggests that intention is a key ingredient in the treatment process. Maggie observed that she felt a clear difference in the treatment effect on the days the osteopath lacked concentration.

Just occasionally… and she’s not in tune with me. And I don’t feel I’ve had the effect. But that doesn’t happen very often. But I feel her lack of concentration. It’s funny isn’t it, because even though it still works to a certain extent, I don’t feel that effectiveness… (Maggie, lines 233-235)

The ‘neutral place of exchange’ that McFarlane talks about seems to facilitate healing and is possibly the same ‘place’ that the participants in the current research reach when they report feelings of connectedness and peace. The following quotes from a participant in McFarlane’s research describe her feelings during an intention session.

I definitely felt a connection [between myself and the practitioner]…(I5P4)
I guess I’m not feeling as flustered, as I did when I first came here, yeah, I feel more peaceful. (I5P3) (McFarlane, 2006, p. 48)

In the final sub-theme, ‘Surrender’, McFarlane concludes, “once the body surrenders to the ‘Primary Physician’ the treatment can begin” (p. 52). Perhaps the evolution of receptivity described by Cardy (2004) and demonstrated by the participants in this research are examples of ‘surrender’. When a practitioner or a patient surrenders they enable the ‘Primary Physician’ to work and thus physical and emotional sensations and connection with the ‘Breath of Life’ are perceived.

In her final theme ‘After: The connection of mind and body” McFarlane (2006) discusses how the participants in her study experienced a positive effect on both mind and body. They reported ‘A change in outlook’ (p. 56) which resulted in both a sense of calm and an increase in motivation to get on with everyday tasks. In addition, McFarlane’s participants reinforce the finding that treatment effects continue for a period of time after contact with the osteopath finishes. McFarlane says that the work “may take minutes, hours, days or weeks, but it is a process that
often takes place outside the treatment room” (p. 45), reinforcing the finding that treatment effects continue for a period of time after treatment concludes.

**Summary**

Analysis of the interview transcripts indicated that the experience of treatment by OCF varied depending on the participants’ background, beliefs and current state of health, and the relationship they formed with the osteopath. The first theme "The appearance of health" introduced the idea that the participants experienced a positive shift in their health status through a combined interaction between the treating osteopath, their own innate healing ability and what A. T. Still referred to as ‘Great Architect’ or ‘Master Mechanic’.

The second theme ‘Sensations that signal change’ explored sensations firstly from a physical perspective and then from an emotional point of view and these experiences affirmed to the participants that treatment was working. The first sub-theme ‘A sort of tingling’ described physical sensations such as tingling, energy movement, muscle twitches and temperature changes within the body. It was found that these sensations were experienced at the site of contact with the osteopath’s hands and elsewhere in the body. In the second sub-theme the feelings associated with the emotional or spiritual self were the focus. The data suggested that the participants experienced a sense of connection with the practitioner as well as contact with the ‘Breath of Life’ via the practitioner. Both physical and emotional effects were felt during and after treatment, in some cases for days afterward. Many of the findings collaborated past research by Cardy (2004) and McFarlane (2006) as well as other OCF literature and the implications for these findings will be discussed in the final chapter, ‘Concluding thoughts’.
CHAPTER SIX – CONCLUDING THOUGHTS

Introduction

This chapter will evaluate the overall research process including the strengths and limitations of the study. Implications for future osteopathic education, OCF patients, osteopaths and the health profession in general will be considered. Finally potential research questions arising from the research will then be discussed. An overview of the preceding chapters is provided along with concluding remarks.

Evaluation of the research process - strengths and limitations

Hermeneutic phenomenology was the method of choice for this study, and along with its obvious strengths it also has limitations. The nature of phenomenological research dictates that the number of participants is small, due to the time intensive nature of interviewing and transcription. This dissertation was limited in its scale and therefore findings, by the time limits of a master thesis. Of course having such guidelines in terms of time and scope of research ultimately gives structure and organisation to the process, which is both helpful and necessary. While it could be argued that more interviews would produce an increased richness of data, this was not found to be the case. Five interviews were deemed sufficient due to the failure of new themes to emerge during the last two interviews.

Interviews would ideally be carried out soon after the participants received treatment in order to increase the accuracy of recall. In two cases in this study, several weeks had lapsed since attending the osteopath. This time lapse may have limited or altered the ability of the participants to remember exactly the meaning of the experience.

Interview questions did not delve into the participants’ backgrounds, previous experience of healthcare, or their state of health on presentation to the osteopath, although information regarding these factors did emerge from many of the
interviews. All of these factors appeared to have had an influence on the experience of treatment. Therefore even though there is only brief reference to these factors, it is acknowledged that they may have played a significant role in the differences seen in many of the participant experiences. Future research may possibly explore the ‘place’ from which the participants came to treatment.

In addition those participants recommended by the participating osteopaths were likely to have similarity in character, in that they were all judged to be sufficiently articulate to provide rich interview material. That is they all expressed a tendency to verbalise their OCF experiences. It is acknowledged that the fact that all the participants were female may also give a certain character to the narratives gathered. The language that they used to describe their experiences gave a certain shape to the perception and thus interpretation of those experiences. Males may have possibly given a contrasting account, maybe less emotive and more physiologically or mechanically descriptive. Future research should attempt to include both male and female participants, which would allow for different ‘male’ responsiveness to both treatment and questioning. It is impossible to say with any accuracy how the male experience of OCF may have differed. Consideration of participant ethnicity should also be taken into account in following research into the experience of OCF. The five participants in this research were New Zealand ‘Caucasians’ and different cultural groups may have contrasting experiences. To what degree these factors are limitations are not clear, as qualitative research of this scale does not generally require that the participants exhibit wide variation in terms of age, gender, ethnicity and background. It is acknowledged however that the small sample size and relative homogeneity of the participants in terms of gender, socio-economic status and ethnicity means that findings cannot necessarily be transferred to the general population.

The treatment philosophy of the referring osteopaths was not considered. Although they were all practitioners of OCF there are a number of different treatment models within the discipline. It might be expected that treatment carried out by a biodynamic practitioner compared to a structural practitioner could result in a
different experience. Future studies may include the use of a practitioner interview prior to conducting those receiving treatment, in order to give an insight into their treatment philosophy and their view of what is happening during treatment. McFarlane (2006) found that the intention of practitioner has an influence on the treatment experience and therefore this is another factor that may possibly need to be considered.

However, despite these limitations, this study does provide a rich description of the ‘lived experience of treatment by OCF’ and contributes to a body of knowledge that is sparse in nature. Osteopathic literature tends to be largely from a quantitative perspective, and while this approach is of considerable importance, there is a distinct need for research that addresses the complex nature of OCF. This research adds to the findings of Cardy (2004) and McFarlane (2006) who also explored aspects of OCF, and may help practitioners of OCF to correlate their own perceptions of treatment with those their patients report.

As previously outlined, phenomenology has as its goal, the exploration of the nature of a lived experience of a phenomenon. This method proved to be appropriate in order to illuminate the lived experience of treatment by OCF. By following a research methodology that is faithful to the research goal and providing a clear audit trail of the research process, the study has established credibility and rigor. The process of formulating the research question as a patient of OCF and progressing to the role of a researcher has enabled a wider view of the world of OCF to be explored.

**Implications of the research for education and practice of OCF**

This research has drawn attention to several areas of importance that may have implications for the way in which OCF is taught. Teachers of OCF may be warranted in reminding their students that some concepts are difficult to explain and understand in conventional terms. Furthermore permission to dream, feel, accept and get washed away by the experience of OCF in whatever form it may take should be given. In no way does this equate to permission to be lazy in the study of
OCF, for the practice by all accounts requires concentration and practice (Becker, 2001; Brooks, 2002; Jealous, 2003). However by giving students consent to share whatever experience, no matter how unconventional, with their peers may increase the overall understanding of OCF. It may be advantageous to compare that which the student performing treatment and that which the person being treated is experiencing to allow early correlation between practitioner and patient experiences. Students should be encouraged to share their experiences of treatment while their fellow students learn to treat, taking note of the range of experiences and how they evolve over time. Moreover, sharing of the post treatment effects of OCF maybe helpful to build up a history of possible experiences to share with future patients.

This research also suggests that more emphasis should be given to post-treatment effects. All the participants in this study reported feeling as though treatment was continuing, often for days after the treatment session, and therefore osteopaths should always convey this possibility to their patients.

Finally, this research highlights the powerful results of OCF that should be communicated as a possibility to both students and patients alike. Students of OCF would ideally receive mentoring and treatment experience alongside an experienced practitioner who would be able to provide guidance and feedback to the novice.

**Areas for future research**

The results of this study highlighted the subjectivity of the experience of treatment by OCF. In some respects this research has only served to add to the mystery that surrounds OCF. The experiences of the five participants in this research exhibit a number of similarities. However, due to the small sample size, and homogeneity of the group, these findings may not be representative of experience of OCF for all patients. Possibly, a similar study carried out by an independent researcher and five new participants, including males as well as females, may give the findings more transferability. Therefore it a recommendation for future research similar in
nature to this study, that addresses the limitations identified above would not only give weight to the findings of this research but also provide a possibly contrasting male view. It might also be interesting to conduct a survey of all OCF patients attending a particular practice to ascertain if the experiences reported by this group of participants are typical. It is possible that those patients referred by the osteopath are very atypical and the usual experience is something quite different.

As mentioned previously, there was no consideration of the treatment method or philosophy that the associated practitioners of OCF employed. Individual practitioners of osteopathy are free to interpret and apply the teachings of osteopathy in whatever way they choose within the scope outlined by the Osteopathic Council of New Zealand. There may be clear differences in experience by patients treated by an osteopath working structurally compared to one working with the biodynamic model. Currently there is no research that addresses such differences. The experience of treatment by OCF may vary depending just as much on the treating osteopath as the participants themselves. Thus it would be useful for future research to compare experiences of OCF between these two and possible other models. In addition, an interview could be carried out with the associated osteopath, both before and after treatment of the participant. This would provide an insight into their treatment philosophy as well as possibly providing a link between what the osteopath perceived or felt was happening to the participant and what the participant reported.

Interviews with the osteopath and with the participant immediately after treatment while the experience is still fresh in their minds may provide more accurate recollection. Research along these lines would serve to deepen the current understanding of the practice of OCF from both a practitioner and patient point of view.

**Concluding thoughts**

This research represents the experience of OCF from a patient perspective. It is
important to note that this is only one interpretation of any number of interpretations that could have resulted from analysis of the data collected. Other research from previous students of osteopathy, Cardy (2004) and McFarlane (2006) in particular, give complementary views that add to the body of knowledge related to patient experience of OCF. McFarlane’s (2006) research also provides some narratives of patient experience, while Cardy (2004) describes OCF from the practitioner point of view with an emphasis on the experience of the ‘Breath of Life’. These and other accounts have helped to build a more comprehensive picture of the total experience. Overall this research has shown that treatment by OCF results in a complex array of physical, emotional and spiritual experiences that result in a deep sense of connection between the patient, osteopath and ‘Breath of Life’.
REFERENCES


Greene, E., & Goodrich-Dunn, B. (2004). *The psychology of the body*. Philadelphia: Lippincot Williams & Wilkins.


Appendix A – Ethics approval letter

Dionne Greene  
43 Mt Albert Rd  
Mt Albert  
Auckland  

July 26 2007  

Dear Dionne  

Your file number for this application: 2007.733  
**Title:** The lived experience of osteopathy in the cranial field (OCF)  

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: 25 July 2007  
Finish date: 30 November 2008  

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.  

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

Yours sincerely  

Deborah Rolland  
Deputy Chair, UREC  

RMOL ref#: 962  
cc: Dr Elizabeth Niven  
Carla Sutton
Appendix B – Participant information sheet

An investigation of patient experiences of treatment in the Cranial Field of Osteopathy

About this research:
You are invited to take part in a project, which investigates the experience of treatment by osteopathy in the cranial field (OCF). I am interested in researching this topic from the perspective of the client in order to further understand the practice of OCF.

The researcher:
Dionne Greene, Masters of Osteopathy Student, Unitec New Zealand.

This project is being supervised by Dr. Elizabeth Niven, and Dr. Dianne Roy, Unitec New Zealand.

Taking part in the project:
This project will investigate your experience of OCF during and after treatment. This will be done through an in-depth interview, which will be tape-recorded and transcribed verbatim. Dionne will interview you 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 experiences of treatment by OCF. A copy of the transcript will be posted to you as soon as possible after the interview for you comment and verification of accuracy. You will
be able to withdraw any or all of the interview data form the research project up to two weeks after receiving you copy of the interview transcript. All identifying features will be removed from the information gathered and will be presented within the context of the complete group data.

**Any concerns:**

If you have any further questions or concerns please feel free to contact me directly on (09) 846 9682, 027 5328214 or dione.greene@xtra.co.nz.

If you wish you may also contact my principal supervisor Dr. Elizabeth Niven on (09) 815 4321 ext 8320 or eniven@unitec.ac.nz.

Thank you for reading the information sheet – please keep it for your records.
Appendix C – Participant consent form

An investigation of patient experiences of treatment in the Cranial Field of Osteopathy

PARTICIPANT CONSENT FORM

A research project submitted in partial requirement for the degree of Master of Osteopathy, Unitec New Zealand, 2007. This is a study of patients’ experience of osteopathy in the cranial field (OCF). It explores a patients’ perspective of treatment by OCF.

The research is being done by Dionne Greene (post-graduate student). Dr Elizabeth Niven and Dr Dianne Roy from the School of Health Science at Unitec are supervising the project.

Name of participant: ________________________________

I have seen and read the information sheet dated __________. I have had an opportunity to discuss the research with Dionne and to have my questions answered. I understand that I may seek further information from the researchers.

I understand that the research involves a single, face-to-face interview and that the interviews will be tape-recorded.

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

I understand that if I wish to withdraw my interview data from the study I may do
so until 2 weeks after being given the opportunity to verify the information collected in the interview.

I understand that my participation in the study is confidential, and that the information I provide will become anonymous in any report made on the study.

I have had enough time to consider my participation, and agree to participate.

Name:

Signature:

Witness:

Date:

Participant copy/researcher copy (delete one).

This study has been approved by the Unitec Research Ethics Committee for the period 25th July 2007 to 30 November 2008. 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 – Information for the participating osteopath

The Lived Experience of Osteopathy in the Cranial Field (OCF)

INFORMATION FOR PARTICIPATING OSTEOPATH

My name is Dionne Greene. I am currently in my second year of a master’s degree in osteopathy at Unitec New Zealand. For the purpose of completing the research component of my course, I have chosen to explore the phenomenon of experience related to treatment using osteopathy in the cranial field (OCF).

I intend to interview approximately five patients’ currently receiving treatment by OCF about their experiences both during and immediately after treatment. Study participants would each be interviewed once, for about an hour. The information gathered would be used to describe the nature of this experience, the forms that it takes and factors that may be related to it. Physical, spiritual, cognitive, and emotional experiences are of particular interest during, immediately after and in the following few days post-treatment.

Patient confidentiality is paramount and all participants will be offered the opportunity to retract any of their comments from the data after transcription. Access to the interview transcripts will be restricted to the supervisors and myself.

I would ask you to identify suitable participants and have you provide them with an information sheet that I will leave with you, outlining the research project. If the person were interested in being involved I would request that you ask them for permission to pass their phone number onto me. Once I receive their phone number I will contact them within 1-2 days and arrange a suitable time and place to
interview them. Alternatively they may wish to phone me directly. You will be asked to sign a non-disclosure agreement in order to protect the identities of clients that have been put forward as potential participants.

Thank you for your assistance in this project.

Dionne Greene
Primary Researcher
Ph 846 9682
Email: dione.greene@xtra.co.nz

Dr Elizabeth Niven
Principal Supervisor
Email: eniven@unitec.ac.nz

Dr Dianne Roy
Associate Supervisor
Email: droy@unitec.ac.nz

This study has been approved by the Unitec Research Ethics Committee for the period 25\textsuperscript{th} July 2007 to 30 November 2008. 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 E - Key words and concepts - initial analysis

<table>
<thead>
<tr>
<th>Participants Voice</th>
<th>Key Words</th>
<th>Concept</th>
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<tbody>
<tr>
<td>Maggie</td>
<td></td>
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<tr>
<td>I might experience feelings of warmth. Her hands are incredible. Her hands are instantly hot. She has amazing hands. (Maggie, line 172-173)</td>
<td>Warmth</td>
<td>Energy movement</td>
</tr>
<tr>
<td></td>
<td>Hot</td>
<td></td>
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<tr>
<td>I can just feel my whole brain clear. Blood rush to my head? I don’t know. That’s just like what it feels like. Like I have had a total blockage… not total of course because I’m still here. And suddenly I just feel I can just think clearly and move clearly… quite different. And energy I suppose. A-certain energy goes into you. (Maggie, lines 256-260)</td>
<td>Whole brain clear Blood rush to head</td>
<td>Energy movement</td>
</tr>
<tr>
<td></td>
<td>Think clearly</td>
<td></td>
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<tr>
<td></td>
<td>Move clearly</td>
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<td></td>
<td>Energy goes into you</td>
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<tr>
<td>I became very aware of my legs. And this happened on a regular basis when I went to Kate. When she started treatment my legs would jump like I had fleas. All over my legs would twitch. Little twitches right down. It was just like there were fleas jumping on my legs. That would last quite awhile. Sometimes 10 minutes. 5 minutes. Like a little twitch. I never used to get it originally… it was something that happened later on in treatments, then I used to get it quite regularly, when she first started the treatment. It was like little nerve twitches right down my leg. It was like something had been released and my legs were coming alive. Very strong. (Maggie, lines 261-268)</td>
<td>Legs would jump Would twitch Little nerve twitches Like something had been released and my legs were coming alive</td>
<td>Energy movement</td>
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<td></td>
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<tr>
<td>… she started working on me and all of a sudden… sal had my eyes closed… and all of a sudden I felt these waves. I could actually see them. I couldn’t … I didn’t just feel them I think I could see them when I think about it… Yes… just visually I could just see these waves. And they were very soothing waves. They weren’t scary waves or anything. They were very soothing and they were just … you know, floating along there quite nicely and… I must admit it was quite an experience. (Maggie, lines 24-30)</td>
<td>I felt these waves I could actually see them They were very soothing Floating along</td>
<td>Energy movement</td>
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<tr>
<td>But I know I had them once more, but I never ever experienced the strength of those waves again.I really felt my whole body. When I think about it… I really felt like my whole body was just waving along. (Maggie, lines 70-72)</td>
<td>Whole body just waving along</td>
<td>Energy movement</td>
</tr>
<tr>
<td></td>
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<tr>
<td>Yes… yes… yes it was like I was flowing with the waves. It was quite strange. I could actually feel them. I could feel the waves. I don’t quite know how… (Maggie, lines 77-78)</td>
<td>Flowing with the waves</td>
<td>Energy movement</td>
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<tr>
<td>They were quite faint. Really…yeah like a…yeah I suppose you know when you see waves on the hot pavement. Yes because I had my eyes closed. But I know I saw them. And I think… not sure. No I’m not sure about that, but they could have been a grey-blue colour. (Maggie, lines 81-84)</td>
<td>Waves on a hot pavement</td>
<td>Energy movement</td>
</tr>
<tr>
<td>Vanessa</td>
<td></td>
<td></td>
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<tr>
<td>(Describing the feeling of leaving her body) It’s a physical thing so…I feel it in my legs… I feel like everything starts to go quiet. It’s kind of in a way it’s almost like the beginnings of passing out. But it’s not as strong. And I leave… I … I get tingling in my legs. And I might even get tingling in my arms. (Vanessa, lines 31-34)</td>
<td>Everything starts to go quiet Tingling in my legs Tingling in my arms Not feel very steady Energetically they have left</td>
<td>Energy movement</td>
</tr>
<tr>
<td></td>
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<td>Tissues</td>
</tr>
<tr>
<td>I feel I lose my legs. If I was to walk I would not feel very steady on my legs. I know they are there, but energetically they have left. (Vanessa, lines 83-84)</td>
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</tbody>
</table>
own way. And I feel emotions leaving or coming over my body. It’s pressure. I might feel it in my stomach, feel it in my throat, in my heart. So just different feelings, mainly in the chakra areas. Sometimes I will feel it moving up (gestures to mouth). (Vanessa, lines 126-129)

Oh and heat. I might feel stuff shifting somewhere in my body… I might feel tingling going down my legs. Tingling or energy moving around my body. Pulsing. (Vanessa, lines 136-137)

It really depends on the session. Sometimes I feel amazing afterwards. I have a higher level of energy and perception. Happy and content. I think as I work through the different issues that are in my body. As they come up. Say something comes up. You work through that issue and you go into a place of that higher energy… blissful state. And then another thing will come up and you will kind of go down into that emotion… then I’ll have another session and at the end of that I’ll come back to that higher energy level. (Vanessa, lines 193-199)
Appendix F – Concepts and themes - second stage of analysis

<table>
<thead>
<tr>
<th>Participants Voice</th>
<th>Concept</th>
<th>Sub-Theme</th>
<th>Theme</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Nadia</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I just felt looked after... he nurtured me... I felt like there was hope. (Nadia, lines 7-8)</td>
<td>Nurturing</td>
<td>Therapeutic relationship</td>
<td>The Appearance of Health</td>
</tr>
<tr>
<td>I remember it quite vividly because it had such a positive effect on me. I left ...calm... At the time I attributed that to the talking though... not so much the treatment, but now looking back that might not have been quite the case. He just talked to me in such a way that like I said I finally felt hope. (Nadia, lines 17-20)</td>
<td>Nurturing</td>
<td>Therapeutic relationship</td>
<td>The Appearance of Health</td>
</tr>
<tr>
<td>I’m not actually sure when the first time was that I felt something. I think in the first session I was just so shut down...half dead really. No vitality at all. And maybe that’s why nothing registered. But steadily I have become more aware of sensations during treatment. (Nadia, lines 36-39)</td>
<td>Vitality</td>
<td>A Move Toward Health</td>
<td>The Appearance of Health</td>
</tr>
<tr>
<td>Often very intense. But then just as often very gentle and peaceful and... happy. And I always feel like I am gaining mental clarity... or emotional balance... that’s what I mean about it always being the same. That aspect is always the same. I get rebalanced. (Nadia, lines 39-43)</td>
<td>Mental/Emotional clarity</td>
<td>A Move Toward Health</td>
<td>The Appearance of Health</td>
</tr>
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<td>... like my soul... my essence... had been walled up in a cave and now this...this treatment... or this person.... I don’t know if it’s the osteopath... Anyway... but somehow that primal part of me that I had abandoned... that was frozen... lost ... was somehow found. Found and acknowledged... (Nadia, lines 261-264)</td>
<td>Mental/Emotional clarity</td>
<td>A Move Toward Health or A Sense of the Ineffable</td>
<td>The Appearance of Health Or Sensations</td>
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<td>I had injuries... problems... dissolve... dissolve painfully. Almost like the injury is on rewind. What I mean is... Like the reason for the injury... or the way I developed the problem... gets traced backwards. (Nadia, lines, 67-72)</td>
<td>Physical health</td>
<td>A Move Toward Health</td>
<td>The Appearance of Health</td>
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<td>I got woken up and reintroduced to the fact that I was alive and interacting with ... everything. (Nadia, line 162)</td>
<td>Mental/Emotional Clarity</td>
<td>A Move Toward Health</td>
<td>The Appearance of Health</td>
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<td>The osteopath that I saw was about the same age as me, and so, so gentle. I just felt looked after... he nurtured me... I felt like there was hope. Before he even put his hands on me really. He took a very detailed case history and that made me feel like he was really wanting to find out just where the problem started. About all sorts of things that nobody had asked me before. Things about my birth and childhood accidents and illnesses... what jobs I’d done in the past... hobbies... friends... all sort of things. Building up a picture of me that wasn’t just me at the moment I came to him. (Nadia, lines 5-8)</td>
<td>Nurturing</td>
<td>The Therapeutic Relationship</td>
<td>The Appearance of Health</td>
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<td>Well... each osteopath is different... and I’m different with each osteopath. I think that first practitioner was incredible. Maybe it was because he brought me out of a state of such... turmoil... woke me up. I was just so grateful. (Nadia, lines 258-259)</td>
<td>Nurturing</td>
<td>The Therapeutic relationship</td>
<td>The Appearance of Health</td>
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<td>Cranial osteopathy... seems to put me back together. It gets all the fragments, muddled up from the stress of life, and arranges them back perfectly. You know those boards at the airport... that show the arrivals</td>
<td>Vitality/Physical health/</td>
<td>A Move Toward</td>
<td>The Appearance of Health</td>
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and departures... they click across all the letters of the alphabet, but finally fall into the right sequence to make sense. Maybe at some point when we are really healthy all our words are spelt right automatically. But slowly they get confused and the words are mis-spelt or have letters missing. The osteopath puts his hands on and all those letters fall back into place... Fly back even... (Nadia, Lines 88-100)

When he put his hands on I didn’t feel like he was doing anything. He was just holding my head. It was nice... but I remember thinking afterward that he hadn’t really done any treatment as such. He didn’t even feel like he moved his hands. But I really wanted to go back even so. There was something going on. (Nadia, lines 11-12)

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<td>The Inherent Healing Mechanism – the Primary Physician OR The Therapeutic relationship</td>
<td>The Appearance of Health</td>
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<tr>
<th>Jennifer</th>
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| I felt with the first practitioner it felt like it was quicker. It felt like the symptoms diminished more. With the second one it felt like it was getting better but it was slower. If they were both very different and I liked both of them...but one felt like they had more... at the time... more was happening within my body perhaps. (Jennifer, lines 14-16)

Then I lay down and it felt ... really peaceful and relaxing. And I did feel ummm... changes in my body. I went into a really really deep relaxation and I really didn’t want it to stop. It felt lovely. (Jennifer, lines 35-37)

I sort of felt like it was like the two hemispheres of the brain sort of being realigned or getting rebalanced. And it felt... and then so of got into my whole body was getting more balanced (gestures in a circle)... in a circular motion. (Jennifer, lines 52-54)

The practitioner was very professional. Went through a detailed history, which I quite liked. And did a complete check up...quite medically sound. Checked out all my vertebrae even though I wasn’t going to get manipulated or anything. That felt really good. And then I lay down and it felt ... really peaceful and relaxing. And I did feel changes in my body. I went into a really, really deep relaxation and I really didn’t want it to stop. It felt lovely. (Jennifer, lines 22-25)

There felt like an enormous amount of relief around when she did the sacral work. Like that congestion went away. It felt like it was flowing better... the blood supply or something was flowing better around the pelvic area. (Jennifer, lines 67-68)

Heat and a lot of movement. Like my blood was flowing better... And I suppose floaty. But floaty in my head. (Jennifer, lines 84-85)

And it changed as well, where the pain would be. Like initially it started off as this terrible nerve pain in my ear and then it progressively went a little bit around my forehead. And affected the nerves around my eye and all down my face and a little bit down my throat and the nerves in my gums... inside... and it got better... the most dominant one... it still keep coming back into my ear, but it seemed to shift a lot around my forehead. And then it sort of got better. And now it’s settled. (Jennifer, lines 119-124)

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<td>The Appearancen of Health</td>
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