Is *Sacral Listening* Applied in a Uniform Way?

A qualitative study

Master's thesis for the degree
"Master of Science" in Osteopathy
at the **Donau University Krems**
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by

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Abstract

This study deals with the question: Is *Sacral Listening* applied in a Uniform Way?
The answer to this research question, which is also the title of this Master's thesis, is based on three pillars.

The first pillar is a survey of literature. Here research is undertaken, examining how the sacrum is described in osteopathic literature and what interconnections exist between palpation, perception, and interpretation. Subsequently, clarification is sought as to how Sacral Listening is viewed by different authors in literature.

The second pillar consists of a quantitative survey conducted with 50 osteopaths. The goal of this survey is to establish relevance for the research question of the Master's thesis. Questions are posed, mainly in relation to the degree of familiarity with *Sacral Listening* testing and its application in everyday practice.

The third pillar on which this Master's thesis is based comprises of 12 guideline-based expert interviews concerning *Sacral Listening*. The interview is a method of qualitative social research.

The hypothesis was clearly rejected: *Sacral Listening* is not applied in a uniform way. This outcome was substantiated by many individual results of this study. There is great diversity in the application of the testing as well as in the frequency of its use in osteopathic practice. For some therapists it is an integral part of every osteopathic examination, for others it is a method used only in concordance with certain other criteria. A further element of disparity lies in the interpretation of what was perceived. This, in turn, is not only dependent on the intention or the approach but also on the individual inner picture of the sacrum which each osteopath has formed in his or her mind.

Finally, the diversity in assessing *Sacral Listening* results from each therapist's individual development in the way he sees and applies this testing.

What then is the relevance of this result for osteopathy and osteopathic research? The outcome of this study has a relevance for basic research in osteopathy. The demand for a standardization on the basis of scientific research which only legitimizes what is both proven and applied in a uniform manner appears to be premature. If osteopathy was subjected to such judgement it would be castrated and would be robbed of one of its greatest tools. This observation underlies a claim made by the DO journal last year

> *"We have to make it perfectly clear that this place [referring to the place of academi-calization and scientific research] can only exist and develop right amidst the osteopathic-clinical experience and the everyday practice of dealing with the suffering of the patient. We must call for science to actually create osteopathic knowledge rather than just providing evidence about the effectiveness of osteopathy. And we must insist that scientific curiosity rather than tedious formalism determines academic research."*(Breul et al., DO 2/2008, p.1)

Key Words:

qualitative research - quantitative research - sacral listening - palpation - perception - living picture of anatomy - interpretation

Declaration in Lieu of Oath

I hereby declare that I produced the submitted Master's thesis with no assistance from any other party.

I have marked as quotations all passages which were reproduced verbatim or near-verbatim from the published or unpublished work of others. All sources and resources that I used for my thesis have been identified. No thesis of identical content has ever been submitted to any other Examining Board.

November 2009 Brigitte Krapp

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1. Introduction

For the recognition of osteopathy it is important to establish framework conditions for its research studies without being subjected to the criticism of the scientific community. (Muzzi, 2005, S. 16)

During the development phase of my Master's thesis, this statement remained in the fore of my mind as my interest was drawn towards conducting a study of the palpation testing *Sacral Listening.*

This testing is an integral part of my osteopathic examination of the patient.The patient is in supine position. The hand of the therapist is moved, preferably from caudal, under the patient's sacrum. Elbow and forearm rest between the patient's thighs on the therapy bed. The ball of the hand is positioned under the coccyx and the fingers are splayed, so that the thumb and the little finger are in a position under the sacroiliac joint. The palm and the other fingers are in contact with the sacrum. (Magoun, 2000)

In the course of observing other osteopaths applying *Sacral Listening* during the Master's course in osteopathy in Vienna and after exchanging views with colleagues about *Listening* in general and in specific situations, the question arose which then became the topic of my Master's thesis:

Is Sacral Listening applied in a uniform way?

The answer to this question is to be researched on the basis of a qualitative study, which constitutes the framework of this Master's thesis. This is done with the tool of the guideline-based interview. The interviews are conducted with osteopaths backed by longstanding experience; most of whom also take an active role in lecturing on osteopathy.
On the basis of the interviews, the intentions and the interpretations of the interview partners concerning *Sacral Listening* are compiled. Carrying out the Master's thesis within this framework was further encouraged through another statement by Muzzi in which he describes the danger:

> *to reduce ourselves in our osteopathic research to a framework that is too rigid and too limited, at the expense of our specificity and at the price of forfeiting the philosophy specific to our own skilled art and our therapeutic tool, the hand.* (Muzzi, 2005, p. 16)

The goal of this study is the establishment of agreement in the application of the testing, and its documentation. It is hoped that the results of this study may open up new possibilities for further research protocols.

In order to ascertain the relevance of this study, I have conducted a quantitative survey with 50 osteopaths. The survey indicates the tendency to which degree respondents are familiar with *Sacral Listening* and the extent to which it is applied by the respondents in their therapeutic practice.

2. Survey of Literature

In the course of the quantitative survey that was conducted with 50 osteopaths, the question arose, whether they were in possession of any records concerning *Sacral Listening* from their period of training as osteopaths. The majority of the students reported that some hand-written notes existed. Consequently, the next step was a study of osteopathic literature concerning *Sacral Listening*. This study revealed the importance which palpation is generally given in osteopathy.To demonstrate this, it must be mentioned that Krause (2006) and Chaitow (1996/2001) dedicate a book each to this subject.

In a book about osteopathic diagnosis, palpation is described *as being possibly the most important tool in the hands of the osteopath.* (Sammut/Searle-Barnes, 1998/2000, p. 140).

Chaitow describes palpation as the centrepiece of every diagnostic finding. In her preface to Chaitow's book, Frymann writes:

> *A sensitively performed palpation is the key to diagnosis, and the more subtly it is applied, the less it is perceived on the outside.* (Chaitow, 2001, preface.)

Liem describes a method of palpation in osteopathy:

> *This consists firstly in tuning in to the tissue that is about to be palpated. Then the perception of the area in question is enhanced, magnified in order to finally lead to an interpretaion of the impulses that were perceived. The interpretation of the palpation provides meaning, translates the perception and places it in its anatomical, physiological and pathological context.*

Liem outlines in his description the inner connection between palpation, peception, and interpretation. The interpretation or explanation of what was perceived stands in close affinity to the knowledge of anatomy, physiology and pathology.

This relationship between palpation and perception is Höppner's subject, too (2008). To him, palpation is a question of perception, and the process does not happen in the hands but "somewhere between the ears". In his elaboration he alludes to Still's claim, that every osteopath should at all given times have a "*living picture of anatomy*" (Höppner, 2008, p.13) as a mental image and that one can only palpate what one knows.

In relation to these statements by Liem on Höppner the following will demonstrate, how the sacrum, or in other words the "living picture" of the sacrum is described in osteopathic literature. It is the purpose of the following outline to give such insight.

2.1. The Sacrum from an Ostheopathic Point of View

Adequate anatomical knowledge about the sacrum and its neigbouring structures is to be assumed. The reason for stating the views of osteopathy in a rather detailed fashion is to illustrate the great range of descriptions of the sacrum and its dysfunctions. This is important in order to develop an understanding for the inner connection of palpation, perception and interpretation of the sacrum by means of *Sacral Listening*. This relationship has already been mentioned before in the statements by Höppner and Liem. Another reason for the following review is the intention to build a basis on which to clarify the differences in the application of *Sacral Listening* expressed by different authors in literature, as well as creating a basis for an understanding of the interviews in chapter 5.

W. G. Sutherland (Liem, 1998) developed the craniosacral concept in the 1930's. In this concept of osteopathy the sacrum is seen in as directly anatomically linked with the cranium. Sutherland (2008) describes the fundamental connection beween the cranium and the pelvic bowl via the dura mater in great detail. On the basis of this dural link which comprises both the intraspinal and the intracranial membrane, and as such is named by him the "*Reciprocal Tension Membrane"* (Sutherland), he explains what he considers a fundamental principle, the *"Primary Respiratory Mechanism"* (PRM) which is defined as:

> "*The involuntary motion of the sacrum between the ilia." (Sutherland, 2008, II -122*)

According to Liem (1998) the term *Reciprocal Tension Mebrane* is to be seen as a functional unit of the dura with its horizontal and vertical components.Among the horizontal components are the tentorium cerebelli and the diaphragm sellae. The vertical system includes the falx cerebelli, the falx cerebri and the spinal dura.

> "*The dural membranes, on account of their adhesion to the cranium and the sacrum, regulate the involuntary motion of the different cranial bones and of the sacrum in craniosacral rhythm"* (Liem, 1998, p.185)

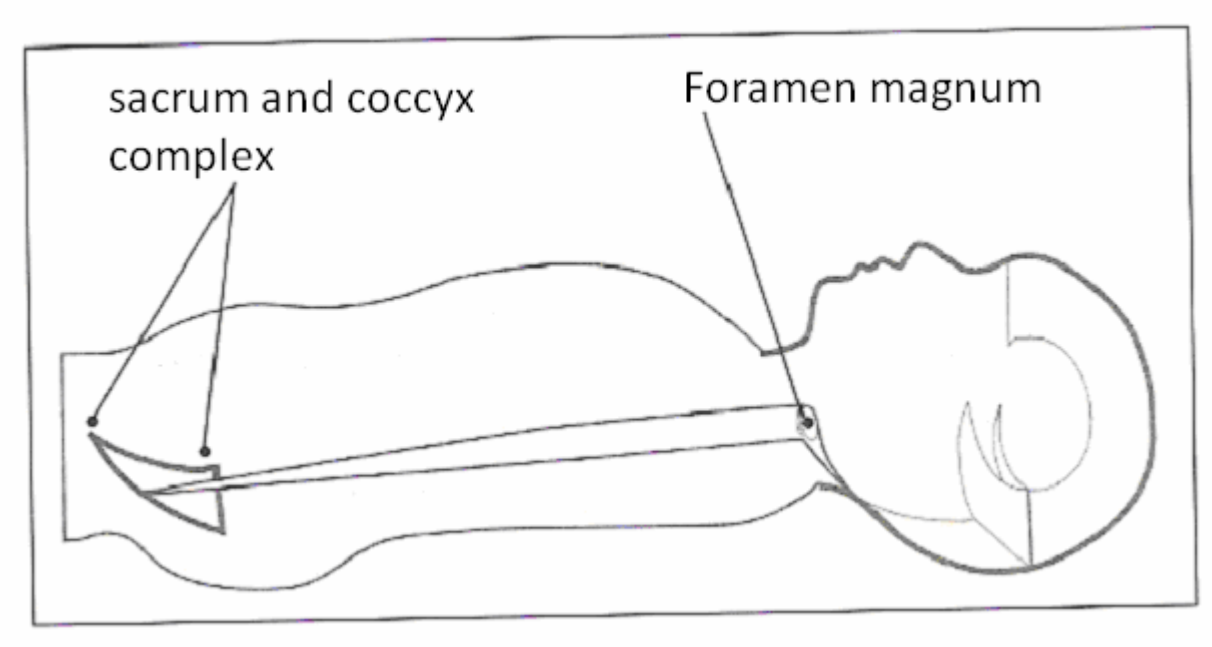

Fig.1 Continuity of the intracranial and intraspinal dural membrane (Liem, p.178)

Becker (2007, p.I-143) uses the term *tension membrane* as well, and denotes the sacrum as the lower pole of this *tension membrane*.
This lower pole is also mentioned by Handoll (2004), however in the context of the *Primary Respiratory Mechanism*. The involuntary motion of the sacrum during *PRM* takes place along one axis. This axis is on the S2 segment level. For Handoll, the transversal fulcrum[1], as he calls it, is a functional point. The importance of his realization is reflected in the following statement:

> *"If the functional sacrum is in congruence with the anatomical sacrum, everything is well."* (Handoll, 2004, p.33)

Likewise, he describes the sacrum as a *"differential"* (Handoll, 2004, p.33) According to Handoll, the differential enables the rotation of the two lower extremities to the inside and the outside. To substantiate this, he adds some anatomical reasons. Stating them in detail here would exceed the scope of this study.

Handoll (2004), as opposed to other authors (Helsmoortel, 2002; Magoun, 2000; Cloet, 1999) describes the movement of the sacrum in the *respiratory mechanism* in two parts. The first part consists in the raising of the sacrum in an upward movement towards the head. The second part consists in a backwards rotation, so that during the flexation phase the base makes a posterior movement, and the apex an anterior movement.

In Liem's work (1998) about the involuntary mobility of the sacrum between the ilia we find an addition to the above mentioned description of movement. This addition involves a movement synchronized with that of the occiput and of the counter movement of the sphenoid bone. To him, the axis along which the sacrum moves is a hypothetical one. The context of the synchronous movement of the sacrum with the occiput and the reverse sphenoid movement as described above is important to him, in order to arrive at an understanding of cranial dysfunctions that may affect the sacrum, and vice versa.

The description of this interaction of articular fixations in the iliosacral joint to fixations within the joints in the cranial mechanism and its consequences had already been established by Sutherland (2008). He points out that a lowering of the sacrum to the anterior causes a

[1] stillpoint or (variable) centre of a movement (Liem, 1998, p. 277)

change of position of the fulcrum at S2. He also states that due to fixations at the iliosacral joint, the fluctation of the cerebrospinal fluid is impeded.

In relation to this movement of the sacrum, the sagittal movement of the sacrum without the exertion of weight is described by Mitchell as the "*respiratory sacroiliac movement"* (Mitchell, 2006, p.46) He emphasizes the clinical relevance of the functional movement of the pelvis in relation to voluntary and involuntary breathing. In his opinion, restricted breathing movement in the sacroiliac joint significantly increases breathing work. He cites functional, anatomic correlations beween the spine, the pelvis and the urogenital diaphragm as reasons.

Mitchell confirms the movement axis at the S2 sacrum segment as described by Magoun (2000) and other authors (Liem, 1998; Handoll, 2004). This breathing axis, as he calls it, was validated by x-ray studies by himself and Pruzzo (Mitchell; Pruzzo, 1971).

According to Mitchell (2006), neither in the case of the *PRM* linked movement, nor in the one linked to breathing is there any quantification of movement. Mitchell distinguishes between two kinds of craniosacral movement: the inherent craniosacral rhythm with its small movement amplitude and the movement of sacrum oscillation with a greater amplitude, as a manifestation of a cranial dysfunction. These oscillations center around an oblique axis.

Besides Sutherland's classical model of the dual synchronous mobility of the sacrum via the dural core link, Milne describes a very different model, which he calls *" the liquid-electric model" (Milne, 1999, p. 3)* In this model there is no specific axis of rotation. The main axis of movement rotates around the circumference of an imagininary swimming sphere, which surrounds the sacrum; its lateral curves extending to the iliosacral joints.The flowing motion of the sacrum resembles the walking motion. During flexation, both sides of the sacrum move to the anterior alternately. Milne talks about a movement around the vertical axis and of a superior movement, while the base posterior and apex anterior move toward the small pelvis, and a simultaneous torsional movement on the vertical level during the extension- and flexion cycle. To him, modifying factors are the tonus of the lumbar, abdominal and perineal musculature as well the leg musculature.

We find very different references to the sacrum in the work of Helsmoortel et al. (2002). They describe a viscerocranial connection with the sacrum and point out the interaction of dysfunctions in this region.

In this process a loss of intestinal tension, caused by ptosis and resulting in an increased weight exposure on the pelvic floor, can lead to a reflex increase of the pelvic floor muscular tonus as a result of the preceding dilatation.The sacroiliac joint is exposed to abnormal tension and the sacrum itself is restricted in its dynamic. As opposed to other autors (Magoun, 2000; Mitchell, 2006; Liem, 1999)
Helsmoortal calls this movement the *involuntary mobility* (Helsmoortal et al., 2002, p. 150) of the sacrum between the ilia. It is hindered when the sacrum is constricted in its dynamics.

Furthermore, he gives a desciption of a neurological link between the intestine and the sacrum, namely in the parasympathic supply. He describes the course of these fibers to their outlet at sacrum level through the foramina sacralia pelvina anterior towards the small pelvis. Here they join with orthosympathic fibres which in turn come from the deep lumbar and sacral sympathic chain ganglia, to form the plexus hypogastricus inferior. From that point they take a bilateral anterior direction towards supplying the pelvic organs. Altered activity of the parasympathetic affects the pelvic floor muscles, which are, among others, innervated by the n. pudendus. This is a further mechanical inluence that has a bearing on the sacroiliac joint, which the author mentions in his study

He describes a third reference to the sacrum in the complex fascial system of the pelvic region, in which the rectum is embedded as well. A part of this system stabilizes the organs of the small pelvis laterally, like two splints. They run from the synphysis pubica to the sacrum. Through his description of these functional links the author suggest, how - irrespective of traumatic interference- a restriction of the involuntary motion of the sacrum can be caused.

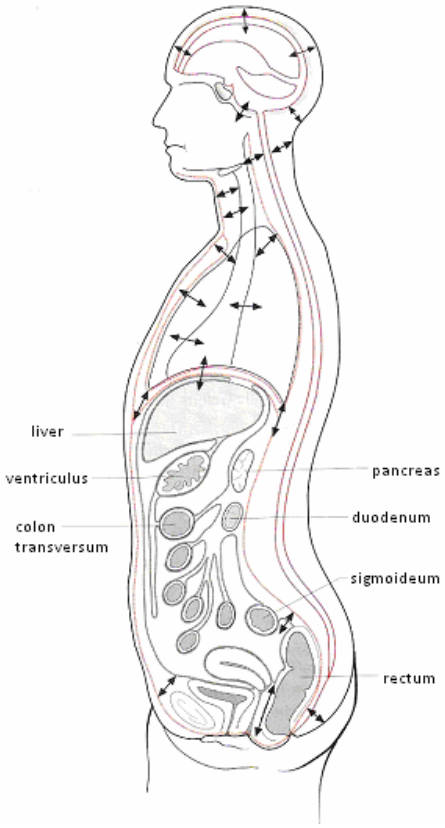

Fig. 2 schematic diagram: intestine in ptosis; pelvic floor increases its resting tonus and stabilizes the intestine; the sacroilioc joint gets exposed to strain. (Helsmoortel et al, 2002, p. 150)

Handoll (2004) points to a different kind of dysfunction in his research. It is the possibility of a shift of the functional sacrum into the lower thorax or the upper lumbar region, after a fall affecting the apex of the sacrum. As a contrary example, following a difficult forceps delivery, he describes the possiblity for the functional sacrum to be located between the knees of the mother.

Becker's (2007) descriptions are in agreement with those of Handoll and Sutherland. He adds a description of the impact of a restricted sacral mechanism which builds up a resistance against the free movement of the thoracic and the cervical spine. Knowledge about the ossification of the sacrum is crucial in osteopathy in order to recognize interosseous lesions of the sacrum.

Liem (1998) provides a differentiated description of ossification and further divides it into prenatal and postnatal ossification. The individual steps of ossification take place at different

ages of the young person. He determines the completion of this process of ossification between the ages of 25 – 28.

The same knowledge about the ossification becomes apparent in the work of Handoll (2004). In a given lesion of the sacrum he differentiates between two kinds of intraosseous compression. These are firstly the deformation of the cartillages that are not connected yet, caused by serious trauma during adolescence. He also alludes to late ossification and its varying temporal sequence in the sacrum. At the same time he remarks that the final form of the sacrum in the adult is determined by its previous shape. Secondly, there is intraosseous compression, this second type can occur at any time. If the elasticity of a bone is overextended, this bone will return to its limits of its pliability. Some of this deformation will, however, remain in the bone. Palpation can sense this as a change in the quality of the bone. In his explanation he refers to the mechanical properties of the sacrum.

He describes these properties in general in another place (Handoll, 2004, p. 15) The living bone is flexible, pliable and malleable. He refers to a source in Gray's Anatomy (1980, p.252). The bone tissue is a viscous, biphasic, pliant and elastic substance like fiberglass. The bone proves to be a highly vascular, living, perpetually changing, mineralized connective tissue. Here, and likewise in his comments in which he describes this tissue as cells embedded in an anamorphous and fibrous organic matrix, Handoll relates to the source given above.This matrix is permeated by inorganic calcium phosphoricum. 20% of the weight of the basic substance consists of water, 30-40 % of the dry weight consist of organic material, mostly collagen. 60 – 70 % are constituted of inorganic mineral salts like calcium, magnesium, phosphorus and carbonate. (Gray's anatomy, 1980, p. 255). When the mineral components of the bone are dissolved through weak acids, the remaining organic bone maintains its form, turns most flexible, however, and can be cut with a knife or tied into a knot. These data are drawn by him from another publication on anatomy (Lockard & Hamilton, 1965). The drying up of bone specimens indicates a progressive loss of the mechanical characteristica of living bones such as elasticity, plastic deformation as well as pressure and tension related qualities.

In Milne (1999) as well, we find a description of the quality of the sacrum as a bone. He characterizes the inherent suppleness of the bone as a further component in the mobility of the

sacrum. Similarly to Handoll he finds the reason of this suppleness in the osseous matrix of the connective tissue. This matrix permits minute multilateral movements.

A further study of the sacrum, on quite a different level, is also to be found in Milne's work (1999). He attributes the sacrum to the second sacral chakra. In connection with the root chakra which has its place in the coccygis and the perineum, he names four aspects which he associates with those two centres: stability, support, sexuality and spirituality.

Mentioning this approach is important in order to appreciate Milne's interpretation of the palpation of the sacrum which will be dealt with in paragraph 2.3.2. about Perceptive Information.

This chapter makes it clear, what diverse approaches of looking at the sacrum exist, both in terms of the structural level as well as in regard to the description of the movements of the sacrum in the literature compiled here; and in doing so very different focal points can be set. This is very obvious in the work of Helsmoortel, who emphasizes the viscerocranial context in relation to the sacrum. As initially described, the "living picture " of the sacrum is of great importance to palpation of the sacrum and consequently to the *Sacral Listening* testing, following Höppner's (2008) claim that one can only palpate what one knows.

2.2. Palpation Experience

It is the goal of the following chapter to introduce those authors providing descriptions of palpation, including the palpation test *Sacral Listening*.
Attention is immediately drawn to Becker (2007) who gives a comprehensive recording of palpation in general. Becker (2007) differentiates between four levels of palpatory skill.

The first one is the superficial contact, in which only the touch receptors of hand and fingers are used. The next level consists in the involvement of proprioceptive channels of certain muscles. This level enables the therapist to tune in with the tension in the part of the mechanism that he is in contact with.

On the penultimate level the therapist's own sensoric impulses come into play. Becker describes this interaction on three levels.

> *Once you have established your hand-contact and you have tuned your proprioceptive channels on reception,* (the 3rd level of perception begins now) *you begin listening to what happens in this body physiology* .(Becker, 2007, S. I-154)

He calls this level the "senso-motoric level". The following final level is hard to describe. For Becker it is the quantum level, on which he obtains more information than on the others. At this level, Becker says:

> "*you agree to letting yourself be used by the body physiology of this patient while you listen to the news"*. (Becker, 2007, p.I-157)

In his explanation, Becker expresses the view that during this kind of palpation there is a dissolution of the boundaries between therapist and patient. The objectifying approach of the therapist is overcome.

Upledger (1996) deals with these levels described by Becker in a very different manner. His advice is to palpate with the entire hand and to *meld* its palpating part into the part of the patient's body that is to be examined.. There is an effect of synchronization while the hand comprehends what happens inside the patient's body. After the *melding in* and the *synchronization (*Upledger, 1996, p. 42) have taken place, the therapist is able to use his own proprioception in order to understand what the palpated part of the body is doing. Proprioceptors are those sensory receptors embedded in muscles, tendons and fascia which convey to us information about or own body position in relation to space. Upledger, like Becker, clearly acknowledgers this dissolution of the boundary. He clearly uses the term "melding ".

Liem (Liem et al., 2008) describes a very different palpation experience. He refers to tantric traditions which possess a differenciation into three levels of experience. One level, the outward experience is connected to the form. Here, the osteopath gives his attention to particular details of the tissue, that is he concentrates on sensing certain defining features of the tissue,

*This approach is characterized by an "objective" view, systematic observation and rational understanding. (*Liem et al., 2008, p.25)

To Liem, the second level is the inner experience. Attention is focused on the form and its context. In the context of this thesis and its focus, this would be the sacrum. The osteopath sees relational patterns and fields between form and context. His summary comes to a recognition of a hierarchy. First he talks of the organ, followed by the tissue and the entire human body. Next her specifies the inner experience of the patient and his cultural and social environment. By means of palpation, these relational patterns are brought alive to the therapist and the patient.

The third level is, according to Liem, the realization that form and space are identical. Their duality no longer exists. Experience now takes place without the aid of methodological props and models. Palpation is immediate and intuitive. This third level of direct experience can only be achieved through a learning process of the systematic and rational understanding on the two other levels of experience. Liem reports of the same phenomenon of dissolution as the two previous authors. However, he points out that firstly, there is no methodology on the the last level and that secondly this level can only be reached by a process of experience.

This wide range of assessment of the experience of palpation shows, into what dilemma osteopathy has manoevred itself. This dilemma is expressed in the following questions, taken from an editorial of the DO journal (2009):

"Do we palpate with our hand, the senses, our whole being?
What is in effect the medium of palpation, its language?
Can we palpate things past as well as things present?"
(Breul, 2/ 2009, p.1)

2.3. The Application of *Sacral Listening* in Literature

The main criteria in the choice of authors who write on *Sacral Listening,* was an identical initial position of the patient, namely the supine position, and the positioning of the therapist's hand under the sacrum. The number of authors who write about the application of *Sacral*

Listening is limited. Becker and Fryman stand out from the other authors because of their comprehensive, if diverging characterization of *Sacral Listening*. Both were students of W.C. Sutherland. The differences between the authors begin with the term given to this testing and the wide range of titles given to the chapters dealing with aspects connected to *Sacral Listening.*

Becker describes *Sacral Listening* in the chapter *"Diagnostic Touch"* (Becker, 2007, S. I-193)

"Perceiving palpation = Diagnosis" (Fryman, 2007, p.215) is the title used in Frymans work.

Magoun calls his study: "*Palpation of the Involuntary Respirational Mobility"* (Magoun, 2000, p. 164)

Cloet's description is to be found unter the title "*Diagnosis and Treatment of Sacrum Dysfunctions"* (Cloet, 1999, p.89). It is not further dealt with here, because it appears to be a replication of Magoun's concept (2000). Cloet's book was published in 1999 in German, the first edition of Magoun in English appeared in 1966.

Upledger's explanations are to be found in his chapter on "*Craniosacral Motion: The Technique of Palpation."* (Upledger, 1996, p.42)

Croiber writes about his application of sacrum testing in his chapter "*Routine examination"* (Croiber, 2006, p.258)

In the further course of this thesis, the testing will be refered to as *Sacral Listening.*
The use of all these different terms and definitions confirms the need to ask:

"Is *Sacral Listening* applied in a uniform way"?

2.3.1. Application of the Testing

In the following, the implementation of the testing and its variations in the practice of the above mentioned authors will be described. In so doing, the starting position both of the patient as well as the therapist will be looked at.

2.3.1.1. Starting Position

As mentioned in the introduction to chapter 2.3. concordance in the supine position of the patient was a selection criteria in the choice of literature. The following paragraph deals with distinctions or additions of the authors in regard to this initial position.

Magoun (2000) and Upledger note that a similar test can be implemented when the patient is in prone position.

According to Magoun, the quality of the therapy bed can affect the perceptive feeling during palpation.

As opposed to other authors, Fryman points out in her book as well as in her seminar (2007)[2], that patient rolling is to be avoided. The patient is guided by the therapist in order to lift the pelvis and allow the therapist to slide his hand under the sacrum and place it there. However, Frymann gives the reader no justification as to the reasons for this procedure. The author of this paper experienced in one of her seminars that an incorrect result was recorded in perceiving palpation, when the patient was rolled.

According to Becker (2007) it is irrelevant whether during sacral listening the legs are stretched out or bent.

The other authors (Upledger, 1999; Croiber, 2006) report of no differences resulting from the patient's initial position.

The mere fact that the initial position of the patient during the Sacral Listening testing offers such different explanation, makes it clear, that this aspect is weighed very differently.
Once again, Frymann has to be mentioned, who considers it an interference with the flow of information, if a patient moves into the starting position himself. The different concepts as to the initial position alone would qualify for the question to be posed:

Is *Sacral Listening* applied in a uniform way?

[2] attended by the author in the autumn of 2007

A further defining criterion for the litererature under examination was the placing of the therapist's hand under the sacrum. This positioning of the hand is given different emphasis.

Croiber (2006) simply gives the instruction to place the hand under the sacrum.

Magoun (2000), Frymann (2007), Upledger (1999) and Becker (2007) define points of reference which have to be assumed by the hand.

Becker (2007) and Upledger (1999) require the fingertips to be in touch with the fifth vertebra.

Fryman (2007) states that the touch of the fingertips merely goes to the sacral base.

Magoun (2000) also describes a contact of the fingertips with the sacral base, but also, by means of splaying the fingers, establishes an additional contact between the thumb and the little finger and the respective sacroiliac joints.

For Magoun (2000) and Upledger (1996) an additional point of reference is the contact between the therapist's ball of the hand and the coccyx.

Becker (2007) and Croiber (2006) position - in addition to the caudal hand- the underarm of the cranial hand like a bridge across the spinae iliaca anterior superior.

To Becker, the contact points of the cranial hand, in combination with the elbow of the inferior hand positioned at the sacrum, serve as a fulcrum point. Becker considers this fulcrum point an important component of palpatory diagnosis. In another passage of his book (Becker, 2007, p.I.-170) he describes the fulcrum as a static lever connection. which, because of the increase of pressure it produces, automatically enhances the depth of the palpatory contact at the end of the lever, namely the hand and fingers.

Fig..3 Sacrum palpation (Becker p.I-194)

The most significant difference is discernible in Becker's practice of using fulcrums. Further discrepancies appear in relation to the therapist's hand. According to some authors, the hand has contact to neighbouring structures beyond the sacrum.

2.3.1.2. Applying *Sacral Listening*

In this paragraph, irrespective of the way the therapist positions his hand at the sacrum of the patient, the implementation of the testing as appplied by the individual authors will be explained and compared.

Magoun (2000) talks about a a light elastic response or a palpation during deep breathing, shallow breathing and when the breath is held in order to test the mobility of the joints. This application merely refers to the examination of the mobility of the sacroiliac joints, which are part of the *primary breathing mechanism*, which continues even when the breath is held.

Croiber requires the hand to be pressed against the sacrum und lifted up, as if the therapist slides it between the two iliae; in this process the cranial arm moves the spinae to the outside, in order to relax the ligamentous system on the reverse side of the iliosacral joint. He takes it as given that the sacrum then follows the tensions of the tissue. In a further description of his concept, he talks about a micromobility test (Croiber, 2006, p. 259), in which the therapist applies minute movements of rotation and lateral inclination to the sacrum. As a further induction he describes a light caudal traction at the sacrum and the subsequent release of this traction until finally the therapist's hand curves or flattens in order to test the sacrum.

For Magoun and Croiber the testing is reached through induction, that is, the impulse is given from the outside. To Magoun, this impulse can be triggered by the patient's breathing or can be initiated through light elastic suspension.

Croiber applies multilateral movements. The movements can be seen as "passive mobility tests",[3] even if this concerns movements of limited amplitude. This stimulus is applied in order to assess the subsequent reaction.

Frymann (2007) takes a contrasting position in regard to "Sacral Listening" to the others. She requires the practitioner to focus on the respective parameter of the sacrum under examination. The parameters vary in

a. form
b. texture
c.mobility of the sacrum

She provides the practitioner with certain questions for each parameter. She obtains information through these questions.She obtains information in regard to these questions. Frymann uses a minor *induction* as she calls it , as the only reference to the neighbouring structures of the sacrum in order to gain information. At L5 level it is a light caudal tug in relation to the sacrum. The link to the ossis ilii is tested by means of increased breathing. The lower arm in superiour position is used in a bridging function between the two iliac bones. The elbow and the fingertips touch the lateral aspects of the spina iliace anterior superior respectively.

Fryman clearly states, that with the exception of the two previous point, the collection of information is effected entirely by a change of attention to the different aspects of the sacrum.

Becker's approach differs from the other authors in the sense that he uses a fulcrum in *Sacral Listening*. He further describes the procedure he follows which consists in following movements that occur on micrometric level in the patterns that he registers. He talks about a gentle but definite hand contact which allows the forces of the body demonstrate their full potential of activity. This is even more clearly expressed in his instruction:

[3] „Passive mobility test is a movement carried out by the therapist, in which the amplitude of the movement, its quality as well as the subjective result of the movement can be assessed (Sammut/Searla-Barnes, p.158)

> *Allow the function and dysfunction of the tissue to speak to you through your hands and the fulcrum points instead of trying to feel something in the tissue. Allow the inner biodynamic forces to show their own unfailing potential instead of applying a force from the outside.* (Becker, 2007, S. I-177)

Upledger remarks that beginners may feel a sense of numbness in the hand resting under the sacrum. He claims that this paresthesia, which is caused by pressure, does not reduce the proprioception of the hand. On the contrary, there is an increase in sensitivity through the sensation of touch being "off line". Upledger advocates, like Becker, the use of the elbow as a support. However, he does not offer any specific term for this element of diagnosis. The hand "melds" with the sacrum. Elsewhere he explains:

> *The therapist remains as passive as possible. The boundaries between him and the patient should be shifted towards the body of the therapist. After a short while the hand begins to tune in with the body of the patient. Now, we shift the boundary between us and the patient up to our own wrist or lower arm. While this transition takes place, our proprioceptors convey to us information via the hand, the wrist and the lower arm, which seems to be withing the patient's body.* (Upledger, 1996, p. 42)

Upledger and Becker follow a passive approach in which merely the contact initiated on the proprioceptive level is activated via a fulcrum.

In comparing the descriptions mentioned above, it becomes evident that there are different levels of experience in palpation; and these differences are expressed likewise in the interviews of chapter 5.2. Before this comparison can take place, it is necessary to define these different levels.

According to Psutka (2009), osteopaths define two kinds of palpation, the mechanistic and the complex one. The first one follows the cartesian dualism. The osteopath moves the structures of the patient to obtain information. The subject is thereby separated from the object. In the second one, the complex palpation, the practitioner works in calm and stillness to give the structure of the patient the opportunity to move him. The boundaries between the therapist as the subject and the patient as the object have ceased to exist..

If this definition of different palpation experience is taken as the basis for a comparison, then Magoun's and Croiber's concept must be classified as mechanistic palpation, since in the concept of both of them an induction is applied during *Sacral Listening*.

Becker's and Upleger's concept of *Sacral Listening* can be classified as complex palpation., since both authors report of being moved. This corresponds to the views given in paragraph 2.2. of this chapter in which Upledger talks about a *melding and Becker* quotes *"to be moved by the body physiology of the patient."* (2007, p. I-154).

Is Frymann's application passive and can it be classified as complex palpation? Or does she tend towards mechanistic palpation, since Frymann actively focuses on the different parameters of the sacrum and in so doing distinguishes between subject and object? At any rate, a clear classification is difficult in Frymann's case.

2.3.2. Perceptive Information of the Testing

The following describes the kind of information which therapists obtain on the basis of *Sacral Listening*.

As mentioned before, Magoun (2000) describes mainly the experience of involuntary respirational mobility of the sacrum through *Sacral Listening*. This involuntary motion is part of the *primary breathing mechanism*. It exists, since the sacrum is in contact with the occiput through the spinal cord's strong dural sheath . Magoun describes this movement as a to and fro swaying around an axis.

Upledger (1996) talks about a motion in the *craniosacral system*; in its flexion phase the upper part of the sacrum moves anterior; whereas during the extension phase it moves posterior.

With experience, one perceives differences in the responding field of the movement, in the symmetry of the movement and in the energy driving it. This enables the therapist to discern deviations from the norm and to draw diagonstic and pathophysiological conclusions.

Upledger stresses the fact that only experience enables the therapist to place information gained during the testing into its context.

Magoun's as well as Upledger's perceptive information, which they gain through "sacral listening" are interrelated to the *Primary Respirational Mechanism.*

As explained before, in Frymann's case the information of the perceptive palpation of the sacrum depends on the focus. By means of systematic questioning she obtains information within the parameters of movement about the range of the movement, the amplitude.

Another point to be inquird into is vitality. It is the reaction force with which this movement is expressed. And as a further point she names the direction of the pattern, the attentiveness to an impact of force or the region of force.The information which Frymann obtains from the movement parameter appears to be identical to those of Upledger.

The information about the form corresponds to the position of the sacrum in relation to its surrounding osseous structures and its own form. Questions of texture provide information about how the sacrum feels: whether it is hard, elastic, or whether oedemas exist. Consequently, the informtaion that the therapist gets is, according to Frymann, a compound result of many individual pieces of information.

Croiber (2006) identifies structures that provide the therapist with information. The light caudal traction at the sacrum supplies information about the stability, the elasticity and the symmetry of the nerve tissue; here he draws attention to the plexus sacralis and the plexus lumbalis as well as the caudal part of the dura mater spinalis. As far as the pliability of the bone, the intraosseous information, is concerned, he points out that the therapist can feel any deformation caused by a fall, impact or compression.

Becker (2007) describes the information to be obtained during diagnostic touch as a process of perceiving kinetic energies in this stressed area, which act as a dysfunctional pattern in the body with its inherent solid-semiliquid-liquid mechanism. Elsewhere he writes that in the diagostic palpation of the sacrum and its mobilty and motility, one can gain insight into the breathing mechanism of the patient and the inherent tonus qualities of the ligaments and the

membranes. A perception of restriction may suggest to the therapist the age of the dysfunction. (Becker, 2007, p. I-316)

Milne (1999), who has so far not yet been mentioned in his approach and implementation of *Sacral Listening* receives a different kind of information in his questioning of the sacrum, comparable to that of Frymann. This information is to be seen in a different context of looking at the sacrum. As previously mentioned, Milne associates the sacrum with the second sacral chakra. In conjunction with the root chakra which is located in the coccygis and perineum he specifies four aspects that he associates with these two centers: stability, support, sexuality and spirituality. To give Milne's ideas their fair place, they shall be quoted verbatim here:

> *"How does this human being perceive his own sensual and sexual needs? (Is flowing motion possible for the sacrum on the anterior-posterior level?)*
> *Is he too hard on himself (rigid sacrum)?*
> *Is he too soft (a disintegrating 5th lumbar disc, an excessive life)?*
> *Does he allow himself no joy, no pleasures? (Can the sacrum swing out laterally?)*
> *Does the sacrum want to support the life he is leading?*
> *Is he open for new things? Does he widen his horizons?*
> *Does his attitudes permit a benefitting, flexible approach?*
> *Does he know his own positions in important matters?*
> *Is he able and willing to assume a point of view?*
> (Milne, 1999, p.95)

Milne, like Frymann relies on a questioning of texture, form and mobility of the sacrum.This questioning is embedded in a different context. It becomes apparent here, that an alterered context invariably leads to a different interpretation. This chapter indicates clearly that the perceptive information a practitioner receives through the *Sacral Listening* method , stands in close interrelation to the methodology, and the intentions of its implementation.

3. Methodology

Initially, an inter- and intrareliability study of the *Sacral Listening* testing was planned.The feedback of the proposal of this study (Sommerfeld, Musil, 2008) resulted in questions

arising, which had to be clarified prior to the implementation of such a study. Firstly, the degree of familiarity with the testing had to be researched as well as the question whether osteopaths had been trained in this method of testing. Secondly, the question arose whether osteopaths actually refer to this testing in the same terms of language.This feedback resulted in the following design of the study. It is divided into a quantitative first part, a survey, and into the qualitative main part: the guideline-based expert interview **.**

3.1. Survey

The survey, which underpins the relevance of this study, is a method of quantitative research.

3.1.1. Quantitative Research

The method of this survey is one of quantitative social research.
A characteristic of quantitative data collection methods (Wolf, Priebe, 2000) is, among others, the structured and standardized survey. Data analysis is achieved through statstics. In this survey descriptive statistics are used (descriptive character).

The quantitative approach is predominantly used in order to verify theories. In this concept, first a hypothesis is formulated, which is then to be verified in a research process, i.e. it will consequently be rejected or accepted. In the framework of this process, hypotheses can be confirmed as well as rejected (Wolf/Priebe, 2000).

The hypothesis under examination here is as follows:
The group of respondents are familiar with the application of Sacral Listening and pre - dominanttly apply it in their everyday practice.

As mentioned in the the introduction to this study, this survey is conducted to confirm whether the *Sacral Listening* test is an integral part of the everyday work of the osteopaths who were questioned, as it is in the practice of the author. The survey therefore serves as a means of assurance of relevance for this study under the title:

Is *Sacral Listening* applied in a uniform way?

3.1.2. Selection of the Survey Group

Fifty osteopaths took part in the survey. Forty osteopaths are or were participants of the "Master of Science" degree course in osteopathy. This degree programme is conducted at the university of Krems /Austria in cooperation with the Vienna School of Osteopathy (WSO). The course can be applied for by osteopaths who have completed their training as an osteopath at other schools recognized by WSO. (Janda, 2007). The selection of the group guarantees a wide spectrum due to their training background from a variety of schools.

Ten more osteopaths were added to the group to increase the number of feedbacks. The selection of these added osteopaths was on a random basis and not a result of any systematic decision. The reason for this inclusion was merely to avoid over-emphasizing one particular school or region.

Again, it should be mentioned, that the purpose of this survey is merely a confirmation of relevance and, based on the number of respondents, its results can in no way be generalized in view of the general population.

3.1.3. Implementation

The survey was conducted primarily by e-mail. Five osteopaths were questioned personally. After a description of *Sacral Listening* in the starting position of the patient and the position of the therapist's hand, four questions were to be answered:

- **Was *Sacral Listening* taught during your training course?**

The question whether Sacral Listening was taught during the professional training provides information about the degree of familiarity with the testing in the professional training centres and its familiarity among the participants in this survey themselves.

- **If positive, are you in possession of any documents ?**

The question about the documents about the testing opens up the possibility to access these documents in the further course of the study.

- **Do you apply this testing in your everyday practice?**

This question is directly related to the relevance of this study.

- **At which school did you receive your training?**

The question about the school where professional training was received may offer indications as to the use of the testing in practice.

3.2. Interviews

The research on the content of this Master's theses was carried out on the basis of guideline – based interviews. The guideline-based interview is used as a qualitative research method.

3.2.1. Qualitative Research

This research method was chosen because of its suitability in obtaining undistorted and comprehensive information. The focus is on the description, the interpretation and the understanding of contexts, the setting up of classifications and the formulation of hypotheses. It is well suited for all applications in which a diffentiated description of individual ideas and impressions is required, as is the case regarding the research question, "*Is Sacral Listening applied in a uniform way?"*

> *"It is the approach and the claim of qualitative research to depict living worlds, from the perspective of the persons involved. Its goal is to contribute to a better understanding of social reality and to focus attention on procedures, patterns of interpretation and structural characteristics."* (Flick et al, 2007)

3.2.2. Selection of Interview Partners

Some interview partners were known to me as lecturers. The choice of others occurred after previous exchanges of views about matters concerning the *Sacral Listening* testing. They all

have in common a completed training in osteopathy and several years of work experience. Eleven of them are qualified under the certification "DO". The preparation of a scientific study is a prerequisite for obtaining this certificate. Nine of them are involved as lecturers. The first four interviews were initially conducted as trial interviews, in order to test the guideline and to improve the running of the interviews. They were, however, included in the evaluation, in order to attain greater spectrum and diversity. The use of *Sacral Listening* in daily practice was a criterion as well in chosing the interview partners.

The interview partners are listed below in a chronological order based on the date of the interviews taken.

1. Monika Dunshirn, M. Sc. DO., (November 2008)

2. Anett Hörster, M. Sc. DO., lecturer (December 2008)

3. Carsten Pflüger, M. Sc. DO., EVOST Student (December 2008)

4. Friederike Kaiser, M. Sc. DO., (December 2008)

5. Patrick van den Heede, M.Sc. DO., i.a.lecturer at WSO (February 2009)

6. Richard Lappas, MD, DO, lecturer at DGOM (March 2009)

7. Max Giradin, DO., EVOST lecturer, i.a. of prep courses (April 2009)

8. Andreas Behrens, M.Sc. DO., EVOST student (April 2009)

9. Luc Fieux, i.a. lecturer at Sutherland College, co-author of " Osteopathische Techniken im Viszeralen Bereich" , Hippokrates, 2005 (April 2009)

10. Steven Decoster, DO., B. Sc.(hons), former lecturer (April 2009)

11. Sandra Bartu, DO., lecturer (April 2009)

12. Hartmut Fritzsche, lecturer, translator for Laurie Hartmann's, "Handbook of Osteopathic Technique", Pflaum Verlag, 1997 (April 2009)

Three osteopaths were co-students from my batch during my Master's course. Through constant communication in the course of our common study programme I am aware that they all have different approaches in their work.

Monika Dunshirn was my coach during my degree course at WSO.

Anett Hörster was a co-student at WSO.

Carsten Pflüger was a co-student at WSO. He is meanwhile a student at EVOST.

Friederike Kaiser was a co-student at WSO.

Patrick van den Heede was one of my lecturers at WSO. The practical part of his seminar resulted in my interest to conduct an interview with him on his practice of *Sacral Listening.*

There was an exchange with Richard Lappas years ago on *Sacral Listening*, after he had attended a seminar with Viola Frymann. He is a doctor and long-standing lecturer at DGOM.
Max Giradin is one of two lecturers at EVOST (Evolutionary Medicine within the Osteopathic Field). Carsten Pflüger recommended him to me as an interview partner.

Andreas Behrens is a student at EVOST. His interview was of interest with regard to the interview with Carsten Pflüger, who is likewise a student at EVOST.

Luc Fieux is a longstanding lecturer at Suterhland College and co-author of the book "Osteopathische Techniken im Viszeralen Bereich", Hippokrates Verlag (2005).

Steven Decoster was active as a lecturer in Belgium for many years. A co-student recommended him to me.

Sandra Bartu works with Viola Frymann. She conducts postgraduate courses on children with Viola Frymann in Switzerland and is the head of SICO, a school of osteopathy that was founded in collaboration with Philippe Druelle.

Hartmut Frizsche was a lecturer at OAM. He is the translator of the book "Handbook of Osteopathic Technique " by Laurie Hartmann

3.2.3. Guideline-Based Interview

The guideline-based interview was chosen as the methodic tool. Its task will be described in the following paragraph .

The task of a guideline in an interview, Kaufmann (1999) writes, is to offer flexible guidance and to promote a dynamic process of interviewing that is much more valuable than the simple answering of questions. He recommends a logical sequence of questions which together form a whole.

It was attempted to adhere to the questions of the guideline as far as possible. In some cases it happened that the interviewees in their responses integrated answers to more than one question. Therefore, in theses cases the order of the questions had to be altered. In one interview the adherence to the guideline was abandoned. Interrupting the explanations of van den Heede would not have been conducive to the collection of relevant data. The questions of the guideline developed both from the previous quantitative survey as well as from literature research.

The guideline contained the following questions:

- When do you apply *Sacral Listening* in your practice?
- How do you implement it? What information do you receive?
- What is the terminology you use?
- Have there been changes in the way you implement *Sacral Listening* or in the information you receive?
- How do you asses the inter- and intra-rater reliability of the information you receive?

The interviews were conducted in German and were recorded with a dictation device. All interview partners were asked permission for publication of the interview within this thesis. All gave their consent.

3.2.4. Qualitative Content Analysis

The evaluation of the interviews was conducted in several steps. The interviews were transcribed. It must be mentioned, however, that any written documentation and fixation of the spoken word necessarily reduces its contextual character. Every interview was processed and categorized on the basis of the guideline.The numbering of the interview partners was maintained in the categorization. The individual categories in the interviews were systematically dealt with. All interviews were brought into correlation and similarities and differences were worked out. (Mayring in Flick, 2007)

3.2.5. Aim of the Qualitative Content Analysis

The aim of the content analysis according to Mayring (Flick, 2007) is the systematic processing of the interview material, which was recorded with a dictation device. The basic idea of the qualitative content analysis according to Mayring (Flick, 2007) consists in adhering to the qualitative analysis steps of systemeatic content analysis (strict conformity to rules, embedding in a situational context, quality criteria) without running the risk of premature quantification.

3.2.6. Techniques of Qualitative Content Analysis

The summary content analysis reduces the material in a way that allows the essential contents to be maintained, while a clear and comprehensive short text can be formulated. It is a suitable tool in situations where the content level of the material is of paramount importance and a compressed and clearly comprehensive short text is required. The underlying thought of categorization is to make use of the procedures of summary content analysis in order to gradually develop categories from within the material.

3.2.7. Potential and Limitations of Qualitative Analyis

The systematics of qualitative content analyis usually follow previoulsly defined procedures. This makes the process transparent, comprehensible, easy to learn and it allows transfer to other research questions. As a rule, there is a categorizing system in the centre of the analysis, which is, however, revised in a feedback circuit and the material is flexibly integrated. (Mayring in Flick et al., 2007).

4. Evaluation of the Survey

As mentioned in the introduction to this Master's thesis and in chapter 3.1. *Survey*, the purpose of this quantitative survey was to establish relevance for this study. 45 out of 50 osteopaths surveyed responded and were included in the evaluation.

4.1. Familiarity with the Testing

Was *Sacral Listening* taught during your training course?

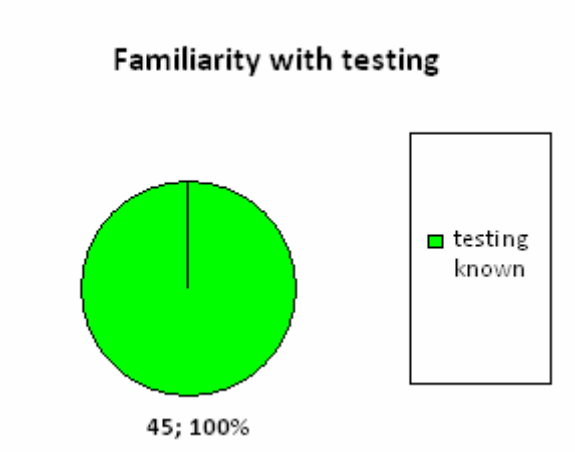

Fig. 4, diagram 1: Familiary with Testing

The result of the survey confirms the assumption that all osteopaths participating in the survey had been taught the testing at their school of training, or respectively that they were familiar with it.

4.2. Documents Used

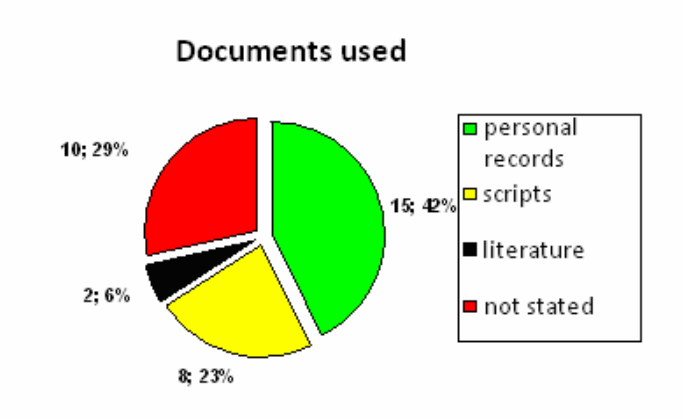

Fig. 5, diagram 2: Documents Used

Ten osteopaths did not respond to the question concerning the documents used on the topic of the testing. Two osteopaths from an identical school of training quoted Cloet and Groß's book *"Osteopathie im kranialen Bereich"* (1999). Eight osteopaths reported to be in possession of scripts on the testing. The majority of the respondents make use of their own records.

4.3. Frequency of the Testing

How often do you apply the testing in your everyday practice?

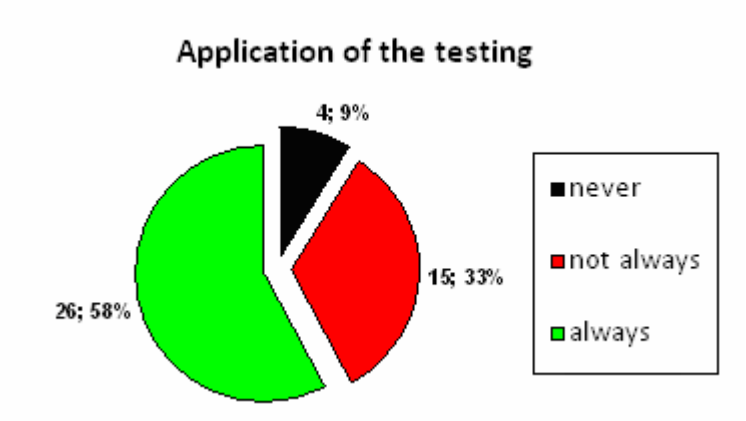

Fig. 6, diagram 3: Frequency of the Testing

The testing is applied by 26 osteopaths in each of their therapeutic sessions. A third of the respondents reported not using the testing with every patient. Four osteopaths never use this testing.

The fact that 91 % of the respondents apply *Sacral Listening* in their everyday practice confirms the relevance of this study.

4.4. Distribution of Respondents According to Training Schools

At what school did you receive your training?

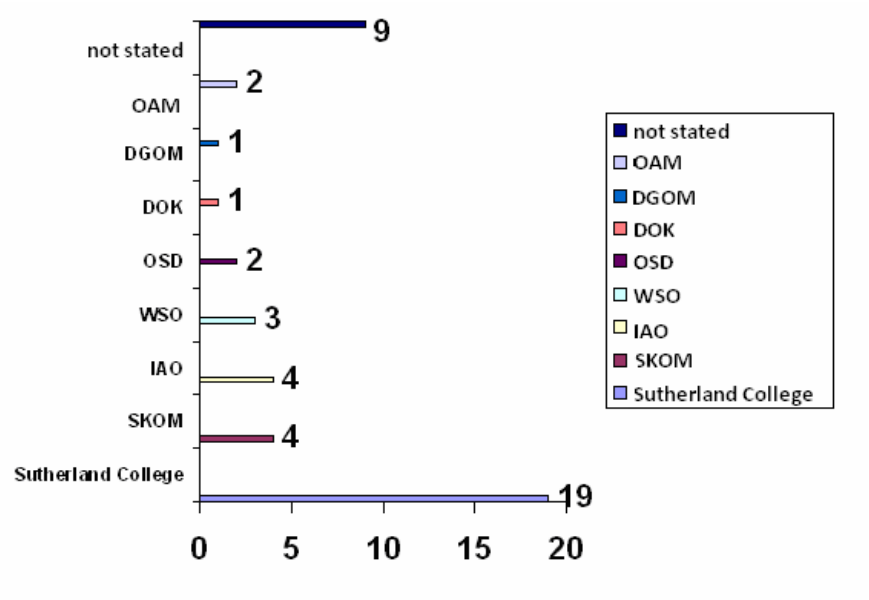

Fig. 7, diagram 4 : Distribution of respondents according to schools.

The majority of respondents (19) attended Sutherland College. Nine osteopaths gave no details concerning this point. IAO and SKOM were attended by 4 osteopaths respectively. Two osteopaths were at OSD and two at OAM. One participant obtained his training in osteopathy at DOK. One participant was trained at DGOM..

5. Evaluation of the Interviews

The evaluation of the interviews contributes to establishing an overview on how *Sacral Listening* is applied by the interviewed osteopaths. The comparison of the interviews is used to answer the question of the thesis:

"Is *Sacral Listening* applied in a uniform way?

The questions were posed on the basis of the guideline. This guideline was developed both from a study of relevant literature as well as from the outcome of the survey conducted with fifty osteopaths.

5.1. Application of *Sacral Listening*

The quantitative study revealed clearly that the testing was applied differently by the osteopaths. Against this background the question was formulated:

When do you apply *Sacral Listening*?

The arguments for the use of *Sacral Listening* are manifold and are not easy to relate to each other in order to reach a valid comparison. For some interview partners, *Sacral Listening* is an integral part of each basic examination. This is confirmed by the result of the suvey in chapter 4.3. of this thesis in which 26 out of 45 osteopaths reported applying the testing in every osteopathic session.

Anett Hörster uses *Sacral Listening* as a standard procedure in every initial examination, in order to obtain an impression of the position the sacrum assumes in her hand. (2nd int.: lines 7/8, 10/11)

Friederike Kaiser makes a similar statement, emphasizes however, that although *Sacral Listening* is used with every patient, it is no global test to her. She considers it a testing of the pelvis and the *cranio-sacral system* (4th int.: lines 6/7, 9/11).

Friederike Kaiser also gives information about the structural level at which she obtains information while applying *Sacral Listening.*

The following statements all have in common, that *Sacral Listening* is part and parcel of every initial examination. Max Giradin uses it first and foremost along with the other levels of perception such as looking at, smelling and listening to the patient; not always but most of the time, as he says. (7th int.: lines 5-10).

Andreas Behrend replies: *"Actually, basically with almost every patient."*(8th int.: line 6)

Luc Fieux anticipates a variety of information resulting from *Sacral Listening* and therefore applies it as a global examination technique in every session. (9th int.: lines 7-9)

Sandra Bartu's anwer is: *"Always and with each patient"*. (11th int.: line 7)

For Hartmut Fritzsche it is an integral part of his basic examination, with the exception if this may be "*too close, too intimate*" for the patient. He would not, for instance, use *Sacral Listening* with a bashful teenager (12th int.: lines 6/7, 10/14).

Richard Lappas uses *Sacral Listening* both as *General Listening* and as *Local Listening*. In every examination the hand is in contact with the sacrum. He uses other starting positions of the patient as well when implementing *Sacral Listening;* this may be in a standing or in a seated position (6th int.: lines 7-18)

The previous statements reveal a further differentiation. Some osteopaths divide *Sacral Listening* into *global* and *local* testing. This view is reflected in the statements of Luc Fieux and Richard Lappas.

Steven Decoster describes *Sacral Listening* as a local testing, therefore it is not used in every single examination. (10th., lines 5-12)

The level at which the sacrum is seen by the osteopath further affects the use of *Sacral Listening.* In this context, the levels that are addressed by the interview partners are of a very

different nature in each individual case. Dunshirn makes it dependent on the question whether she is working on the level of biodynamic or craniosacral osteopathy. Accordingly, she assigns the testing to each respective field and uses it as relevant. In doing so, she uses other means of testing to obtain an overview. The outcome of the testing determines, whether she continues to work in a bodydynamic or crainosacral direction.

She applies *Sacral Listening* in both these fields of her practice (1st int.: lines 18-39)
Carsten Pflüger reports that there are moments during an examination session, where his hand is at the sacrum, in order to find out information about the structural or so-called functional level, or rather to "listen" as the term expresses.(3rd int.: lines 8-13) The term *Sacral Listening* is not clearly defined for him.

Patrick van den Heede, on the other hand, talks about a different level. It is the midline area that he mentiones when palpating the sacrum. The way he applies *Listening* depends on previous information which he gets from the occiput. Van den Heede justifies his contact with the sacrum with the morphogenetic development and explains the role the sacrum plays within this development. (5th int.: lines 7/8, 14-19).
As mentioned in the beginning of this chapter, it is difficult to establish a comparison between the statements of the individual interview partners. However, in relation to the given research question it can be unequivocally stated that there is no uniformity in the choice of *Sacral Listenin*g as an examination tool among the different interview partners.

5.2. Implementation and perception of *Sacral Listening*

The literature analysis resulted in two approaches to the application of *Sacral Listening* on the basis of Psutkas's definition (2009). The first approach, as expressed in Upledger's (1999) and Becker's (2007) work, is defined, according to Psutka as *"Complex Palpation"* (2009, p. 17) In this method, the practitioner works in silence, in order to provide the patient's structures the opportunity to move him. This approach was clearly expressed in chapter 2.3.1.2 of this thesis which dealt with the implementation of the testing.

The other approach, the "*mechanistic palpation*" (2009, p. 17) applies among others to Croiber's (2006) descriptions. It is characterized by an induction. The osteopath moves the patient's structures in order to obtain information. Frymann's approach (2007) could not be clearly classified unter Psutkas definitions, since her work in regard to *Sacral Listening* is characterized by both an induction and a focussing. The information to be obtained with this testing depends on the procedure. This fact, which has already been dealt with, resulted likewise from the literature research.

The next objective of the guideline-based interview results from the above mentioned facts. Here we are concerned with questions about the application of the testing and the question what kinds of information can be gained through *Sacral Listening.*

As will be demonstrated, analyzing the different approaches in implementing *Sacral Listening* was far from easy. Monika Dunshirn aptly comments on the complexity at hand:

> *" In my work I always try at first to approach my work in a frame of mind as neutral as possible, even refraining from using the sacral testing.. I constantly attempt to keep my hand neutral or to keep myself neutral in order to allow information to come to me. Yet, there are moments and situations, in which I begin to ask questions (1st int.: lines 45-49). I don't pose these questions to myself, but rather to the tissue of the patient in front of me – or rather they are not real questions, I do not pronounce them." (1st int.: lines 52-54)*

Dunshirn describes two main approaches. In the first she attempts to allow the flow of information from a neutral position. This "allowing to let information come" is a passive approach and suggests a "*Complex Palpation*" (Psutka, 2009, p. 17). It is difficult to define, in how far the second approach (which consists in questioning the tissue of the patient) can be classified as induction. This kind of questioning differs from that applied by the other interview partners. Monika Dunshirn talks about "Questioning the tissue"

Anett Hörster asks herself questions during the implementation of *Sacral Listening* in order to gain the desired information. They usually begin with: "How…" and relate to the vitality, the mobility and the connections of the sacrum to the neighbouring structures. (2nd int.: lines 13-16). The exploration of variables of the sacrum is a focussing on certain parameters. This is

reminiscent of Frymann's approach (2007).Here, too, it becomes apparent through questioning that a focussing takes place. A subject- object relation, similar to Monika Dunshirn's is recognizable.

Carsten Pflüger divides the information he obtains through *Sacral Listening* into two areas. Induction at the sacrum provides him with structural information. This, however, does not represent *Listening* in the classical sense to him. In his view, it is not mandatory to work at the sacrum during *Listening*. He believes that – provided the cranial concept is correct- *Listening* can be carried out theoretically from any point of the body." (3. int.: p. 17-27) Carsten Pflüger's attempt to obtain information on the structural level is in line with Psutka's *"Mechanistic Palpation*" (2009, p.17). Applying Listening at the sacrum leads him to an evaluation of the mobility of the neurocraniums or the neuralgic systems, which experience an ascending movement in the embryonic development. This implies no judgement but rather a listening, to see whether a pattern can be detected or not. (3rd int., lines 27-30)
His *"classical Listening",* as Pflüger calls it, can be called a c*omplex palpation* since he revises his evaluation into a *Listening*. It is obvious that during palpation he works from within a system which is also his mental framework. The mobility he talks about is, in his view, related to the embryonic development of the neurological systems.

> *"The hand serves simply as a surface of contact. The receptors of the hand perceive any change and report these changes to the brain, and what the brain interprets is actually the change which takes place within one's own receptors. One might say you actually feel yourself, because the receptors perceive change. Receptors are after all in the hand and not on the hand, but all receptors are in the body."* (3rd int.: lines 106-111).

These statements resemble those of Upledger (1996). The information that Carsten Pflüger obtains is, in his view, much less dependent on palpation but much more on perception. He claims this perception does not take place in the hands but in the brain. It is dependent on the therapist's inner picture of anatomy. He emphasizes an awareness of a living image of anatomy and of the forces governing embryology. This approach gives him access to and understanding of a complex system within the human organism (3rd int.: lines 70-90). Carsten Pflüger's statement highlights the interdependence of palpation, perception, and

interpretation. The similarity to Höppner's (2008) work about palpation and perception is no coincidence. Carsten Pflüger is a former student of Höppner.

Friederike Kaiser does not comment comprehensively on the implementation of *Sacral Listening.* She also demonstrates a two-fold application. Friederike Kaiser mentions that she first attempts to allow information to come. Her next step, on the structural level, is induction (4th int.: lines 39-45). However, Friederike Kaiser uses the term "*provocation"*, not *induction.* When Friederike Kaiser talks about provocation testing it becomes apparent, however, that this can be equated with induction. This example may demonstrate that in some cases the application may be uniform, yet the nomenclature differs. She further comments on the type of information she gets through *Sacral Listening.*

> *"I obtain structural information as to the mobility of the iliosacral joints and generally all pelvic joints – including the flexible connections between the organs in the small pelvis, and I get information about the mobility and the amplitude etc; I also obtain information about the cranio-sacral system, the way the axes run, and about the quality of the primary respiratory system" (*4th int.: lines 13 – 18)

Her perception works on the basis of a different *living picture of anatomy*, to be more precise of two pictures. One is the image of the pelvis as a functional unit with its osseous and visceral links and the other is the craniosacral system.

Patrick van den Heerde stands for the approach of *complex palpation*. Asked during the interview whether his application of *Sacral Listening* is of a questioning or a focussing nature, his anwer is clear:

> *"The small of the back cannot be questioned . I can only receive. Be still and low. If you touch the lower back you should do nothing except for letting the hand sink in. You should not ask: What is offered here? – You simply can't say that."* (5th int.: lines 147 – 151).

Van den Heede describes the procedure here, which is very much like Becker's:

> "*The practitioner simply gets the energies inherent in the healthy, dysfunctional or traumatized condition of the patient to tell him the story of the problem. Therefore he*

needs no techniques. On the contrary, he is even told not to stand in the way." (Becker, 2007, p. I-180)

It is a pure form of listening. The tissue tells the story and the interpretation can follow. The interpretation is dependent on the inner picture of the sacrum. This fact is reflected in the quote:

"Still claims that every osteopath should at all given times have a mental image of 'a living picture of anatomy', and that you can only palpate what you are familiar with anatomically, both on the macroscopic and the microscopic level. (Höppner, 2008, p.16)"

Patrick van den Heede gives a comprehensive picture of the sacrum. What he says reflects the close bond of knowledge and experience . Both are essential prerequisites for palpation. He draws on the concept of morphogenesis, in which the sacrum represents a kind of counterpart to the occiput. He sees a reference to the occiput and its inherent neurological structures, like the medulla oblongata and the cerebellum (5th int., lines 10 – 30).It enhances the formation of the brain and of the spinal column (5th int., lines 130 – 135). Unlike Carsten Pflüger who talks about the forces of embryology in general terms, van den Heede draws an exact picture of the morphogenesis of the sacrum. He also describes the connecting fascial structure of this system, i.e. the dura and the ligamentum longitudinale. At this point he refers to Sutherland who had already described this link via the dura. He uses the phenomenon of the fascial structures as a basis to explain the context of a compressed sacrum and possible dysfunctions that are likely to affect the cardiovascular system (5th int.,lines 33-48). Beside the medulla, the cerebellum and other central structures of the neurological system, van den Heede names another neurological structure. He talks about the *plexus hypogastricus inferior* which is located in front of the sacrum, as the microbrain of the lower back (5th int., lines 103 -106). He brings the connection of the sacrum, uterus and pregnancy into correlation with the mechanical-structural component.

In his view, as far as the compression of the sacrum is concerned, he determines an external and an internal compression. His description of what he perceives during *Sacral Listening* is built on these concepts.

"[…]I may be looking for it, but the lower back might be located outside of the body, i.e. it can be in B-position or in C-position, which indicates that at an earlier time it experienced a traumatic event, a lateralized whiplash injury[…] or a fall occurred while it was in a high or a low position in the pelvis. You can only interpret these things if you let the small of the back tell its tale, and this tale is about tensity, about position, about being aligned, and perhaps about a kind of movement-related expression. The way to to discover the story leads via impacts of warmth, of weight; but if you don't get hold of this row of perceptions, you will not be able to tell that story" (5th int., lines 152 – 161)

Van den Heede receives further information from the fact that no or very little movement is perceivable , because often the sacrum is so restricted and inhibited in its mobility. The impressions, as he calls it are light or harder pressure surfaces that can be perceived opposite the impressing parts within the sacrum. At this point he explains the laterality of the individual segements in relation to each other. This laterality is confirmed to him by the ossification or inner energy storage which is located in an area more to the right or the left in the sacrum. He subdivides the information obtained: they either result from a mechanistic past, caused by compression or a perso-electric result. He notes that in the latter case nuclei of field disturbances exist, which the sacrum integrates into its osseous part. Van den Heede differenciates between two kinds of compression in the same way that Handoll does. (2004).
Patrick van den Heede describes in the further course of the interview, that the lower back appears at times "*like being located outside of the pelvis"* (5th int., line 152). A high position of the sacrum in cranial direction in fact represents a point of compensation, which the sacrum has found in order to relieve the brain stem.

Handoll (2004) also mentions the high position of the sacrum, however not in a context of compensation but of trauma.

It becomes evident, how diverse osteopaths may interpret the outcome of their perception. A further quality of the sacrum is described by van den Heede as "dryness". He sees an element of extension static that can express itself as a dryness in the entire body. The sacrum remains withdrawn. In this context he sees no actual extension and flexation movement of the sacrum,

rather a pelvis which as a whole opens and closes, which evinces homeostasis. (5th interview, p. 55-120).

Receiving such detailed explanations from Patrick van den Heede - both on the subjects of the image of the sacrum as well as the application and interpretation of the testing - can be attributed to the technique of interviewing applied here. As mentioned in paragraph 3.2.3. adherence to the guideline was abandoned in this case.

Richard Lappas approaches from a totally different viewpoint on anatomy when he descibes his application of *Sacral Listening*. He goes back on the classical *"palpation in layers"* by Greenman (2005) in which he starts from a flat sensation on the bone toward periost to place his focus deep, both in the ventral and the dorsal domain. He identifies neurological as well as ligamentous and muscular structures onto which he focusses and which, if the need arises, he disregards. In this phase of *Listening* he talks about "*local"* or *"regional" Listening* (6th int., lines 31-43). From this starting point he describes the next step in which Listening enters into the wider picture

> *"[…] and then I try to work in a manner as differentiated as possible. so that I can say, I allow myself to be guided, wherever that may take me. This is the easiest and the most difficult thing both at the same time." (6th int., lines 45-48).*

In Lappas' case there is a transition *during* the process of *Listening* from focussing to being guided. Here, a parallel to Max Giradin can be detected. In Richard Lappas' case the mental attitude in the course of *Sacral Listening* changes from focussing to *"being guided"*. He describes his hand position to be located flat on the sacrum, between the legs of the patient. He reserves the option, however, - in contrast to Viola Frymann - to change his usual procedure with certain patients. Similar to what Upledger describes (1996) he talks about a sinking in of the hand, *"a gradual dying"* in order to gain contact in the deep. (6th int.. lines 63-70).

Whereas the interview partners so far are concerned only with their own way of implementation, Max Giradin additionally makes use of some outside "*parameters"* in order to create an optimal environment. He names for example light, room temperature, the correct hight of the therapist's bed and the body position of the therapist (7th int., lines 24-30).

To him, a correct body posture, from the position of the feet, the way the therapist sits, to the position of the lower arms is a prerequiste for the optimization of his fulcrum. The fulcrum is to him like it is to Becker (2007) an inherent part of *Listening.* (7th int., lines 38-50). After the setting up of his fulcrum he clarifies further steps of implementation. He makes a difference between: *"assessing what is at hand*" and the actual *Listening.* His first questions are in relation to *"consistency"* (7th int., lines 51-53). He sees this step as an introductory one "*without a special mental attitude".* (7th int., line 53). This *"perceiving of form"* is not at all identical to him with *"Listening;,* he observes a big difference:

> *"The first is, well, perceiving the form, but the listening to the system requires from me a withdrawing into myself. It means that I go to my points of reference and focus on them in a sense of full awareness; I would go as far as saying that from a certain point in time the tension in the body becomes intolerable and at a later moment, the sense of its own awareness disappears from my body. This is the moment where I no longer feel my hand. And from that moment, when perception has gone from my own hand. when I can sense the system beginning to express itself."* (7th int., lines 56-64)

The expression of the system can, according to Giradin, come across as a certain pattern of tension, a wavelengh, a frequency. There can be very little or nothing happening (7th int., lines 65-68).

Giradin and Upledger (1996) correspond in their postulation of a withdrawing into oneself. The exact description of the fulcrum brings Becker (2007) to mind. It is above all the second stage that Max Giradin himself calls the actual *Listening*. This stage can be associated with *complex palpation.* For him the chronology of *Listening* remains the same, regardless whether the cranium or the sacrum are palpated (7th int., lines 76-78)

To Behrens , *Listening* opens up an opportunity to tune into various embryonic levels and in doing so to determine whether he wants to work at the "*parietal"* (=> " Homunculus Internii") the *"visceral"* (=> "Homunculus Viscerocranii") or on the *"neurocranial"* (=> "Homunculus Neurocranii") level. (8th int., lines 25-30). He obtains different information from each of the Homunculi named above, since each of them provides different palpation qualities *("consistence")* of the tissue, ranging from viscosity to turgor, tension and malleability. Behrens gives an example:

> *"[…] of course I can now, as it were, tune into the 'Homunculus Neurocranii' and look at the consistence which can range from viscosity to malleability; and depending on which consistence I perceive, I enter a different system within this homunculus, since I perceive a bone as malleable, not primarily as viscous* (8th int., lines 43-48).

Behrens follows a testing approach, yet he is interested in the quality of the consistence.
Höppner supports Behren's approach in one of his articles:

> *"Within palpation, the physical properties of a given field of metabolism play an important role. Depending on the dimension, the properties of metabolism appear as a phenomenon of tension, which can be differentiated as viscosity, turgor, tension, visco-elasticity and malleability. This is an important, palpable indicator when entering the human system." (Höppner, 2008, p. 18)*

Similar to Carsten Pflüger, Andreas Behrens takes the view that besides certain basic theoretical information, one must have mental images, both embryological and antomical ones, in order for the information received through *Sacral Listening* to make sense and be meaningful.(8th int., lines 20-35). The phrasing Andreas Behrens uses reflects, like Carsten Pflüger's, his involvement as a student at EVOST and thereby his familiarity with Höppner's views.

Luc Fieux visualizes the sacrum , when it rests in his hand as *"a fluid-like bag"*. (9th int., line 14). Similar to the other interview partners his approach is of "a testing nature". It is a questioning at *"PRM level"* as he puts it. Fieux asks, among other things, how movement is expressed. He also inquires into the condition of tension in the fascial system. In doing so he names pelvic structures like the perineum anterior, posterior and the laminas, which he regards as further reciprocal tension membranes. An additional question deals with the quality structure of the sacrum itself. (9th int., lines 18-39).

In the description of the pelvis as a functional unit, embedded in a *"tensegrity model of compression and tension"* (9th int., lines 59 - 65), a parallel to Friederike Kaiser's view can be found. She also regards the pelvis as a functional unit during the testing.

Luc Fieux justifies his questioning approach during *Sacral Listening* with his professional involvement as a lecturer. He considers the didactics of passing on the skill of *Listening* as extremely difficult. (9th int., lines 79-84). He classifies the information he receives according to the structural level he is on. He differenciates between a fluid, a membraneous and an osseous level. Luc Fieux makes it clear, like his predecessor, that the information he receives is always dependent on the question, at which level of his inner concept he finds himself. He describes a *structural level*, which places him in opposition to Carsten Pflüger and Andreas Behrens who describe a *systemic level.*

To Steven Decoster, *Sacral Listening* is a sensing of tension qualities at the sacrum. (10th int., lines 24-28). The information he receives is hard to describe and to classify for Decoster. He perceives and attempts to find a solution on the basis of his perception. Decoster's comments do not allow a clear classification as to whether his approach can be assigned to *mechanistic* or to *complex palpation* or even to both..

Sandra Bartu describes the way she applies *Listening* as a systematic procedure which she keeps applying in an almost identical way. After a global first assesment the further procedure is marked by a perceiving, a *searching* in different structural levels. These are, in close affinity to Fieux the osseous, the membranous and the fluid level. Bartu lets herself be guided by the direction and the quality of a traction (11th int., lines 9-20). Bartu believes that her initial approach to *Sacral Listening* was a systematic questioning, however,

"[…] after all these years I would say, today this information just comes, as if this testing had become automated, I just do the listening and simply get the results from the sacrum. This is how it probably works out." (11th int., lines 27-30)

She describes the *Listening* as a quick test, which she applies on the patient in each session in order to make the information available as a reference for the next treatment. (11th int., lines 20-23). Bartu uses the nomenclature of the information in a descriptive way. She takes note of whatever differs from the norm (11th int., lines 35-44) and describes the procedure as known from Viola Frymann. Their long period of cooperation, spanning over decades, is clearly recognizable.

Hartmut Fritzsche describes a target-oriented and structured approach in his application of *Sacral Listening* as well. He considers the symmetric positioning of the hand on the sacrum as vital in order to allow an objective perception to be made possible. His first target in perception is the musco-skeletal part of the sacrum itself and its neighbouring structures. He works in a questioning manner. His focus is on quality of the tissue, mobility, and tension. Similarly to Bartu, Fieux, and Kaiser, Fritzsche watches out for fascial traction, including their quality and direction. (12th int., lines 20-35) **.** When asked by the author whether this may be more a "questioning of structures" or a "letting information flow", Fritzsche describes a different approach:

> *"First and foremost I let information come to me, as sheer Listening, where I expect nothing and search nothing but rather try to be blank like a white canvas."*
> (12th int., lines 39-44)

In case no information comes through to him, Frizsche concedes, he additionally uses induction by questioning into mental structures or by inducing light movement." (12th int., lines 45-46). There is a parallel here to Croiber (2006) who also works with motion induction.

These explanations of the different interview partners as to their application of *Sacral Listening* make two points very clear: In the application, similar to what was researched from literature, two different approaches can be discerned. One is the use of a focus and the other one is pure *Listening.* According to Liem (Liem et al., 2008), focussing can be seen as a preliminary stage of *Listening*. This method of palpation was dealt with in chapter 2.2. *Palpation Experience.* This mental transition was described in detail by Max Giradin while Richard Lappas only touches upon this phenomenon.

Likewise, there is no uniform concept of the sacrum reflected in the statements of the interview partners. If we work on the assumption that perception is contingent on an image and an idea of the sacrum, it is not surprising to find little agreement as well, as far as perception is concerned.

5.3. Development of *Sacral Listening*

In his description of the method of palpation Liem (Liem et al. 2008) points out that the third level, which is the one associated with direct experience, can only be reached through a learning process of systematic and rational understanding on the other levels of experience. On the basis of this realization of a development process in the application of the palpation testing *Sacral Listening* the interview partners were asked about a possible change in their personal approach to the testing.

Monika Dunshirn reports that many things have changed for her in relation to this testing. They concern processes within herself, although the test, as seen from the outside, may still *"look the same"*. Years of experience result in Dunshirn receiving the information necessary in much less time. Another added factor is that meanwile she is able to run the testing "*with a neutral hand"* (2nd int., lines 63-76).

Anett Hörster states that the procedure of her testing has remained largely unchanged over the years, but that meanwhile she receives information which is more extensive and more relevant. She adds that the overall quality of perception has improved. (2nd int., lines 63-76).

Carsten Pflüger regards *Sacral Listening* as a technique; this corresponds to the way he implements it. Meanwhile he has moved towards a new approach: the attempt to understand the system and to gain an awareness for a living picture of anatomy and of the forces of embryology. This knowledge enables him today to recognize patterns and dynamics in the tissues at hand. An opportunity opens up to access a complex system in the human organism. In this process it is irrelevant which part of the body he palpates. (3rd int., lines 135-157)

Friederike Kaiser (4th int., lines 60-65) and Richard Lappas (6th int., lines 71-73) shared a similar initial approach to *Sacral Listening* via the craniosacral rhythm in quality, amplitude and frequency. In the course of many years of working with patients, however, new aspects emerged and were integrated into the work with *Sacral Listening*.

Richard Lappas concedes that an exclusively craniosacral route of access is not the only solution, but that an osteopathic entry way would likewise be possible. (6th int., line 75).

Andreas Behrens believes that with increasing theoretical knowledge his palpation skill has also improved. His statement comes close to Höppner's (2008) quote:

> *"Palpation is a question of perception and this happens somewhere 'between the ears' – in the grey cells."*(8th int., lines 51-56)

Giradin's actual practice has little to do with what he had once learned. A defining change in his testing occurred at the moment when - more or less by chance - he developed a new awareness for what *Listening* really was.

> *"[…]If you want to listen, you yourself have to be still. You have to withdraw as far as possible, because only then can you truly listen"[…]* (7th int., lines 82-93)

Since then, his understanding of *Sacral Listening* has remained unchanged.

Decoster considers two elements as essential for the development of palpation: a knowledge and an intellectual interest in philosophical topics as well as the development of technical skills. They are part of the general development of the therapist. He believes his answers to this interview, had it been conducted five years ago, would have been very different. (10th int., lines 86-101).

For Sandra Bartu, the testing with regard to its exploring nature has gone through a change. Today it is no longer systematic, but subconscious. (11th int., lines 76- 85)

Hartmut Fritzsche reports of more global and comprehensive information. He suspects, that the process of implementation has become swifter and more spontaneous, that he need less time get a feel for the structures, and that it has become easier for him to differentiate between the nuances. (12th int., lines 69-74).

It became clear that in their response every single interview partner reported a change in the development of their testing. To Giradin, Pflüger, Behrens, Dunshirn and Decoster this is primarily a change in awareness in relation to the testing. In the case of Hörster, Kaiser, Lappas and Fritzsche a widening of the sprectrum of perception can be discerned. Sandra Bartu experienced change through routine, comparable to learning to drive a car. This same element of routine is also addressed by Monika Dunshirn and Hartmut Fritzsche.

There are three main reasons for this process of change and development: Change of awareness, increase of knowledge and the insights gained thereby. A final fourth reason is change through routine.

In relation to the research question it can be stated that the uniform application of the *Sacral Listening Testing* is dependent on awareness, knowledge and experience.

5.4. Assessment of Inter- and Intrareliability

As mentioned in chapter 3, *Methodology,* the original plan was to write a reliability study about *Sacral Listening* testing. Prior to such a study questions had to be clarified which resulted from the feedback of WSO. One of these questions was, whether in this testing the osteopaths actually speak the same language. Against this background, the interview partners were given questions concerning their views on the reliability of the tests. The interview partners were not given explicit definitions for the terms reliability, inter- and intrareliability, since they were assumed to be known. For the understanding of this passage of the interviews the following definition, as laid down by Krause is given here:

> " *The reliability is an indicator of the reliability of a procedure or a test. A test can be deemed as reliable when repeated procedures lead to the same results."* (Krause, 2007, p.29)

He describes the differenciation between inter- and intrareliability as follows:

> *"An agreement in test results, in which two therapists examine the same patient is called 'interindividual reproducibility' or 'interrater reliability'. The agreement in test results in which one therapist works with one and the same patient is called 'intraindividual reproducibility' or 'intrarater reliability'." (ibid. Krause)*

Some respondents rate the intrarater reliability relatively high. The interview partners tend not to use the term 'reliability' in its scientific context, as is revealed in the following statements.

Dunshirn has, based on the experience of many years, come to trust the tests which she uses. They are reliable to her (1st int., lines 80-112).

Girardin does not believe that intrareliability is possible, since two different systems are involved, the "you" and the "I". He is fully convinced of the reliability of his own use of the test, in the sense that the information he perceives is correct. (8th int., lines 126-136).

Fritzsche regards the information he receives from the sacrum as subjective, yet coherent and right in the framework of his perception and his concept (12th int., lines 79-89).

As a test has been performed many times over, Hörster ist one hundred percent sure of a high rate of intrareliability. Within her team she also sees a high rate of interreliability. This, however, she prefers to confine to her practice team, because they not only went through the same training, but also shared experience, certain procedures and use a uniform terminology. (2nd int., lines 36-47)

Bartu arrives at a similar assessment. She sees the reliability of her palpation as the basis for her osteopathic work. She reports on an agreement within her team, as well. (*11th int., lines 92-102)*

To Pflüger it is essential in which system the work takes place. If it is a testing that is exclusively structural, like a sacrum test, or if there is an element of tension in the system. he rates reproducibility in the course of a treatment as high. In the cranial concept he rejects the term "reliability"

> *"because a very individual and very subjective contact with the other system comes into existence, actually you become transformed into one system and you feel a resonance with that system, and this is by nature very individual and will accordingly, be of a different, not reproducible character each time.* (3rd int., lines 175-190)

Friederike Kaiser does not specifically deal with an assessment of the reliability of the testing. She cannot see any final reliability. She advocates treating the patient on the basis of what she finds (4th int.,p. 77-87).

Lappas does not answer the question directly, but - like Fieux - designs a theoretical concept for a study. He believes that in a case of a serious tissue lesion, ten experienced therapists

should come to the same conclusiong when examining one and the same patient. He quotes as an example a patient with a tumor or a patient with a perineal tear. To him, these alterations are in the fascial focus (6th int., lines 95-120).

Fieux goes along with that statement. If in a tissue, which for him is in a constant dynamic state, an overriding static density exists, different therapists ought to be able to detect this density. As an example he describes a patient with hypotension, abdominal hypotonia in which the abdominal cavity lies on the pelvic one. After a fall of the patient onto the sacrum, this traumatic density should be found as quality. (9th int., lines 141-161)
Behrens rates the intrareliability in *Sacral Listening* as low, the reason being different palpation experience of tissue, its interpretaion and the wide range of terms and language (8th int., lines 59-70).

Decoster sees the same problems. (9th int., lines 107-124). An evaluation of reliability, as previously mentioned, remains subjective if made in a non-scientific context. Yet, some results show points of agreement. One of them is the respondents' reliance placed on their own perception of the testing.

The statements of Monika Dunshirn, Anett Hörster, Hartmut Fritzsche, Sandra Bartu and Max Giradin reflect this fact. Some interview partners provide arguments similar to each other when it comes to their expectation of a low intrareliability *Sacral Listening*, and their reasoning for factors that would result in a high intrareliability. It is the experience in the field of palpation, its interpretation and nomenclature.

We find these arguments in a positive assessment in regard to their own professional teams in the statements of Anett Hörster and Sandra Bartu. Andreas Behrens and Steven Decoster use exactly the same reasons in their negative assessment of intrareliability.

A totally different approach comes from Luc Fieux and Richard Lappas. Both believe that a structural lesion at a patient's sacrum will be found and identified in the same way by different therapists.

6. Summary

The answer to the central question of this thesis:

Is Sacral Listening applied in a uniform way?

is an unequivocal no.

Sacral Listening is not applied in a uniform way.

The literature analysis, in conjuction with the quantitative survey and the interviews make it clearly visible, that there is **no** uniform concept of *Sacral Listening.* This evidence was substantiated by many individual results of this study. The interviews reveal, as does the literature, clear differences in the application of the testing. One of them lies in the application of the testing by means of focussing in which attention is focussed on particular parameters which are to be dealt with in *Sacral Listening* . In doing so, an additional induction, like a caudal traction at the sacrum may be added.

The other approach presupposes transition in the consciousness of the therapist. Becker (2007) calls it the quantum level. Upledger (1996) talks about melding in attempting to describe this level. For Liem (2008) this is a level of palpation where any duality is overcome, there is no longer any inclusion of methodological props and models. Patrich van den Heede (2009) describes the state the therapist assumes at this level with the words "*be still and lo*w. *The system expresses itself" (Giradin, 2009).* Even at this level differences in the descriptions of the authors and the individual interview partners emerge.

In the application of *Sacral Listening* as well, the quantitative survey and the interviews reveal considerable differences. This is expressed in the fact, that some therapists apply the testing in every examination, whereas others don't regard it as a standard tool.

Further discrepancies can be seen in the interpretation, which is not only dependent on the intention, that is the approach, but also on the individual osteopath's mental image of the sacrum, see chapter 2.1. *The Sacrum from an OsteopathicPoint of View.*
A further point of divergence is the development the therapist himself/herself has gone through in relation to this testing. This development is detailed in chapter 5.3. It is caused by

an increased or a changed experience in the method of palpation. Changes in perspective of how the sacrum is seen, also play a role in these developments.

The study clearly reveals that even a singular element like the *Sacral Listening* palpation testing opens up a wide array of approaches, states of consciousness, concepts and applications in the field of osteopathy. What then is the relevance of this result for osteopathy and osteopathic research? The outcome of this study has a relevance for basic research in osteopathy. The demand for a standardization on the basis of scientific research which only legitimizes what is both proven and applied in a uniform manner. appears to be premature. If osteopathy was subjected to such judgement it would be castrated and would be robbed of one of its greatest tools. This observation underlies a claim made by the DO journal last year

> *"We have to make it perfectly clear that this place [referring to the place of academi-calization and scientific research] can only be and develop right amidst the osteopathic-clinical experience and the everyday practice of dealing with the suffering of the patient. We must call for science to actually create osteopathic knowledge rather than just providing evidence about the effectiveness of osteopathy. And we must insist that scientific curiosity rather than tedious formalism determines academic research."* (Breul et al., DO 2/2008, p.1)

In retrospect, I would refrain from using the trial interviews as a testing of the guideline and a training for the interviewer as mentioned in chapter 3.2.2. I would rather evaluate them in their entirety before further interviews were recorded. This would have benefitted the last point in the interviews. Had the interviewer chosen a different approach, the interviewees might have expressed themselves in a more scientific mode. The *living picture of the sacrum* as well might have been worked out in more detail. These are realizations which surfaced only after the evaluation of the individual interviews was completed.

This study has certainly stimulated my interest to further explore the nature of palpation and of perception.

Finally, I would like to say that writing this thesis has greatly widened my knowledge and my experience in the field of osteopathy, both in a general sense and in particular in relation to the research objective of my thesis.

7. Explanation of Terms

DGOM	German Society of Osteopathic Medicine
DO	Diplom-Osteopath (D.O.)
EVOST	Evolutionary Medicine within the Osteopathic Field
Fulcrum	Still point of variable center of a movement
OAM	Osteopathic Academy Munich
PRM	Primary Respiratory Mechanism
SICO	Swiss International College of Osteopathy
WSO	Vienna School of Osteopathy

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N.B.: All quotation appearing in this thesis were taken from literature written in the German language. In the case of such literature that was first published in English, quotations appearing in this translation may therefore be not identical with the original wording..

9. List of Figures