Contacting with Clarity –
The communicative purposes of osteopathic touch

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A research project submitted in partial fulfilment of the requirements for
the degree of Master of Osteopathy, Unitec New Zealand, 2014
Declaration

Name of candidate: Anneke Barrington

This Research Project entitled “Contacting with Clarity – The communicative purposes of osteopathic touch” is submitted in partial fulfilment for the requirements for the Unitec degree of Master of Osteopathy.

CANDIDATE’S DECLARATION

I confirm that:

• This 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: 2012-1026

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

Student ID Number: 1006406
Abstract

Objective: The aim of this qualitative study was to explore and describe osteopaths’ perspectives on the communicative purposes of their professional touch.

Background: Touch is a key defining feature of osteopathy. Physical contact between osteopaths and their patients is essential to communication during examination, diagnosis and treatment. Yet there is no existing research that describes the communicative purposes of touch from the perspective of osteopathic practitioners.

Methods: Purposive sampling led to the recruitment of five participants who were osteopaths registered and practising in New Zealand. Data were collected during single semi-structured interviews, which were then transcribed and analysed using the framework of interpretive description.

Results: Nine sub-themes emerged in the data, which were grouped into three key themes. Theme [A] Negotiation – communicating through the process highlighted the ways in which osteopaths use touch to communicate with their patients through the stages of a consultation. Theme [B] Reassurance and Empowerment – a therapeutic embrace explored how osteopathic touch communicates qualities of reassurance, care and empowerment which are considered invaluable components of the therapeutic process. Theme [C] Awareness – ensuring professionalism emphasised the need for osteopaths to maintain a context that is always appropriate for their professional touch, through the use of consent and boundaries, and conveying competence.

Conclusion: Touch is an important tool used by osteopaths to communicate with their patients. For the participants, clarity and continuity are two key qualities of osteopathic touch that aid its communicative intentions. These include engaging the patient, establishing trust, providing reassurance and care, allowing patient involvement and empowerment, and conveying professionalism. Limitations of this study and indications for future research are considered.
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Introduction

Touch is both a central component of social interaction and an integral element of osteopathic practice. The physical contact that occurs between osteopaths and their patients is essential to the processes of examination, diagnosis and treatment, and also contributes to practitioner-patient communication. Yet there currently exists no published research concerning the role of touch in osteopathy, including no qualitative accounts of osteopaths’ professional experiences of touch.

In fact, the concept of touch has not been widely explored within most of the manual therapy professions to which it is so crucial (Lederman, 2005). However, one recent unpublished qualitative study (Consedine, 2007) examined and described the patient’s experience of touch during a consultation with an osteopathic practitioner. The suggested indications for future research included an investigation into the practitioner’s experience of touch, stating that it could enable researchers and practitioners to “understand and appreciate the subtle differences that exist in the perceived quality of touch that occurs in the osteopathic session” (Consedine, 2007, p. 106).

This thesis aimed to take up this suggestion of further research, to provide greater understanding of the phenomenon of touch from the perspective of osteopaths. Qualitative research methodology was used to investigate osteopathic touch from the practitioner’s point of view, exploring osteopaths’ use of touch as a tool to communicate with their patients, and their interpretations of the role that touch plays in the therapeutic relationship.

Purposive sampling led to the recruitment of five participants who were registered osteopaths practising in New Zealand. Data were collected during single semi-structured interviews, which were then transcribed and analysed using the framework of interpretive description, which takes inspiration from hermeneutic phenomenology. Data analysis drew out key themes in the data, suggesting that touch plays a crucial role in the communication that occurs between an osteopath and their patients, and thus the therapeutic process.

The Oxford English Dictionary defines touch as “to bring one’s hand or another part of one’s body into contact with; to come or to bring into mutual contact” ("Oxford Dictionaries," 2010). For the
purposes of this thesis, the definition of touch will include all physical contact that occurs between an osteopathic practitioner and their patients, within the professional setting.

This thesis begins in Part One with a review of literature relevant to the study topic and an outline of the methods and methodology used in the study. Part Two takes the form of a manuscript written according to the guidelines of the International Journal of Osteopathic Medicine, which are outlined in Appendix A. Part Three is a section of appendices which includes additional conclusions (Appendix B), a summary of the data analysis process (Appendix C), ethics approval (Appendix D), participant information sheet (Appendix E) and consent form (Appendix F), as well as the interview schedule used in the study (Appendix G).
Part One: Literature Review and Methodology
Literature Review

Literature on the subject of touch is limited within most fields, and very little exists within the field of osteopathy. Therefore, this review will begin by considering touch in relation to development and attachment to provide context about interpretations of touch that are relevant to the study. It will then briefly examine the use of touch as therapy within psychology, before considering the role of touch in communicating emotion, and touch as a tool for patient-practitioner communication. Touch research within the field of nursing will be highlighted, as this is a healthcare domain that, unlike many others, has placed significant emphasis on the subject. Key literature about touch within the broader context of manual therapy will then be considered. Because the undertaken literature search revealed no published research specifically about touch within the field of osteopathy, the review will conclude by examining recent commentary and key unpublished qualitative studies about touch within the international osteopathic profession.

The Sense of Touch in Relation to Development and Attachment

Of relevance to osteopathy is the fact that there is no specific organ of touch; it is the body as a whole that receives tactile information. Philosophical understanding of touch takes the view that touch is unique from the other human senses because it is a two-way experience, it requires no medium, and it is the first sense to develop (Nathan, 2000).

Touch is certainly the most developed sense at birth and it contributes to cognitive and emotional development during infancy and childhood (Field, 2001; Hertenstein, 2002). Bowlby’s (1969) attachment theory includes the concept that a person’s early experiences of physical contact, particularly between parent and infant, enable them to associate human touch with the feelings of physical and psychological well-being. Touch in the form of regular neonatal massage has been shown to have beneficial psychological and physiological results in full term and preterm infants (Field, 1998). It is also proposed that early touch experiences contribute to some of the significant psychological responses that occur in physical therapy (Lederman, 2005; Nathan, Chaitow, & Lousada, 1999).
Psychology and Touch

Although in fields such as psychiatry, touch has traditionally been considered inappropriate, recent research in psychiatry has shown that touch can be useful in psychiatric treatment once a caring relationship has been established (Salzmann-Erikson & Eriksson, 2005). A qualitative study investigated the meaning of physical contact for patients who have been treated for psychosis. Results revealed that touch can allow one's feelings to be acknowledged and creates a sense of affinity, which is crucial to the search to feel a sense of belonging within a community (Salzmann-Erikson & Eriksson, 2005).

Touch has also been integrated into certain areas of clinical psychotherapy. Early advances by Wilhelm Reich saw the therapist facing the patient and making physical contact when necessary, rather than being a removed observer (Nathan et al., 1999). Following this, other body-oriented psychotherapies have developed such as biosynthesis, biodynamics and Gestalt therapies (Milne, 1995; Nathan et al., 1999). Leijssen (2006) explains that the use of touch in psychotherapy can provide care and support, and encourage openness and self-expression.

Communication and Emotion

Nathan (2000) highlights the importance of touch in the context of communication, in which non-verbal communication has the ability to convey messages that verbal communication can not. According to Hertenstein, significant literature indicates that touch serves communicative functions between caregivers and their infants, including soothing and regulating the infant’s state, and communicating positive or negative emotion (Hertenstein, 2002). Although the significance of touch to the communication of emotion has not been widely studied, research has shown that touch communicates the hedonic values of emotion (positive or negative) and that it can amplify the intensity of vocal or facial displays of emotion (Knapp & Hall, 2009).

In addition to this, a study of emotional communication in adults demonstrated that touch effectively communicates distinct emotions, including anger, fear, happiness, sadness, disgust, love, gratitude and sympathy (Hertenstein, Holmes, McCullough, & Keltner, 2009). Robustness of
the study was enhanced because participants were unacquainted and allowed to touch research partners on the whole body in any manner they chose, in order to communicate specific emotions.

**Patient-Practitioner Communication**

According to Williams (1997), touch is a form of non-verbal communication that is important for a successful therapeutic relationship, and can be an important element of patient-practitioner communication. An observational study examining verbal and non-verbal communication between physical therapists and patients with back pain found that touch was the most common non-verbal behaviour used (Roberts & Bucksey, 2007). A study investigating patients’ experiences of massage in Psychomotor Physiotherapy (Ekerholt & Bergland, 2004) showed that there is a non-verbal dialogue between practitioners and patients, which is supported by verbal communication, and the combination of the two improved the therapeutic process.

A qualitative examination of UK osteopaths’ clinical decision making and therapeutic approaches (Thomson, Petty, & Moore, 2014) included an interpretation of osteopaths’ interactions with patients as being patient-focused. This involved talking and listening, helped to construct knowledge of the patient as a person, and enabled the participants to learn from their patients. Silverman et al. (2005) and Billings and Stoeckle (1991) argue that touch is one of numerous factors that have the ability to communicate practitioners’ interest in the patient.

Chang (2001) found that touch is thought to create an emotional bond between patient and caregiver and is necessary to promote positive psychosomatic changes. A qualitative study in northern Sweden interviewed twelve healthcare professionals to understand the meaning of lived experiences of giving touch in care of older patients (David Edvardsson, Sandman, & Rasmussen, 2003). The findings showed that giving touch in the care of older patients is a transforming experience for the carer, in which they perceive themselves as a valuable person and as a professional capable of easing patient suffering. They also become able to see the person behind the disease as a human being.

In a qualitative research paper completed at the British School of Osteopathy that examined osteopaths’ understanding of empathy, it was discovered that osteopaths found their highly
experienced and sensitive palpation skills to be a key tool for empathising with patients (Jones, 2010). Osteopaths highlighted touch as an alternative or additional approach to empathising with patients, explaining that physical contact with patients is a way to feel their discomfort and pain, either physical or emotional.

The relationship between practitioner and patient was also examined in a constructivist grounded theory qualitative study which interviewed twelve UK registered osteopaths about clinical decision-making and therapeutic approaches in osteopathy (Thomson, Petty, & Moore, 2013). Participants’ therapeutic approach influenced their approach to clinical decision-making, the level of patient involvement, their interaction with patients, and therapeutic goals. Several participants focused on control and responsibility of patients’ problems, and patient passivity. On the other end of the spectrum, some participants emphasised patient learning and patient facilitated control of treatment direction. There was only one mention of touch in this study, in the context of palpation and a resulting sense of restriction in tissues, which was acknowledged by one of the participants who viewed their practice in terms of technical rationality.

**Touch Research in Nursing**

While touch within modern medicine is largely technical and procedural in nature, recent nursing literature focuses on the human significance of touch as an expression of care (Nathan, 2000). Prior to 1990, the majority of research focused on defining touch, categorising types of touch and explaining its purpose (O'Lynn & Krautscheid, 2011; Routasalo, 1999). Types of touch described in nursing research have been categorised according to purpose, such as instrumental or necessary touch, expressive or non-necessary touch, and protective touch (Estabrooks, 1989). Necessary touch has been described as deliberate and task-orientated, and non-necessary touch as more spontaneous and affective (Routasalo, 1999). Protective touch which may prevent a potentially dangerous event from occurring is not often discussed in the literature (O'Lynn & Krautscheid, 2011).

Since the 1990s, the majority of nursing research has considered how often these types of touch are used, with which parts of the body they are associated, and the broader perceptions of touch held by nurses and patients. It has been noted that one encounter between a nurse and a patient
may involve several types of touch (Estabrooks, 1989), but it has not generally been specified how to distinguish between the types of touch (Mulaik, Megenity, Cannon, & Chance, 1991; O' Lynn & Krautscheid, 2011; P. Routasalo & Isola, 1996). Gender of nurses has also been emphasised in research about how nurses perceive touch, with a stated fear held by male nurses of their touch being misinterpreted by patients (O' Lynn & Krautscheid, 2011).

A recent qualitative study sought to describe the attitudes of laypersons about intimate touch provided by nurses. Results demonstrated that participants valued clear communication about touch, that they preferred to be given choices about touch, and that they preferred to be touched professionally. The conclusion made was that nurses and other healthcare professionals who provide intimate care should have awareness about patients’ attitudes towards touch (O’Lynn & Krautscheid, 2011).

Many researchers have associated certain themes with nursing touch, including connection and presence, reassurance, spirituality, and caring (Chang, 2001; Fredriksson, 1999; Gleeson & Timmins, 2005; Sundin & Jansson, 2003). Estabrooks and Morse (1992) investigated nurses’ touching style and found that it is learnt during three stages - from the nurses’ cultural background, while in nursing school and during constant interaction while working. This study also found that from the nurses’ point of view, the touching process is composed of two stages: entering and connecting.

**Manual Therapy and Touch**

Similar to touch research in nursing, research within the context of manual therapy provides insight into the types of touch used. A study which used video analysis to observe communication between physiotherapists and their patients, divided touch into the following categories: instructional, examination, supportive, procedural and caring (Talvitie, 2000). Another qualitative study identified four types of touch used by physical therapists within a treatment session – caring, therapeutic, assistive, and touch used to perceive or provide information (Helm, Kinfu, Kline, & Zappile, 1997). The paper also identified factors which influenced acquisition of a touching style – family and culture, education, and clinical experience. However, the report lacked a clear account of the theoretical framework in which the data was examined. Also, the categories of the
structured interview format reflected the conceptual framework that resulted from the study, which gives no certainty that the expected categories did not shape the findings.

Results of a more recent study divided touch in the physiotherapy setting into eight single intent categories (Roger et al., 2002). These categories, in order of how frequently they were identified, were: assistive touch, preparation, providing information, caring touch, therapeutic intervention, perceiving information, security and building rapport. The research also highlighted the need for the physiotherapist to adapt their touch based on observation of patients’ needs, and the role of clinical experience in the acquisition of a touching style. This study has high reliability and rigour, as the results were substantiated by triangulation, peer examination, use of supporting quotes, and participants’ checking of data. The methodology was objective, with the use of both qualitative and quantitative methods – fifteen experienced physiotherapists were videotaped treating two to three patients; the participating physiotherapists watched the tapes and reported on the types of touch used, and each was involved in a semi-structured interview.

In a qualitative study that explored professional values of Australian physiotherapists, almost one third of the participants valued the maintenance of boundaries, considering it essential due to the hands-on nature of their work and the level of trust ascribed to them by patients (Aguilar, Stupans, Scutter, & King, 2013). This observation indicates that boundaries in relation to touch may be an important tool for maintaining professionalism within manual therapy fields.

This literature review revealed no existing research into touch within the chiropractic field. However, a chiropractic commentary by Davis and Bove (2008) claims that the act of touch itself, when performed during diagnostic procedures, can have a positive psychological and physiological impact. They also argue that intention-driven touch during treatment communicates confidence and a healing intention on the part of the chiropractor (Davis & Bove, 2008). Consideration of patient comfort in relation to touch was mentioned in a qualitative investigation of patients’ perspectives of informed consent for chiropractic care (Winterbottom, Boon, Mior, & Caulfield, 2014). The study identified a patient/practitioner feedback loop in which participants and practitioners discussed the amount of pressure applied and the level of comfort; this was considered important to minimising the perception of risk of physical harm.
Touch in Osteopathic Literature

The concept of touch is not often mentioned within osteopathic texts, with several key exceptions including Lederman (2005), who explores therapeutic intent regarding touch, different types of touch as forms of expression, and the interpretation of touch. A chapter about touch in an unpublished study guide from the British School of Osteopathy reiterates that there is very little literature on touch and suggests this is because it is largely taken for granted (Nathan, 2000). Nathan (2000) claims that touch as a sense deserves greater attention in osteopathic literature, and hopes for future osteopathic research on touch because osteopaths are in “a privileged position in our work to understand touch in a deep way that can add considerably to the corpus of medical therapeutic knowledge” (Nathan, 2000, p. 1).

Key osteopathic textbooks discuss palpation (Chaitow, 1997; Ward, 2003), which is defined by Oxford Dictionaries (2010) as the examination of a part of the body by touch, especially for medical purposes. While palpation is technical and diagnostic in nature, touch is defined as “to bring one’s hand or another part of one’s body into contact with; to come or to bring into mutual contact” (“Oxford Dictionaries,” 2010). The word touch also has emotional meaning other than just a faculty of perception through physical contact, such as to affect or concern; to produce feelings of gratitude, gratitude or sympathy in (“Oxford Dictionaries,” 2010). Nathan (2000) argues that the efficacy of touch within osteopathy would be limited considerably if its use was restricted to the procedural nature of palpation. He outlines a number of non-procedural considerations of touch, including the expressive and emotional nature of touch, the mutual component – that to touch someone is also to be touched, the concept that some people might need to be held in order to be healed, and the importance of the practitioner’s awareness of their own personal agenda around touching (Nathan, 2000).

Elkiss and Jerome highlight that touch in an osteopathic setting is more than just a data-collecting palpatory process, but an “intensely meaningful, heartfelt, therapeutic interaction with touch as the interface” (Elkiss & Jerome, 2012, p. 515). Osteopathic touch is considered to be a method of communicating empathy that is complemented by the use of verbal communication.
Osteopathic Commentary on Touch

A German Osteopathic Congress in Berlin in 2008 included an aim to investigate the phenomenological experience of touching and being touched within the context of osteopathic care (Donnelly, 2009). According to Donnelly’s (2009) review of the conference, some presentations emphasised the practitioner’s experience, and awareness, of touch, which provides further evidence of the relevance of this subject to the field of osteopathy. However, none of the presentations relating to osteopaths’ experience of touch offered a reflective commentary on the process (Donnelly, 2009), highlighting the need for a qualitative study that seeks detailed reflection on this subject directly from osteopaths.

Touch was the theme of an osteopathic professional development course in London, which aimed to explore “what makes touch therapeutic beyond its direct mechanical/physiological effects and how this awareness can be used to enhance the quality of the therapeutic process” (“Touch as a therapeutic intervention,” 2011). Themes discussed included the psycho-physiological aspects of touch, touch as communication and intention, touch as silent dialogue, touch and emotion, and the development of therapeutic touch.

Although awareness of the significance of touch may be increasing within the osteopathic profession, the lack of osteopathic research into touch means that information is imparted from the personal experience of individual practitioners and touch research within other modalities, without the utilisation of evidence from in-depth research that explores the experiences of osteopathic practitioners.

Qualitative Research on Touch in Osteopathy

The experience of osteopathic touch from the point of view of the patient was explored in an unpublished qualitative study (Consedine, 2007). The research is comprehensive and rigorous, reflected in the use of reflexivity by the researcher to examine his preconceptions prior to the study and to confront his bias during data analysis, processes recommended by Lincoln and Guba (2000). The study also makes use of both investigator and theory triangulation by utilising multiple
perspectives in the data analysis process, tools noted by Janesick (1994) to increase rigour. Verbatim quotes are used in the reporting of results as a way of grounding themes firmly in the data.

One of the major conclusions of the study was that, for the patients interviewed, the experience of touch in an osteopathic session involves a sense of care and security. Touch is seen to constitute an important part of the therapeutic relationship for the participants, as it supports and validates their experiences, and it also communicates practitioner humanism and professionalism (Consedine, 2007). The study raises several themes of relevance to an exploration of touch from the osteopath’s point of view, including the concept of support as part of the therapeutic process, the experience of care, tenderness or reassurance in the practitioner’s handling, the connection between touch and the maintenance of clinical distance and boundaries, and the conveyance of clinical competence and confidence through touch (Consedine, 2007).

An unpublished Austrian thesis (Schuster, 2007) aimed to explore touch, perception and communication in the context of osteopathic treatment. It is essentially a review of touch literature in the fields of physiology and psychology which relates this literature to the context of an osteopathic treatment. The intention of the review appears to be an emphasis on exploring and valuing the relevance of types of touch other than just tactile and technical. However, the translation into English is poor and difficult to interpret. Also, the thesis does not include direct perspectives from osteopaths.

A dissertation project completed at the British School of Osteopathy (Grace, 2000) used qualitative interviews with eighteen osteopaths in the aim of providing a platform from which future research into touch could begin. The study revealed communication as a key theme, discovering that osteopaths wish to communicate their motives through touch, especially the intent to care for their patients; and that osteopaths become highly effective communicators through the use of touch. It also highlighted that osteopaths have expertise with touch, which is built up with experience. However, the participants were all at the time employed by the British School of Osteopathy, which could be viewed as a form of research bias. The study was also limited by being very broad with ambitious research questions which meant the results did not provide much depth. This was compounded by the reliance on largely quantitative methods of data analysis for a phenomenon that could have been more richly analysed using largely qualitative methods.
Another shorter unpublished enquiry aimed to identify osteopaths’ views on the significance of touch when treating elderly patients (Lisboa, 2008). The literature review is not comprehensive and the question list is brief and limited, focusing largely on osteopaths’ interpretations of how they believe their touch affects elderly patients. Despite this focus, the paper does reveal some general findings about osteopaths’ interpretations of touch: osteopaths consider touch as part of a package of care and they view touch as either procedural or healing in nature.

Combined, these qualitative studies suggest the significance of touch as a form of non-verbal communication within an osteopathic treatment session. However, the majority of these studies are neither published nor comprehensive, indicating a need for the significance of touch to be explored fully from the osteopath’s viewpoint within a comprehensive study.

Summary

This chapter has outlined literature relating touch to human experience and more specifically the health professions. It has summarised existing research about patient-practitioner communication, and touch in the healthcare settings of nursing, manual therapy, and osteopathy. The following chapter will explore the methodology that guided the research process as well as the practical applications of the chosen research methods.
Methods and Methodology

Methodology

A qualitative research approach was utilised for this study, partly due to the significant lack of literature on the role of touch within osteopathy. Morse and Field (1996) explain that qualitative research methods are commonly used when an area of research is not well examined. Similarly, Thorne (2008) points out that qualitative research seeks to generate empirical knowledge about human phenomena for which measurement is inappropriate or premature, but for which depth and contextual understanding would be useful. Qualitative research takes an holistic approach without reducing research participants to functioning parts (Morse & Field, 1996). This approach is suited to osteopathic research because osteopathy as a form of health treatment is intended to be holistic in nature, acknowledging that parts of a whole are in intimate connection and cannot exist or be understood independently of the whole ("Oxford Dictionaries," 2010).

‘Interpretive description’ was the chosen framework used for this study because it aims to integrate knowledge gained from inquiries into human experience with the reflective clinical reasoning process, “searching for underlying meanings that might further illuminate what is happening and develop a deeper appreciation toward what would ultimately be the optimal clinical response” (Thorne, 2008, p. 50). This approach takes inspiration from hermeneutic phenomenology yet it allows the health researcher to create a design logic suitable to health research aims (Thorne, Kirkham, & MacDonald-Emes, 1997). Phenomenology seeks participants’ descriptions of their lived experience of a phenomenon. Hermeneutic phenomenology focuses on meaning and interpretation, identifying researcher biases and assumptions and considering them essential to the interpretive process (van Manen, 1997). The researcher actively acknowledges their own experiences of the phenomenon and reflects on how they may influence the research process, so that the researcher’s unique perspective is utilised during the data interpretation process (Koch, 1996).

This significance of the researcher’s perspective is apparent in interpretive description, with the researcher considered to be the interpreter, responsible for ultimately determining what constitutes data, which data has relevance, and how conceptualisations are structured (Thorne,
Within the framework of interpretive description, the researcher is free to draw upon data analysis guidelines provided within the body of qualitative methodological literature, as long as the researcher actively comprehends data, synthesises meanings, theorises relationship and re-contextualises data into findings (Thorne et al., 1997). The approach was also suited to this particular project because it is amenable with smaller scale qualitative investigations of phenomena that can inform clinical understanding.

Recruitment and Sampling

According to Morse and Field (1996), appropriateness is one of the crucial principles that should guide qualitative sampling. Appropriateness refers to the identification of participants who can most accurately inform the research in relation to the aims of the study (Morse & Field, 1996). Therefore, purposive sampling was used in this study, so that participants were recruited according to their experience, based on the rationale that individuals with extended experiential background are best equipped to provide access to the phenomenon (Thorne, 2008). Invitations of participation were sent to osteopaths with at least five years’ experience who practice using a range of treatment styles. It was believed that osteopaths with a minimum of five years’ experience would be comfortable with their practice and in a position where they would be able to reflect on their use of touch. Exclusion criteria excluded osteopaths who practice solely using osteopathy in the cranial field because it was considered that osteopaths who use a range of treatment styles would provide richer data about the different types of osteopathic touch.

Although participants were not required to be graduates of a specific formal training programme, in order to meet the inclusion criteria they had to be registered to practice with the Osteopathic Council of New Zealand and be currently practising in this country. Inclusion criteria also expected that all participants had experienced the phenomenon – the experience of touch within the context of osteopathic practice. The selection of osteopaths to invite was based on the researcher’s knowledge of osteopaths developed as a student of the osteopathy course at Unitec, as well as recommendations from tutors and osteopaths.

Congruent with qualitative approaches that seek an in-depth exploration of the phenomenon (Thorne, 2008), the study used a small sample size of five interviewees to provide richness and
depth of information. This sample size was also guided by the number of participants used in recent research projects of similar scale to this one (Consedine, 2007; Mitchell, 2005). Of the five participants, three were female and two were male. Two were educated in osteopathy at Unitec Auckland, two at the British School of Osteopathy, and one at the European School of Osteopathy.

Data Collection

Interviewing was the sole data collection method, which suited the aim of the project to examine the phenomena of touch from the perspective of osteopaths. Data were collected during single, in-depth, semi-structured interviews with five osteopaths registered and practising in New Zealand, with each interview approximately one hour in duration. Four of the interviews were face-to-face and one was an online audio interview conducted via the Skype application, a software program that uses the internet to make audio/video calls. Prior to the recording of interviews, participants were given an information sheet (Appendix E), which was fully explained to them before they signed the participant consent form (Appendix F).

A pilot interview was conducted at the beginning of the data collection process, to train the researcher in developing effective communication and to test interview questions. Prior to the commencement of further interviewing, a period of reflection on this initial interview allowed for refinement of the areas of focus for the study. Data from the pilot interview were included in the final study. A theme list was constructed using concepts arising from the literature review and pilot interview, which was used as a guide during interviews to ensure a broad discussion of issues relevant to the study topic. Please refer to Appendix G for this interview schedule. After the first three interviews were completed, a period of reflection occurred in which this list of themes was expanded and revised in relation to data emerging from the existing interviews. This allowed for refinement of direction for the final two interviews, to ensure that the research questions were well covered.

Each interview was recorded and transcribed personally by the researcher prior to the next interview taking place, which served to maintain confidentiality for the participants. It also enabled constant reflection on interview technique and resulting development of skill. This early
engagement with the emerging data contributed to continuing reflection on the researcher’s own developing ideas about the phenomenon.

**Data Analysis**

Data analysis in much qualitative literature is broken down into a step-by-step sequenced operation, but Thorne (2008) argues that the process of analysis is actually more complex than this. Interpretive description does not prescribe a sequence of steps for data analysis. Instead the process is outlined as comprehension of data, synthesis of meanings, theorisation of relationships and recontextualisation of data into findings (Thorne et al., 1997). However, guidelines for the complex process of data analysis can provide a useful framework. Within the interpretive description approach, the research can be informed by data analysis guidelines in qualitative literature. As outlined below, this study drew upon van Manen’s hermeneutic perspective (1997), in which formulation of a thematic understanding is seen not as a rule-bound process, but as a free act of seeing meaning.

Once interviews had been conducted, interview transcripts were given to the participants for checking, to enhance the credibility of the data (Sanders, 2003). Immersion in the data led to the identification of thematic statements, using van Manen’s three methods for isolating thematic statements (1997). The detailed reading approach involved looking at each sentence or groups of sentences to understand what they revealed about the phenomenon in question. Next, the selective or highlighting approach determined which statement revealed the most about the phenomenon. Then the holistic reading approach looked at the text as a whole and aimed to identify notable phrases that capture its fundamental meaning. Within this process of immersion in the data, formulation of meanings were constructed and organised into clusters of themes and sub-themes, which were then validated by text from the original descriptions (Sanders, 2003). Refer to Appendix C for a summary of the data analysis process, and to Appendix B for additional conclusions that were drawn from the data but not included in the final study report.
Maintenance of Rigour

Historically there has been a lack of consensus about the best ways to ensure rigour within qualitative research; however transparency is agreed to be essential (De Witt & Ploeg, 2006; Koch, 2006; Mays & Pope, 2000; Porter, 2007; Rolfe, 2006). De Witt and Ploeg (2006) use the terminology ‘openness’, meaning that the study is opened up to scrutiny through explicit and systematic accounting for decisions. The most successfully used method of applying transparency is the use of an audit trail, a written record that provides evidence of decisions made throughout the research process, allowing the reader to ‘audit’ as they read, judging the process by logic and their own experience (Bradbury-Jones, 2007; Rolfe, 2006; Thorne, 2008). In addition, an electronic journal was used throughout the proposed project, which acted as a record for audit, providing dates, outlining key decisions and the reasoning behind them.

Rolfe (2006) argues that as well as recounting the actual course of the research process, a quality audit trail should also explain the rationale behind decisions, and provide reflexive commentary. This concept of reflexivity is widely emphasised as a key tool in the maintenance of rigour within qualitative research (Bradbury-Jones, 2007; Koch, 2006; Koch & Harrington, 1998; Mays & Pope, 2000; Rolfe, 2006; Thorne, 2008). Bradbury-Jones (2007) advocates that a research journal also be used as a reflexive journal, to help the researcher to reveal subjectivity and how it affects the research. Reflexivity involves awareness of how the researcher and the research process can shape the collected data (Mays & Pope, 2000) and critical reflection on oneself as a researcher (Bradbury-Jones, 2007). Therefore, the electronic journal kept during this project also acted as a reflexive journal, in which personal ideas, thoughts and feelings about the phenomena and the research process were recorded and reviewed. Refer to Appendix C for an excerpt from the reflexive research journal.

The principal researcher personally transcribed and reviewed each recording between interviews, to review interviewing technique and to allow for reflection on the researcher’s own developing ideas about the phenomena. The ideas arising from the interviews during data analysis were regularly reflected on to confront any ongoing researcher bias. Because subjectivity needs to be made explicit from the outset (Bradbury-Jones, 2007), personal and intellectual biases of the researcher, and preconceptions about the topic, were identified at the start of the research
process. This was achieved through the researcher being interviewed by another qualitative researcher using the same interview schedule to be used in the study.

Although criticised by some, triangulation techniques have been commonly used to increase the rigour of qualitative studies (Janesick, 1994). Triangulation involves the use of multiple theories, methods, approaches or researchers to obtain a more complete picture of a phenomenon (Mays & Pope, 2000). The study used investigator triangulation in the form of consultation with the research supervisors, and theory triangulation through re-examining data and emerging themes in relation to other fields of study.

Thorne (2008) suggests some excellent tools for maintaining rigour during the process of data analysis, which were utilised in the study. These included avoiding ‘premature closing’, or not assuming the first ‘light bulb’ moment in analysis to be the most meaningful and important; avoiding misinterpretation of frequency, which is the assumption that concepts are more relevant or important if they occur frequently; and being aware of the potential for ‘over-inscription’ of self, which involves periodically stepping back from the data to challenge intellectual linkages that are being formulated (Thorne, 2008). Refer to Appendix C for further detail relating to the data analysis process. Rigour was maintained during the writing process by aiming for a balance between the voice of the study participants and the researcher’s explanations or interpretation (Thorne, 2008). Verbatim quotes were used to ground the themes more firmly in the data and to provide ‘resonance’, which allows the reader to intuitively perceive the meaning of the phenomena (De Witt & Ploeg, 2006).

**Ethical Considerations**

Ethical approval for this project was granted on the 18th of April 2012 by the Unitec Research Ethics Committee, which was then renewed for one year, with final data collection completed prior to 18th of April 2014. The research process included the following procedures and guidelines to ensure the ethical standards of the study. Refer to Appendix D for the letter of ethics approval.

The subject of consent was addressed by ensuring that potential participants were fully informed of the study aims and how their input would be used; this was verified through use of a consent
form which participants read and signed. This form stated the aims of the research and how anonymity was to be achieved. Participants were informed of their right to withdraw from the research project up until two weeks after the interview transcripts were returned to them for approval.

Confidentiality and anonymity were maintained throughout the research process. From the beginning of data collection, participants were given a pseudonym and the researcher was the only person who had information that linked participants with their pseudonym. Audio files and transcripts were filed on a password-controlled computer.

Issues of sensitivity and withdrawal were considered because participants were to be discussing their personal viewpoints and experiences of osteopathic practice, which could be potentially sensitive information. Although this situation did not happen to occur, it was considered that if interviewees were to become distressed for any reason, they would be given the option to withdraw from the interview, or to pause for a period of time. Any interview material they did not wish to be used would have been deleted.
References


Part Two: Manuscript
Contacting with Clarity - The Communicative Purposes of Osteopathic Touch

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ABSTRACT

Objective: The aim of this qualitative study was to explore and describe osteopaths’ perspectives on the communicative purposes of their professional touch.

Background: Touch is a key defining feature of osteopathy. Physical contact between osteopaths and their patients is essential to communication during examination, diagnosis and treatment. Yet there is no existing research that describes the communicative purposes of touch from the perspective of osteopathic practitioners.

Methods: Purposive sampling led to the recruitment of five participants who were osteopaths registered and practising in New Zealand. Data were collected during single semi-structured interviews, which were then transcribed and analysed using the framework of interpretive description.

Results: Nine sub-themes emerged in the data, which were grouped into three key themes. Theme [A] Negotiation – communicating through the process highlighted the ways in which osteopaths use touch to communicate with their patients through the stages of a consultation. Theme [B] Reassurance and Empowerment – a therapeutic embrace explored how osteopathic touch communicates qualities of reassurance, care and empowerment which are considered invaluable components of the therapeutic process. Theme [C] Awareness – ensuring professionalism emphasised the need for osteopaths to maintain a context that is always appropriate for their professional touch, through the use of consent and boundaries, and conveying competence.

Conclusion: Touch is an important tool used by osteopaths to communicate with their patients. For the participants, clarity and continuity are two key qualities of osteopathic touch that aid its communicative intentions. These include engaging the patient, establishing trust, providing reassurance and care, allowing patient involvement and empowerment, and conveying professionalism. Limitations of this study and indications for future research are considered.

Key words: care, communication, education, empathy, empowerment, osteopathic medicine, osteopathy, professionalism, reassurance, therapeutic, touch
INTRODUCTION

Touch is integral to osteopathy. A key defining feature of osteopathic practice is that practitioners touch their patients to aid the restoration of health.\(^1\) The physical contact that occurs between osteopaths and their patients is essential to the processes of examination, diagnosis and treatment. It is also recognised that touch is an valuable form of non-verbal communication between patient and practitioner that is important for a successful therapeutic relationship.\(^2, 3\)

Despite this, existing research into osteopathic touch is limited. A review of the literature found no published research directly concerning the role of touch in osteopathy, including no qualitative accounts of osteopaths’ professional experiences of touch. The role of touch as explored in osteopathic literature has tended to utilise research from other healthcare disciplines.\(^1, 4, 5\) However, a recent unpublished qualitative study examined and described patients’ experiences of touch during a consultation with an osteopathic practitioner.\(^6\) One of the major conclusions of the study was that, for the patients interviewed, the experience of touch in an osteopathic session involves a sense of care and security. Touch is seen to constitute an important part of the therapeutic relationship for the participants, as it supports and validates their experiences, and it also communicates practitioner humanism and professionalism.

The phenomenon of touch has also not been widely explored within most of the other manual therapy professions to which it is so crucial, and the healthcare context in general,\(^4\) with the exception of investigations within nursing and physiotherapy literature.\(^7-11\) While touch within modern medicine is largely technical and procedural in nature, recent nursing literature has focused on the human significance of touch as an expression of care and reassurance.\(^1, 8\)

Both nursing and physiotherapy research have tended to categorise touch into distinct types. Earlier physiotherapy studies emphasised the procedural elements of therapeutic touch, as well as recognising its function in providing care.\(^7, 11\) Results of a more recent study divided touch in the physiotherapy setting into eight single intent categories - assistive touch, preparation, providing information, caring touch, therapeutic intervention, perceiving information, security and building rapport.\(^9\) This research also highlighted the need for the physiotherapist to adapt their touch according to observation of patients' needs. These studies provide some understanding of the role of touch in manual therapy, but the extent to which this can be generalised to osteopathy is
uncertain, as it is a separate profession with some unique techniques and a distinctly holistic approach.\textsuperscript{5, 12} Another limitation of the majority of the physiotherapy literature is that it focuses on types of touch used, without examining other professional factors in relation to touch, such as how it mediates professionalism.

Although awareness of the significance of touch may be increasing within the osteopathic profession,\textsuperscript{13, 14} the lack of osteopathic research into touch means that information is imparted from the personal experience of individual practitioners and related knowledge from other healthcare modalities. This highlights the need for evidence from in-depth research that explores and validates the experiences of osteopathic practitioners. The current study uses qualitative research methodology to investigate osteopathic touch from the practitioner’s point of view, exploring osteopaths’ use of touch as a tool to communicate with their patients, and their interpretations of the role that touch plays in the therapeutic relationship.

METHODS

This study was conducted using the framework of interpretive description which, when applied in a healthcare setting, aims to integrate knowledge gained from inquiries into human experience with the reflective clinical reasoning process.\textsuperscript{15} The approach takes inspiration from hermeneutic phenomenology, which focuses on meaning and interpretation, maintaining awareness of the potential influence of researcher biases and assumptions on the interpretive process.\textsuperscript{16}

Purposive sampling led to the recruitment of five participants who were osteopaths registered and practising in New Zealand. All participants had a minimum of five years’ professional experience and practiced using a range of treatment styles. Data were collected during five in-depth, semi-structured interviews, which were then transcribed and analysed. Four interviews were face-to-face and one was an online audio interview conducted via the Skype application, a software program that uses the internet to make audio/video calls. All stages of the research process were conducted by the primary researcher.

The study employed the interpretive description process of data analysis, outlined as comprehension of data, synthesis of meanings, theorisation of relationships and
recontextualisation of data into findings.\textsuperscript{17} Van Manen’s three methods for isolating thematic statements were also drawn upon – the detailed, highlighting and holistic reading approaches.\textsuperscript{16} Within this process of immersion in the data, formulation of meanings were constructed and organised into clusters of themes and sub-themes, which were then validated by text from the original descriptions.

Prior to data collection, the principal researcher was interviewed to identify any preconceptions and subjectivity. Transparency was applied in the use of a reflexive electronic journal which acted as an audit trail. Recordings were transcribed by the principal researcher between interviews, to allow reflection on developing bias. Rigour during data analysis included avoidance of premature closing and misinterpretation of frequency.\textsuperscript{15} Preliminary findings were presented at a research forum and were discussed by fellow osteopathic students and osteopaths. It was confirmed that the findings fitted their experiences and allowed them some insight into aspects of practice they may not have consciously considered. No major ethical issues were identified in conducting the research and ethics approval was granted by the Unitec Research Ethics Committee. Pseudonyms are used in this report to maintain participant confidentiality.

**RESULTS**

To convey the depth and richness of the communicative purposes of osteopathic touch, the data were arranged into three main themes: [A] Negotiation – communicating through the process, [B] Reassurance and Empowerment – a therapeutic embrace, [C] Awareness – ensuring professionalism. Each of these themes and their three sub-themes are supported by a quote from the raw data to express the participants’ key ideas.

**THEME A: Negotiation – communicating through the process**

Throughout an osteopathic consultation, a fluid negotiation takes place between the patient and the practitioner, and between the mediums of touch and verbal dialogue. Theme [A] is about this negotiation and the involvement and engagement of the patient in the process. Touch is used for engaging, which establishes contact and trust, and for disengaging, which signals the end of
treatment. Touch also forms part of a dialogue that communicates movement through different stages of the consultation, and ensures patient comfort and involvement.

*My intention is that they maintain some sense of involvement... in contrast to going to a medical specialist where the patient is often very passive. Trying to maintain some kind of involvement or engagement of the patient with the process as well is quite important (Rupert).*

[A1] **Engaging – initiating the therapeutic union**

*I put my hands on their shoulders. I just rest my hands there, and to me that’s a handshake if you like. That’s the saying hello. I think it gives me an awful lot of information but I think it lets the patient feel that they can relax (Paula).*

The physical component of the therapeutic relationship begins with engagement, in which a connection between patient and practitioner is made via the first application of touch. Subsequent to a greeting touch which is often in the form of a handshake to establish personal contact and convey professional status, the first physical contact within the treatment room usually has a diagnostic purpose. However, it also has important communicative intentions, including engaging the patient and establishing trust. All of the participants identified the importance of clarity in the first touch, which aims to instil confidence in the osteopath’s abilities, and reassure the patient that they will be comfortable.

[A2] **Dialogue – listening and explaining**

*I’m talking with it, I’m kind of explaining what I’m doing with my hands, and I’m getting feedback from them at the same time as well, so that kind of keeps me in tune with where they’re at with my touch (Anna).*

During osteopathic examination, diagnosis and treatment, a dialogue takes place between the practitioner and patient, which can have both verbal and physical elements. Verbal
communication about touch allows osteopaths to maintain patient involvement, and stay in tune with their comfort levels. Practitioners explain their findings, discussing the touch and diagnosis with the patient. They also use intuition through touch and visual cues to pick up if a patient feels uncomfortable, and change the touch accordingly. A dialogue can take place with the patient’s physical body, in which the practitioner uses a listening touch, or reads signals from the body to find out what is needed next. Touch itself is used as a communication tool, for guiding, signalling what might be coming next in treatment, or indicating an intended movement such as a tap on a patient’s left shoulder if the practitioner needs them to roll onto their left side.

[A3] Disengaging - returning the patient to themselves

It’s a finishing off touch that brings everything back together... one of my teachers used to say you give the patient back to themselves. You’ve been moving their body for them and now you’re going ‘ok it’s yours again’ (Anna).

Disengagement is the process by which the practitioner withdraws their touch at the end of the session. All of the participants agreed that this process deliberately utilises touch to signal to the patient that the treatment component has ended. Touch is sometimes used to do a physical re-evaluation at the end of treatment, which is then discussed with the patient. Some practitioners deliberately end with a particular type of technique, as a ‘finishing off’ touch. Other practitioners use whichever technique is necessary for the patient at the time, and follow that with a particular touch such as a tap on the shoulder, or the osteopath putting their hands together, which signals that the therapeutic touch between practitioner and patient has ended.

THEME B: Reassurance and empowerment – a therapeutic embrace

Osteopathic touch provides qualities of reassurance, care and empowerment which are considered invaluable components of the therapeutic process. Theme [B] is about osteopaths embracing and supporting change in the patient, through attendance and support which provide continuity of touch, through care which allows empathy, and through education which fosters empowerment.
You can talk as much as you like to patients, but what you do to them and the way you touch them can actually give them a little glimmer of understanding that things can change, that they don’t necessarily need to be like they are, that the future could be different to the way things are right now (Rupert).

[B1] Attendance and support – reassuring through contact

It might be the lower back that’s the problem and I might be touching their shoulders as they’re moving, but I’m maintaining touch and through that shoulder I’m still touching that low back. So that continues the treatment approach and therefore reassurance for the patient (Paula).

Reassurance is often expressed through initial touches, to confirm that the osteopath is touching in the right area and that they’re aware of pain, or to affirm that the patient will feel better soon. Several participants pointed out that reassuring touch is used more often for patients with an acute presentation because they may be anxious or bracing themselves due to their pain. Continuity of touch can be a tool to give patients a sense of being held and supported emotionally. Support can also apply in a physical way, in which touch is used to ensure patient comfort. A brief maintenance of contact can be used to ground the patient and help them feel comfortable again after quick techniques such as a seated cervical (neck) manipulation.

[B2] Care – a physical empathy

You don’t have to sort of put your head down and pat them on the shoulder and go ‘oh that must be awful’. You can actually just slow down what you’re doing. Like, you kind of stop and say ‘that must be really hard’... you can almost pause the technique and not move your hands and just change the way your hands are engaged with the patient. (Rupert).

The sub-theme of care concerns the empathy that can be expressed through touch when a patient shares emotional issues with the practitioner. All of the participants agreed that they maintain
physical contact with the patient if they start to share emotions during treatment, but that there is usually a subtle and subconscious change in the quality of the touch, in order to convey care. This continuity of contact aims to acknowledge the person as a whole and reassure the patient that expression of emotion is a normal part of the therapeutic process.

[B3] Education – fostering empowerment

I did some oscillation and I found all the hot spots in his spine and I said “Do you feel that? That’s your adrenals. Do you feel that? That’s me pushing on the erector spinae muscles around the rib heads. That’s your heart”. It freaked him out. And he changed... he just felt ‘whoa, there’s stress on my body, it’s affecting my body, oh my god. You know, I better do something’; it actually brought it home to him (Anna).

All of the participants believe in using touch to educate their patients in order to aid the therapeutic process. A key aim of this ‘teaching touch’ is to empower and de-medicalise patients by showing them how to be more in touch with, and in charge of, their bodies. Touch can be used directly to demonstrate physical imbalances or highlight stress in the body to patients. Touch is widely used to help explain diagnoses and what is happening during treatment. It is also used to demonstrate posture, effective breathing, stretching and exercises, or to teach patients why it might be best not to self-manipulate.

THEME C: Awareness – ensuring professionalism

The therapeutic relationship between an osteopath and their patients relies on the practitioner retaining awareness of their professional role. Theme [C] highlights the need to maintain an appropriate context for touch, which is achieved through obtaining consent and ensuring clear boundaries. Confidence in relation to touch conveys competence and professionalism which benefits the therapeutic process.
I’d never want a patient to feel like they were touched out of context or inappropriately because if that ever happens then your therapeutic process is never going to happen, you’ve lost it (Dave).

[C1] Consent – sanctioning the therapeutic process

You’ve got to be comfortable as the practitioner touching them. I think if you’re too removed and too professional and sterile, then you’re actually dangerous the other way round, because you might touch and the patient might not consent to that necessarily but you might be thinking well I’m not thinking anything dodgy so this is OK (Dave).

Consent is considered important to the therapeutic process by all of the participants in this study. This includes clear communication with the patient prior to examination and treatment, in order to gain permission to touch the patient. Consent can be especially important in relation to certain techniques that may be considered frightening, such as manipulation or high-velocity thrusts, so that patient trust is not broken. Consent is also crucial in relation to treating certain areas of the body that are considered private such as the chest, breasts, groin, buttocks or pelvis. Osteopaths maintain more awareness and caution around these parts of the body, and good verbal communication with the patient is always essential when touching these areas.

[C2] Boundaries – protection through clear roles

The key boundary with touch is that my touch always has a purpose. I wouldn’t just fluff my hand around and happen to land upon something. There’s a reason why I touch my patients and it’s simply for a professional purpose. And my patients know that. And there’s no light touch in terms of brushing or caressing or anything along those lines (Jane).

All of the participants mentioned that boundaries in relation to touch are crucial for maintaining the professional nature of the relationship and ensuring personal and professional protection for
the osteopath. Avoiding casual touch and ensuring that all touch is purposeful and follows a logical pattern are important steps that help to retain the distinction between friendship touch and professional touch. Sometimes physical barriers are also important to retain clear boundaries, such as the osteopath facing one direction and the patient in the other when the practitioner’s arm is around the patient during a thoracic examination.

[C3] Confidence – allowing effective treatment

Every single time you put your hands on, you want to send the message like I’m right on it. And I know what I’m doing and I’m not going to faff [sic]... I think the patient’s belief in your ability has a huge effect on how the treatment is received into the body (Anna).

Osteopaths’ confidence in their ability can be conveyed through their use of touch, and this is considered beneficial for the therapeutic process. Being clear, efficient, concise and direct with touch are viewed by the participants as key tools in demonstrating competence, which helps the patient to relax and receive the treatment well. Maintaining a logical order to touch and ensuring that it is purposeful in nature can also be important for conveying competence. Confidence develops with experience; increased knowledge and skill enable an osteopath to naturally find the level of touch that is appropriate for each patient.

DISCUSSION

This research demonstrates that osteopathic touch is more than just a tool for diagnosis and treatment; it is a method of communicating with the patient. Touch is used to communicate throughout the osteopathic consultation, and to signal stages of the process to the patient. Clarity is an important quality of osteopathic touch, which aids intended communicative purposes such as engaging the patient, maintaining trust, and instilling confidence. Continuity of touch allows osteopaths to stay in tune with their patients, by providing reassurance and empathy, and allowing empowerment through education. Osteopaths are usually aware of some of the effects
of their touch on their patients, and of the significance of consent and boundaries to the maintenance of professionalism around touch.

**Negotiation**

The significance of the early stages of a healthcare interaction to the overall therapeutic result has been established in much literature. Consedine’s qualitative study, which examined the experience of osteopathic touch from the point of view of patients, identified that the first touch communicates to patients that the practitioner is connecting and attending to them and their body. This corresponds with the current study’s acknowledgement of practitioner communicative intentions in relation to first touch, in terms of engaging the patient and showing interest. Literature has acknowledged that touch is one of numerous factors that have the ability to communicate practitioners’ interest in the patient. The sub-theme of engagement also identified that osteopathic practitioners are aware of the significance of clarity and directness in their first touch within a consultation. The beginning of a consultation is an especially crucial time for clear and effective communication to take place, and this can include clarity of communicative touch.

The sub-theme of dialogue highlighted that the communication between practitioner and patient during an osteopathic session has both verbal and physical elements. Consedine’s study showed that patients have a conscious perception of this dialogue and an understanding that communication is an important component of the patient-practitioner relationship. A study examining patient’s experiences of massage in psychomotor physiotherapy showed that there is a non-verbal dialogue between practitioners and patients, which is supported by verbal communication, and the combination of the two improved the therapeutic process. A qualitative examination of UK osteopaths’ clinical decision making and therapeutic approaches included an interpretation of osteopaths’ interactions with patients as being patient-focused. This involved talking and listening, helped to construct knowledge of the patient as a person, and enabled the participants to learn from their patients.

Participants in the current study mentioned the ability of verbal communication around touch to ensure patient involvement and practitioner attunement to patient comfort levels. Similarly,
Elkiss and Jerome point out that verbal explanations around the intentions and purposes of touch, and what is found during the palpatory examination, can help to put patients at ease and enhance confidence and trust. Within the current study, dialogue was also seen to involve the use of intuition if a patient feels uncomfortable and the changing of the application of touch accordingly. This concept of a response quality to the practitioner’s touch was raised from the patients’ point of view, and is corroborated in physical therapy literature. A qualitative inquiry into physiotherapists’ views of the clinical encounter found that sensitivity to the patient and adapting techniques where necessary was considered important by physiotherapists. Correspondingly, a study of physiotherapists’ use of touch in inpatient settings highlighted the need for physiotherapists to adapt their touch according to observation of patients’ needs.

The sub-theme of disengagement emphasised the process by which the practitioner withdraws their touch from the patient at the end of a treatment session. This was described as a ‘finishing off touch’ in which the practitioner signals the end of treatment, and ‘returns the patient to themselves’. This sub-theme is reflected briefly in Consedine’s study, in which one patient commented on the presence of the osteopath’s support which is noticeably withdrawn at the end of treatment, which encourages the resumption of ‘self-responsibility’.

Reassurance and empowerment

The contemporary move within healthcare away from a paternalistic view of the patient’s role has made way for a more ‘patient-centred’ approach in which patients may be considered autonomous partners in the healthcare relationship. Coulter outlines some of the key features of patient centeredness as good communication, education, attention to physical comfort, and emotional support/empathy. The sub-theme of attendance and support in the current study highlighted osteopaths’ provision of emotional support and reassurance through continuity of touch. This is reflected in the patients’ view that touch reinforces the sense of support and its importance to the therapeutic process. The osteopathic view also recognised the significance of patient comfort, which has strong similarity to the view in Consedine’s study that patients can feel relaxed, comfortable and nurtured within a consultation. Osteopaths’ observations that reassuring touch is used most frequently for patients with acute symptoms concurs with a similar observation within the aforementioned study of physiotherapists’ use of touch.
Physiotherapists reported that reassuring touch was used most with patients who seemed anxious or nervous.

As Elkiss and Jerome point out, therapeutic touch communicates a sense of being cared for, and is a method of communicating empathy that complements the communicative ability of words. Similarly, the sub-theme of care in the current study showed that when patients share emotions during treatment, osteopaths intend to express care and empathy through their touch. In a qualitative research paper completed at the British School of Osteopathy that examined osteopaths’ understanding of empathy, it was discovered that osteopaths found their highly experienced and sensitive palpation skills to be a key tool for empathising with patients. Osteopaths explained that physical contact with patients is a way to feel their discomfort and pain, either physical or emotional. Consedine’s participants also identified the link between the sense of being cared for and the practitioner’s touch. However, Consedine’s study pointed out that care and support are mediated by both physical and verbal dialogue, and that touch is a component of care rather than a single contributing factor.

Caring touch has been identified within research about touch in the context of manual therapy, which has tended to categorise touch into distinct types. A study which used video analysis to observe communication between physiotherapists and their patients divided touch into the categories of instructional, examination, supportive, procedural and caring. Another qualitative study identified four types of touch used by physical therapists within a treatment session – caring, therapeutic, assistive, and touch used to perceive or provide information. Distinction between types of communicative touch did play a role in forming the sub-themes in the current study. However, complete categorisation of distinctly different types of touch was avoided as it would have overlooked the continuity that participants believe is inherent within all osteopathic touch.

*Touch is like, a spectrum, it’s a fluctuating thing... its moving, it’s flowing, it’s doing different things all the time so it’s like a dance. Its not going to be ‘and now I’m doing reassuring touch for 2 seconds, reassurance ok we’re going to move onto care now, a little deeper, a little harder, right OK.’ No, it’s not like that. It’s flowing, it’s changing all the time and it’s a non-verbal communication (Anna).*
This flowing, changing sense of continuity within osteopathic touch was also reflected in the recognition by all of the participants that therapeutic touch can be subtly changed to express care when it is needed, and that the maintenance of physical contact is usually necessary and beneficial.

Healthcare communities widely recognise the significance of patient education.\textsuperscript{29} Patients who are well educated and informed have a greater ability to understand and manage their own health, and nurturing of understanding by healthcare practitioners can result in improved patient satisfaction and treatment outcomes.\textsuperscript{30} The sub-theme of education confirmed that touch is used as a key tool to educate osteopathic patients and therefore aid the overall therapeutic process. Physiotherapy studies have also identified the provision of information to patients as a significant purpose of professional touch.\textsuperscript{7, 9} The ability of osteopathic touch to highlight stress in the body to patients was shown in the current study and is reflected in the following quote by authors Elkiss and Jerome: “What begins as a palpatory examination quickly becomes a tactile conversation as the patient gains greater proprioceptive self-awareness of structural and motion impediments”.\textsuperscript{25}

Although all the participants in the current study use touch to empower their patients through knowledge, one recent study revealed that not all osteopaths have education and patient autonomy as their goal.\textsuperscript{24} Twelve UK registered osteopaths were interviewed in a qualitative study examining clinical decision-making and therapeutic approaches in osteopathy. Several participants focused on control and responsibility of patients’ problems, and patient passivity. On the other end of the spectrum, some participants emphasised patient learning and patient facilitated control of treatment direction. Three theoretical models of therapeutic approaches were formulated to characterise study participants and their clinical practice – the Treater, the Communicator, and the Educator. The Educators focused on teaching, empowering, and exchanging knowledge with patients to allow self-management of pain and dysfunction. This model fits most closely with the sub-theme of education in the current study, in which education and empowerment through touch was viewed by all the participants as an aid to the therapeutic process.
Awareness

Reflective practice is increasingly considered essential for the competency and professionalism of healthcare practitioners as it enables the development of professional self-awareness and self-regulation. The theme of awareness highlighted osteopaths’ attendance to professionalism in their touch through their reflection on the use of consent, boundaries and confidence. All participants valued clear communication around consent prior to the use of touch during examination and treatment. The Code of Ethics published by the Osteopathic Council of New Zealand, the appointed professional authority with which all osteopathic practitioners must be registered, states that diagnosis and treatment must be carefully explained in easily understandable language, and that informed consent applies to every component of the consultation.

This process was further detailed in a study exploring informed consent practices of physiotherapists in the treatment of low back pain. A model of informed consent in physiotherapy was described as implicit, embodied and continuous with the treatment process. Importantly, non-verbal body language provided active cues of assent or dissent which were interpreted by physiotherapists as implying consent or refusal, and it was concluded that informed consent cannot occur separately from assessment and treatment processes. Similarly, Lim considers consent as a continuous discussion that fits within an evolving consultation, from prior to treatment through to the discharge period.

Verbal communication around touch was considered by osteopaths in the current study to be particularly important in relation to certain body areas or particular techniques such as high-velocity thrusts. A study exploring patients' preferences of consent procedures in a sample of UK osteopathic patients showed that patients favour verbal communication for receiving information and giving consent. A qualitative investigation of patients' perspectives of informed consent for chiropractic care identified a patient/practitioner feedback loop in which participants and practitioners discussed the amount of pressure applied and the level of comfort; this was considered important to minimising the perception of risk of physical harm. This concept of feedback about touch was suggested within the dialogue theme of the current study, in that osteopaths discuss comfort levels with patients and adjust touch accordingly.
Therefore, the dialogue that occurs around touch forms an important part of the consent that is necessary for touch in an osteopathic consultation.

Perceived practitioner competence was another consideration of consent within the chiropractic study.\textsuperscript{36} When patients perceived practitioners as competent, this created feelings of safety for the patients. The current study’s sub-theme of confidence highlighted that osteopaths’ confidence in their ability is conveyed through their use of touch, and that clear touch applied in a logical order is the most effective method for achieving this. The patients in Consedine’s study also identified confidence as a distinct feature of osteopathic touch that reassured them of practitioners’ competence and the therapeutic process.\textsuperscript{6}

As Coulter points out, patients’ experiences can influence the effectiveness of treatment and health outcomes, and the current study demonstrated osteopaths’ understanding that a patient’s belief in their competence will affect the treatment.\textsuperscript{27} A study of physiotherapists’ conceptions of establishing therapeutic relationships showed that participants aimed to initiate a safe and secure environment for patients to help instil confidence in them as practitioners.\textsuperscript{23} The sub-theme of confidence in the current study identified that confidence develops with experience. This was similarly noted in an observational study in which inexperienced physiotherapists used fewer affective behaviours to engage with patients because they focused more on technique application due to lack of confidence.\textsuperscript{37}

The sub-theme of boundaries emphasised the restrictions in relation to touch which osteopaths consider to be crucial to maintaining the professional nature of their practice. Comparatively, Consedine’s research revealed that osteopathic patients are aware of the professionalism that is maintained through purposeful touch that ensures a clinical distance.\textsuperscript{6} Participants recognised an absence of non-procedural touch and were conscious that practitioners deliberately avoid any potential for an emotional relationship to develop through touch. Patients considered that any infringement on these perceived boundaries would result in them feeling unsafe.\textsuperscript{6} In a qualitative study that explored professional values of Australian physiotherapists, almost one third of the participants valued the maintenance of boundaries, considering it essential due to the hands-on nature of their work and the level of trust ascribed to them by patients.\textsuperscript{38}
CONCLUSION

Experienced osteopaths appear to be fluent in the language of touch. An examination of osteopaths’ perspectives of the communicative purposes of their professional touch demonstrated that touch is a significant tool for communicating with patients. Clarity and continuity of touch were highlighted as two key qualities that aid the communicative intentions of osteopathic touch. These include engaging the patient, establishing trust, providing reassurance and care, allowing patient involvement and empowerment, and conveying professionalism.

Analysing this research within the context of manual therapy and wider healthcare literature highlighted that touch and verbal dialogue combine to allow effective patient-practitioner communication that enhances the therapeutic process. The literature indicated that touch in manual therapy is an important component of patient care and that touch is adapted in response to need. It was shown that the dialogue that occurs around touch forms an important part of the consent and boundaries that are necessary for professional touch. The literature also suggested that touch could be more widely used as a tool for providing empowerment of patients through education.

Limitations of the study include that the extent to which participants upheld their intentions in practice was not examined and that the results can not be generalised beyond the participants of the study. However, rigour was observed to enhance credibility of results, and the aim was not to produce findings that could be generalised, but rather a rich exploration of the communicative purposes of professional touch for the participating osteopaths.

Future research could examine the extent to which these findings might be generalised, how they compare to the perspectives of osteopaths in other countries and with practitioners who have less experience. Research observing osteopaths in practice could help to confirm the reliability of the findings in this study and the extent to which participants uphold in practice the perceived communicative purposes of touch.
REFERENCES

21 Billings JA, Stoeckle D. The clinical encounter: A guide to the medical interview and case presentation (2nd ed.) Amsterdam: Elsevier Health Sciences; 1998


Part Three: Appendices
Appendix A: Guidelines for International Journal of Osteopathic Medicine (IJOM)

The Editors of the Journal welcome contributions for publication from the following categories: Letters to the Editor and Editorials, Reviews and Original Research articles, Commentaries, Clinical Practice articles (Case Studies) with educational value and Protocols.

The Guidelines are separated into the following sections:

A Online Submission
B Types of Contributions
C General Guidance
D Preparation of the Manuscript
E Specific Guidance for Original Research Articles
F Specific Guidance for Protocols
G Post Acceptance

(A) ONLINE SUBMISSION
Submission to this journal proceeds totally online at (http://ees.elsevier.com/ijom). You will be guided stepwise through the creation and uploading of the various files. The system automatically converts source files to a single Adobe Acrobat PDF version of the article, which is used in the peer-review process. Please note that even though manuscript source files are converted to PDF at submission for the review process, these source files are needed for further processing after acceptance. All correspondence, including notification of the Editor's decision and requests for revision, takes place by e-mail and via the Author's homepage, removing the need for a hard-copy paper trail.

The above represents a very brief outline of this form of submission. It can be advantageous to print this "Guide for Authors" section from the site for reference in the subsequent stages of article preparation.

Submission of an article implies that the work described has not been published previously (except in the form of an abstract or as part of a published lecture or academic thesis), that it is not under consideration for publication elsewhere, that its publication is approved by all authors and tacitly or explicitly by the responsible authorities where the work was carried out, and that, if accepted, it will not be published elsewhere in the same form, in English or in any other language, without the written consent of the Publisher.

(B) TYPES OF CONTRIBUTIONS - word limits exclude tables, figures and reference list.

Letters to the Editor (up to 1,000 words)
As is common in biomedical journals the Editorial Board welcomes critical responses to any aspect of the journal. In particular, letters that point out deficiencies and that add to, or further clarify points made in a recently published work, are welcomed. The Editorial Board reserves the right to offer authors of papers the right of rebuttal, which may be published alongside the letter.

Reviews and Original Articles (2,000 - 5,000 words)
These should be either (i) reports of new findings related to osteopathic medicine that are supported by research evidence. These should be original, previously unpublished works; or (ii) a critical or systematic review that seeks to summarise or draw conclusions from the established literature on a topic relevant to osteopathic medicine.

Short review (1,500-3,000 words)
The drawing together of present knowledge in a subject area, in order to provide a background for the reader not currently versed in the literature of a particular topic. Shorter in length than and not intended to be as comprehensive as that of the critical or systematic review paper. These papers typically place more emphasis on outlining areas of deficit in the current literature that warrant further investigation.

Research Note (up to 1,500 words)
Findings of interest arising from a larger study but not the primary aim of the research endeavour, for example short experiments aimed at establishing the reliability of new equipment used in the primary experiment or other incidental findings of interest, arising from, but not the topic of the primary research. Includes further clarification of an experimental protocol after addition of further controls, or statistical reassessment of raw data.

Preliminary Findings (1,500-2,500 words)
Presentation of results from pilot studies which may establish a solid basis for further investigations. Format similar to original research report but with more emphasis in discussion of future studies and hypotheses arising from pilot study.

Commentaries (up to 2,000 words)
Includes articles that do not fit into the above criteria as original research. Includes commentaries and essays especially in regards to history, philosophy, professional, educational, clinical, ethical, political and legal aspects of osteopathic medicine.

Clinical Practice
Authors are encouraged to submit papers in one of the following formats: Case Report, Case Problem, and Evidence in Practice.

i. Case Reports - usually document the management of one patient, with an emphasis on presentations that are unusual, rare or where there was an unexpected response to treatment (e.g. an unexpected side effect or adverse reaction). Authors may also wish to present a case series where multiple occurrences of a similar phenomenon are documented. Preference will be given to reports that are prospective in their planning and utilise Single System Designs, including objective measures.

ii. The aim of the Case Problem is to provide a more thorough discussion of the differential diagnosis of a clinical problem. The emphasis is on the clinical reasoning and logic employed in the diagnostic process.
iii. The purpose of the Evidence in Practice report is to provide an account of the application of the recognised Evidence Based Medicine process to a real clinical problem. The paper should be written with reference to each of the following five steps: 1. Developing an answerable clinical question. 2. The processes employed in searching the literature for evidence. 3. The appraisal of evidence for usefulness and applicability. 4. Integrating the critical appraisal with existing clinical expertise and with the patient's unique biology, values, and circumstances. 5. Reflect on the process (steps 1-4), evaluating effectiveness, and identifying deficiencies.

Protocols (1,500 - 2,000 words)
The IOM accepts the submission of protocols of randomised interventions, systematic reviews and meta-analyses, observational studies, and selected phase I and II studies (novel intervention for a novel indication; a strong or unexpected beneficial or adverse response; or a novel mechanism of action), with the overall aim to encourage good principles in clinical research design.

The editors are looking for studies that will appeal to a wide general readership. The question being addressed and the planned design and analysis will need to be as original as possible, topical, and valid. All protocols will be subject to the journal's usual peer review process.

New section - Osteopathic Education:
Papers which focus on osteopathic education in the clinical/practice environment and in academia are welcomed for a new section of the International Journal of Osteopathic Education. Papers from academics involved in the teaching of students in the classroom are welcomed alongside those from clinical staff involved in the education of osteopaths in practice, through post-qualifying education and training initiatives. It is essential that the evidence-base to education is developed and this is reflected in papers submitted for publication. In alignment with the journal's overall Aims and Scope, papers submitted for consideration of publication should be relevant to an international audience, even if they are national in scale of study. The editorial team wish to encourage submission of papers that demonstrate:

- Innovation and development of education
- Creativity in teaching and learning strategies
- Evaluation and quality assurance of academic standards
- Advancement of practice-based education
- Collaborative interdisciplinary education initiatives
- Delivery and evaluation of education within osteopathic and related services.

AudioSlides

The journal encourages authors to create an AudioSlides presentation with their published article. AudioSlides are brief, webinar-style presentations that are shown next to the online article on ScienceDirect. This gives authors the opportunity to summarize their research in their own words and to help readers understand what the paper is about. More information and examples are available at http://www.elsevier.com/audioslides. Authors of this journal will automatically receive an invitation email to create an AudioSlides presentation after acceptance of their paper.

(C) GENERAL GUIDANCE

Submission Declaration

Submission of an article implies that the work described has not been published previously (except in the form of an abstract or as part of a published lecture or academic thesis), that it is not under consideration for publication elsewhere, that its publication is approved by all authors and tacitly or explicitly by the responsible authorities where the work was carried out, and that, if accepted, it will not be published elsewhere in the same form, in English or in any other language, without the written consent of the copyright-holder.

Ethical considerations

Human subjects. Work on human beings that is submitted to The International Journal of Osteopathic Medicine should comply with the principles laid down in the declaration of Helsinki; Recommendations guiding physicians in biomedical research involving human subjects. Adopted by the 18th World Medical Assembly, Helsinki, Finland, June 1964, amended by the 29th World Medical Assembly, Tokyo, Japan, October 1975, the 35th World Medical Assembly, Venice, Italy, October 1983, and the 41st World Medical Assembly, Hong Kong, September 1989. The manuscript should contain a statement that the research has been approved by the appropriate ethical committees related to the institution(s) in which it was performed and that subjects gave informed consent to the work. Studies involving experiments with animals must state that their care was in accordance with institution guidelines. Patients' and volunteers' names, initials, and hospital numbers should not be used. In a case report, the subject's written consent should be provided. It is the author's responsibility to ensure all appropriate consents have been obtained.

Patient anonymity. Studies on patients or volunteers require ethics committee approval and informed consent which should be documented in the manuscript.

Patients have a right to privacy. Therefore identifying information, including patients' images, names, initials, or hospital numbers, should not be included in videos, recordings, written descriptions, photographs, and pedigrees unless the information is essential for scientific purposes and you have obtained written informed consent for publication in print and electronic form from the patient (or parent, guardian or next of kin where applicable). If such consent is made subject to any conditions, Elsevier must be made aware of all such conditions. Evidence of written consent must be provided to Elsevier on request.

Even where consent has been given, identifying details should be omitted if they are not essential. If identifying characteristics are altered to protect anonymity, such as in genetic pedigrees, authors should provide assurance that alterations do not distort scientific meaning and editors should so note.

Authors submitting manuscripts as Case Reports, Case Problems, and Evidence in Practice should ensure that they have received consent from patients who are the subject of such reports. A statement to this effect should be included in the manuscript.

If such consent has not been obtained, personal details of patients included in any part of the paper and in any supplementary materials (including all illustrations and videos) must be removed before submission.

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You are requested to identify who provided financial support for the conduct of the research and/or preparation of the article and to briefly describe the role of the sponsor(s), if any, in study design; in the collection, analysis and interpretation of data; in the writing of the report; and in the decision to submit the paper for publication. If the funding source(s) had no such involvement then this should be stated. Please see http://www.elsevier.com/funding.

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Manuscripts going forward to the review process are reviewed by members of an international expert panel. All such papers will undergo a double blind peer review by two or more reviewers. All papers are subject to peer review and the Journal takes every reasonable step to ensure author identity is concealed during the review process. The Editors reserve the right to the final decision regarding acceptance.

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Contact details for questions arising after acceptance of an article, especially those relating to proofs, will be provided by the publisher.

(D) PREPARATION OF THE MANUSCRIPT

Submitted papers should be relevant to an international audience and authors should not assume knowledge of national practices, policies, law, etc. Authors should consult a recent issue of the journal for style if possible. Since the journal is distributed all over the world, and as English is a second language for many readers, authors are requested to write in plain English and use terminology which is internationally acceptable.

Abbreviations - Avoid the use of abbreviations unless they are likely to be widely recognised. In particular you should avoid abbreviating key concepts in your paper where readers might not already be familiar with the abbreviation. Any abbreviations which the authors intend to use should be written out in full and followed by the letters in brackets the first time they appear, thereafter only the letters without brackets should be used.

Statistics - Standard methods of presenting statistical material should be used. Where methods used are not widely recognised explanation and full reference to widely accessible sources must be given.

Manuscript Layout

The manuscript with a font size of 12 or 10 pt double-spaced with wide margins (2.5 cm at least) and number pages consecutively beginning with the Title Page. Depending on the paper type (see above) this should include the title, abstract, key words, text, references, tables, figure legends, figures, appendix. Microsoft Word or similar programme should be used.

Please check your typescript carefully before you send it off, both for correct content and typographic errors. It is not possible to change the content of accepted typescripts during production.

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Papers should be set out as follows, with each section beginning on a separate page:

Title page

To facilitate the blinded peer-review process, two title pages are required. The first should carry just the title of the paper and no information that might identify the author or institution. The second should contain the following information: title of paper; full name(s) and address(es) of author(s) clearly indicating who is the corresponding author; you should give a maximum of four degrees/qualifications for each author and the current relevant appointment only; institutional affiliation; name, address, telephone, fax and e-mail of the corresponding author; source(s) of support in the form of funding and/or equipment.

Keywords

Include four to ten keywords in alphabetical order, which accurately identify the paper’s subject, purpose, method and focus. These should be indexing terms that may be published with the abstract with the aim of increasing the likely accessibility of your paper to potential readers searching the literature. Therefore, ensure keywords are descriptive of the study. Use the Medical Subject Headings (MeSH®) thesaurus or Cumulative Index to Nursing and Allied Health (CINAHL) headings where possible (see http://www.nlm.nih.gov/mesh/meshhome.html).

Abstract

Both qualitative and quantitative research approaches should be accompanied by a structured abstract of no more than 250 words. Commentaries and Essays may continue to use text based abstracts of no more than 150 words. All original articles should include the following headings in the abstract as appropriate: Background, Objective, Design, Setting, Methods, Participants, Results, and Conclusions. As an absolute minimum: Objectives, Methods, Results, and Conclusions must be provided for all original articles. Abstracts for reviews of the literature (in particular systematic reviews and meta-analysis) should include the following headings as appropriate: Objectives, Data Sources, Study Selection, Data Extraction, Data Synthesis, Conclusions. Abstracts for Case Studies should include the following headings as appropriate: Background, Objectives, Clinical Features, Intervention and Outcomes, Conclusions.

Text

The text of observational and experimental articles is usually, but not necessarily, divided into sections with the headings; introduction, methods, results, discussion. In longer articles, headings should be used only to enhance the readability. Three categories of headings should be used:

• major headings should be typed in capital letter in the centre of the page and underlined (i.e. INTRODUCTION)
• secondary ones should be typed in lower case (with an initial capital letter) in the left hand margin and underlined (i.e. Participants).
• minor ones typed in lower case and italicised (i.e. questionnaire).

Do not use ‘he’, ‘his’ etc. where the sex of the person is unknown; say ‘the patient’ etc. Avoid inelegant alternatives such as ‘he/she’.

Statement of Competing Interests

When submitting a manuscript you will need to consider if you, or any of your co-authors, are an Editor or Editorial Board member of the International Journal of Osteopathic Medicine. If this is the case you will need to include a section, at the end of your manuscript immediately before the reference section, called “Statement of Competing Interests”. Example statement, which may require editing, is as follows: [Name of author] is an Editor of the Int J Osteopath Med; [Name of author] is a member of the Editorial Board of the Int J Osteopath Med but was not involved in review or editorial decisions regarding this manuscript.
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Text: Indicate references by superscript numbers in the text. These should generally appear at the end of the relevant sentence and should be directly after punctuation. The actual authors can be referred to, but the reference number(s) must always be given.

List: Number the references in the list in the order in which they appear in the text.

Examples:

Reference to a journal publication:

Reference to a book:

Reference to a chapter in an edited book:

For journal articles, the abbreviated title of the journal should be used. Authors should refer to the National Library of Medicine database for journal abbreviations (http://www.ncbi.nlm.nih.gov/nlmcatalog/journals).

Note shortened form for last page number. (e.g., 51-9), and that for more than 6 authors the first 6 should be listed followed by "et al." For further details you are referred to "Uniform Requirements for Manuscripts submitted to Biomedical Journals" (J Am Med Assoc 1997;277:927-934) (see also http://www.nejm.org/general/text/requirements/1.htm).

Web references - As a minimum, the full URL and access date should be given. Any further information, if known (DOI, author names, dates, reference to a source publication, etc.), should also be provided. Web references should be included in the reference list.

Tables, Illustrations and Figures
Tables, illustrations and figures should be placed on separate pages as separate electronic files and not placed within the manuscript. Each table, illustration or figure should be accompanied by a number (e.g. Table 1) and a brief description of the content of the table, figure or illustration, below the table, illustration or figure. All tables, illustrations or figures should be referred to in the manuscript.

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At submission stage, authors of reviews and original research articles are required to provide three to four bullet points outlining the manuscript implications for clinical practice.

(E) SPECIFIC GUIDANCE FOR ORIGINAL RESEARCH ARTICLES
The text of original research for a quantitative or qualitative study is typically subdivided into the following sections:

Introduction
State the purpose of the article. Summarise the rationale for the study or observation. Give only strictly pertinent references and do not review the subject extensively. Do not include data or conclusions from the work being reported.

Materials and Methods
Describe your selection of observational or experimental participants (including controls). Identify the methods, apparatus (manufacturer's name and address in parenthesis) and procedures in sufficient detail to allow workers to reproduce the results. Give references and brief descriptions for methods that have been published but are not well known; describe new methods and evaluate limitations.

Indicate whether procedures followed were in accordance with the ethical standards of the institution or regional committee responsible for ethical standards. Do not use patient names or initials. Take care to mask the identity of any participants in illustrative material.

Results
Present results in a logical sequence in the text, tables and illustrations. Do not repeat in the text all the data in the tables or illustrations. Emphasise or summarise only important observations.

Discussion
Emphasise the new and important aspects of the study and the conclusions that follow from them. Do not repeat in detail data or other material given in the introduction or the results section. Include implications of the findings and their limitations, and include implications for future research. Relate the observations to other relevant studies. Link the conclusion with the goals of the study, but avoid unqualified statements and conclusions not completely supported by your data. State new hypothesis when warranted, but clearly label them as such. Recommendations, when appropriate, may be included.

Conclusion
A summary of the pertinent findings and, relevance of the study and implications of the study for future research.

CONSIDERATIONS SPECIFIC TO TYPES OF RESEARCH DESIGNS

Manuscripts are required to adhere to recognized reporting guidelines relevant to the research design used. These identify matters that should be addressed in your paper. These are not quality assessment frameworks and your study need not meet all the criteria implied in the reporting guideline to be worthy of publication in the journal.

You are encouraged (but not required) to provide a brief description of the reporting tool employed in your manuscript to guide the editors and reviewers.

Reporting guidelines endorsed by the journal are listed below:


Qualitative researchers might wish to consult the guideline listed below:


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All manuscripts submitted to the journal should be accompanied by an Author Contribution Statement. The purpose of the Statement is to give appropriate credit to each author for their role in the study. All persons listed as authors should have made substantive intellectual contributions to the research. To qualify for authorship each person listed should have made contributions in each of the following:
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may include contributions of technical assistance, proof reading and editing, or assistance with resources and funding. The statement may be published in the paper as appropriate.

Example of suggested format (note the use of author initials):

AB conceived the idea for the study. AB and CD contributed to the design and planning of the research. All authors were involved in data collection. AB and EF analysed the data. AB and CD wrote the first draft of the manuscript. EF coordinated funding for the project. All authors edited and approved the final version of the manuscript.

(F) SPECIFIC GUIDANCE FOR PROTOCOLS

Organisation of a Protocol - the following need to be adequately addressed.

• Title
• Abstract/Summary - this should provide a concise description of the purpose of the Protocol and should not exceed 200 words.
• Background, including rationale and any previous systematic review(s).
• Keywords - provide 4-10 keywords.
• Principal investigator(s); contact details.
• Aim(s).
• Design (randomised, double-blind) - including inclusion and exclusion criteria; intervention(s)/method; primary and secondary endpoint(s); side-effects reporting and quantification.
• Statistical analysis - including sample size and power calculations; type of analysis; statistical testing.
• Ethical issues - including ethics committee approval; informed consent form and information sheet.
• Publication plan.
• Time required - an estimation of the time required to run the protocol should be given per separate step and for the whole protocol, including reporting.
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- One copy of manuscript and;
- Tables, figures and illustrations, uploaded separately and correctly labelled;
- Reference list in correct style and correct in-text referencing;
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Appendix B: Additional Conclusions

There were three sub-themes in this study that presented concepts that were not raised by the participants in the equivalent study of patient’s experiences of osteopathic touch (Consedine, 2007). The sub-theme of disengagement was briefly alluded to by one of Consedine’s participants who observed the withdrawing of the osteopath’s support at the end of the treatment. However, disengagement was acknowledged by all of the osteopaths interviewed within the current study, as an important concluding process that specifically utilises touch as a communication tool. The sub-theme of education in this study highlighted how touch can empower patients through the sharing of knowledge. This was not mentioned by the participants in Consedine’s study. Instead, their observations of the immense knowledge held by osteopaths formed the sub-theme entitled knowledge – with seeing fingers. Lastly, the sub-theme of consent was not raised by the osteopathic patients. Yet, for the osteopathic practitioners who participated in the current study, consent was considered vital to the therapeutic process, and to the use of touch in an osteopathic setting.

These thematic differences provide depth to the combined body of research that is formed by these two studies. They also serve to highlight that some issues about the phenomenon of touch are more important to osteopaths with their aim to maintain professionalism in their practice, than they are to osteopathic patients. However, these differences also indicate the usefulness of future research that would examine patients’ perceptions of the sub-themes of disengagement, education, and consent. As mentioned, the combination of the current study with the previous study of patients’ experiences of osteopathic touch, especially if published together, will create an important body of work that richly explores how touch is used in an osteopathic setting. The majority of existing osteopathic literature focuses on the more technical interpretation of touch (palpation) so data that explores the more emotive and communicative elements of touch is an important addition to the literature.

As well as aiding understanding among healthcare practitioners, this research has potential implications for osteopathic practice, as it provides insight into the types of touch used by osteopaths and the communicative intentions behind them. It could also generate awareness of the emotional and communicative components of touch and the role these take in the therapeutic relationship. For teachers and educators in osteopathy and other physical therapies, this research
will provide data about the osteopathic practitioner’s experience of touch, which may assist in improving the emphasis on the role of touch within training. Researchers have emphasised the importance of including the role of touch within healthcare education (Helm et al., 1997; Nathan, 2000).

The aforementioned qualitative study which examined clinical decision-making and therapeutic approaches of UK osteopaths, found an association between a lack of postgraduate education and technical rationality (Thomson et al., 2014). The implication that can be drawn from this is that undergraduate osteopathic education, in the UK at least, focuses largely on technical skills and knowledge. Therefore, critical evaluation of practice and the consideration of professional artistry are curriculum components that may be needed to balance this technical focus within osteopathic training. The current research has the potential to be used in osteopathic education settings, to aid student understanding of the way in which their developing touch skills will be used to communicate with patients.
Appendix C: Summary of Data Analysis

The organisation of sub-themes within Theme A: Negotiation was partially guided by the interview approach, in which participating osteopaths were asked to talk about their use of touch during an entire osteopathic consultation, chronologically from beginning to end. Therefore, the sub-theme of engagement arose from the descriptions of touch that takes place at, or near, the start of a consultation. The sub-theme of disengagement described the touch that takes place at the end of a session, and the sub-theme of dialogue outlined the touch that is used in the middle parts of a consultation.

Data Analysis of sub-theme [A1] Engaging – initiating the therapeutic union

The following excerpt of data analysis is included as an example to demonstrate how raw data were organised into a sub-theme. Quotes from the raw data are presented in italics, with researcher analysis in standard text. Text that is in bold represents either headings proposed by the researcher or concepts which were considered by the researcher to be particularly important in terms of strongly representing the phenomenon.

Handshake - has the dual purposes of establishing personal contact and conveying professional status. For Dave, the handshake is his way of non-verbally saying “I’m the osteopath, I’ll be looking after you today”. Some of the participants don’t use handshakes uniformly, but rather in certain situations such as with new patients or with people from certain cultural groups (Anna), where it is considered especially important to establish a relationship with the patient prior to the diagnosis and treatment parts of the process.

An alternative to this initial contact is expressed by Rupert who, for patient’s he’s met before, puts a hand on their arm or shoulder, or a hand on their back as they go through a door, to convey that he’s interested and wanting personal contact with the patient rather than just physical.

*Important to be really clear about ‘this is who I am and I’m going to be treating you’, to make that clear at the start of the process so the patient knows who is working on them.*
Subsequent to this initial brief physical contact, the first touch that an osteopath uses within the treatment room usually has an evaluative or diagnostic purpose. However, it also has the simultaneous communicative intentions of engaging the patient, establishing trust, instilling confidence and providing reassurance.

Anna explains that her first diagnostic touch typically involves standing the patient up and lightly touching the top of their head, their shoulders or their pelvis, with the communicative intentions of making contact and establishing trust.

*It’s an introductory touch; it’s a touch that says ‘I know where you are, so you can trust me.’ Because I sort of put my hand on and I find where they are... it’s like it’s that immediate recognition of ‘this person’s making contact, they’re not just touching, they’re going like ‘whoom’’. If your first touch isn’t good then you’ve lost that person*

Similarly for Paula, the first touch is about making contact with the patient, and also helping them to relax.

*I put my hands on their shoulders. And I just rest my hands there, and to me that’s a handshake if you like. That’s the saying hello. And I think it gives me an awful lot of information but I think it lets the patient feel that they can relax.*

All of the participants identified the importance of clarity in the first touch, to both instil confidence in the osteopath’s abilities and reassure the patient of comfort and a therapeutic result.

Dave’s first touch – gentle to confirm in the right place – this is reassuring and instils confidence.

*then probably the first contact is probably, like if, always ask someone to identify where their site of pain thing is, and then the first sort of contact is probably on that painful site. But always quite gently. Just to confirm basically this, and its more of a light touch, and its just is this the area, are we in the right place.*

The first touch has to be a good one, has to be clear and purposeful.

Paula – reassuring firmness to touch during diagnosis, makes patient feel calm, that they’re in good hands.

*Its light but its directed so it has, I hope, a reassuring firmness about it. Which makes a patient feel calm, makes them feel that they’re in good hands. That they can, the treatment’s started. So that touch had dual purposes, reassuring but also diagnostic? Absolutely.*
Jane – instilling confidence, this can also be considered reassuring.
Where as, Jane’s first touch is firmer, but has a similar purpose of instilling confidence.
Firm. Its not hard and not a hard touch, its not an aggressive touch, its not assertive but I think if you do soft touch with a patient, soft as in palpation, light palpation is fine but soft as in wishy washy, it doesn’t work, they don’t know what’s happening and it doesn’t instil a lot of confidence in you if you, if you don’t put your hands on. And if it’s really soft and light then it may just be a pat on the shoulder talking to a friend as opposed to this is something we’re going to do and this is where we’re going and this is what’s going to be happening next.
Jane also uses the intro touch to introduce to new patients that touch is the process involved.

Anna – first treatment touch with some people is firm and direct to send a clear message.
Anna - Establishing trustworthiness, this practitioner knows what she’s talking about.
Getting the feedback I need but also reassuring the patient, “hello, we’re ok, we’ve got contact’.

For Anna, the first touch has a reassuring quality – that everything is going to be fine, trust.
Cos if your first touch isn’t good, then you’ve lost that person. They’re going to be like ‘oh I don’t know if I like this person, I don’t know if I trust this person, I don’t know if I’m going to surrender to this person’. You know, so, that first touch actually has to be a good touch. If it’s a pokey touch or if its, they’re going to go ‘aw, this is going to hurt me, I don’t know if I like this’. [laughs] ‘Maybe I should go now’. So it’s like ‘OK, I know you’, its gentle touch. It’s soft. It’s like ‘oh, warm hands, soft hands, its ok, this is fine’ [whispers]. And I also know where you are, and its OK, we’re going to sort it out. I think that’s sort of what I try and do with my first touch.

Dave – reassuring patient that they have contact.
go through a sort of more structural analysis, I probably am a bit firmer, just to, and I think that’s partly just to get hands on, make sure I’m getting the feedback I need, but also possibly reassurance of the patient, like hello, we’re OK, we’ve got contact here. But again hopefully not too, if any patients let me know, and I always say that, let me know if anything’s sore, if anything hurts, if any touch points are sore or painful, and normally I won’t prod away at them, I just leave them be.

Rupert – conveying interest. Rupert – hand on their back during examination for reassurance. Conveying interest, listening and engaging.
Its usually a kind of, the next touch is often sort of when I’m observing how they stand, how they move, I would actually put my hand on their back or their shoulders while I’m standing
behind them or to the side of them looking at them. Just again to kind of give some context to what’s going on.

Not so much emotional. Maybe its more conveying interest and also if they’re telling me where it hurts, me saying so this is where you’re feeling it is a way of confirming that I’ve been listening to what they’re saying and giving them a chance to say no no its further up or over or, its more here, or yes that’s it or that sort of thing.

Dave – first touch is an interface of here’s me, let’s see how you respond to this – introducing himself, judging initial patient reaction (so perceiving is always part of it).
And so just that first touch is kind of a OK I guess in a way its almost like a interface of here’s me and let’s see how you respond to this. Are you, do you have any expectation or anticipation of it being stronger, softer, any expectation of not being touched at all.

Rupert – my intention is that the patient maintains some sort of involvement.

Paula – first treatment touch is grounding.

Anna often then comments to the patient about her initial impressions ‘you feel pretty tired, or you feel, have you had a hard week or had a hard time?’ And I mean I don’t even know this person, or this person knows me and knows that I know. It immediately kind of goes ‘boom’, this person is not messing around and they’ve already made contact.”

Paula - Its both. Its light but its directed so it has, I hope, a reassuring firmness about it. Which makes a patient feel calm, makes them feel that they’re in good hands. That they can, the treatment’s started.

So that touch had dual purposes, reassuring but also diagnostic?
Absolutely. That’s giving me clues. Its giving me clues as far as the kind of rotations in the body, the twists, the side-bending, the shortening, the compressions, the you know all of that. All of that is part of that little data bank of information that you’re picking up through the finger tips and hands, you know the whole palm really and being able to then translate that into what’s going on and into my own mental picture as far as, and you know obviously whether that fits with the case history.

As can be seen by the text that was bolded in this excerpt, these key points were summarised and formed into paragraphs within the manuscript results section. A quote was selected from the raw data within each sub-theme, which was considered to most effectively summarise the participants’ views.
Excerpt from reflexive research journal

To provide another example of how the sub-theme groupings were established, an excerpt from the researcher’s reflexive research journal is given below.

26 April 2014

_Education seems like it could be just one sub-theme of empowering. So I could include this in another theme. It seems like education/empowering would fit best in the reassurance section. It is a quality that osteopaths provide to help the patient. Would it need a new overall title other than reassurance – or maybe education can be considered part of reassurance?_

This excerpt demonstrates the consideration that was given to how each sub-theme fitted with other sub-themes and within overall theme groupings. At one point in the data analysis process, the researcher thought that education would be an overall theme of its own. But reflection on the depth of data about education revealed that it really fitted as a sub-theme. In the end, the heading of _reassurance_ was changed to _reassurance and empowerment_ to incorporate the theme of education.

Excluded Data

It is worth mentioning in this summary of the data analysis process that there was some data that was excluded from the final results section of the study. The interviews included some data about how touch may vary for different groups, such as acute/chronic patients, males/females, babies and children, and people from different cultures. However, the depth of this data was not considered to be satisfactory for inclusion, and it did not fit clearly within the study aim of outlining the communicative purposes of osteopathic touch. There was some data about osteopaths’ views of the differences between palpation and touch, but again this was not considered a meaningful addition to the overall study aim. Finally, there was data about the information that osteopaths get from their patients through touch. This concept was alluded to in the dialogue section, where it was mentioned that there is a two-way flow with touch, and that osteopaths respond to the signals they receive from their patients. However, any data that focused more on the technical information that osteopaths perceive through palpation was not
included. This was partly because it was not considered to be of strong relevance to an exploration of the communicative purposes of touch, and partly because it is a subject that deserves independent research of its own.
Appendix D: Ethics Approval

Anneke Barrington
106 Lynwood Road
New Lynn
Waitakere 0600
Auckland
19.4.13

Dear Anneke,

Your file number for this application: 2012-1026
Title: Osteopaths’ applications and experiences of touch within the context of their practice

Your application for an extension to the above research project has been reviewed by the Unitec Research Ethics Committee (UREC) and has been approved for the following period:

Start date: 19.4.13
Finish date: 19.4.14

Please note that:

1. The above dates must be referred to on the information AND consent forms given to all participants.

2. You must inform UREC, in advance, of any ethically-relevant deviation in the project. This may require additional approval.

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

Yours sincerely,

[Signature]
Gillian Whalley
Deputy Chair, UREC

Cc: Clive Standen
Cynthia Almeida
Appendix E: Participant Information Sheet

Information for Participants

Osteopaths’ applications and experiences of touch within the context of their practice

You are invited to participate in a research project conducted within the Master of Osteopathy program at Unitec Auckland, New Zealand.

The Study
This purpose of this study to explore the phenomenon of touch from the perspective of osteopaths. Although touch is one of the key defining factors of osteopathic practice, there currently exists no published research concerning its role within osteopathy.

The key aim of the study is to qualify the types or forms of touch that are applied within an osteopathic consultation and investigate practitioner’s intentions behind these applications of touch. The study also aims to explore the factors that influence osteopaths’ use of touch, and osteopaths’ experiences of the emotional and communicative components of touch and the role these take in osteopathic practice.

How you are able to participate
Participants will be interviewed about their professional experiences of touch using a semi-structured interview, allowing for open discussion which will be guided by both the interviewer and interviewee. The interview is expected to last for a maximum of 1.5 hours and will be audio-taped for accuracy and later review. The interviews will be conducted at a pre-arranged place and time, which is mutually convenient for both the participant and the primary researcher. You will be asked to complete a consent form before the interview commences.

Inclusion criteria for participants in this study:
- The participant must hold a current Annual Practicing Certificate with the Osteopathic Council of New Zealand and be currently practicing in this country
- The participant must have at least five years’ experience working as an osteopath and practice using a range of treatment techniques

Withdrawal from the study
Participants will be free to withdraw from the interview at any time and your interview script would be subsequently excluded from the study. Once the interview transcript is returned to you for approval, you will have two weeks in which you may withdraw your transcript if you wish, which can be done by contacting the primary researcher by phone using the contact details below.

Use of information
Information from your interview will be used in preparing a research dissertation. This dissertation may also be used for future purposes as part of a journal article and/or presenting findings at a conference or an osteopathic educational institute. You will not be individually identified in any reports, as all interview
comments will be attributed to a pseudonym which can only be identified by the primary researcher. All information will be stored securely on a password secured computer for a minimum period of 5 years.

If you would like more information or you have any concerns about this research project you can contact the primary researcher or principal supervisor at any time:

**Primary Researcher**
Anneke Barrington  
Master of Osteopathy student (Unitec NZ)  
Mobile: 021 404 131  
Email: annekeb@vodafone.co.nz

**Principal Supervisor**
Elizabeth Niven  
Senior Lecturer Osteopathy (Unitec NZ)  
Phone: (09) 815 4321 x8320  
Email: eniven@unitec.ac.nz

*This study has been approved by the Unitec Research Ethics Committee from 15th April 2013 to 15th April 2014. If you have any complaints or reservations about the ethical conduct of this research, you may contact the Committee through the UREC Secretary (Ph: 09 815 4321 ext.7254). Any issues you raise will be treated in confidence and investigated fully, and you will be informed of the outcome.*
Appendix F: Participant Consent Form

Thank you for agreeing to participate in this research project being undertaken for the Master of Osteopathy programme at Unitec New Zealand.

Participant Consent Form

Osteopaths’ applications and experiences of touch within the context of their practice

This project aims to explore practitioners’ experiences of touch, and to qualify the types or forms of touch that are applied within an osteopathic consultation.

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

I have had the research project explained to me and I have read, and I understand, the Participant Information Sheet provided.

I have had the opportunity to ask questions and have them answered.

I understand that I don’t have to be part of this if I don’t want to and I may withdraw from participating in the research at anytime up until two weeks after the interview transcripts are returned to me for approval.

I understand that everything I say is confidential and none of the information I give will identify me and that the only person who will know what I have said will be the Primary Researcher Anneke Barrington.

I understand that all the information that I give will be stored securely on a computer for a minimum period of five years.

I understand that my discussion with the researcher will be taped and transcribed and no material could identify me if used in any future reports on this project.

I understand that I can see the finished research document.

I am aware that I may contact the Primary Researcher Anneke Barrington on (021) 404 131 or the Principal Supervisor of the research Elizabeth Niven at Unitec, (09) 815-4321 ext 8320 if I have any queries about the project.

I have had time to consider everything and I give my consent to be a participant in this study.

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

Primary Researcher: …………………………………………………………………………………………………………………………………… Date: ……………………………

Participant/Researcher Copy

The participant should retain a copy of this consent form

This study has been approved by the Unitec Research Ethics Committee from 15th April 2013 to 15th April 2014. If you have any complaints or reservations about the ethical conduct of this research, you may contact the Committee through the UREC Secretary (Ph: 09 815 4321 ext.7254). Any issues you raise will be treated in confidence and investigated fully, and you will be informed of the outcome.
Appendix G: Interview Schedule

1) Welcome the participant and thank them for their participation. Explain the aims of the study to the participant, and outline what their involvement will entail and approximately how long it will take. Ensure participant understands both the information sheet and the consent form and reiterate their right to withdraw from the interview or research process at any stage. Participant will then sign consent form.

2) General questions – How many years the participant has been practicing as an osteopath, details about their qualifications, any formal training they have done relating specifically to the subject of touch.

3) Introductory remarks – “As the study intends to explore the use of touch within osteopathic consultations, I’d like you to think about one of your consultations from today and tell me about all the ‘touch’ elements that were involved. You can describe each touch element, what its purpose was and it’s intended meaning, why you chose to use that particular form of touch, and what impact you think it had on the patient. If you like, you can start with the initial contact that your hand made with the patient, even if it was just a handshake”.

4) It is expected that the interview will cover the following areas, and if they are not discussed during the interview conversation, I will raise these ideas to the participant at the end of the interview to ensure a full exploration of the phenomenon:
   - Procedural and non-procedural touch within an osteopathic consultation
   - Factors that influence use of touch or development of a touching style/touching expertise
   - Touching style and adaptation of touch to a specific patient
   - Boundaries and professionalism in relation to touch, practitioner awareness of their own agenda around touching
   - Communication from the osteopath through touch (care, support, competence, trust)
   - Information gained from the patient through touch
   - Effects of touch on the osteopath and the patient
   - Differences between touch and palpation, relationship between touch and the technical aspects of osteopathic practice, influence of the core principles of osteopathy on use of touch
   - Issues around touch and gender

5) The interview will have a semi-structured format, allowing an open and fluid discussion about touch within an osteopathic consultation. I will remain alert to any discomfort that may be expressed by the participant and respond appropriately, for example by checking their agreement to continue, reminding them of the confidential nature of the interview and research, moving to a safer topic, or discontinuing the interview if necessary.

6) Thank the participant for their participation in the interview, and assure them of their confidentiality through the use of a pseudonym. Request that they contact me if they have any questions or concerns about their involvement in the research.