„Osteopathy – the way from therapy to prevention“

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*von **Mag. Marion May***

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Eidesstattliche Erklärung

Hiermit versichere ich, die vorgelegte Masterthese selbständig verfasst zu haben.

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Datum Unterschrift

This paper is dedicated to my little children
Flora Sophie and Vitus Matthäus
and my partner Bernhard.
Thanks a lot for your understanding and love!

1 Abstract

Study Design

Problem-centered interview with six patients

Outline/Problem Definition

During my career as a therapist I kept and keep meeting patients who attend therapy due to a certain clinical presentation. But even after the original problem disappeared, they stay with me as patients. Often I care for them in a pre-emptive way. At this point I ask myself the question: “Why do patients keep attending therapy?”

Research Question & Objective

0) Which are the reasons for osteopathic long-term-therapy?
1) Which aspects are to be expected from the disease, the osteopath, the therapist and the environment of long-term therapies?
2) What significance does well-being have thereby?
3) What significance does quality of life have thereby?
4) What portion of the changes can be assigned to touch?

Hypothesis

Osteopathic treatment influences the different sensitivities of patients.

Relevance for the Patients

Changes in the sensitives of patients due to osteopathic treatments have a relevance.

Relevance for Osteopathy

The aim of the study at hand is to point out various motivations for a long-term therapy and to capture the changes in different sensitivities. The significance of the social component and of the aspect of touch shall also be accounted for in the interviews. Osteopaths may use this results for their own work, e.g. the importance of talking during the treatment.

Methodology

The main field of the questions in the problem-centered interview in this study refers to the components of well-being, which could have been changed by long-term therapeutic situation. The target group for this investigation are people who see an osteopath over a longer period of time. Even after the “healing” of their so-called main problem the stay with the therapist as a “patient”. Interviews were conducted with a total of six persons. The inquired patients were between 37 and 64 year old.

Results

The basic question “Why do patients attend therapy over the course of years although the primal problems ceased to exist?” could be answered. The more difficult it is for experts to define well being, life-satisfaction or quality of life, the easier it seems for the interviewees to express this terms but also the perceptions connected with them. Because of the various diseases of the interviewees restrictions of well being, life-satisfaction and quality of life appear. Restricted mobility, fears, sleep deprivation, restriction within everyday life, spare time or within the job, as well as decreased social contacts because of the disease are experienced by these patients. All of them report on pain, in most cases this led them to the osteopath. It is crucial that the osteopathic therapy can only have full efficiency in connection with the therapist. Concerning therapy pain reduction, improvement in mobility, in physical or psychic area or an obvious diminution of medication is cited. Depending on the technique the therapist is carrying out, the interviewees report about relaxation up to sleep, a physical well being, warmth or floating, just to name physical indications. Because of therapy, operations could be retarded for years during the same level of quality of life. Concerning the psychic part, happiness, reduction of fear, joy of living or energy are named. Also tears of joy because of bettering or just out of a moment of happiness were experienced by the patient and also mentioned within the interviews.

Critical Reflection/Perspectives/Conclusions

All patients that took part in this study consulted therapists because of complaints, most often this was pain. Disease meant a change of life situation, due to the osteopathic treatment certain further changes in different sensitivities came along as well. For the interviewees osteopathy is a life-concept in the sense that they deal more consciously with themselves. Thus social contact and nearness is a crucial factor for long-lasting, long-term therapy. That means that osteopathy should unite social, economical and ecological ideas.

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2 Introduction

During my career as a therapist I kept and keep meeting patients who attend therapy due to a certain clinical presentation. But even after the original problem disappeared, they stay with me as patients. Often I care for them in a pre-emptive way. At this point I ask myself the question: “Why do patients keep attending therapy?”

All their lives, people are searching for happiness, contentedness, a positive quality of life and the feeling of well-being (Frank, 2007).
These factors rank surely very high on the scale of people’s needs, after the originally satisfied basic needs such as sleep, food, drink, etc.
Now, can an osteopathic therapy influence the needs mentioned above at first?
Influence on a psychic level, such as the feeling of security, even though it mainly works with the patient on a physical level, e.g. using the cranio-sacral therapy? And just how important is touching in general and what value does it have for therapy?

From this four specific questions arise for me:

1. Which aspects are to be expected from the illness, the osteopathy, the therapist, the therapy and the environment of long-term therapies?
2. Which significance has the feeling of well-being in this?
3. Which significance has the quality of life?
4. Which proportion does touching have in these changes?

At the start of my thesis it will be important to define these assumed needs which experience change more specifically.

Quality of life and well-being are two terms which can hardly be seperated, because they are often used as synonyms. Concerning quality of life, research was done mainly in social sciences and medicine (Glatzer, 1992; Glatzer & Zapf, 1984) in recent years, and concerning the term of well-being in psychology (Renwick, Brown & Nagler, 1996)

According to researchers, the difficulty of clearly separating well-being from quality of life arises from the fact that well-being is a parameter and indicator of quality of life (Diener & Suh, 1997; Veenhoven, 2001)

Psychological research discovered the field of contentedness in life and the closely related constructs “happiness” and “well-being” for themselves only in the 1960ies (cf. Bradburn, 1969; Andrews & Whitey, 1976; Campell, Converse & Rodgers, 1976. In Schuhmacher et al, 1996, p.1)
Bradburn is seen as one of the pioneers for the research of well-being in the American region. He assumes that a balance of positive and negative feelings is crucial.
Collectively the term well-being has to be based on a multi-dimensional concept (cf. Abele & Becker, 1991; Diener, 1984; Diener, Lucas & Oishi, 2005).
It is due to the president of the American Psychological Assosciation (APA), Seligman M.E.P. that right now the term “Positive Psychology” resounds throughout the land in the research of well-being.

“*Psychology is not just the study of disease, weakness, and damage. It also is the study of happyness, strength, and virtue*“(Seligman, 2002,pp.xiv).

Well-being, contentedness, happiness, constructive thinking, such as hope, trust, optimism, but also strenght, talent and virtue should be

researched and their influence on life and those of our fellow men made visible.

Glatzer & Zapf (1984) and Glatzer 1992) dedicated their study mainly to the research of the quality of life. At first, these research results were integrated into the field of social science, whereupon clinical circumstances of life and their subjective evaluation in terms of contentedness or well-being were researched.
The latest research focus their interest on the results for the health-related quality of life, because they show importance for medicine (cf. Bullinger, 1997).
The terms which I consider important for my thesis and require a more specific defintion, seem to be well-being, contentedness, quality of life, touching, being touched and emotion. These are discussed in more detail in the following chapter and their close coherence is presented.

3 Theoretical basis

3.1 Well-being

3.1.1 Definition of well-being

The dictionary defines well-being as a "*good physical and emotional feeling*"(DUDEN, 2002, S. 1056).
This explanation does not seem to come up to the manifold aspects of the construct of well-being.
The definition of the term well-being can be basically restricted to the German-speaking countries and the USA.
Becker (1994) seems to play an important part in this field of research, whereat he proposes a structural model of well-being. This model distinguishes between the current and the habitual well-being. While the current well-being describes the present experience of a person, the habitual well-being is based on aggregated emotional experiences (general well-being during the last weeks and months) and can be regarded as a relatively solid condition. Researchers seem to emanate, that people with a developed habitual well-being are mostly in a state of well-being and contentedness. Another difference concerns the mental and physical well-being. If these two further aspects are recombined with the shapes of habitual and current well-being, four different forms of well-being emerge:

1. The current mental well-being encloses positive emotion (happiness, elation), a positive mood and the current absence of medical conditions.
2. The habitual well-being describes the rare appearance of negative feelings and emotions (habitual absence of medical conditions), as well as frequent positive feelings and emotions.

3. The current physical well-being covers a current positive physical condition (vitality, fitness), as well as the absence of medical conditions.
4. The habital physcial well-being means a long-term absence of medical conditions as well as habitual positive physical conditions.

On the level of cognitive evaluation a habitual contentedness of the psychic condition arises from the habitual psychic well-being and a habitual contentedness with the physical condition from the habitual physical well-being. Both aspects of contentedness construct a general and area-specific life-satisfaction (cf. Mayring, 1994).

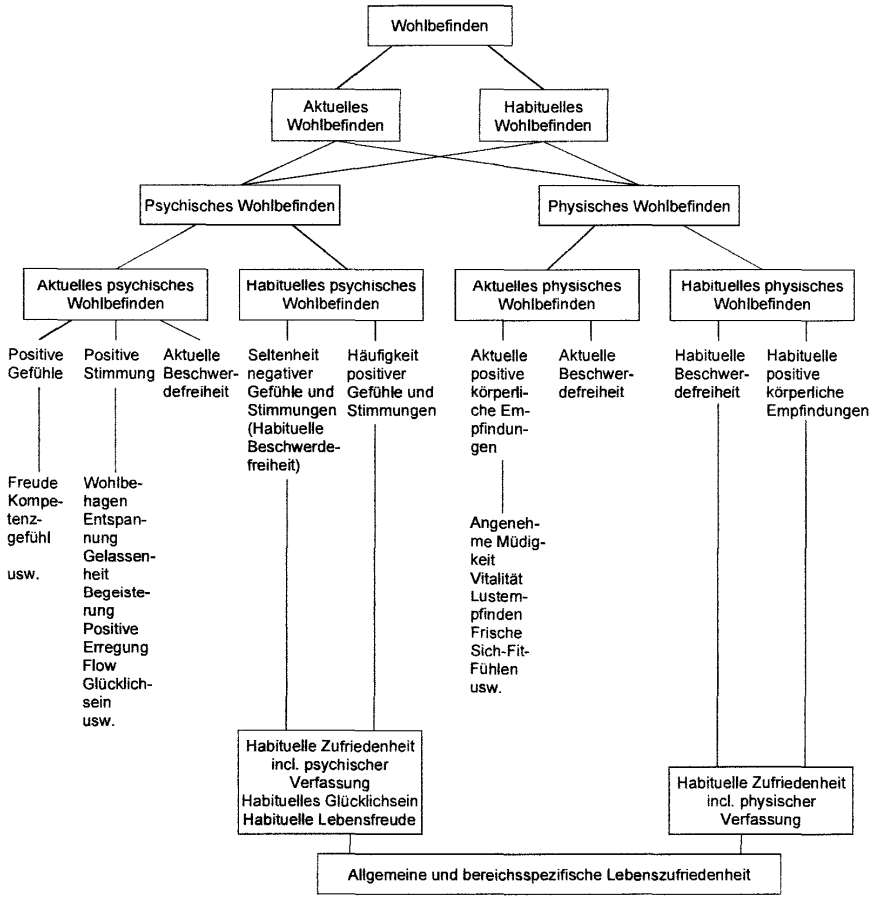

Figure 1 Model of well-being according to Becker (1994)

People can achieve current well-being directly from pleasant impulses, successful action, social attention or pleasant phantasies. Indirectly it can result from a reduction or disposal of aversive conditions.

Becker (1991) divides the current well-being in four subitems:

1. „Flow“ (cf. Csikszentmihalyi, 1999): high activatedness
2. Calmness: low activatedness
3. Positive sentiment („excitement“): high agitation
4. Positive sentiment (relaxation): low agitation

According to Becker (1991) current well-being thus is „*das momentane Erleben einer Person, die positiv getönten Gefühle, Stimmungen und körperlichen Empfindungen, sowie das Fehlen von Beschwerden*.“ (p. 13) [„*the current experience of a person, the positively tinted feelings, emotions and physical sentiments, as well as the absence of medical conditions*.” Translation L.W:]
Referring to the statement by Becker, several deductions can be made for the results of the following analysis by means of a questionnaire. It is the aim of each osteopathic treatment, to discharge the patient with mainly positively tinted sentiments and without physical medical conditions. At least on this level there seems to be a correlation between the characteristics of well-being cited in literature and the experienced situation after an osteopathic treatment. The results in the empirical part will show, how far this can be assigned to the habitual well-being as well.

Grupe (1976) outlines the aspects of well-being as follows:
„*Da das Befinden nicht etwas ganz und gar Natürliches ist, sondern immer auch von den spezifischen Wertvorstellungen abhängt, die ein Individuum vertritt, oder die in einer Gesellschaft, der es zugehört, vorherrschend sind, kann es auch keine allgemeine Definition dessen geben, was Wohlbefinden ist. (…) Fassen wir dies alles zusammen, so*

zeigt sich Wohlbefinden als eine positive Grundbefindlichkeit des Menschen. Es ist von unterschiedlichen Bedingungen körperlicher, seelischer und sozialer Art sowohl aktuell, als auch langfristig bestimmt. Zwar ist einerseits ein eher privates Ereignis, dass nicht nur in hohem Maße von individuellen Voraussetzungen abhängig ist, sondern auch von persönlicher Einschätzung und Bewertung bestimmt wird; andererseits steht es aber ebenso unter dem Einfluss von kulturellen und sozialen Wertvorstellungen. Im Wohlbefinden zeigt sich die Realität unmittelbarer Art, in der Subjektives und Objektives nicht voneinander geschieden sind. Es kennzeichnet den Menschen in dem veränderlichen und zugleich dynamisch-offenen Verhältnis zu sich selbst, zu seinem Körper und zu seiner sozialen und kulturellen Umwelt. Es ist nichts Stabiles und Festes, vielmehr ein instabiler Teil eines instabilen Mensch-Umwelt-Verhältnisses. Wer es hat, kann nicht sicher sein, es auf Dauer zu behalten; wer ihm ständig nachjagt, der findet es kaum“ (360f).

[„*Because the condition is not something entirely natural, but always dependant on specific moral concepts an individual represents or those which prevail in the society they are part of, there can be no general definition of well-being. (...) If we summarizes all these aspects, well-being presents itself as a positive general condition of human beings. It is a determined by different physical, mental an social conditions, currently as well as on long-term. On one hand it is a private experience which does not only strongly depend on individual preconditions, but also on personal assessment and evaluation: on the other hand it is influenced by cultural and social moral concepts. In well-being reality shows itself directly, where subjectiveness and impartiality are not separated. It characterizes human beings in their changeable and dynamically open relationships to themselves, their bodies and their social and cultural environment. It is not something stable and solid, more of an instable part of an instable relationship between humans and environment. Whoever possesses it cannot be sure to keep it in the long run; whoever chases it permanently will hardly find it*.” (360f) translation: L.W.]

Different theories referring to well-being describe this quality, situation or process. The focus on one hand on the human-centered aspects of well-being and on the other hand on the environment-centered aspects. Or the mutual influences of both aspects (cf. Becker, 1991; Diener et al, 1999).
In their theory of mental health Becker & Minsel (1986) tried to incorporate the different constituents. Mental health is defined as the ability to cope with external and internal demands. Based on a hierarchic model mental health is set as main factor on the top level; followed by a subcategorization on seven areas of indicators.

Mental-physical well-being

1. Meaningfullness vs. depression
2. Self-forgetfulness vs. Self-centeredness
3. Absence of medical conditions vs. nerviness

Self-actualisation

4. Expansivity
5. Autonomy

Self- and externally procured esteem:

6. Self-esteem
7. Ability to love

Contrary to Becker, who is concerned with deliberations on the topic of well-being German-speaking areas, in the USA a theory-conducted multi-dimensional model of well-being developed.
According to Ryff (1989) this empirically confirmed model contains six dimensions, which seem to largely agree with Becker's dimensions:

1. Self-acceptance
2. Positive relations to others

3. Autonomy
4. Copying with the environment
5. Sense in life
6. Personal growth

In order to clarify these theoretical statements one could say, that human beings feel well if they accept themselves in their wholeness and can conduct open, warm-hearted, honest relationships with other people, live a chiefly self-determined life, personal needs shall be satisfiable and aims attainable. Furthermore human beings should experience steady development.

In the USA , this conceptualisation proceeds one step further (cf. Keyes, 2002) and gives the emotional well-being (positive prevailing mood, happiness, contentedness in life) and the six dimensions of positive functioning by Ryff (“psychological well-being) the additional term of social well-being which is clarified in five subitems:

1. Acceptance of other people
2. Conviction that society has the potential of positive development
3. Impression that one’s own life is useful for society and one’s contribution is appreciated by others
4. Interest in society and the conviction that societal activities are logical, predictable and meaningful.
5. Social Integration

Ryff and Singer (2002) stress that mental health are not to be considered a discreet situation, but a multi-dimensional dynamic process, which means that well-being is the result of an intellectual, social, emotional and physical commitment in life.

Closing this chapter on definition of well-being the theory of Subjective well-being by Diener and his co-workers (cf. Diener, 1984, 2000; Diener, Suh, Lucas & Smith, 1999; Diener, Suh & Oishi, 1997) shall be mentioned. Thereby the Subjective well-being consists of two main constituents:

1. emotional oder affective constituent
2. cognitive-evaluative constituent

The emotional constituent can be split up into the sub-constituents „positive affect“ and „negative affect“ as well as happiness (as a long-term positive affective condition) (Mayring, 1991). These constituents build the subjective emotional well-being. The cognitive-evaluative constituent of the subjective well-being contains the global (general) and the area-specific contentedness in life. Thereby the circle seems to close with the model by Becker (1991) (see fig. 1). The evaluation of the interviews in the empirical part of this thesis should later on largely support this claim.

3.1.2 Physical well-being

Because the psychic and emotional constituent often prevails in different explanatory approaches and models, here the focus shall lie on the physical well-being. As an osteopath I consider this of importance, because touch in therapy chiefly applies to the bodily level, even though human beings have to be seen in their wholeness. Which aspects also shall be addressed through the physical contact between therapist and patients, will be specifically described in the chapter Touch.

3.1.2.1 Definition

According to Frank (2007) physical well-being is
„*ein subjektives Phänomen. Es geht dabei um Sinnesreize (sehen, hören, tasten/spüren, riechen, schmecken) und interozeptive Reize*

(Empfindungen innerhalb des eigenen Leibes wie z.B. Körpertemperatur, viszerale und genitale Empfindungen, Gleichgewicht), welche körperliche Empfindungen hervorrufen, die im gesamten Körper oder in Teilen des Körpers spürbar sind und in positiver Weise wahrgenommen und bewertet werden. Sie gehen mit einem zumeist bewussten, als lebendig, lustvoll bzw. genussvoll erlebten Bezug zum eigenen Körper einher und werden als Zustand des Behagens empfunden. Körperliches Wohlbefinden kann demgegenüber aber auch als ein Zustand erlebt werden, bei dem der eigene Körper gänzlich zurücktritt und als vollkommene Selbstverständlichkeit empfunden wird, so dass uneingeschränkte Zuwendung des Bewusstseins auf die Umwelt möglich wird. Wichtig ist schließlich, dass körperliches Wohlbefinden nicht gleichzusetzen ist mit körperlicher Gesundheit oder Fitness und sich nicht auf das Erleben von körperlicher Funktionstüchtigkeit oder Leistungsfähigkeit beschränkt" (S. 133).

["*a subjective phenomenon. It deals with sensory stimuli (seeing, hearing, touching/feeling, smelling, tasting) and interoceptive stimuli (perceptions within the body, such as body temperature, visceral and genital perceptions, balance), which evoke physical feelings sensible in the whole body or parts of it and which are perceived and evaluated in a positive manner. They mostly accompany a conscious, lively, pleasurable relation full of relish with the body and are perceived as a condition of contentedness. Physical well-being can on the other hand also be perceived as a condition where the own body steps back and is felt as a perfect implicitness and thus the absolute attention towards environment is made possible. It is important that physical well-being is not equalised with physical health or fitness and is not restricted to the experience of full functionality or capability*." (S. 133) translation: L.W.]

Physical well-being is seen as a vital dimension of health (Mayrin, 2003; Schmidt 1998), but concurs only partly with impartial health-criteria (e.g. physical functionality-test, medical opinion). This can be observed in physically sick people who despite physical symptoms experience

subjective well-being, if the extension and the intensity of their medical condition do not determine the entire consciousness. Physical health is a vital condition for the unrestricted experience of bodily functionality and capability, but does no guarantee on its own the feeling of physical well-being. Human experience remains restricted, if the readiness for perceiving pleasant feelings is missing or the ability for pleasurable, agreeable or vitalising bodily experiences has not been encouraged throughout the course of life. Essential basic needs are not adequately satisfied and important psycho-social and health-protecting factors cannot be developed (Taylor, 1990; Mittag, 1998).

Frank et al (1990) made it their business to develop a questionnaire for the acquisition of the current physical well-being (FAW), which only takes into consideration positive aspects of physical well-being (c.f. Frank, Vaitl & Walter, 1990; Frank, 1991, 2003). Seven factors could be found by means of a factor-analytical examination of the structure of current well-being and confirmed in a replication-study. By means of these factors physical well-being can be described differentiatedly. The following chart gives an overview of the sub-aspects of physical well-being, which are at the same time the factors/scales and the highest-ranking item of the FAW. The FAW comprises current physical well-being reliably and validly (Frank, 1991, 2003).

Tab. 10.1. Struktur des körperlichen Wohlbefindens

Faktor / Skala (FAW)	Itembeispiele (Kurzfassung)
Zufriedenheit mit dem momentanen Körperzustand	▬ mit körperlichem Zustand einverstanden ▬ kann meinen Körperzustand genießen
Ruhe und Muße	▬ genieße die beschauliche Ruhe um mich herum ▬ spüre, dass körperliche Erholung einsetzt
Vitalität und Lebensfreude	▬ spüre nachwirkende freudig Erregung ▬ verspüre Tatendrang
nachlassende Anspannung, angenehme Müdigkeit	▬ fühle mich angenehm schläfrig ▬ bin rechtschaffen müde
Genussfreude / Lustempfinden	▬ spüre, dass eine angenehme Berührung nachwirkt ▬ habe mir Genüsse verschafft
Konzentrations- und Reaktionsfähigkeit	▬ kann mich gut konzentrieren ▬ bin zu konzentrierten Bewegungen fähig
Gepflegtheit, Frische, angenehmes Körperempfinden	▬ fühle mich sauber und frisch ▬ fühle mich gepflegt

Table 1: Model of physical well-being (Frank et al, 1990)

Subjectively healthy and physically affected people (covered with the question: Does your current state of health affect you to do things you would like to do?) differ substantially in their physical well-being. Apart from receding strain, more strongly experienced by subjectively health-impaired and pursuit of pleasure which is not touched by health-impaired, all scales of the FAW are more strongly pronounced by subjectively healthy people (cf. Frank, Vaitl & Walter, 1995).

3.1.2.2 Indicators for body-related regulations of well-being

Frank (2007) asks in his book „Therapieziel Wohlbefinden“ [„Well-being as goal of therapy“ translation: L.W.] the question: „*Wann wird eine Beeinflussung des körperlichen Wohlbefindens notwendig?*“ (S. 135) [„*When is the interference with physical well-being necessary*?“ translation: L.W.]

An indication of body-related regulation of well-being results above all:

- As pre-emptive measure with subclinical pathology.

- With residual symptoms of the affective discomfort (e.g. affective disorders, social phobias, panic disorders or anankasms) as selective focus of positive, body-related possibilities of experience and completion.
- With stress-induced illnesses as an aid for quick re-regulation of consequences of pressure (physical relief), for sensitizing for personal physical possibilities and limits and for the build-up of stress-alleviated alternative ways of live with an adequate rhythm of exertion and relaxation.
- With disorders of the body image and bodily perception (e.g. with eating disorders, bodily dismorphic disorders, somatorform disorders).
- For the amendment of quality of life in case of chronic diseases and for the compensation of bodily constraints and handicaps.
- Within the health-improvement during rehabilitation.
- For the support of general treatment-compliance.
- As measurement of the terminatory stabilisation (ibidem, p. 135).

These fields of indication are predominately designed for psychotherapeutic illnesses, nevertheless I consider especially for the last four indication points good possibility to influence the physical well-being via osteopathy. Depending on the diagnosis of the patients who are assigned for therapy, the potential of the osteopathic treatment concerning the influence on the physical well-being can surely be seen in the psychic/psychotherapeutic field.

Finally it can be stated, that an improvement of the physical well-being can be achieved with directed interventions in a specific way that this is also reflected in clinical health parameters and is connected with a positive psychic condition (Frank, 2007).

3.1.3 Well-being from a neurobiological/neurochemical point of view

3.1.3.1 Definition and catalyst

In which areas and what happens in the brain when positive feelings – a central role of well-being – are experienced?
These questions seem to be as important as the definition of the term well-being. Is the cranio-sacral therapy on one hand able to influence these specific cerebral structures or can positive stimuli and their knowledge about the triggering factors in therapy lead to changes in well-being of every kind? Thereby this field of cerebral research seems to be relevant for the handling of this subarea of my investigation.

In everyday language, emotions are often equalled with feelings. Positive affects accompany positive feelings, negative effect on the hand accompany negative feelings. Current emotion research proceed from assumption that a feeling in its specificity as an experiential sensity can only be seen as a partial aspect of emotions.
Lang (1993) and other emotion researchers propose a description of the emotional occurrences on a minimum of three levels:

1. A subjective emotional level which can only be captured by interviews and introspection.
2. An autonomous physiological level which can only be registered by appropriate measurement recorders.
3. A motor behavioural level whose aspects can be measured by observation of behaviour.

The result that emotions are frequently accompanied by characteristic cognitions, triggering motor action which mostly consist of complex sequences of action, but can also include mimic expressional behaviour. Bodily changes in the endocrinological and the immunological field can be

found as well as changes of an autonomous way, such as reactions of the heart rate.

All these reactions seem to be a part of a neuronal network which has emerged during the evolutionary development of mankind. Reaction which help us to react as quick as possible to specific environmental stimuli. Thereby the existence of a certain number of basic emotions seems to be important, whereby researchers give different information about their total number. Panksepp (1998) lists seven basic emotions, Izard (1992) names ten and Plutchik (1989) eight, whereby all of them list more negative emotions than positive ones. However, they all agree that basic emotions appear at an early ontogenetic stage, are universal, i.e. are to be found in every culture and own a specific physiologic basic pattern and a high evolutionary adaptation value.

Wundt (1903) as a contrast supposed that all emotions could be described by a dimensional approach. Two dimensions about the extension of emotions take centre stage, meaning valency and agitation.

Valency hereby describes whether something is experienced as pleasant or unpleasant. Agitation describes the intensity of a feeling.

As in many areas of investigation nowadays, it is attempted to integrate and connect this great number of models. Stemmler (2002) connection in his model of basic emotional systems different biologically orientated emotion theories and combines them with cognitive approaches.

He assumes "*dass die Aktivierung eines Basisemotionssystems von verschiedenen Gefühlen begleitet sein kann. Das aktuelle Gefühl richtet sich danach, in welchem Ausmaß das Ziel eines aktivierten Basisemotionssystems erreicht wurde*" (Stark & Kagerer, 2007, S. 265) ["*that the activation of a basic emotional system can be accompanied by different feelings. The current feeling complies with the extent to which the aim of an activated basic emotional system was reached*"].

In this model positive feelings can be triggered mainly by environmental stimuli, but also by inner stimuli, such as thoughts. These stimuli can have a directly rewarding (positive intensifier) effect or an indirectly rewarding

one by avoiding punishing events. Positive intensifiers are distinguished into primary and secondary intensifiers. Positive emotions can be triggered by positive intensifiers even without the else required learning effect. In this theory's favour it can be said that e.g. infants can already distinguish between pleasant and unpleasant. From birth on sweet taste is preferred to bitter one.

Secondary intensifiers require learning processes mostly in a traditional form or operant conditioning.

"*So ist z.B. der Anblick von Geld erst belohnend, wenn der symbolische Wert von Geld gelernt wurde*" (ebenda, S. 265). ["*The sight of money is only be rewarding when the symbolic value of money has been learned*."]

According to Berridge (1996) Positive feeling such as wanting and liking are another important aspect in the possible triggering of stimuli and emotions.

3.1.4 Neurobiological basis

The neuropathologist Papez (1937) was one of the first to be able to identify different structures in the brain of which we know now that they play an important role in emotional processing. The hypothalamus, the thalamus, the mammilary bodies, the anterior cingulate cortex, the hippocampus and the fornix are describes as part of a neuronal network, also called Papez-circuit. MacLean (1949) continued the investigation of Papez and introduced the term of the limbic system used for the location for emotions nowadays.

This system consists of parts of the diencephalon (thalamus, hypothalamus), the mesencephalon (ventral tegmental area, central grey), the endbrain (amygdala, insular and orbifrontal cortext, anterior cingulate cortex, hippocampus, basal ganglia).

Works by Damasio (1994), Rolls (1999) and LeDoux (2000) and the following figure provide the basis for the intended explanatory approach of the neurobiological emotional model.

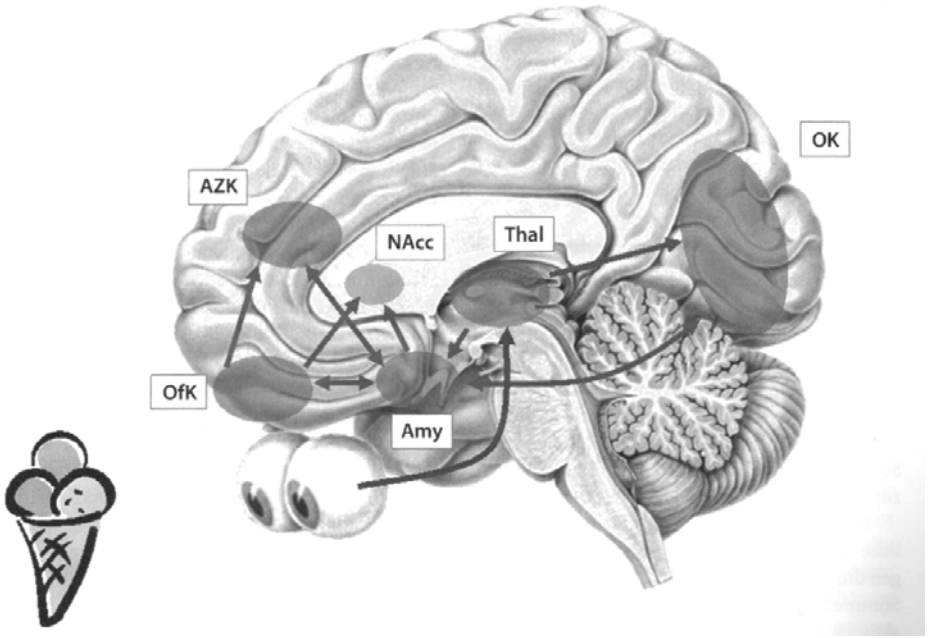

Figure 2: Path of emotional processing (Damasio, 1994; Rolls, 1999; LeDoux, 2000)

Amy = Amygdala

Thal = Thalamus

OfK = Orbifrontal Cortex

AZK = Anterior cingulate cortex

NAcc = Accumbent nucleus

OK = Occipital Cortex

According to figure above the understanding of the neurobiological structures and their cooperation on the way of emotional development can be facilitated.

The visual information is transformed into nerval impulses in the retina. The thalamus – also called the door to the cortex – serves as the switching control centre on the further path of the stimuli. If the latest researches of LeDoux (2000) are to believed, information goes along two

parallel ways: a quick, but “imprecise” way directly to the amygdala and a slower processing way to the amygdala via the cortex. In this system the central role of determining the emotional meaning of a perception is assigned to the amygdala.

During the quick direct way from the thalamus to the amygdala processing takes place without consciousness. This means, when information reaches the thalamus we do not yet know what we see. The different, already lead over this loop several times with specific physical characteristics, can lead to us feeling attraction or disgust for “this stimulus” without us knowing why.

During the “normal” slow way of processing information the visual stimulus firstly reaches the occipital lobe, which triggers the primary and secondary visual processing. Furthermore the translation via the temporal lobe is effected, whereby memory traces, i.e. things already learned, assign a meaning to the occurred. A precondition for memory is an intact hippocampus in the temporal lobe. The amydgala in cooperation with the orbifrontal cortex assess the stimulus once again. Both structures are closely connected with the other parts of the brain and influence each other mutually. Whether a stimulus receives heightened attention or not, is decided consequently by the anterior cingulate cortex, which is connected to the attention networks in the parietal lobe and the dorsolateral prefrontal cortex. An ideal information processing is guaranteed if additionally to the information connected with meaning, rear projection from the amygdala and pre-processed stimuli from the occipital lobe and the temporal lobe are consulted. A closer efferent connection between amygdala with the hippocampus and the central grey conduct the physiological side effects of emotions. In the already mentioned prefrontal cortex finally the cognitive processes take place which lead to directed action, which in turn lead to open behaviour via the basal ganglia. According to Damaio (1998) a decision for action is decisively influenced by earlier emotional experiences.

„*Körperliche Erfahrungen in früheren Situationen dienen als sog. Somatische Marker, die uns unbewusst zu Handlungen veranlassen, die mit angenehmeren Erinnerungen verbunden sind. (…) Die hier beschriebenen Prozesse dürften weitgehend sowohl bei negativen, als auch bei positiven Emotionen ablaufen*“ (Stark & Kagerer, 2007, S. 267). [„*Physiological experiences in early situations serve as so-called Somatic Markers which unconsciously lead us to actions which are connected with pleasant memories. (...) The processes described here are supposed to occur largely during negative and positive emotions*.”]

Finally the rewarding system discovered by Olds and Millner (1950), which consists of parts of the brain stem, the striatum in the cerebrum and the accumbent nucleus, is assigned an important role in the positive evaluation of stimuli. Additionally the accumbent nucleus possesses a large number or opiate receptors, which are on their turn important for the reception of neurotransmitters. The following chapter is dedicated to the neurotransmitter dopamine which seems to be playing an important role here.

3.1.5 Neurochemical neurotransmitters like dopamine and oxytocin

If well-being is seen from an evolutionary point of view, arguments can be listed, that seeking situations which are associated with well-being, are of fundamental importance for the survival of the organism and the species and therefore can be considered as an advantage in selection (Nesse, 2004; Buss, 2000)

How the dopaminergic and oxytocin sytem is exactly constructed in its neurobiological form, would go beyond the scope of this thesis. What I consider important is how the well-being in its entire from is influenced by these two neurotransmitterls and which possibilities this gives to body therapy, such as osteopathy.

Highly simplified it coul be said, that well-being as a positive affect arises when certain needs are satisfied. With regard to social needs, well-being is associated with a state of social closeness, safety and security, whereby oxytocin and dopamin play a central role (Esch & Stefano, 2004; 2005).
The central nerval mode of operation of the oxytocin which effects well-being, is based on three functions not independent from each other according to Kirsch & Gruppe (2007):

1. Reduction of fear
2. Moderation of stress reactions
3. Construction of close social relations

That would mean that the experience of social closeness and relations cause a reduction of stress and fear through the influence of oxytocin on the amygdala. Furthermore, the simultanous stimulation of oxytocin receptors in the brain leads to an activation of the limic dopamin signal, which lead to enhancement of well-being via the enhancement of anticipatory joy and the heightening of activity (Liu & Wang, 2003). The dopamin system would constribute to an increase in consumatory action or generally emotionally tinted activities via the increase of the stimulus movtivation (see previous chapter). It is decisive, however, that the receptiveness of the two systems is differently developed in different persons. The receptiveness of the oxytocin system seems to be determined by experiences in early infancy; as opposed to the dopamin system for which genetic pre-dispositions are assumed. The receptiveness of the dopaminergic system seems to influence the ability of feeling love and closeness and thus being able to build social relations. For the near future it can be expected that researchers will identify futher genetic, environmental factors – also called genetic-environmental-factors, which have a decisive influence on the receptiveness of the transmitter system (Capsi & Moffitt, 2006).

It would be interesting whether these scientific results can also be applied to “osteopathic” touch and their positive influence on well-being. The assumption whether positive experiences regarding physical conact in childhood can lead to positive emotions during therapeutic treatment in adulthood, surely provides an interesting aspect for the evaluation of the results of my interivews. The chapter about touching and being touched should provide the further scientific basis.

3.2 Quality of life

3.2.1 Origin and definition

The orgins of the research dedicated to quality of life lie in the socio-scientific charity- and social-indicator-research, whereby “quality of life” is seen as a generally amount of congruence of clinical living conditions and their subjective evaluation (well-being, contentedness) with regard to a large population and which plays a pivotal role in the scope of the so-called welfare-report (cf. Glatzer, 1992; Glatzer & Zapf 1984; Zapf, 2000).
While at the beginning the focus was places on social and economic indicators of quality of life such as income and material security, political freedom and independence, social equality, legal certainty or the health care of the population, in recent years subjective indicators of quality of life such as subjective well-being and life-satisfaction are accounted for (cf. Diener & Suh, 1997).
In the recent two decades generally a trend can be observed toward regarding “quality of life” as a concept related to the individual (cf. Fuhrer, 2000). Research was chiefly dedicated to health-related quality of life (HRQOL). Nowadays this is a central psychologic resarch topic and an evaluation criterion constantly gaining importance in medicine. Especially with regard to chronic diseases and disabilities questions about health related quality of life come up. Important medical fields concerned with this are oncology, cardiology, surgery and psychiatry.

Nowadays, the assessment and evaluation the results of medical treatment measurements are not only concerned with changes in clinical symptomatology or the prolongation of life, but increasingly with how sick people subjectively experience their health condition, how they deal with everyday life and how they conduct their social relations (cf. Lorenz & Koller, 2002). Even the health-economic point of view does not only focus on calculation the costs for the prolongation of life by medical treatment, but also on the maximisation of quality of life and therefore on cost-effectiveness-analysis (Wasem & Hessel, 2000).
As an osteopath, businesswomen and author this fact makes me attentive, because these are thoughts which come up in everyday practise. On one hand the health funds demand more quality control of our workspace, on the other hand they cut back more and more on reimbursement for therapies. I, who writes about the way from therapy to the prevention, see osteopathy as a possibility to increase the patients' quality of life, avoiding sickness absences and major surgeries or delaying them and therefore contribute a lot from a health-ecological point of view to maintaining people healthy.

Even if there is no generally binding definition of the term "health-related quality of life" and the demarcation from related concepts such as "well-being" and "happiness" proves difficult, there is a consensus that an operational definition is useful. It considers the health-related quality of life as a multi-dimensional construct, which include the physio-emotional, emotional, mental, social, spiritual and behaviour-related components of well-being and the functional ability (of the activity capability) from the affected person's subjective point of view. The health-related quality of life refers to the subjectively perceived health condition respectivley the experienced health (cf. Bullinger, 2000; 2002).
Accoring to Patrick & Erickson (1988) the concept of health-related quality of life can be split essentially in to four contentual subzones:

- Physical discomforts due to diseases, which are seen as the main cause for the limitation of quality of life by many patients.
- The psychic condition refering to emotional affectivity, general well-being and life-satisfaction.
- Functional limitations in everyday life such as work, household and free time due to diseases.
- The construction of interpersonal relations and social interaction as well as limitations in this field due to diseases.

A definition of the WHO places its focus on the entire life situation and the cultural characteristics of the affected persons. Quality of life is defined here as the individual perception of the personal life situation in the context of the particular cultural and the particular moral system and with regard to their own golas, expectations, evaluation criteria and interests. The individual quality of life is thereby influenced by the physical health, the psychological condition, the level of independence, social relations and the ecological environmental characteristics. (cf. The WHOQOL-Group, 1994).

Representatives of an indiviualised definition (cf. Carr, Gibson & Robinson, 2001) see quality of life and an individual factor, which can not be compared between different persons as a principle, bescause the relevant dimensions differ from person to person. Accordingly, the representatives of this approach assume, that quality of life can only be described intra-individually. A generalisation across different persons is only made possible due to a definition of quality of life, which captures the difference between the aims individually aspires to and the realisation attained. Therefore, the difference between performance and target has to be considered during the operationalisation of quality of life. Especially with seriously ill patients processes of adaptation can be observed over course of disease, which can also effect the subjective evaluation of the personal health condition. These dynamic changes in the individual

assessment dimension have received heightened attention over the recent years under the term “response shift” and shoul be considered accordingly during the interpretation of outcome-studies within research dedicated to quality of life (Sprangers & Schwarz, 1999).

3.3 Life-satisfaction

In demotic literature such as e.g. fairy tales and narrations, the topic life-satisfaction occupies a large space, because life-satisfaction in its manifold forms is one of the most frequently expressed aims of mankind. In theology and philosophy this topic has a very long tradition as well (Tartarkiewicz, 1984). As described at the beginning, the concept life-satisfaction, which can be found in literature in close relation with the term well-being, only became a subject of research about 50 years ago. Since a large number of publications on this field was published and gaining an overview has become much more difficult.

3.3.1 Definition of life-satisfaction

Contentedness is seen generally as an emotional state of mind of humans when man considers his needs satisfied.
The dictionary DUDEN (2002) defines as accurately as briefly: being content means either:
“*a) innerlich ausgeglichen, sich mit Gegebenheiten im Einklang befindend und keine Veränderungen der Umstände wünschend*“ [“*internally balanced, being in line with the situation and desiring no changes in circumstances*“] or
“*b) mit den gegebenen Verhältnissen, Leistungen o.Ä. einverstanden; nichts auszusetzend habend*“ (cf. S. 1081). [“*agreeing with the given circumstances, accomplishments, etc. not having anything to critisise*.”]

According to Glatzer (1992) life-satisfaction is the result of a chiefly cognitive evaluation of a situation a person finds himself in. Social comparison with important attachment groups, every single one's individual desires, hopes, expectation and targets respectively their achievements, are the basis for this subjectively conducted assessment.

According to Schuhmacher, Gunzelmann, Bähler, (1996) the term life-satisfaction is based on "*auf der individuellen kognitiven Bewertung der vergangenen und gegenwärtigen Lebensbedingungen sowie der Zukunftsperspektive, wobei die aktuelle Lebenssituation mit eigenen Lebenszielen, Wünschen, Plänen, aber auch mit der Situation anderer Menschen verglichen wird*" (S. 1). ["*the individual cognitive assessment of past and present living conditions as well as the perspectives for the future, whereby the current situation of life is compared with personal targets, wishes and plans and also with the situation of other* (p. 1)."]

Diener (1984) sees general life-satisfaction as a subjectively positively experienced emotional condition which is always related to the achievement of targets in life.

Schuhmacher et al (1996) go one step futher and distinguish between two kinds of life-satisfaction. Between the general (global) life-satisfaction "*und einer auf der Bilanzierung individuell mehr oder weniger wichtiger Lebensbereiche basierender bereichsspezifischer Lebenszufriedenheit*" (p.2) ["*and a field-specific life-satisfaction based on the balanace of more or less important fields of life*."]

3.3.2 Tools for capturing life-satisfaction

Trying to define life-satisfaction already illustrates how difficult it is, to bring this construct into a framework. Many existing instruments are trying to

capture one or the other aspect of life-satisfaction. Mostly questionnaires or interviews are used.
The following two theoretical approaches can be distinguished thereby:

3.3.2.1 The clinical approach

It emanates from
"*beobachtbaren Lebensverhältnissen aus, die von Außenstehenden nach wissenschaftlichen und/oder moralischen Standards bewertet werden können. Die theoretische Voraussetzung ist, dass es identifizierbare Grundbedürfnisse gibt und dass deren Befriedigung das Wohlbefinden bestimmt*" (Zapf, 1984, S. 19). ["*living conditions that can be observed and assessed by outsiders using scientific and/or moral standards. The theoretic precondition is that there are identifiable basic needs whose satisfaction determines well-being*."[

In this approach impartiality refers necessarily to physical, material and personal living conditions.

3.3.2.2 The subjective approach

Here, life-satisfaction is defined by means of individual evaluation of life and positive or negative feeling experiences. These depend on the respective living conditions. In which cases the individual person is content, can only be defined by everyone themselves, according to this theory (Yan, 2003).

3.3.3 Life-satisfaction as dependent variable.

As it has been explicitly mentioned before there is a very close relation between the terms life-satisfaction and well-being. In answering the

questions about the factors influencing the extent of subjective well-being, Mayring (1987) states that the following conditions can be distinguished:

Conditions

- Biographical: Such as interests, lifestyle and capacities.
- Social: Such as resources, norms, ideologies of happiness.

Impartial conditions

- Such as status, supportive system, events and health.

Subjective moderators:

- Cognitive: Such as diagnosis, prognosis and evaluation
- Regarding actions: Subjective moderators such as techniques of being, efforts of accomplishment and happiness.
- Emotional: Such as mood.
- Subjective well-being: such as contentedness, pleasures and happiness.

3.3.4 Correlates of life-satisfaction

For the sake of completeness here the correlates of the different levels of life-satisfaction shall be mentioned. Only the biological correlate “health” shall be dealt with in more detail, because it is an important aspect of my thesis. Further explanations of the other correlates would go beyond the scope of this paper.

3.3.4.1 Biological correlates

Health

Good health can be considered very important for a general life-satisfaction. It is one of the most important factors during the questions. It is surprising that an appropriate assessment of this condition sometimes

proves difficult to healthy young people. Only when health is endangered respectively complaints appear this factor can be assessed appropriately. Therefore close relations between contentedness and the subjectively experienced physical complaints can only be assessed when they appear, are already present or have disappeared already. (Fahrenberg, Myrtek et al, 2000, p. 14f.) In case of clinical physical disabilities or functional impairments, the affected persons are less content compared to healthy people. People who continue to be discontent see the doctor more frequently and seek psychotherapeutic treatment more frequently (cf. Ibidem, p. 16).

Sex

Age

Additionally to the biological correlates psychic correlates are listed, such as e.g. intelligent, personality dimensions, correspondence of self- and external assessment, self-concept and self-confidence and habits. Sociological correlates are listed on third place as correlate specification, such family statues, social networks, familial bindings, socio-economic status, job and cultural differences (cf. Fahrenberg, Myrtek et al 2000; Yan, 2003).

3.4 Touch

Touching and being touched is an essential aspect of my work. In our touch-impoverished world one sometimes longs to be touched, stroked or simply taken into the arms. This seems to be lived differently in each culture. Touch is one of the fundamental stimuli which humans already experience prior to birth in the maternal womb (Nathan, 2001).

Which emotions can emerge within the patient through the frequently close physical contact? Maybe by the means of the following empirical

investigation by the means of interviews with patients aspects concerning touch can be inquired.
Generally it can be said, regardless of patient's past, the therapist hopes that a positive experience of the patients of being touched contributes to a better self-image, a strengthened self-confidence and well being. This will always be the case if touching is carried out considerately, sensitively, confidingly, expertly and respectfully and is accompanied by explanations and asking permission for using one or the other technique. This positive feeling will strengthen the patients' belief in his healing, which will trigger physiologic healing processes in his body. Emotional and bodily experience of a therapeutic touch, i.e. experiencing direct healing in connection with

- Trust in the healing forces of the therapist,
- the conviction that the therapist knows how he can heal and
- the feeling that the therapist wants to heal.

All together these are the basis for a very strong healing force (Nathan, 2001).

3.4.1 The tactile sense

The tactile sense shall not be highlighted from an orthodox medical, physiological point of view here, but rather from a philosophical-psychological angle, which provides the main part of the introduction and explanation I tried to give about the topic I chose.
Nevertheless the tactile sense can be classified as one of the five senses of human beings. Which organ is the tactile organ? According to Nathan (2001) the answer is: the skin, because it reacts extremely sensitively to all tactile stimuli which reach its surface. But we even can feel if we run, breathe, speak, etc. The sensation derived from the skin is a very special kind of perception; we can perceive our entire body in a tactile and kinaesthetic way. The main part of this sensed perception is

proprioception. It has to be like that, because else all movements and bodily sensations would influence our consciousness and occupy the mental processes so much that nothing else could be processed anymore. Summarisingly it can be said, that we feel with the entire body. Therefore the body in its wholeness can be seen as tactile organ (Nathan, 2001, page 120).

"*Dem Tastsinn wurden im Laufe der Zeit immer wieder einzigartige Eigenschaften zugesprochen. Solange er jedoch nur einer von fünf Sinnen war und genau wie Sehen, Hören und die anderen Sinne interpretiert wurde, blieben die ihn auszeichnenden Eigentümlichkeiten ungeklärt. In den meisten Fällen basierten die Theorien über die unterschiedlichen Sinneswahrnehmungen auf der eindeutigen Lokalisierung derselben. Man unterschied ausschließlich auf funktionaler Ebene, um eine formale Struktur schaffen zu können, die auf alle Sinneswahrnehmungen anwendbar ist. Der Tastsinn jedoch untergräbt diese vereinheitlichende Struktur, da der Körper in seiner Gesamtheit das taktile Organ ist. Der ganze Körper in seiner Sensibilität gegenüber Druck, Temperatur und Oberflächenqualität zusammen mit Bewegungsempfindungen, gefühlten Atembewegungen, Puls, der Fähigkeit seiner Hand, manipulative Aktionen durchzuführen, und seinem Bewegungsvermögen bildet die ursprüngliche Basis der menschlichen Existenz. (…) Die Art und Weise, in der die Berührung die Welt erfährt, bestimmt, wie wir sie letztendlich begreifen. (…) Wenn die ursprünglichste Art des seienden, erlebten Körpers als taktile Existenz verstanden werden muss, dann kann der Tastsinn nicht einer allgemeinen Sinnestheorie zugeordnet werden; vielmehr bildet er die Grundlage für eine solche Theorie*" (Wyschogrod, 1981, p.26, 39).
["*The tactile sense has been assigned singular characteristics over the course of time. As long as it was only one of five senses and was interpreted the same way as seeing hearing and the other senses, the peculiarities which characterise it, remained unexplained. In most cases theories about the different perceptual sensations were based on their*

localisation. Only the functional level was distinguished, in order to create a formal structure, which can be applied to all sensuous perceptions. The tactile sense, however, undermines this generalising structure, because the body in its entirety is the tactile organ. The entire body in its sensitivity toward pressure, temperature and surface characteristics together with sensations of movement, felt breathing movements, pulse, the abilities of the hands to carry out manipulative actions and its capability of movement is the original basis for human existence. (...) The way how touch experiences the word determines how we capture it. (…) If the original way of the being, living body has to be seen as tactile existence, tactile sense cannot be assigned to a general theory of sense; it rather provides the basis for such theory."]

3.4.2 Touch as object and subject – touch and empathy

Proceeding from these basic thoughts about the tactile sense another statement can be derived:

"*Sich selbst zu berühren, bedeutet auch berührt zu werden. Von einem anderen Menschen berührt zu werden, bedeutet folglich auch, den anderen zu berühren, denn sowohl der andere als auch ich spüren die Berührung des anderen. Hier liegt der Schlüssel zur Gabe, sich in andere Menschen einfühlen zu können" (Nathan, 2001, p. 121).*
["Touching oneself also means being touched. Being touched by another person hence means, touching the other person, because the other person and I sense the touch of the other. This is the key to the ability of empathising with other people."]

The act of touching on one hand brings touch and analogously on the other hand empathy and sympathy. Contrary to seeing or hearing, ways of perception which do not require closeness, touching depends on tactile stimuli. Touching needs contact – nearness to be able to feel what is felt.

Physical incarnation means fragileness, vulnerability, destructibility (lat. vulnerabilis – vulnerable, allowing damages). This is part of physical existence. The fact we are vulnerable gives us the ability to feel empathy and sympathy. Consequently these two feeling acts are rooted in our physical destructibility – a bodily, kinaesthetic reality.
The heart is the symbol for affection, feelings, emotions, attitude ain inner experiences. And because “flesh” – as Wyschogrod could prove – is experienced as vulnerability during tactile experiences, already Aristotle must have had pointed out the close relation between the tactile sense as the most internal of all senses and the emotional ability of the soul. Tactile experiences are felt with the heart (ibidem, 2001).

3.4.3 Expressive, healing touch versus procedural touch – critical approaches (Nathan, 2001).

By means of touch the therapist gains a part of the information which is required for diagnostic assessment. Simultaneously this touch is part of the treatment. The traditional orthodox medicine, including manual medicine, is classified as mechanical-physical therapy. They see touch as a procedural or meaningful touch. The body is compared to a complex machinery and therapy to technology. These procedures are carried out on an object – the body tissue – like on a machine.
The scientific approach influenced by Descartes assesses manipulation as a purely procedural operation, because body and mind our soul are strictly separated and considered to be independent from each other.
“Carrying out something on someone” instead “doing something with someone” or being “with” the patients underlines the mechanical component to the expense of their personal one. The procedural touch refers to the inanimate as object of action. This might proceed from the assumption, that the passivity immanent to the “suffered” is characteristic for the inanimate and not for something alive. Another reason might be

that techniques are always associated with technology whose objects are largely not human beings (cf. Autton, 1989; Adams, 1997).
As a contrast to this depiction some therapist state that they do not only work with the body of the patient but with the "entire human being". The basis should be the incorporation of their work in a philosophical context, whereby human beings are mainly represented by their body and not their mind and their personality. The treatment of the body would thus equal the treatment of the human being (cf. Blondis, 1982).

According to Nathan (2001) it is not acceptable, to explain the picture of "human being as a body" by means of purely mechanical-physiological terms.
The expressive touch is the most original form of healing. All kinds of holding, rhythmical rocking, caressing, stroking as well as natural massages are healing actions whose origin lie in the maternal womb.

"*Die Erschaffung eines guten Gesundheitszustandes in der Urform ist perfekte menschliche Ganzheit in umsorgter Existenz und kein Wandlungsprozess von Krankheit zu Wohlgefühl*" (Nathan, 2001, p. 107).
["*The creation of good health condition in its original form is the perfect human wholeness in shepherded existences and no transformational process from sickness to well-being*."]

In utero all needs of the baby are constantly satisfied. After birth separation takes place and the child has to establish its own wholeness. This process takes many years and in the early stadium requires a lot of support by means of tactile stimuli, food and other needs. The development of self-wholeness and self-healing is achieved by healing acts of touch, such as stroking, rocking, holding etc. Every human carries primary instinct of "healing" by touching inside (cf. Klaus & Kennell, 1976).
During the proceeding development of human beings this way of healing takes a back seat as humans loose their fears and act more autonomously

when they are unhappy. In the western world with a few exceptions modern medicine does not treat physical handicaps by touching anymore. Drugs are prescribed instead which evidently do not or only to very little extent require interpersonal transaction. However, this trend seems to reverse in recent years. By means of the wide-spread wellness-thoughts alternative healing methods such as e.g. shiatsu, tuina, etc. which do work with physical contact take the place of drugs as primary means of healing.
The likeness between touching in order to heal children and a "primitive" healing touch of adults includes a common concept of wholeness which is in stark contrast to our dualistically influenced view.
"*Instinktive, expressive Berührungsformen – besonders das Halten eines anderen Menschen – sind die einzig verfügbaren heilenden Akte zur Linderung des emotionalen Leids eines Erwachsenen*" (Nathan, 2001, p. 108). ["*Instinctive, expressive ways of touching – especially holding another person – are the only available healing acts for relieving the emotional suffering of an adult*."]
I as an osteopath do not see patients in any way as machines. But I have to admit that this approach regarding the procedural or expressive touch leads me to reconsidering my concept of treatment. It is easy to say that one aspires to capture and treat a human being in his wholeness, but if that always is achieved, i.e. in the case of every health problem, remains to be seen. However, an intense engagement with the patients and constant concentration while acting is surely required.

3.4.4 Touching as placebo

The aspect of the placebo effect during healing, which can be traced back to the patient seeing the therapist as a person who is in an inexplicable way omniscient, capable and caring, can be considered as transferred healing. If touching leads to healing, the healing process is likely to be triggered by the expressive component of touch and not the procedural one. Investigations in the field of backache indicate that currently no

therapy is better than the normal course of the disease and the placebo effect (Waddell, 1987). The fact “touch-as-placebo” has to be awarded at least a line of thought in my thesis. More detailed research in this field is surely necessary.

3.4.5 Osteopathy in Psychotherapy

Writers like Shaw, Randell and above all Latey (1982) argue that manual therapy has a psychotherapeutic potential without the patients having to express their feelings verbally or without requiring a psychological analysis. This can be attributed to the perception of the cause, such as e.g. permanent muscle contraction and muscle ache as a consequence becoming manifest on a prelingual level.

“*Die Symptome des erwachsenen Patienten – körperlicher Schmerz und Unwohlsein – können als ein Nebenprodukt oder sogar als ein notwendiger kreativer Akt des Nicht-Fühlens seitens des Kindes interpretiert werden. Dieses Verhalten war einmal notwendig, um die schmerzhaften emotionalen und existentiellen Folgen der elterlichen Zurückweisung früher kindlicher Bedürfnisse und Wünsche zu vermeiden. Wären diese kindlichen Bedürfnisse damals befriedigt worden, dann hätten sie dem Kind sinnlichen und emotionalen Genuss gebracht*“ (Nathan, 2001, S. 153). [“*The symptoms of an adult patient – physical pain and indisposition – can be interpreted as a side product or even a necessary creative act of non-feeling on the part of the child. This behaviour was once necessary to avoid the emotional and existential consequences of the parental rejection of early infantile needs and wishes. If these infantile needs had been satisfied, they would have given the child sensuous and emotional pleasure*.”]

If the perception and integration of this old emotional somatic conflict occur unconsciously the necessity of an open psychotherapeutic dialog might be avoided.

An important part of this theory is that the patient receives pleasure though the application of osteopathic medicine. The manual contact confronts the patient with a series of pleasant emotions, including some which emerge during pain relief or improved physical reaction, embracing or rocking or calming rhythmical massage. These experiences should influence the patient time and again in a reliable way. Over the course of time the patient learns to associate his body no longer with pain, but with pleasure (Shaw, 1996).
But not only touch, also manual medicine in the form of standardised osteopathic treatment was classified as psychotherapeutically effective – and not only effective in some psychological way. It is agreed upon, that such an approach includes those physical ailments can be of a psychogenic cause (Nathan, 2001).

Concluding the theoretical scientific part, I would like to list five points from the book “The Osteopathic Management of Psychosomatic Problems”. These descriptions from Dunn’s publication correspond with my assumption, as the evaluation in the following chapters show.

Dunn (1948) writes:

(1) *Die beruhigende Wirkung des manuellen Kontakts: Wir erinnern uns noch daran, wie viel Trost und Sicherheit uns die warmen, liebenden Hände unserer Mutter in frühester Kindheit spendeten, wenn wir von Sorgen und Ängsten geplagt wurden. Und wenn wir krank sind, neigen wir dazu, emotional in unsere relativ unbeschwerte und relativ sichere Kindheit zurückzugehen. Bei Krankheiten mit emotionaler Ursache verstärkt sich diese Tendenz noch. Deshalb kann ein kranker Patient in psychologischer Hinsicht bestmöglich von den Handlungen seines Osteopathen profitieren.*
[The calming effect of manual contact: We still recall how much comfort and security the warm, loving hands of our mother gave us

in early infancy, when we suffered from sorrows and fears. When we are sick, we tend to emotionally go back to our relatively untroubled and secure childhood. This tendency increases in case of diseases with emotional causes. Therefore a sick patient can benefit psychologically in the best possible way from the actions of his osteopath.]

(2) *Die Wirkung der physischen Handlung. Die Tatsache, dass der Osteopath am Körper des Patienten „etwas tut", hat neben den rein physiologischen Reaktionen, die aus der manuellen Handlung heraus resultieren, auch einen psychologischen Effekt. Jeder von uns hat eine geistige Vorstellung von seinem physischen Körper. Psychiater sprechen hier vom „Körperschema". Im Verlauf einer therapeutischen Behandlung sieht und fühlt der Patient eine Veränderung in der Körperstruktur, was zu einer positiveren geistigen Vorstellung von sich selbst führt.*

[The effect of the physical action. The fact that the osteopath "does something" with the body of the patient has a psychological effect additionally to the purely physiological reaction resulting from the manual action. Everyone of us has a mental image of his own physical body. Psychiatrists talk about "body scheme". Over the course of a therapeutic treatment the patient sees and feels a change in his body structure which leads to a more positive mental self-image.]

(3) *Die Wirkung einer verringerten Spannung der Skelettmuskulatur auf die Psyche. Diese Wirkung bedarf keiner näheren Erläuterung. Wir alle kennen das Gefühl nachlassender emotionaler Anspannung, die auf Muskelrelaxation im Zuge einer qualifizierten osteopathischen manipulierenden Therapie erfolgt.*

[The effect of an alleviated tension of the skeletal muscles on the mind. This effect does not require further explanation. We all know the feeling of decreasing emotional tension following the muscle relaxation due to a qualified osteopathic manipulating therapy.]

(4) *Die Wirkung verbesserter viszeraler Funktionen auf die Psyche. Auch das Gefühl des Wohlbefindens, das mit einer einwandfreien Funktion der inneren Organe einhergeht, ist dem Osteopathen nur allzu gut bekannt und bedarf deshalb ebenfalls keiner näheren Erläuterung. Ebenso wenig muss ich wohl erläutern, dass die osteopathische Behandlung bei korrekter Anwendung die Funktion der inneren Organe stärkt.*

[The effect of improved visceral functions on the psyche. The osteopath is very familiar with the feeling of well-being that accompanies a faultless function of the inner organs and thus doesn't require further explanation either. Neither do I have to explain that an osteopathic treatment, if applied correctly, strengthens the function of the inner organs.]

(5) *Die Wirkung von Zuwendung und Aufmerksamkeit. Von einem Menschen, dem wir Respekt und Achtung entgegenbringen, Zuwendung und Aufmerksamkeit zu erfahren, ist Balsam für das eigene Ego. Allein die Tatsache, dass eine osteopathische Behandlung den Therapeuten Zeit und Mühe kostet, löst beim Patienten ein Gefühl des Ernstgenommenwerdens aus, was sich wiederum positiv auf die Psyche auswirkt*" (Dunn, 1948, 196-199).

[*The effect of affection and attention. Receiving affection and attention from a person we respect and esteem is balm for the ego. Simply the fact that an osteopathic treatment requires time and effort form the part of the osteopath leads the patient to a feeling of being taken serious."]*

Work with texts about well-being, quality of life and life-satisfaction showed a close connection of the three terms. One term is sometimes used in the explanation of the other. The interviews shall bring out possible changes of well-being, quality of life or life-satisfaction via long-time osteopathic therapy. Aspects which emerge from being touched during treatment will also be discussed.

Summarisingly it shall be said that Dunn's experiences should not be reassessed and confirmed. Maybe they can be thought-provoking impulses for my assumption that changes of human sensitivities can be achieved via osteopathic treatments.

4 Interview series

4.1 Approach of the investigation and relevance

The process-like course of a disease and its overcoming from the first step to the doctor to the decision to start therapy, maybe even to experiencing “healing” is very complex. The reasons why patients continue to see an osteopath even after “healing”, whereby this stand for the complete absence of medical complaining or improvement of the original problem, seem to be manifold but hard to explain.
This results in an incredibly large amount of data and facts that cannot all be dealt with within the frame of this master thesis. Thus these remarks only refer to a limited extract of the patients’ motivations, which, according to my point of view, has not been taken into consideration neither by the patients nor by my colleagues so far.

The aim of the study at hand is to point out various motivations for a long-term therapy and to capture the changes I undertook in different sensitivities. The significance of the social component and of the aspect of touch shall also be accounted for in the interviews.

Four basic questions arise from this consideration for this study:

1. Which aspects are to be expected from the disease, the osteo-path, the therapist and the environment of long-term therapies?
2. What significance does well-being have thereby?
3. What significance does quality of life have thereby?
4. What portion of the changes can be assigned to touch?

The complexity of the subject and the differences of the initial position of the patients require a highly cross-linked approach to the situation which shall be accounted for by the use of a qualitative research method.
Especially the literary and personal experiences as an osteopath served as a basis for the construction of a schema of categories for the evaluation of the conversation with the patients.

4.2 Method

4.2.1 Target group

The target group for this investigation are people who see an osteopath over a longer period of time. Even after the “healing” of their so-called main problem they stay with the therapist as a “patient”.
Interviews were conducted with a total of six persons. The inquired patients were between 37 and 64 year old. The information from these conversations was evaluated with regard to approach, disease and the effect of osteopathy. The names of the patients were largely changed in the following presentation and in the extracts of the interviews in order to guarantee anonymity.

At the time of the investigation the osteopathic patients were in treatment for different periods of time. The duration lies between two and a half and seven years. The symptoms of the disease, the original disease which made the patient see an osteopath are of entirely different origin, whereby tension and back aches were claimed by nearly every patient.
All inquired persons are female. Their age is between 38 and 64 years, whereby two patients are under 40, two persons between 40 and 50 and two persons are 64 years old.

From the description of the target group it can be seen that the composition of the sample is very heterogeneous. But this should not be of disadvantage to this investigation, but rather a gain.
By inquiring the different persons an ample picture of the patients' motivations for them attending long-term therapy can be achieved. Furthermore, changes of condition and social aspects of therapy shall be pointed out.

Due to the small size of the sample it cannot be assumed that the choice of persons is representative of all osteopathic patients. Much less is it admissible to transfer the results other forms of bodywork-therapy. There restrictions are very well admissible and arguable in qualitative social research, if they are not disregarded in interpretation (Mayring, 1990).

Subsequently the persons taking in the study shall be presented briefly.

The patients

Mrs. Baumann, 64 years, was a financial accountant and is now retired. She is a widow and lives alone in her household. Her two children are 30 and 36 years old and live in another federal state, therefore the contact is limited to rare visits. Her problems are the pelvic floor, tensions in her nape and tinnitus. She is seeing a male therapist for treatment for about four years.

Mrs. Kumpler, 37 years, is married and has a nine-year-old son. She is masseuse with her own office, practises above all tuina. Due to her complaints with her shoulder she started attending osteopathy about two and a half years ago. Her shoulder pains triggered existential fears which have disappeared now due to her being free of complaints now. Her therapist is female.

Mrs. Rosenberger, 50 years, is unmarried and has no children. Mrs. Rosenberger has learned more jobs, such as chemist, retail- and wholesale employee. After 34 years she quit her employment and wants to concentrate on life-coaching. Her health-problems become manifest in unspecific pains in all joints, but especially in her shoulder wherefore she sees a female therapist for six years now.

Mrs. Moosbauer, 64 years, is also unmarried and has no children. She lives alone, but is integrated very well into a social network via her circle of friends. Prior to her retirement she was a teacher for English and Geography. The reason for starting osteopathic therapy was an arthrosis in her knee, which is treated by a female therapist for six years now. Since last year she also suffers from a cardiac disease.

Mrs. Friedrich, 48 years, is married and has four children aged 27, 26, 20 and 9. She teaches religious education. Additionally she just completed training as a mediator. Now she wants to extend this field of activity. Due to her head aches and tension in her nape she started seeing an osteopath about eight years ago. During that time she injured her biceps tendon in an accident, which was also treated by an osteopath after the operation.

Mrs. Huemer, 38 years, is married and at the time of the interview had had her first son only five days ago. She is solicitor and lecturer, but at that time taking maternal leave. In 2003 she started seeing an osteopath due to pain in her cervical vertebrae. Since then, albeit short interruptions, her (female) therapist treats the pains and tensions which keep coming back due to stress and overly strain.

4.2.2 Choice of method

In this thesis sub-topic of osteopathic patients as well as the changes of e.g. their condition due to “long-term therapy” shall be investigated and presented.

According to Dilthey, a non-descriptive psychology proceeds from the object, meaning “*nicht von vorformulierten Hypothesen, sondern vom unmittelbaren Erlebnis des seelischen Zusammenhangs*“ (Mayring, 1990, p. 5). [“*not pre-formulated hypothesis, but from the direct experience of the mental context*.”]
In order to do justice to this scientific approach, the method has to orient itself by the object, i.e. it has to be specifically determined concerning the object. Based on a descriptive procedure, explanatory constructs can clarify and control connexions (Mayring, 1990).

In order to meet the conceptual requirements of this study, a qualitative method seems appropriate, because it offers the option of a complex perspective of the problem, independent from the situation. The variety of the changes and sensations which emerge over a long period of time due to osteopathy, can be described, understood and maybe even empathised a little. Apart from these advantages of a qualitative approach, the heterogeneity of the small sample makes a statistically unobjectionable and representative study impossible. Subsequently, I would like to list the arguments which were decisive for the choice of the chosen used instruments for data collection and evaluation.

4.2.2.1 Data collection

In order to capture the complexity of the question at hand a combination of different methods for data collection is required.

Mayring (1990) demands a stronger integration of different qualitative approaches, that their compilation has to refer to the object and the question of the investigation: *"…kreative qualitativ orientierte Forschung bedeutet Vielfalt, nicht Einseitigkeit, bedeutet Gegenstandsbezogenheit, nicht Methodenfixiertheit*" (p. 98). ["*creative qualitatively orientated research means variety, not onesidedness, means relatedness to the object and not fixedness on the method*."]
Additionally to the use of different sources of date result can be considered from different perspectives and compared. The aim of this so-called triangulation is not to reach complete accordance with the results, but rather to piece them together to a kaleidoscope-like picture.

Like in a triangle, where only the connection of the three braces creates the sound of the instrument, the quality of the investigation of qualitative research can be amplified by connection several ways of analysis. (Mayring, 1990, p. 106).

The study at hand used the following methods of data collection:

- Generation of a so-called foreknowledge by literary study
- Inclusion of personal experiences as an osteopath
- Problem-centered interviews with patients

The method of the problem-centered interview shall be discussed further in chapter 4.2.3.1.

4.2.2.2 Data evaluation

After the study of relevant literature, the qualitative content analysis according to Mayring seemed the most appropriate way of evaluating the material at hand to me. Even though the material could be dealt with more profoundly with methods such as the objective hermeneutics or the

psychoanalytic textual analysis, economic aspects as much as the required psychoanalytic knowledge of the analyser exclude such way of processing.

According to Mayring (1990) the qualitative content analysis is appropriate "*für systemische, theoriegeleitete Bearbeitung von Textmaterial*" (p. 90) ["*for systemic, theory-guided processing of textual material*."]
Thereby a great amount of data has to be dealt with. Theory-guided means, that new data material is not collected in a purely descriptive way, but that the researcher gains a specific foreknowledge prior to the empiric investigation by means of literary research or from other sources of information. Proceeding from this foreknowledge he develops a certain system of categories with specific aspects of analysis. A systematic procedure during analysis means a gradual dissection and processing of the material.

In chapter 4.2.3.2 the basic assumption, aims and the approach of this methods will be presented.

4.2.3 Material and methods

4.2.3.1 Interview

According to Wottawa and Thierau (1990) *"[ist] für die Erfassung der subjektiven Erklärung für das Verhalten sowie generell für sehr komplexe kognitive Strukturen und deren Veränderungen (…) das offene oder teilstrukturierte Interview ein aufwendiges, aber unverzichtbares Hilfsmittel*" (p. 126-127) ["*the open or partly structured interview is a time-consuming but indispensable resource for capturing and subejctively explaining behaviour as well as generelly for very complex cognitive structures and their changes.*"]

Wottawa and Thierau also (1990, p. 128) distinguish different from of interviews:

- The “structured interview“ uses a questionnaire, the “unstructured interview” only a conversational guideline.
- “Open inquiry“ allows a free answering, “closed inquiry” the interviewed person in only given two or more answering options.
- If frequency distribution and comparability shall be achieved, individual answers are “standardised”, i.e. assigned to categories of answers. “Not standardised” methods abstain from this categorisation.
- Depending on how authoritatively the interviewer conducts the conversation, the style is called “soft”, “neutral” or “hard”.

From the interview techniques compared by Lamnek (1995, vol. 2) (narrative, problem-centered, focussed, receptive as well as in-depth interview) the “problem-centered interview” seemed to be most appropriate for this study. During this approach a field of problems defined by the researcher is inquired, using a flexible guideline.
Witzel (1985) call the problem centered interview as integration and combination of methods and ways of inquiry. The interview itself is used in this framework additionally to the biographical method, the group discussion, the case study and the content analysis.
Here only the methods used in this study, namely the interview and in chapter 4.2.3.2 the content analysis, shall be discussed.

The problem centered interview is an open, semi-structured inquiry whereby the interviewed persons answer relatively freely, but are guided back to the concrete topic by the interviewer time and again. According to Witzel (1982) three important principles serve as a basis for this method:

Problem-centeredness means that the investigator has already elaborated the most important clinical aspects of a social problem prior to the interviewing phase and can empirically proceed from there.

Object-relatedness means that the concrete design of the procedure has to relate do the specific object. It must not only consist in the absorption of premade instruments.

Process-orientation focuses on the gradual gain and analysis of data. Thereby the connection and the constitution of the individual elements emerge slowly and in constant comparison with related methods.

According to Mayring (1990) the interviewer should enter the topic with "probing questions". The subjective importance of the topic for the individual can thus be assessed very well. "Guideline questions" lead through all essential aspects of the interview. In case aspects relevant for the topic arise during the interviews which are not listed in the guideline, the interview should touch these aspects with "ad-hoc-questions" (p. 48).

After the interview a postscriptum is compiled which also contains information the interviewer receives prior and posterior to the actual interview and contains nonverbal conspicuities. According to Lamnek (1995) *"…ist diese Form des besonderen Umgangs mit dem Befragten auch Teil des wissenschaftstheoretischen Verständnisses einer qualitativen Vorgehensweise*" (Vol 2, p. 97) ["t*his form of special contact with the interviewee is also part of the epistemological understanding of the qualitative approach*."]

The problem-centered interview as an open, half-structured inquiry offers in this study the option of an ample, but nevertheless topic centered collection of data. After filling in a "personal social form" for the collection

of personal data, probing questions about the personal approach to osteopathy and general questions referring to the disease are asked, following the demands of Mayring (1990). Subsequently frequency and duration of therapy were inquired. The main field of the questions refers to the components of well-being, which could have been changed by long-term therapeutic situation. Finally specific answers are classified, whereby answers that could not be categorised shall be included in the interpretation. Therefore the interview should be called “semi-standardised”. The conversational style of the interview is soft, i.e. empathic and hardly authoritative.

Recorded tapes serve for the “conservation” of the conversation content. These recordings are fully transliterated and subsequently evaluated content analytically (see chapter 4.2.3.2). After the interview postscriptum was written, which contains noticeable aspects of the interview situation, the expression and the preliminary talk and the post-interview conversation. These brief descriptions serve for replenishing and occasionally explaining the interview content. Information which does not emerge from the tape recording can be included in the evaluation.

The interview guideline serves as “contentual support” and for facilitating the evaluation. If all relevant areas should be captured specifically, precisely formulated questions as well as enquiries are necessary (Seiler, 1994).

In the study the interview guideline is designed as follows: After salutation and introductory words by the interviewer, personal dates are inquired using a “personal social form” (O). Subsequently probing questions about the approach to osteopathy and the disease of the patients are asked (A). The following part refers to the quantitative aspects of therapies (B). A further distinction is made in condition (C) and social details (D) of the patients.

A guideline serving as an example is to be found in the Appendix (Appendix 1).

4.2.3.2 Qualitative content analysis

According to Lamnek (1995) the qualitative content analysis should analyse material which "*auf irgendeine Weise menschliches Verhalten oder soziales Handeln repräsentiert*" (Vol. 2, p. 176) ["*in some way represents human behaviour or social action*"]
As already explained in chapter 4.2.2 this is a method which gradually analysis the material by means of a theory-guided system of categories. Via this classification the qualitative content analysis is distinguished from other methods of textual processing which are more orientated toward interpretation and hermeneutics.

According to Mayring (1985) there are three basic forms of qualitative content analysis which can be used individually or in combination:
By means of summarising the material should be reduced to the essential content, a manageable corpus should be created by means of abstraction. Paraphrasing, generalising and reduction are techniques of this method.
The explication serves for an analysis of content. Thereby additional information is added to passages in need of explanation, which shall amplify comprehension and explain the text.
During structuration certain aspects of the material are selected in order to assess the material with regard to criteria previously determined. Therefore categories are defined which are illustrated using "anchor examples", i.e. prototypic examples. Coding rules serve for an unambiguous assignment of the text passages to individual categories (cf. Chapter 4.2.3.4).

Qualitative versus/ and qualitative content analysis

Mayring (1985) distinguishes qualitative from quantitative content analysis by means of three criteria:

Qualitative content analysis uses numerical terms, it has nominal levels of measurement (ordinal, interval or ration scale of quantitative content analysis) and means an understanding, interpreting getting-engaged in the individual case with its complexity.

The discussion about the two approaches which seemingly conflicting approaches excluding each other shall not be continued in this thesis. I would rather use the advantages of both approaches, whereby the focus lies on the qualitative analysis and the interpretation of the collected data material.

Huber (1989) writes thereto: *"…in der Praxis gibt es keine ausschließlich quantitative Inhaltsanalyse. Quantitative und qualitative Verfahren müssen ergänzend benutzt werden, wobei einmal das Gewicht mehr auf den interpretativen, ein anderes Mal mehr auf den quantifizierenden Beiträgen liegen kann*" (p. 42) *["… in practice there is no exclusively quantitative content analysis. Quantitative and qualitative procedures have to be used complementarily, whereby sometimes the focus can lie more on the interpretative on other times more on the quantifying input."*]

The following analytical steps according to Huber (1989) shall document the procedure and make the complementary use of both possibilities controllable with regard to methods:

Via the analysis of the context, as the collection of additional data for explaining context-dependant interpretation, defective conclusions of the developmental situation of the text can be prevented.

The determination of analytical units (word, word meaning, sentence, topic, passage, entire text) and of codifications for the individual categories makes the interpretation and editing of data transparent.

The investigation of the effect of osteopathic sessions used repeatedly used over a long period of time on the different aspects of well-being and especially the meaning of touch in this context cannot rely on tested investigative methods due to a lack of or the small number of already publications. Therefore and option has to be found, whereby the collected data can be evaluated and interpreted. The qualitative content analysis seems to be an appropriate tool, because it gives a certain structure due to its theory-guided categorisation but on the other hand remains open for entirely new information. The categorisation system in this paper is constructed on one hand by the study of relevant literature and on the other hand by means of experience value (expert knowledge). Over the course of the interviews the categories are expanded and completed. By means of the questions the transcripts of the inquiry with osteopathic patients are systematically trawled and analysed gradually according to the categories. By using the subsequently written postscript the demand of a context analysis is met. The individual life situation of the individual is also given attention during the inquiry. Additionally the frequency of specific, but contentual congruent answers is paid attention in this thesis. Therefore data can be submitted to a certain quantification and statements about the frequency of certain modes of effect of osteopathy over a long period of time can be made.

4.2.3.3 Data edition

In order to be qualitatively evaluable, the tape recording of the interviews has to be taken down in written form. This was carried out by a transcription of the entire inquiry.

Mayring (1990) writes about the line of thought concerning transcription: "*Durch wörtliche Transkription wird eine vollständige Textfassung verbal erhobenen Materials hergestellt, was die Basis für eine ausführliche interpretative Auswertung bietet*" (p. 64). ["*During literal transcription a complete textual version of the verbally collected material is produced which offers the basis for a detailed interpretative evaluation*."]

The choice of transcriptional has to be taken with regard to readability and economy. During very delicate, e.g. analytical procedures relating to depth psychology have to be transliterated accordingly exactly. Accents, change of mood, etc. have to be taken in regard which often restricts the readability and the clarity of the data material greatly (Zepke, 1984).

In the study at hand a choice of relevant attributes was made which should be included in the transcription. This are pauses, changes of the voice, laughter and expletives (utterances like "mhm, ah, ahm,..."). The exact reproduction of accents does not seem necessary, because in this investigations focus on the contentual aspects of the conversations.

4.2.3.4 Data evaluation

Qualitative research demands in it complexity and variety an adaption of the selection procedure to the situative reality. Therefore general models can be used as guidelines, but certainly not as a "recipe" for the one's own study. The study of different possibilities of data processing and finding an appropriate instrument therefore means the first step of evaluation (Lamnek, 1995, vol. 2; Witzel, 1985).

For the evaluation of the interview the procedure described in chapter 4.2.3.4 seemed most appropriate to me.

4.3 Evaluation of the interviews

For the evaluation of the interviews a technique of qualitative content analysis (cf. Chapter 4.2.3.2) as described by Mayring (1985; 1995) was used: Structuring. By means of a system of categories a certain structure is applied to the material. All textual passages corresponding with the categories are extracted from the data material and assigned to them. Three steps of an unanimous assignment of the text passages to the corresponding categories can be described.

Firstly a definition of categories is established, whereby it is exactly determined which text passages are to be assigned to which category. Subsequently so called anchor examples are found, which serves as typical examples for a category in the form of concrete text passages. Were demarcation problems between categories arise, coding rules are formulated which allow a unanimous assignment (Mayring, 1995).

But even within the method of structuring, Mayring distinguishes four modes of evaluation which serve for different aims:

- A formal structuring wants to sift out the inner structure of the material according to specific formal structural points of view.
- A contentual structuring wants to extract and summarise material about certain topics.
- A standardising structuring wants to find specific distinctive characteristics in the material and described them in more detail.
- A scaling structuring wants to define characteristics about specific dimensions in the form of scale points and evaluate the material accordingly (Mayring, 1995, p. 79).

For the processing of the information from the interview the material was submitted to a contentual structuring. Thereby specific topics, contents

and aspects should be sifted out, summarised systematically and assigned to certain categories. The course of the text processing can be organised in individual phases:

- Definition of the analysis unit
- Theory-guided definition of the main contentual categories
- Theory-guided determination of the characteristics and composition of the category system
- Formulation of definitions, anchor examples and coding rules for the individual categories
- Material flow, reference designation
- Material flow, processing and extraction of references
- Editing, if necessary revision of systems of categories and category definition
- Paraphrasing of the extracted material
- Summary per category
- Summary per main category (Mayring, 1995, p. 78, 83)

By studying relevant literature and the personal work as an osteopath a theoretical foreknowledge on the topic “Osteopathy – the way from therapy to prevention” was acquired. Based on this basis the analytical unit and the structural dimension were defined and preliminary category system was designed. Subsequently followed the coding, reference designation and assignment to individual passage with regard to defined dimensions. In another material flow the text was examined for information material, which cannot be assigned to existing categories. The category system was modified in order to revise the transcribed interviews once more. The paraphrasing of the quotations and the summary of the reformulated material per sub- and main category were the final steps of date processing.

4.3.1.1 Descriptions of results and interpretations

During the description of the results in the empiric part of this study the topics dealt with in the interviews were systematically outlined. Thereby literal or contentual quotations of the interviewees were used to illustrate the categorised and paraphrased results. If it seemed necessary for capturing the meaning of the statements the context was explained in more details.

The questions asked during the conversations were normally not mentioned literally, but with regard to content. The quotations concerning individual topics shall provide a practical, but nevertheless organised overview over the statements of the different test persons.

The interpretation was carried out analogously to what Mayring (1990), following Danner, called “hermeneutic helix”. Based on a first preconception once reaches a preliminary textual understanding, which furthermore leads to an extended preconception. Thereby preconception and textual understanding change continuously. The model of the helix says furthermore that the personal preconception always influences the interpretation. The understanding of the circumstance develops further in dealing with the object, which determines a change in the attitude of the researcher. This means in term, that every interview is influenced by the increase in understanding through the last interviews. The procedures of collection, evaluation and interpretation overlap during the qualitative process. Therefore an interpretatively orientated approach demands a disclosure of this preconception. In the theoretical part of this thesis this demand is met (Mayring, 1990; Lamnek, 1995, vol. 1).

4.3.1.2 Quality criteria

The quality of the investigation results has to take care of to the same amount in qualitative research as in quantitative research. Thereby the

traditional quality criteria of reliability, namely accuracy and validity cannot be unhesitatingly transferred from quantitative research to qualitative research.
Mayring therefore formulates (1990) six universal quality criteria of qualitative research.

- The documentation of procedure is the detailed reproduction of the investigation process which thereby becomes intersubjectively reviewable. By explaining the precondition, the composition of the analysis instruments, the procedure and the evaluation of the data collection the investigation process becomes comprehensible for others.

- The argumentative backup of the interpretation serves for validation of the interpretation which plays an important role in qualitatively orientated approaches. If this demand is not met the qualitative social research can be alleged arbitrariness and randomness.

- The investigation procedure guided by rules means a systematisation of the approach, which nevertheless does not overly restrict the “openness toward the object”, which is an attribute of qualitative investigation. The demanded systemisation can be seen as a criterion for the concepts of scientificity.

- The nearness to the object as a methodological basic principle of qualitative interpretative research must not the lost. If the research is not directed at the natural environment of the people concerned, an open, equal relation between researcher and research object cannot be achieved anymore and this kind of science discredits itself.

- The communicative validation means a revision of the results by their regeneration to the people concerned. From the reactions of the research objects to the analysis results and the interpretation important conclusions can be drawn concerning the relevance of the results.

- Triangulation finally means the use of different methods, theoretical approaches, interpreters and sources of data. This shall lead to an extensive, more detailed, but thereby sometimes even contradictory capturing of phenomena (Mayring, 1990; Lamnek, 1995, vol. 1)

4.3.2 Conduct of investigation

In the following chapters 4.3.2.1 to 4.3.3. my approach to the test persons, the course of the interviews and the location of the investigation shall be described. The exact explanation of this procedure shall eliminate ambiguity and make the study methodically “transparent”.

4.3.2.1 Approach to the patients

After the first euphorical commitment of a colleague finding enough patients for this series of interviews did not seem to be a problem for me. After she had talked to her patient, only one patient remained in the end that consented to the interview. A colleague, Mrs. Hölzl, immediately established to three “long term patients” of hers. The rest of the acquisition was conducted via another colleague who also promised me to patients as interviewees.
During the first conversation with the patients, which was conducted over the phone in every case, I explained the procedure of the interviews and the aim of the investigation. Subsequently time and place of the interview procedure was arranged.

Already during the first contact over the phone the consent to recording the interviews on tape and the use of scientifically processing the interviews was obtained. Thereby anonymity was guaranteed.

4.3.2.2 Conduction of the interviews

At the start of the meeting my conversational partners were informed in more detail about the aim of the investigation. The test persons were given a short overview over the subsequent questions. I asked them to address important topics I did not ask about specifically. Finally anonymity was promised once more and the persons concerned could eliminate existing unclarities.

The interview itself was conducted following the provided guideline (see Appendix 1). Thereby the personal data were collected first and subsequently the different aspects of “long-term therapy and their possible reasons” were asked about. Prior to switching off the tape recorder I thanked the inquired persons for their contribution.

Prior as well as after the official tape recordings conversations took place from which I gained further information. This information, frequently completing the content of the interviews was taken down in the postscript concerning the inquired persons and sometimes was used for interpretation.

4.3.3 Location of the interviews

The inquiry of the interviewees took place in different locations. Four of the interviews were conducted in my own office. This proved handy, because the setup of the microphone did not have to done several times. I considered it a further advantage of speaking in my own office that one could undisturbedly about all problems and subjects. Two interviews were

carried out in the homes of the interviewees. This option had advantages and disadvantages. The interviewees considered it positive that they did not have to go anywhere and could take part in the interviews in familiar and comfortable surroundings. The disadvantage of conducting the interviews at the patients' homes was that one could be disturbed by telephones or family members. Despite the short interruptions the method of conducting interviews in the interviewees homes proved pleasant, because their housing situation as well as interpersonal contacts, e.g. with family members should be observed and exploited.

5 Results

5.1 Results Question 1

5.1.1 Disease

In this section the **disease patterns**, the **progress of the disease** and the **present state of disease** shall be depicted in some detail.

5.1.1.1 Disease patterns

The disease patterns of the patients are manifold. On the one hand accidents, such as a rupture of the cruciate ligament, cartilage damages, rupture of the biceps ligament but on the other hand also tensions and overloading can lead to disease patterns such as, e.g. tinnitus. But what all patients have in common is that they mention the factor “pain” in connection with their very different disease patterns. Pain seems to be the decisive impulse for medical or therapeutic consultation.

…weil der Schmerz überhaupt keine Pause mehr gemacht hat. (Fr. Krumpler, 46)
[… because pain did not stop anymore at all.]

Also begonnen hat das Ganze glaub ich mit, wie ich das erste Mal hingekommen bin, da hab ich relativ viel Kopfschmerzen gehabt, extreme Nackenverspannungen, dann im Lendenwirbelbereich wenn ich länger gestanden bin, hab ich das Gefühl gehabt ich kann nicht mehr stehen. Ja so hat`s begonnen. (Fr. Friedrich, 42-44)
[I think it all started with, when I went there for the first time, I had heavy headaches, extreme neck tensions, and around the lumbar vertebrae, there I had the feeling if I was standing longer that I could not stand anymore. Yes that is how it all began.]

Also grundsätzlich geht`s um die Schultern, die durch Kalkablagerungen so Reizungen haben, wobei die Kalkablagerungen durch die Osteopathie nicht mehr da waren, die Reizungen trotzdem. Also ich war auf Kur und da haben Sie mir das dann noch einmal geröntgt und es waren die Kalkablagerungen gar nicht mehr da und ich hab gefragt, warum das teilweise immer noch weh tut, ja einfach weil die Reizung da ist. (…) und wegen so Schmerzen in den Weichteilen im Rücken. So

ähnlich vermutlich wie ein Weichteilrheumatismus, so genaue Diagnose hab ich da nicht, es tritt einfach immer wieder so ein, unvermutet auf, heftige Schmerzen (Fr. Rosenberger, 46-51)
[Basically it's about the shoulders, that have such irritations because of such chalky deposits, whereby the chalky deposits were not there anymore because of osteopathy, but the irritations remained. And so I took a cure and there they made an x-ray again and the chalky deposits were not there anymore and I asked why that still hurts, because the irritation is still there. (…) and because of the pain in the soft tissues of the back. Similar to soft tissue rheumatism I guess, I don't have an exact diagnosis, it just occurs sometimes unexpectedly, very heavy pain.]

All six patients know problems with the spine, whereby the original problems were not in every case the reason for the osteopathic consultation.

5.1.1.2 Progress

As the disease patterns strongly vary, many different disease progresses seem to be preprogrammed. Nevertheless all patients talk about a massive improvement of the symptoms or even "healing" of the primary disease after the acute phase of the disease. All in all the therapists are good companions during the progress of disease who help patients with word and deed, but also with concrete exercises.

Am Anfang eigentlich nur am Knie, und dann haben wir Rückenschmerzen dazugenommen, weil bei mir scheinbar jetzt so die ganze rechte Seite leidet, aber Ursache ist das Knie, Schonhaltung und so (…) also Kreuz, manchmal auch die Leber. (atmet tief)…verschieden, wird alles miteinbezogen jetzt. (…) tu selber zu Hause viel für die Wirbelsäule. Mach meine Übungen in der Früh schon und schau, dass ich ja, dass da die Schmerzen eher in Grenzen gehalten werden. (Fr. Moosbauer, 97-100 und 278-279)
[In the beginning it was only the knee, then we included the backaches, because obviously my entire right side is affected now, but the original cause is the knee, relive posture and so on (…) the back, sometimes also the liver. (breathes deeply)… different, everything is included now. (…) I do a lot at home by myself for the spine. I do my exercises already in the morning and take care that I, that pain is kept in a limit.]

Das war ein Unfall, da ist die Bizepssehne gerissen. (…) Die ist fixiert worden, mit drei Schrauben fixiert worden und dann war ich auf Reha und dann haben wir wieder weiter gemacht. (…) Also wenn ich in meinen Schultern Verspannungen spüre, dann mach ich die Übungen wieder. Aber leider nur, solange bis sie weg sind und vielleicht wär`s schon auch besser oder weg, wenn ich die regelmäßig machen würde… (Fr. Friedrich, 51, 61-62 und 395-397)

[That was an accident in which the biceps ligament was torn. It was fixed, fixed with three screws and then I was to a rehab and then I continued by myself. (…) I mean if I feel tension in my shoulders I start with the exercises again. But unfortunately only as long as the tension is there, maybe it would be better or even gone, if I made them on a regular basis…

Despite her residual symptoms, the tinnitus, Mrs. Baumann was able to improve her additional complaints.

…ich hab einen ziemlichen Tinnitus und da hab ich wirklich schon so viel ausprobiert und jetzt hab ich mir gedacht, na vielleicht hab ich da noch eine Chance, aber den hab ich mir mittlerweile noch behalten, also ich hab ihn noch immer. (…) am Rücken, diese Verspannungen, dann bei der Wirbelsäule, das ist sicherlich wirklich sehr viel besser… (Fr. Baumann, 61-63 und 332-333)
[…I have a relatively strong tinnitus and I've already tried a lot and then I thought maybe I have still a chance, but I still have it. (…) in my back, these tensions and the spine, that is certainly much better now…]

But not only primary disease, also pregnancy was therapeutically attended.

…und daraufhin hat sie eigentlich immer individuell ihre Behandlungen auf diese Regionen abgestimmt und seit sie gewusst hat, dass ich schwanger bin, hat sie eben die ersten 12 Wochen in der Region unten gar nichts gemacht, weil sie gesagt hat, da ist die Empfehlung, man soll nicht zuviel in dem Bereich machen und dann haben wir sehr viel speziell, weil lustigerweise dann die Halswirbelsäule besser geworden ist, dass ist alles psychisch, und daraufhin hat sie dann sehr verstärkt, auch durch diesen Kurs, den sie da gemacht hat, wir haben immer gesagt, wir üben am lebenden Objekt, haben wir dann eigentlich sehr viel für die Schwangerschaft, (…) weil ich hinten natürlich am Steißbein recht oft Beschwerden gehabt hab… (Fr. Huemer, 95-101 und 103)
[… and then she individually adjusted her treatment to the different areas and when she knew I was pregnant, she did nothing in the area down there at all for the first twelve weeks, because she said there is this recommendation of not doing too much in these areas and then we specifically, because funnily at that time the cervical spine got much better, that is all psychogenic and then she did very much, also because of this course she attended, we always said we "practice on a living object", we did a lot for the pregnancy, because I had tailbone complaints very often…]

Over the course of a long-term attendance of patients by their therapists very often new diseases or injuries occur that actually all therapists try to perceive and to treat.

5.1.1.3 Present state of disease

Today all patients seem to have found measures that help them to deal with recurrently arising symptoms or pain. The osteopathic treatment. Pain triggers thereby are very often stress, overload or the pattern of one's own personality. Mrs. Baumann says about this topic:

…wo ich beim letzten Behandeln kaum mehr was gespürt hab, da hat es jetzt wieder mehr weh getan, weil einfach wieder, ja durch den Alltag, weil ich so geartet bin, wie ich geartet bin, wo ich mich bemühe, mich schon zu verändern, aber trotzdem lasse ich mir wahrscheinlich schon immer sehr viel raufhängen und, also dass ich dann schon immer wieder spüre, das ist jetzt wichtig, dass ich hinkomme und dass ich dann nachher eine wesentliche Erleichterung… (Fr. Baumann, 336-340)
[…although I hardly felt it anymore at the last treatment, now it started to hurt again, yes, because of the daily routine, because I am like that, that I try to change, but I think I let myself be burdened very much, and then I feel that it is important to go there and after that it's a great release…]

…das war lange mühsame Arbeit und da kann ich jetzt nicht sagen, das war jetzt der Zeitpunkt, weil wir haben ja dann natürlich wieder Rückfälle, wenn ich mich zu sehr stress, dann zieht`s mir es sofort wieder, die Sonja sagt dann eh immer, sie merkt total den Unterschied zwischen Ferien und Schule und ich tu nebenberuflich lektorieren und hab ich da mehr, wird`s automatisch immer ein bissl schlechter… (Fr. Huemer, 311-314)
[… that was long and hard work and I can't say now, okay, that was the point, because of course there is occasional relapse, if I stress too much and then it's dragging again, and then Sonja always says that she can absolutely observe the difference between holidays and school-time and as a side job I work as a reader and I always feel it automatically a little bit more if I have some more work to do…]

In addition to that coldness and long working days seem to disprove the state of the body.

…es sind wirklich diese äußeren Faktoren, die jetzt eine Rolle spielen, es ist dieses Nass-kalte und eben die Feuchtigkeit an sich, aber es ist auch diese trockene Kälte, die mir, es ist eigentlich Kälte, die mir Schwierigkeiten bereitet. (...) Wenn ich einen 10 Stunden Tag habe, weiß ich einfach am Abend ich brauche mir nichts mehr vornehmen, es ist. (…) Dann reicht`s. (Fr. Krumpler, 425-427, 430-431 und 433)
[…it's really these external factors that play a role, this wet and cold weather and dampness per se, but it's also this dry sort of coldness that, actually it's coldness in general, that makes trouble. (…) If I have ten hours a day, I know in the evening I don't have to plan anything, it's. (…) That's enough.]

For Mrs. Friedrich the greatest achievement of all is the near-complete reduction of pain killers.

Also, wenn ich ehrlich bin, das Kopfweh ist total weg. Wenn ich Kopfweh hab, das sind einzelne Tage im Jahr, wo ich mir denke, ja das darf ich auch haben, also und ich hab früher echt Dauerkopfschmerz gehabt und viele Tabletten genommen. Brauch ich nicht mehr. Ja, Nackenverspannungen sind da und mal mehr, mal weniger. Muss aber dazusagen, ich hab einen Bandscheibenvorfall in der Halswirbelsäule und ich denke mir vielleicht die schlechte Haltung immer wieder und, ja , Schulter ist weitgehend, das ist was jüngeres, weitgehend eigentlich schmerzfrei, bis zu einem gewissen Punkt. (Fr. Friedrich, 370-375)
[To be honest, the headache is gone. If I have headaches that's only on single days of the year and then I think, yes, that's okay. I mean in the past I really had continuant headaches and took many, many pills. But I don't need them anymore. Yes, there is still the neck tension, sometimes more, sometimes less. But I have to add that I suffered a disc prolapsed of the cervical spine and it's also the bad posture I guess and yes. The shoulder is nearly, I mean that's something more recent and is nearly pain-free, to a certain point.]

5.1.2 Osteopathy

Access, expectations, interconnectedness with other therapies and influence of the osteopathic treatment on changes/healing concerning the symptoms are issues of the chapter osteopathy.

5.1.2.1 Access

The single patients all had different access to osteopathy. On the one hand patients were sent to osteopaths by physicians or colleagues from physiotherapy and on the other hand they took notice of osteopathy because of word-of-mouth recommendation.

Mrs. Moosbauer consulted a therapist because of medical recommendation.

Die Hausärztin hat mich zur Physiotherapie (betont dies) geschickt und ich bin da gelandet (lacht). Des war`s. (Fr. Moosbauer, 5)

[The family doctor sent me to a physiotherapist (stresses that) and I winded up here (laughs). That was it.]

However, again and again accident plays an important role, too.

Durch Zufall. Ich hab ein Trommelseminar gemacht bei der Frau Puchinger, also wir haben es miteinander gemacht, ich hab Sie gefragt, was Sie macht, sie hat mir das erzählt und ich hab das interessant gefunden und nachdem ich eh immer Beschwerden hab, hab ich mir dort einen Termin ausgemacht. (Frau Rosenberger, 3-5)
[By chance. I attended a drum seminar by Mrs. Puchinger, I mean we attended the seminar together, I asked her what she was doing, she told me, and I found that really interesting and because I have complaints from time to time I decided to make an appointment there.]

5.1.2.2 Expectations

What do patients expect from osteopathy? „*Hilfe und Besserung*“ [“Help and recovery“] (Fr. Baumann, 110) is not only what this individual patient expected, it seems as if this is what all the interviewees expected. Mrs. Rosenberger, however, regards the osteopathic treatment only as support or assistance and says about herself:

Einfach Besserung, im besten Fall Heilung. Aber das erwarte ich zwar nicht, weil das eigentlich ich von mir nur, ich mich selber nur heilen kann, glaub ich, unterstützen, aber Besserung auf alle Fälle, hab ich schon erwartet, weil sonst wäre ich nie hingegangen und hätte nie das Geld ausgegeben. (Fr. Rosenberger, 101-103)
[Simply improvement, in the best case recovery. But I don’t expect that, because I think, this is something I have to do by myself, the healing. I think support, or improvement at least, I certainly expected that, because otherwise I would never have gone there, I wouldn’t have spent the money on it.]

Mrs. Rosenberger is the only interviewee who raises the financial issue, which is certainly not negligible due to the numerous therapeutic sessions. However, it seems quite usual that patients consult an osteopath without even knowing what he is actually doing.

Nein, gar nicht, weil ich nicht gewusst habe, auf was ich mich da einlasse. …Na ich hab schon gewusst, aber ich hab damit nichts anfangen können, für mich war`s eine völlig neue Welt. (Fr. Friedrich, 92 und 94)
[No, not at all, because I did not even know into what exactly I was getting myself… I mean I knew it, but I could not make any sense of it, that was an entirely new world for me.]

Mit gar keinen. Ich war, bin sehr offen für alles, also egal in welche Richtung das geht, alternativmedizinisch auch, chinesische Medizin und eben auch Shiatsu und ich hab mir gedacht, ich geh gar nicht mit irgendwelchen Erwartungen hin, sondern lass mich überraschen, was man machen kann und es ist glaub ich das Beste, wenn man mit sehr überzogenen Erwartungen hingeht, wird man zwangsläufig enttäuscht. Und ich hab mir gedacht, schauen wir was sich ergibt und schauen wir, was wir machen können und das ist glaub ich besser. (Fr. Huemer, 110-114)
[With none. I was, I am open for new things, no matter what it is, alternative medicine, Chinese medicine and shiatsu, too and I just thought, I went there without any concrete expectations, I just thought I'd let them surprise me, that's what you can do and I think it's the best you can do, if you go there with excessive expectations you'll be disappointed inevitably. And I just thought, let's see what comes out, what we can do and I think that's better.]

High confidence is the basis for this kind of "allowing the therapist to do" or "letting it happen". However, this issue shall be dealt in more detail in chapter 5.1.3, called "The therapist".

5.1.2.3 Interconnectedness with other therapies

As osteopathy defines itself as holistic therapy, it is no surprise that patients have a very open mind about other therapies. Many patients have already tried some traditional therapies, such as physiotherapy, massages etc. but also "alternative medical" therapies, such as shiatsu, tuina or energy healing. Thereby the different therapies were experienced differently.

Ich kenne Shiatsu, eben auch die Tuina natürlich sehr gut, Meridianbehandlungen, ich kenne Akupunktur, also in diesem Bereich eben sehr sehr viel. (Fr. Krumpler, 27-28)
[I know shiatsu and tuina very well, meridian treatment, I know acupuncture, well, in this are a lot.]

Akupunktur hab ich auch gehabt. Ja, das war wie die Bizepssehne gerissen war, bin dann auch, wie das mit der Schulter war bei einem Manualtherapeuten gewesen, wo mich aber mein Osteopath dorthin empfohlen hat. (Fr. Friedrich, 27-28)

[I was treated by acupuncture, too. Yes, that was the time when I had that biceps ligament rupture, and then, when that happened with my shoulder I went to a manual therapist that my osteopath had recommended.]

Ich war schon mal zur Physiotherapie vor 10 Jahren ungefähr, da hat man eine Skoliose festgestellt, das war aber keine Osteopathie sondern reine Physiotherapie. Also da hab ich eine Stunde lang geturnt. (Fr. Huemer, 25-26)
[I consulted a physiotherapist once, about ten years ago, there they diagnosed a scoliosis but that was not osteopathy but only physiotherapy. There I exercised for an hour.]

Some of my interviewees still attend these alternative therapies simultaneously to osteopathy, others currently consult osteopaths only.

5.1.2.4 Influence of an osteopathic treatment on changes/ healing concerning the symptoms

Basically all patients pointed out that the osteopathic treatment significantly contributed to the healing effect of their diseases or at least to an improvement of their symptoms. In the course of the interviews they were provided with a scale, ranging from 0 to 100%, by means of which they should rate the influence in percentages, as the term “big” can be interpreted quite subjectively by the reader. However, the problem is then, as I know from experience, that patients very often rate “big”, scarcely over the middle, i.e. scarcely higher than 50%.

Einen großen Einfluss, ja in Prozenten tue ich mir schwer, wenn ich es jetzt nicht unbedingt, auf diese Stunde beziehe, sondern auf mein gesamtes Sein, dann auf mein gesamtes körperliches Befinden, dann hätte ich gesagt, ist das 60%: Also ein wirklich großer Gewinn für mich. (Fr. Rosenberger, 349-351)
[A big influence, yes, in percent that’s difficult to say, if I don’t refer to exactly this one session, but to my entire being, to my total bodily condition, then I’d say 60%: a real benefit for me.]

Naja, schon auf jeden Fall über 50%. Zwischen 60 und 70 herum. (Fr. Baumann, 299)
[Well, yes, certainly more than 50%. Between 60 and 70, around that.]

Subsequently one patient also gives a reason for this evaluation:

Auf dieses Wohlbefinden… (Pause, überlegt) …wenn ich das prozentuell ausdrücken kann, würd ich vielleicht schon sagen (Pause) …mehr als die Hälfte, weil einfach, ja es wirkt sich in den Alltag dann aus, wenn ich da weg geh, (Pause) na mehr, 75%: Weil ich mich im Körper selber wohler fühl und was noch wichtig ist für mich, ich bin wesentlich sensibler jetzt geworden. Ich ah, horch mehr in meinen Körper hinein, ja ich bin sensibler, spür mehr und durch die Information, die ich da krieg, ist mir dann manches klarer und, ah, weiß manchmal dann auch, was ich tun kann. Grad, wenn`s im Knie irgendwas hat, oder so. Ganz einfache Mitteln, sagt mir da die Frau Hölzl, auf der Gehsteigkante z.B. nur Pendeln. Das sich das wieder ein bissl…(Fr. Moosbauer, 401-407)
[Concerning well-being… (pause, thinks)… if I should rate it in percent, I'd probably say (pause) more than half, because, yes, it affects my everyday life, well, more than that, 75%: because I feel good in my body and what is important as well, I have become more sensitive now. I, ahm, listen inside my body, yes I'm more sensitive, feel more and because of the information I get there, some things have become clearer for me and, ahm, I sometimes know then what I can do. Particularly if there's something in my knee or so. Mrs. Hölzl tells me really simple methods, on the curbside, for example swinging. So that it becomes a little bit…]

Another interviewee thinks that changes due to an osteopathic treatment have very much to do with the therapist but is nevertheless convinced that the osteopathic treatment was successful in her case because she changed therapist.

Ich glaub schon, dass es die Behandlung ist, in Kombination. Ich mein schon, wenn von vornherein die Chemie nicht stimmt, werde ich mich gegen die Chemie, gegen die Therapieform auch wehren. Ich glaube nicht, dass jemand, der, dem der Osteopath oder die Osteopathin unsympathisch ist, oder wo man einfach nicht kann, dass bei dem dann, dass sich der dann entspannt hinlegt oder das der Entspannung erlebt dann. Aber, ich glaub schon, dass es die Therapie an sich ist, die wirkt, ja. Ich war ja bei zwei. (Fr. Friedrich, 334-338)
[I think it is the treatment, in combination. I mean, I think if the chemistry isn't right from the start, I will react against the chemistry, against the form of therapy. I don't think that somebody who doesn't find the osteopath likeable, or if you don't have a way with the osteopath that you can lie down at ease or experience relaxation. But yes, I think it's the therapy per se that is effective. You know, I've consulted two.]

Which influence the osteopath has got thereby, can be read in the following chapter.

5.1.3 The therapist

Gender, support/understanding and the **influence of the therapist on the changes/healing of the symptoms** are the different issues that shall be dealt with in this subchapter regarding question 1.

5.1.3.1 Gender

Half of the patients assert that concerning treatment gender does not play any role for them. As mentioned above, the patients whom I interviewed came from two female and one male therapist.
After her initial reaction, which was a clear „*Nein*.“(16) [“No.”], Mrs. Huemer relativizes this reaction and states reasons for a possible preference.

Überhaupt nicht, auf der anderen Seite muss ich natürlich sagen, grundsätzlich redet sich`s mit einer Frau wahrscheinlich leichter, hab jetzt in meiner Laufbahn mit sehr viel männlichen Ärzten, muss ich dazusagen, zu tun gehabt, hatte da auch kein Problem, aber es ist natürlich ein Unterschied, es ergibt sich, wenn man eine Stunde Therapie hat, dass man anfängt zu sprechen und zu, Erfahrungen auszutauschen und da hat sich mittlerweile ein freundschaftliches Verhältnis aufgebaut, was mit einem Mann in der Art und Weise wahrscheinlich nicht zu Stande gekommen wäre. (Fr. Huemer, 18-23)
[Not at all, but on the other hand I have to say that in principle it is probably easier to talk to a woman, I mean, I have to say that I had to do with many male physicians over the years and I didn’t have any problems with that, but of course there is a difference, I mean it’s clear that if you have a session that lasts for an hour, of course you start to talk and to exchange experiences and from that an amicable relationship had developed which probably would not have developed with a man.]

Mrs. Baumann regards the therapist’s sex as an influencing factor concerning her disease pattern, but still consults a male osteopath.

Mhm, in dem Fall vielleicht schon, weil die Physiotherapeutin eine Frau war und ich mir gedacht habe, na ist auch einmal nicht uninteressant, da auch einmal zu einem Mann zu gehen. Ja, aber nicht prinzipiell. (…), ich kann`s eh ansprechen, es geht um Beckenbodengymnastik, wie bei so vielen Frauen in meinem Alter und ich wollte halt nicht einfach operieren… (Fr. Baumann, 13-14 und 26-27)

[Yeah, in this case probably yes, because the physiotherapist was a woman and I thought it would be maybe interesting to consult a man, too. Yes, but not as a matter of principle. (…), I can say it anyway, it's about pelvic floor gymnastics, as it is the case for many women of my age and I just didn't want to undergo an operation…]

However, the aspect of gentleness associated with the female gender seems to play a role sometimes (cf. question 4).

Das, spielt schon eine Rolle, ja. Da würde ich mich eher, weil`s ja doch sehr sanft ist, da fühle ich mich eher bei einer Frau wohler, als wie bei einem Mann glaube ich, also ich hab`s nicht ausprobiert, aber ich könnte es mir schon vorstellen dass das eine Rolle spielt. (…) ja aufgrund der Sanftheit ist das irgendwie. (Fr. Krumpler, 11-13 und 18-19)
[That plays a role, yes. I would, because it is such a gentle matter, I feel better with a woman than with a man I think, I mean, I haven't tried but I can imagine that it plays a role. (…), yes because of gentleness somehow.]

The pregnant patient who originally consulted therapy because of neck complaints and headaches, talked in the interview about better understanding and more empathy on the part of the female therapist because she, the therapist, had already two children herself, although the patient had no comparison with any male therapist.

5.1.3.2 Support/understanding

To be alone with one's disease can increase or intensify one's sufferings. Expressions such as „*Irgendwo begleitend, ja einfach auch auf der menschlichen Seite*" (Fr. Baumann, 309-310) ["Somehow accompanying, yes also on a human side"] seem to be demands on the part of the patients, not only of the therapist but also of the human being behind. That the relationship sometimes develops from a mere patient-therapist-relationship into something deeper seems to be an enrichment rather than a problem for Mrs. Friedrich.

(Unterstützt) in allen Dingen, ja. Wir reden wirklich über alles, über Gott und die Welt, wie man so schön sagt, dass, mhm, aber vielleicht macht das auch die Freundschaft aus, dass weiß ich nicht,

dass kann ich nicht mehr unterscheiden, wo er jetzt, oder welches Gespräch jetzt den Therapeuten betrifft und welches Gespräch den Freund betrifft. (Fr. Friedrich, 252-255)
[(supported) in all things, yes. We really talk about everything, about everything under the sun, as the phrase goes, that, mhm, but that is what makes out friendship I guess, that is, I don't know, that is something I can't distinguish anymore, which conversation appeals to the therapist and which one appeals to the friend.]

Support and understanding during their "life of suffering" means for some of the patients getting information concerning their body, for others it means discussing different points of view regarding certain different topics.

Gut aufgehoben, und was mir auch taugt, ist die Information die ich dann von der Frau Hölzl bekomm, über Zusammenhänge in meinem Körper. Ich darf dumm fragen, es gibt keine dummen Fragen…(Fr. Moosbauer, 250-251)
[To feel that I'm in good hands and what I really appreciate is the information I get from Mrs. Hölzl, about connections in my body. I may ask stupid questions, there are no stupid questions…]

Da geht`s nicht unbedingt um Tipps, kann ich nicht sagen, weil das ist es ja gar nicht, es ist nur, so wie sie die Sicht sieht und so wie ich die Sicht sehe und da krieg ich einfach immer was mit. (Fr. Rosenberger, 235-236)
[It's not about tips, I can't say that, because that's not what it is, it's about her points of view and my points of view and I pick up on certain things.]

However, according to Mrs. Huemer, confidence can be only built if:

… also wenn man nicht 100% Vertrauen hat, wenn man sich nicht versteht, wenn die und auf das geh ich sehr, wenn die Aura eines Menschen nicht passt, dann würd ich zu dem nicht zur Therapie gehen, dass muss zu 100% passen… (Fr. Huemer, 211-213)
[… I mean, if you don't have 100% confidence, if you don't get along with each other, if the aura of someone does not suit, I wouldn't go there for having a therapy, that has to fit 100%...]

Formatiert: Englisch (Großbritannien)

5.1.3.3 Influence of the therapist on changes/healing of the symptoms

The interviewees all rated the influence of the therapist on changes/healing of the symptoms with the highest percentage points. No matters which therapies they currently undergo, the "human factor" always plays an important role. Mrs. Krumpler says in the interview that the „*der*

*Mensch der das ausführt oder der das transportiert, der 100% wichtig (is*t)“ (400) [person, the human being, who conducts that or transports that is 100% important].

Mrs. Moosbauer has more or less direct comparison with a previous treatment by a physiotherapist.

Ja die hat schon, wenn ich da jetzt vergleich mit der anderen Therapie, die ich da gemacht habe, die normale, also die klassische Physiotherapie, also ist das, liegen Welten dazwischen, wirklich. (Fr. Moosbauer, 413-414)
[Yes she had, I mean, if I compare that to the other therapies I have undergone, the normal, the traditional physiotherapy, I mean that is, there are worlds in between, really.]

That the patients‘ own personality certainly plays a part as well becomes clear from the following statement by Mrs. Rosenberger.

Für mich sehr viel. Weil, es sieht man auch an der Masseurgeschichte. Ich bin sehr personenbezogen und wenn ich mich dann einmal wo wohlfühle, dann mag ich mich einfach nicht mehr auf neue Leute einstellen, das ist beim Friseur so, dass ist bei den Ärzten so und das ist beim…allgemein eigentlich (…) Ich war 34 Jahre in einer Firma, ich bin noch nie umgezogen, ich bin einfach ein Pickenbleiber. Wenn eine Veränderung da ist, nehm ich sie an, aber von selber führe ich sie nicht herbei, sagen wir mal so. Und ich fühle mich so dermaßen wohl, dass ich gar keine Veranlassung hätte, zu suchen, also ich bin wirklich weit gefahren, hätte mir nie gedacht, vorgestellt, dass ich das jemals täte… (Fr. Rosenberger, 356-362)
[For me a lot. Because that becomes clear from this massager story as well. I’m very individual-related and if I feel that I’m in good hands somewhere, I don’t want to adapt to new people, that’s the same for my hairdresser, for doctors and for… that’s generally like that. (…) I worked for 34 years in the same enterprise; I’ve never moved flat, I’m just like that, clinging to everything. If change occurs I accept it, but I wouldn’t cause or bring about change myself, let’s put it like that. And I feel so good that I wouldn’t have any reason to search, I mean I drove really far, I would have never imagined that, that I would do that…]

All six patients agree that the therapist represents the vastly biggest factor concerning the improvement of their complaints.

5.1.4 The osteopathic therapy

The **period of treatment**, the **frequency**, the **duration of therapy** and the **time of day** are the issues of evaluation of the following subchapter on osteopathic therapy.

5.1.4.1 Period of treatment

The periods of time during which the patients accompany their therapists, or vice versa, range from two and a half to eight years. Short therapy interruptions due to hospital stays, longer holidays or parental leaves have not caused the termination of long phases of treatment.

For fun Mrs. Moosbauer considers herself already as part of the furnishings of the therapeutic office.

7 Jahre, dann bin ich sicher 6 Jahre da. Also ziemlich am Anfang (…) Wahrscheinlich. Ich gehör schon zum Inventar (lacht). (Fr. Moosbauer, 74 und 76)
[7 years, that means I've certainly been there for 6 years. That means fairly from the beginning (…) I suppose. I think I'm already part of the equipment (laughs).]

5.1.4.2 Frequency

Concerning the initial phases of therapy, all patients talk of rather short therapy intervals, i.e. between once or twice a week. However, they all state that after their symptoms had improved therapy-free intervals got longer.
A new occurrence of pain even causes one patient to call her therapist late at night and ask for an appointment although this is usually not her way, as she normally respects privacy.

Oder es war ganz was akutes, was ich auch mit Schmerzmitteln nicht weggebracht habe, dann bin ich natürlich auf Druck, hab ich angerufen und geschaut, dass ich kommen kann und das hat mir dann schon immer Erleichterung gebracht. (…) Ich hab schon ein schlechtes Gewissen, wenn ich

sie außer der Zeit anrufe, ich meine das ist eh schon lange her, dass ist schon ein paar Jahre nicht mehr gewesen. Aber am Anfang hab ich dann doch am Abend einmal angerufen und hab gesagt, es geht nicht mehr, ich kann nicht mehr. Also ja dann, aber das schaue ich, dass ich es über Nacht rüberbringe oder am Tag irgendwie schaue, eine Kurzbehandlung….
(Fr. Rosenberger, 85-87 und 425-429)
[Or it was something really acute that I couldn't alleviate with pain killers, of course then I'm under pressure, and I called and tried to make an appointment and that was always great relief. (…) I mean, of course I have a bad conscience, when I call out of office hours, I mean that was a long time ago, that has not happened for years anymore. But in the beginning I called one night and said that I can't bear it anymore. But, yes, normally I try to bear up against it for the night or try to get a short treatment during the day…]

By now, for Mrs. Krumpler the input she gets from osteopathy is not as necessary anymore as it was during the acute phase:

Ja, aber in ganz großen Abständen, alle 2 Monate und es ist auch so, dass ich dieses Verlangen nach der Tuina oder nach, ist nicht mehr so stark wie es früher war, wie ich noch diese argen Spannungen gehabt habe. (Fr. Krumpler, 35-36)
[Yes, but in really long intervals, every couple of months and I mean, this need for the tuina or for, is not as strong anymore as it was previously, when I had these strong tensions.]

Mrs. Friedrich is the only one who talks about therapy-abstinent phases.

Der war am Anfang kürzer, dann oft ein halbes Jahr nicht, wenn ich mich richtig wohl gefühlt habe und dann hab ich wieder angerufen und dann bin ich wieder gekommen und jetzt ist wieder so eine Phase, wo wir, wo ich mit meiner jüngsten Tochter, wo wir regelmäßig gehen und ich denk wenn ich mich dann so, wenn es passt, dann kann durchaus wieder ein paar Monate sein, dass ich nicht gehe. (Fr. Friedrich, 78-81)
[It was shorter in the beginning, later there were periods of half a year in between and if I didn't feel good anymore then I called again and then I went there again. But now it's such a phase again, in which I, in which, we, me and my youngest daughter go there regularly and then, when I think it's okay again then there may well come a period of a few months again in which I don't go.]

On the whole none of the patients wants to miss the osteopathic company in their life.

5.1.4.3 Duration of therapy

It seems as if a duration of approximately 45 minutes to one hour has been established as the standard duration of an osteopathic treatment. From my investigation it becomes apparent that these differences of duration are caused by the therapists own decisions to determine the duration of a therapeutic session.

Meistens ist es, ich kann fast durch die Bank ist es eine dreiviertel Stunde. (Fr. Baumann, 85)
[Most of the times, I can, nearly every single time it lasts three quarters of an hour.]

5.1.4.4 Time of day

My questionnaire does not decidedly take the time of day at which a treatment is conducted into account. However, the time of day seems to have a quite significant influence on the "initial state of the patient", i.e. the emotional condition in which a patient arrives at the therapeutic session and as a consequence also on the final outcome of the therapy.

Ich glaub von meiner Verfassung, wenn ich aus einem Stress heraus komm, dass ich den Termin noch einhalten kann, passiert manchmal, dann, ah, empfind ich`s nicht so in dem Ausmaß. (…) Ja, das glaub ich ist das. Ah, dass ich dann vielleicht gedanklich noch irgendwo anders bin und eigentlich gar nicht da. Das glaube ich trifft`s. Aber wenn ich so locker herkommen kann, ohne jeden Druck, Zeitdruck meinerseits, dann bin ich drauf eingestellt, dass jetzt mein Körper da behandelt wird…. (Fr. Moosbauer, 179-180 und 185-187)
[I think, concerning my condition, if I arrive there out of a stressful situation to make sure I keep the appointment, it sometimes happens then, ah, I'm not able to feel to the same extent. (…) Yes, I think it's that. Ah, that I'm maybe still somewhere else in my thoughts and not really there. I think that's it. But if I can come here so relaxedly, without any pressure, any pressure of time on my part, then I'm able to brace myself for the treatment of my body…]

Mrs. Rosenberger mentions several advantages that speak for therapy in the morning.

…weil ich immer in der Früh hinkomme und praktisch dann noch ziemlich relaxt bin. (…) Ich glaub einmal am Anfang, aber das ist so eine Hetzerei gewesen, da muss man in der Firma auf die Uhr schauen, Maria, hoffentlich komme ich nicht zu spät, hoffentlich übersehe ich die Zeit nicht, muss

ich mir einen Wecker stellen, dann hat man ein Kundengespräch, oder was, dann geht`s nicht. (…) Durch das, dass die Monika relativ weit weg ist, habe ich mir von der Firma eine Stunde Zeitausgleich nehmen müssen nur für`s Fahren und so hab ich das immer vor der Arbeit gemacht und bin dann eine halbe Stunde später in die Arbeit gekommen. (Fr. Rosenberger, 277-288, 283-285 und 288-290)
[… because I always go there in the morning and then I'm practically always relatively relaxed. (…) I think one time, in the beginning, but that was such a hurry, you always have to consult your watch at work, Jesus, I hope I won't be late, I hope I won't overlook the time, I have to set my alarm clock or if you have a meeting with a customer or something like that, then it's not working. (…) Because Monika is relatively far away, I had to take comp time only for the travel time and thus I decided to go there before work and be half an hour late at work.

5.1.5 Setting

On a first glance the setting does not seem to be of such an importance in therapy. On a second glance, however, „*ein heller Raum*" (Fr. Friedrich, 350) ["a bright room"], large facilities and „was Offenes, was Freies und was Schönes" (Fr. Krumpler, 408) ["something open, free and beautiful"] can contribute to an atmosphere of well-being.

Short waits and environmental factors are two important aspects for the patients.

Ja erstens für mich ist es, weil es leicht erreichbar ist, das ist mir auch nicht unwesentlich, ich gehe zu Fuß hin, da kommen schon wieder die ganzen Umweltgedanken auch dazu, dass ich mir denke, brauch ich nicht schon wieder ins Auto steigen und die Luft verpesten, machst eine Bewegung, ja einfach die ganzen Dinge die damit auch positiv zusammen hängen und ja, dass man ja gut dort ankommt, man sich dort auch wohlfühlt, dass der Hr. Freundlinger auch die ganze Zeiteinteilung super hat, also, dass da nicht irre lange Wartezeiten sind, und ja das das einfach angenehm ist. (Fr. Baumann, 322-327)
[Yes, for one thing it is important that it is within easy reach, I walk there on foot, that has to do with a certain environmental awareness, that I think, I don't have to use the car again and pollute the air, and by walking, I even make some exercise, yes, simply all those thinks that can be positively related with it and yes, to arrive there well, to feel good there, that Mr. Freundlinger has a great time management so that there are no really long waits and yes, all that is simply pleasant.]

Das Rundherum ja. Weil Sie Wartebereich ansprechen, ja das ist da angenehm weil man, ja man kommt zurzeit her, man darf sehr pünktlich herkommen und diese Wartezeit eigentlich so minimal

gehalten wird, das schätze ich da sehr. Erleb ich ja jetzt durch diese vielen Arztbesuche, dass das nicht selbstverständlich ist. (Fr. Moosbauer, 434-436)
[The environment, yes. Because you mention the anteroom, yes, that is really pleasant because you come here on time, you are allowed to come here really on time and thus the waits are actually really short, I appreciate that. I know that that cannot be taken for granted, I experience that at visits to other doctors.]

Mrs. Moosbauer mentions a different reason why for her a big room is desirable and necessary.

Dass ist schon sehr entscheidend, vor allem die Helligkeit und dann auch die Größe der Räume, das hängt aber auch zusammen bei mir, mit meiner Klaustrophobie, die ich hab. Dass heißt, das brauch ich einfach um mich wohl zu fühlen. (…) den Lift kann ich nicht herauf benützen, das ist aber kein Problem, ich seh das als sportliche Ertüchtigung, daher rauf, solange es geht (lacht)… (Fr. Moosbauer, 426-429)
[That is very decisive, in particular brightness and seize, in my case that has to do with my claustrophobia that I have. That means I need all that for feeling good. (…) I cannot use the elevator to get upstairs, but that isn't any problem, I regard that as a healthy exercise, which means I walk upstairs as long as I can (laughs)…]

One patient points out that she would not want any ambient music like in a shop. A second patient says that she would not consider background music as disturbing, but that she would be annoyed by a radio broadcast including spoken comments and advertisements.

5.2 Results Question 2

The evaluation of question 2 shall deal with the question whether it is really the factor of change concerning well-being that motivates patients to consult their advisor and companion, i.e. the osteopath, over the course of many years. As the definition of the term well-being was already very difficult, in the following section, called “Which significance does the factor well-being have thereby?“ I would like to single out individual explanatory models, define these as my categories and back them by means of anchor examples from the interviews.

5.2.1 Well-being with regard to the model of Becker (1991)

This structure model consists, as mentioned above, of two main categories, which are the current and the habitual well-being. Furthermore Becker distinguishes four more subgroups, which are current mental, current physical, habitual mental and habitual physical well-being. On a cognitive evaluative level habitual mental well-being becomes habitual life satisfaction including mental health; habitual physical well-being becomes habitual life-satisfaction including physical health. Finally these life-satisfactions result in general and area specific life-satisfaction (cf. Figure 1, Model of Becker).

5.2.1.1 Current mental well-being

According to Becker this kind of well-being is further distinguished into three subitems with their corresponding specifications: positive feelings, positive mood and current freedom of symptoms. Although these were not decidedly inquired in the interviews, as only a general component of well-being was addressed, the interviews revealed usable statements concerning each category or sub-category.

„Positive Gefühle“ (Becker, 1991, S. 58) [“Positive feelings“]

Two of the patients mentioned the term joy, whereby it referred to two different aspects. For Mrs. Krumpler it meant joy about her recovery as well as joy that she allowed herself something.

Ja, Freude, Freude ist oft auch aufgekommen, überhaupt dann wie es schon leichter geworden ist, wo man dann gemerkt hat, jetzt tut das nicht mehr so, jetzt schmerzt das nicht mehr so und man merkt einfach, dass die Spannungen weniger sind, dann kommt natürlich eine Freude auf. … Genau, über die Besserung und einfach auch, dass man sich was Gutes tut. Das man sich die Zeit nimmt und leistet zu sagen, ich tu mir was Gutes. (Fr. Krumpler, 207-209 und 211-212)
[Yes, joy, joy arose many times, especially when it got better, when I realized that, now it doesn’t hurt that much anymore and I can feel that the tensions got less and of course then joy arises… Yes, exactly I was happy about the improvement and about giving myself a treat. That I take the time and allow myself a treat.]

But also:

Naja, wenn Tränen gekommen sind schon Tränen der Freude, also dass weiß ich, und dann Traurigkeit. (Fr. Friedrich, 197)
[Well, when I broke out into tears that were certainly tears of joy, I know that, and sadness.]

In his model Becker (1991), too, states that joy and sense of happiness are the most important representatives of this subcategory.

„Positive Stimmung“ (Becker, 1991, S. 58) [“Positive mood“]

Many different positive moods seem to have emerged in my interviewees due to the osteopathic treatment. Hereby again primarily the initial states, in which the patients arrive at the treatment, seem to be important; the techniques used during the treatment seem to be of secondary influence. As Mrs. Moosbauer says:

…dass ich dann vielleicht gedanklich noch irgendwo anders bin und eigentlich gar nicht da. Das glaub ich trifft`s. Aber wenn ich so locker herkommen kann, ohne jeden Druck, Zeitdruck meinerseits, dann bin ich drauf eingestellt, dass jetzt mein Körper da behandelt wird und da ist vom

ersten Augenblick an das Wohlbefinden da. Da spür ich dann einfach, ja da tut sich was im Körper. Da fängt irgendwas zu fließen an, wird warm oder so, ein Wärmegefühl oft und äh, spür dann oft auch Berührungen am Knie ganz woanders…(Fr. Moosbauer, 185-190)
[… that I'm probably somewhere else in my thoughts and actually not there at all. I think that's it. But when I can come here so relaxedly, without any pressure, pressure of time on my part, then I'm ready for the treatment of my body and then there is well-being from the start. Then I just feel that something's happening in my body. Something starts to flow, it gets warm or so, such a feeling of warmth and, ahm, then I feel the touch on my knee somewhere totally different…]

Furthermore the interviewees talk about what the technique may achieve.

Aber eher wenn er am Kopf, wenn er eher Cranio-Sacral arbeitet, sag ich, dass es eher in die ruhigere, entspannende Phase kommt. (Fr. Friedrich, 156-157)
[But when he works on the head, when he works craniosacrally I say that now it comes to a calmer, more relaxed phase.]

Auch Bilder manchmal, oder Farben, also speziell dann wenn sie den Kopf behandelt, dann kommen relativ oft Farben und Bilder. Die mir ein Wahnsinnsfeeling geben, ein Glücksgefühl, ein Hochgefühl…(Fr. Rosenberger, 178-179)
[Also images sometimes or colors, especially when she treats my head, frequently colors and images come up. That gives me an incredible feeling, a feeling of happiness, a feeling of elation…]

That relaxation can be so deep that it leads to falling asleep does not seem to be an isolated case. The basis therefore is „*Grenzenloses Vertrauen*" (Fr. Friedrich, 125) ["boundless confidence"].

Ich bin entspannt und manchmal schlaf ich auch weg. Oder bin kurz davor, ich will nicht sagen, dass ist so ein Trancezustand, aber doch ein ganz eigener, da schwappe ich zwischen Schlaf und munter hin und her. (Fr. Rosenberger, 270-272)
[I'm relaxed and sometimes I fall asleep. Or at least I'm on the verge of falling asleep, I don't want to say that it is a state of trance but it is a very special state in which I'm something in between, between being asleep and awake.

For Mrs. Huemer it means relaxation without medication.

Also für mich ist es grundsätzlich ein fixer Bestandteil geworden für Entspannung meines Körpers, für Freiwerden ein bissl vom Kopf, es ist einfach, ja für mich der beste Weg für alternativmedizinische Behandlung, also weil ich eher ein Gegner von starken Medikamenten und

diesen Dingen bin, ich such immer die Alternativen und das ist ein wertvoller Beitrag. (Fr. Huemer, 272-274)
[Basically for me it has become an essential element for the relaxation of my body, for becoming free in the head, I mean it's the best way for me, the best form of alternative medical treatment, because I'm against strong medication and all these things, I'm always looking for alternatives and this is certainly a valuable contribution.]

To let go of sorrows for a moment, to relieve oneself from burden and to get a feeling of happiness is what Mrs. Rosenberger and Mrs. Friedrich talk about.

Dieses Hochgefühl, dieses Glücksgefühl und diese Leichtigkeit auch, die es in diesem Moment gibt, also da schwebe ich fast raus. (Fr. Rosenberger, 223-224)
[This feeling of elation, this feeling of happiness and also this feeling of ease that are there for a moment, I'm nearly floating out from there.]

Das Loslassen, die Situation des Loslassens glaub ich ist das. Da liegt man da und auf einmal fühlt man ich so wohl, und denkst, die Welt könnte so schön sein und könnte so gut sein und dann sprudelt alles was halt dann doch belastend ist. (Fr. Friedrich, 200-202)
[This kind of letting go, this situation of letting go, I think it's that. You are lying there and suddenly you feel so good and you think the world could be so bright and everything could be so good and then everything that's still burdening you is flowing out.]

The osteopathic treatment visibly affects the everyday life of these patients. To forget the daily routine for this one hour of therapy causes also changes on a bodily level, as shall be described in the chapters on bodily well-being.

5.2.1.2 Habitual mental well-being

„Seltenheit negativer Stimmungen und Gefühle“ (Becker, 1991, S.58)
[“Scarcity of negative moods and feelings“]

In its acute phase the disease led the patient to desperation. By means of the therapy and the improvement of symptoms she achieved mental balance.

Ja, ja, das funktioniert wieder ganz super, auch so von der psychischen Ebene würde ich es so sagen, dass ich mich wieder viel mehr wahrnehmen kann, dass ich mich wieder mehr spüre im Inneren, von der Mitte raus, weil das war natürlich auch blockiert, wenn sich die ganze Energie immer oben abspielt. Weil ich da schon merke, dass das einfach schon einen Ausgleich geschaffen hat und dass man viele Dinge wieder rationell viel besser abklären kann. Und früher war das oft so, dass ich mir gedacht habe, mah, daran verzweifle ich fast, weil einfach das so gehängt ist, eben nicht mehr schauen zu können, was für Möglichkeiten gibt`s noch, also das. (Fr. Krumpler, 234-239)

[Yes, yes that really works well again, also on a mental level I would say, that I can perceive myself a lot better, that I can feel myself a lot better on the inside, from the center, because that was blocked of course, if all the energy takes place on top. Because I feel I have achieved balance and that I can clear many things a lot better in a rational way. And before it was like that that on many occasions I thought I had to fall into despair, because it was all so blocked and I couldn't even look for any further possibilities.]

At the start of the therapies it seemed as if Mrs. Friedrich had to overcome many more problems.

Naja, eh eher wenn ich so daliege, dass mir die Tränen runterkugeln, aber das ist auch sehr situativ, also das ist nicht jedes Mal, das ist, war am Anfang, also ich begonnen habe, öfter. Mhm, das ist jetzt eigentlich kaum mehr, weil ich weiß nicht, ich fühl mich auch sehr rund in mir. (Fr. Friedrich, 183-185)

[Well it's rather when I'm lying there and tears are running down my cheeks, but that's very situationally now, that doesn't happen every time, it happened more often in the beginning, when I started. Mhm, that hardly happens anymore, because, I feel I'm all square.]

However, how long this altered condition lasts, depends, according to Mrs. Baumann, on her personality.

Das hängt dann wieder, das ist unterschiedlich. Also so irre lange, aber das hängt wahrscheinlich auch mit meiner Persönlichkeit zusammen. Ich, das kann ich jetzt wirklich nicht in Zeitabläufe genau einordnen. Nein, das kann ich wirklich nicht so sagen. Einige Tage…(Fr. Baumann, 264-266)

[That depends on, that is different. Extremely long, but that possibly depends also on my personality. I really can't say that in terms of passages of time, no I really can't. Some days…]

The patients' personality has great influence in terms of moods and feelings. Again and again the interviewees reflect on their patterns of life, which can be discussed with the therapist as well (cf. question 3).

„Häufigkeit positiver Gefühle und Stimmungen" (Becker, 1991, S. 58)
["Frequency of positive feelings and moods"]

Social integration plays a very important role for the well-being of Mrs. Moosbauer. In her relationship to the therapist she experiences many positive feelings that are lasting.

Da bin ich gut integriert ja, genau, und da bin ich sehr dankbar dafür, das ist sehr wichtig für mich, weil ich an und für sich allein sonst leb, also da brauch ich schon diese Beziehungen, wo ich mich wohl fühl und wo ich mich aufgehoben fühl. (Fr. Moosbauer, 298-300)
[I'm well integrated yes, exactly, and I'm really grateful for that as this is very important for me, because basically I'm living alone and that's why I need these relationships in which I feel good and in good hands.]

Mrs. Krumpler sensed the tightness in her shoulder and the stiffness of her neck not only on a bodily level. Today she describes her experiences as follows:

Genau, und nicht mehr schauen, was ist rechts und links, was spielt sich noch ab, das war irgendwie schon, hat schon auch eine Rolle gespielt und das merke ich schon jetzt, dass ich wieder weicher bin. (Fr. Krumpler, 131-132)
[Exactly, I couldn't look neither left nor right, what's happening there, yes that played a role as well and now I notice that I'm much softer.]

5.2.1.3 Current physical well-being

„Aktuelle positive körperliche Empfindungen" (Becker, 1991, S. 58)
["Current positive bodily sensations"]

This partial aspect is dealt with in more detail in the chapter on well-being concerning the model of physical well-being, as the model of Becker and the model of physical well-being along with the questionnaire about

current physical well-being by Frank (see Fig. 2, questionnaire about current physical well-being) contain the same items for current physical well-being.

„Aktuelle Beschwerdefreiheit“ (Becker, 1991, S. 58)
[“Current freedom of symptoms“]
Treatments are not always pleasant and soothing. Three patients talk about painful experiences in therapy, which, however, led to success.

Ja natürlich, am Anfang war es schon so, dass, es hat einfach Zonen gegeben, wo`s wirklich schmerzhaft war, wo ich einfach die Bizepssehne total gespürt habe, so richtig ein Pochen und ja das ist natürlich, aber das sehe ich eher als positiv, wenn das genau angesprochen wird. Oder auch in der Halswirbelsäule, diesen Lymphfluss, das war auch ganz, die ersten Male sehr intensiv, das zu spüren, wie der Liquor, oder die Flüssigkeit eigentlich zum Fließen anfangen und wie sich die Spannung vom Nacken her eben löst. (Fr. Krumpler, 172-176)
[Yes certainly, in the beginning there were zones where it was really painful, where I felt the biceps ligament a lot, really such a throbbing but that is, I mean, I view that as something positive, if it affects that. Or also in the cervical spine, this lymphatic flow that was really intense at the first times, to feel how the liquor, the fluid begins to flow and how this tension in neck releases.]

Aber ich sag manchmal, ja des ist ein angenehmer Druckschmerz und hab dann das Gefühl dass das… (Pause, überlegt) ja, dass der Schmerz weg ist. Manchmal sag ich, wenn ich dann nach der Behandlung aufstehe, „warum komm ich eigentlich zu Ihnen, ich hab eh nichts im Knie!“. Und die Ansätze spür ich aber schon während der Behandlung. (Fr. Moosbauer, 172-175)
[But I sometimes say, yes, that is a pleasant sort of pressure pain and then I have the feeling that that… (pause, thinks) yes, that the pain is gone. Sometimes when I get up after the treatment I ask :”Why do I actually consult you, there’s nothing wrong with my knee!”. But I feel the beginnings already during the treatment.]

Aber das ist gut, oh ja, das weiß ich schon, dass das wichtig ist, weil es einfach nachher leichter wird alles, auch da unter den Schulterblättern, da werkt er oft rein, dass ich mir denke, ohh ... genügt, aber es genügt eben nicht, wenn`s genügt sagt er, und im Endeffekt bin ich dann froh, wirkt angenehm… (Fr. Friedrich, 314-316)
[But that is good, yes, I know that it is important because afterwards everything is at ease, there under my shoulder blades, there he works a lot so that I think, ohh… that’s enough, but it’s not enough at all, he says when it’s enough and in the end I’m really happy, that has such a pleasant effect…]

However, the patient is also aware of the fact that the therapist cannot work miracles in the case of arthrosis and that freedom from pain can only last for a short time in such a case.

Ja, total schmerzfrei, dass ich mir sag, wie ist denn das möglich. Die Frau Hölzl sagt mir dann aber immer das ist sicher nicht von Dauer, und das stimmt dann natürlich auch, ist eh klar. (Fr. Moosbauer, 197-198)
[Yes, totally free from pain so that I ask myself, how on earth is that possible. But Mrs. Hölzl always tells me that this is surely not a permanent state, and of course she's right, certainly.]

That pain continues to exist or recurs does not seem to be any impediment for these six patients to continue to consult the osteopath; rather the contrary seems to be the case. Possible reasons therefore are documented in question 4.

5.2.1.4 Habitual physical well-being

„Habituelle Beschwerdefreiheit" (Becker, 1991, S. 58)
["Habitual freedom of symptoms"]

Bodily symptoms can be successfully treated by the osteopath. However, whether the improvement is a permanent one or not becomes apparent when therapy frequency is interrupted.

… weil ich Drehschwindel gehabt hab, aufgrund der Verspannungen, aber das ist Gott sei Dank, hat sich das jetzt gebessert. Schauen wir ob`s jetzt wieder kommt, wenn ich aufgrund des Mutterschutzes nicht so oft gehen kann… (Fr. Huemer, 71-73)
[… because I suffered from rotary vertigo which was due to the tensions but luckily that has improved. Let's have a look if it recurs now that I can't go there so often anymore because of maternity protection.]

For Mrs. Baumann the reason for her symptoms developed from her personal history, but becomes apparent on the bodily level. Her osteopath could help her on a sustained basis concerning her symptoms.

…aber in meinem Leben waren einige Schicksalsschläge und ich hab da auch sicher einiges am Buckel gehabt oder einiges verdrängt und da hat er mir sehr geholfen diese Spannungen im Schulterbereich und Halswirbelsäule und diese Dinge halt zu… Lösen, ja. (Fr. Baumann, 63-65 und 67)
[… but in my life there were several strokes of fate and I was certainly burdened a lot and I suppressed a lot and he helped me a lot to release these tensions around my shoulders and cervical spine and these things to… solve, yes.]

„Habituelle positive körperliche Empfindung“ (Becker, 1991, S. 58)
["Habitual positive bodily sensation"]

Here again one patient draws a close connection between body and mind. Mrs. Krumpler argues as follows:

Auf der körperlichen Ebene und natürlich tut sich auch wieder was, so vom Stabilisieren im Inneren, so dass man sich einfach mehr aufrichtet, dass man den Selbstwert viel mehr spürt. (Fr. Krumpler, 243-244)
[On a bodily level and of course there's something else happening, a kind of stabilization on the inside, that you straighten yourself and feel the self-esteem a lot more.]

For Mrs. Moosbauer habitual positive bodily sensations include things such as warmth and a flow in the joint. However she cannot feel it in the same way in all zones of the body.

Ich hab den Eindruck, dass ich dieses Fließen und dieses Wärmegefühl, das ich da oft entwickeln kann, grad speziell beim Knie, dass ich das mithinein nehme, mit nach Hause nehme... Bei der Wirbelsäule hab ich noch nicht so dieses… (Pause) dieses… markante Gefühl, hab ich noch nicht, ich spür da manchmal gleich eine Erleichterung, meistens aber dann erst zu Hause… (Fr. Moosbauer, 271-272 und 276-277)
[I've got the impression that I can take this flow and this feeling of warmth that I can develop there, especially in the knee, that I can take that with me, take it home with me… Regarding the spine I still haven't got this… (pause) this…remarkable feeling, sometimes I feel relief immediately but most of the times not until I'm at home…]

5.2.1.5 General and area-specific life-satisfaction

This life-satisfaction consists of habitual contentment including physical and mental state, habitual happiness and habitual joy of life. According to Mrs. Krumpler joy of life can only come up if all pain is absent.

…ich möchte einfach schmerzfrei leben können (…) und das tu ich ja jetzt. (Fr. Krumpler, 79-80)
[… I just want to live without pain (…) and this is what I'm currently doing.]

Retarding a big operation in combination with a good health-related quality of life has been the main goal of Mrs. Mossbauer for many years by now.

…wir haben doch jetzt schon neulich hat mir die Frau Hölzl gesagt, ich glaub das Kniegelenk, die Prothese drei oder vier Jahre hinausgezögert und das aber bei einer Lebensqualität, das ist super. (Fr. Moosbauer, 506-508)
[…we have already, recently Mrs. Hölzl told me, I think it's the knee joint, the prosthesis, that we have retarded it three or four years by now but still I have a good quality of life, that's great.]

Two patients regard osteopathy as the best form of therapy concerning their wholeness.

… ich denk mir für mich ist das eben die Behandlung, dass es mir körperlich besser geht und teilweise auch seelisch. (Fr. Huemer, 279-280)
[… I think for me it's the best treatment for my bodily well-being, but partly also concerning my mental well-being.]

Formatiert: Englisch (Großbritannien)

Leute die mich kennen wissen, dass sich das mache und wissen, dass es mir gut geht und haben auch meine Veränderung mit beobachtet. Wenn wir jetzt die ganzheitliche Veränderung hernehmen. (Fr. Friedrich, 431-433)
[People who know me know that I'm doing that and they know that I feel good and have observed changes as well. If we think of a holistic change now.]

Mrs. Rosenberger and Mrs. Friedrich consider preventive work as something very important.

In regelmäßigen Abständen hin, dass das nicht wieder schlimmer wird. Also schon als Prävention und Vorsorge, würde ich das jetzt nennen. (Fr. Rosenberger, 66-67)

[I go there in regular intervals to prevent worsening. Yes, I would say as a sort of prevention and precaution.]

…jetzt geh ich hin, weil ich weiß, dass das für mich gut ist, dass es wichtig ist, dass er vieles abfangt, bevor ich es, bevor ich es überhaupt check, dass es da ist. (Fr. Friedrich, 106-107)
[… now I go there because I know that it's good for me, that it is important, that it retains many things before I even realize that they are there.]

Moreover the aspect of life-satisfaction is dealt with in detail in question 3 and in the following subchapter concerning the model of Ryff and is furthermore backed by statements of my interviewees.

5.2.2 Well-being with respect to the model of Ryff (1989)

According to Ryff (1989) well-being is divided into six dimensions:

Self-acceptance
Positive relations to others
Autonomy
Environmental mastery
Purpose in life
Personal growth

Subsequently all dimensions are backed by quotations from my interviewees. Again these dimensions were not decidedly inquired but answers to the guideline questions (see appendix 1 interview guideline) yielded corresponding statements.

5.2.2.1 Self-acceptance

To rest in oneself without needing any external influences or distraction. Mrs. Friedrich depicts the time after the treatment as follows:

Ja ich geh jetzt einmal beschwingt die Stiegen hinunter ich geh grundsätzlich Stiegen hinauf und Stiegen hinunter und ich weiß nicht, wenn ich mich sehen würde, vielleicht würde ich lächeln, wenn ich raus gehe, (räuspert und überlegt), genieße das Befinden, auch im Auto, da brauch ich kein Telefon, da brauch ich kein Radio, da fahr ich einfach heim, mit mir und das ist schon immer so. Also das muss ich schon sagen, wenn ich weggefahren bin hab ich wirklich ein entspanntes Gefühl in mir gehabt. Aufgekratzt bin ich nie weggefahren. (Fr. Friedrich, 217-221)
[Yes, for one thing now I descend the stairs in a cheery and lively way, now I principally ascend and descend stairs and I don't know, if I saw myself I'd smile, when I go outside (coughs slightly and thinks), I enjoy this condition, also in the car, I don't need a phone, I don't need the radio, I just travel home together with me and that's always been like that. I have to say when I left there I always had a relaxed feeling, I've never left over-excitedly.]

5.2.2.2 Positive relations to others

People who live alone are very often forced to approach others and to relate with others. Verbal exchange, not only about therapeutic issues, is one important reason why Mrs. Moosbauer goes to her therapy.

… das tut mir sehr gut, weil ich ja, alleine im Haushalt leb und ich freu mich einfach, ja in Beziehung treten zu können mit jemandem und das ist ein Fixtermin, ja man spricht über alles mögliche, belangloses, wo ich selber den Eindruck hab, also hat mit der Krankheit überhaupt nichts zu tun, was halt so im Umfeld, daheim passiert und ja das freut mich schon. Ich könnte mir nicht vorstellen, ah in eine Behandlung zu gehen und das alles ausklammern. Zu sagen, ja jetzt wird das einfach behandelt und dann geh ich wieder zurück in meinen Alltag, also ich kann ihn schon mit hereinnehmen, und das tut gut. (Fr. Moosbauer, 227-232)
[… yes that really does me well, because I live alone and I'm just happy to relate with someone and that is a fixed appointment, yes and you talk about many things, trivial, unimportant things where I often have the impression that has nothing to do with the disease itself, what happens around, at home and yes, that makes me happy. I can't imagine to go to the treatment and to leave aside all these things. Just to be treated and then I go back to my daily routine. I can bring in my everyday life and that does me well.]

The aspect of social contact and positive relation with others seems to be a decisive factor for the feeling of well-being. Similar statements can be found in question 3.

5.2.2.3 Autonomy

Because her child has grown older, today Mrs. Friedrich can enjoy and let therapy linger much better.

Nein, am Anfang war ich eher knapp bei Zeit, da war mein Kind noch sehr klein, da hab ich immer geschaut, dass ich immer gleich heimkomme und dann war ich wieder mit meinem Kind, also, das genieße ich jetzt mehr, dass das jetzt besser nachwirken darf, also von der Zeit her. (Fr. Friedrich, 298-300)
[No, in the beginning I was always short of time, my child was really small then and I always made sure that I come home as fast as possible to be with my child, but now I enjoy that a lot more, that I can let it linger, I mean from a temporal aspect.]

For Mrs. Baumann this new therapy, i.e. osteopathy meant a new chance for getting rid of her complaints.

… ja ich hab mir schon gedacht, dass möchte ich ausprobieren und ich könnte mir vorstellen, nachdem ich schon einige Sachen sonst gemacht habe, dass mir das hilft. Nicht irgendwie eine übertriebene… wie beim lieben Gott, jetzt ist dann alles vorbei oder weg, das nicht, … (Fr. Baumann, 106-108)
[… yes, I thought I would like to try that and I could imagine, I mean after I'd tried so many things before, that that could help me. Not any exaggerated… you know, like dear God would, after that everything's over or gone, not like that…]

5.2.2.4 Environmental mastery

Joy of living and energy to tackle new things are particularly important for one patient. These emerged as soon as she was free from pain.

Lebensfreude, ich, also, das ist das wie ich es am besten definieren kann, dass ich sagen muss, dass diese Schmerzsituation weg ist, dass ich einfach wieder freudiger bin. Und also, dass ich mehr Sachen angehe, dass ich lustiger bin, dass ich auch mal gerne tanzen gehe oder so, und dass ich mich nicht mehr eingeschränkt fühle. (Fr. Krumpler, 304-307)
[Joy of life, yes, I think this is the best definition I can find. I have to say since these painful situations are gone, I've been much happier. And that I tackle new things, that I'm funnier, that sometimes I like to go dancing or things like that and that I don't feel restricted any longer.]

5.2.2.5 Purpose in life

According to Ryff purpose in life includes that personal needs should be satisfiable and aims should be achievable (Ryff, 1989). This is why Mrs. Friedrich pursues a “calmer” path after the therapy in order to let the impressions linger.

Wenn ich was angesprochen hab, was für mich zu klären war, wirkt das sicher länger nach, weil ich die Kommentare meines Therapeuten reflektiere, ja, also das, und ich halte sehr viel auf das was er sagt, menschlich hervorragend. Und sonst fahr ich entspannt einfach weg, egal wohin. In die Schule oder heim. Möchte nicht einkaufen fahren nach einer osteopathischen Behandlung. Also das ins Gewühle werfen, wenn ich das jetzt so überlege, das möchte ich nicht, mache ich auch nicht. (Fr. Friedrich, 290-294)
[If I addressed something I had to clarify for myself, that certainly lingers longer because I reflect on the comments of my therapist, well, yes, I think highly of what he says, really great on a personal level. And otherwise I always leave really relaxedly, no matter where I go. To school or back home, I would not like to go shopping after an osteopathic treatment, where it’s crowded, if I think of it now, I wouldn’t like to do that and I don’t do it.]

5.2.2.6 Personal growth

Human beings should experience themselves in constant development (Ryff, 1989). That this kind of development can be experienced positively on the one hand, but can also cause stress on the other hand is experienced differently by two patients.

Besser, weil ich`s dann angehen kann, wenn was kommt. Weil mir das bewusst wird, weil ich es mir bewusst mache und dann kann ich was tun. (Fr. Friedrich, 204-205)
[Better, because I know how to cope with it if something comes up. Because I’m aware of it, because I bring it to my mind and then I can do something.]

…das war zum Beispiel letztes Mal, im Training, im Thai Chi Training war`s so, da haben wir ein Fragment herausgenommen um das zu perfektionieren und da merke ich einfach schon, wenn ich das nicht 100%ig schön und korrekt mache, dass mich das einfach stresst. Und eigentlich sollte es ja rund sein und von unten rauskommen und da merke ich aber total, dass ich zumache, das meine ich mit Perfektionismus. Dieser Anspruch an mich, wenn der zu hoch wird. (Fr. Krumpler, 442-446)
[… for example during the last Tai Chi training, we took out one fragment in order to perfect it and I realize that it’s stressing me if I’m not able to do it 100% good and correct. Actually it shall be round

and emerge from deep down but I realize that I block, with my perfectionism. These personal claims, if they are too high.]

5.2.3 Well-being with regard to the model of current physical well-being by Frank (2003)

Actually there are seven items in this questionnaire on the current physical well-being developed by Frank (2003). However, in order not to go beyond the frame of this paper I decided to randomly single out five items in order to give the patients some "bits", some hints, for an easier answering of questions. These shall serve as support for the patients concerning their considerations and as a consequence also for their answers. Subsequently the results are assigned to these five items again, which are:

I feel a reduction of tension (for the category reduction of tension, pleasant tiredness)
I have the feeling that I can take off (for the category vigor and joy of life)
I feel that pleasant touch lingers (for the category feelings of enjoyment and pleasure)
I am liberated from pressure (for the category calmness and leisure)
I am content with my current bodily condition (for the category contentment with one's own current bodily condition)

5.2.3.1 I feel a reduction of tension

Actually all six patients consented to this item. They felt this reduction of tension already during the therapy, which lingered also after the therapy, depending on activity. Again the initial status of tension seemed to play an important role here, as well as how fast and how deep the relaxation was experienced (cf. current mental well-being – positive mood and

neurobiological model of von Kirsch & Gruppe (2007) – moderation of stress reactions)

5.2.3.2 I have the feeling that I can take off

Only two patients can reconcile with this statement right away and agree with it. Three patients associated with the image of a rocket and could answer merely by means of “yes and no“. Nevertheless these three patients could agree at least partly that they feel more energetic during and after the treatment. One patient simply answered with “no“, because she does not need this specific change of condition. She feels energetic and full of life anyway. Mrs. Friedrich explains why she answered with “yes and no“:

Grad das Aufgekratzte macht mich oft so handlungsunfähig. Also in einer aufgewühlten, aufgekratzten Stimmung könnte ich nicht durchstarten, da würde ich glaube ich den Faden verlieren. (Fr. Friedrich, 305-306)
[It’s just this over-excited state that often makes me incapable of acting. I mean in such an agitated, over-excited mood I couldn’t get anything accomplished, I couldn’t “take off”, I think I would lose the thread.]

5.2.3.3 I feel that pleasant touch lingers

All patients, except for one, could agree with this statement. But also in case of Mrs. Rosenberger the answer is not a simple “no”. She just states „*Merk ich mir nicht!*“ (309) [“I don’t remember!“] and says that she was generally already somewhere else in her thoughts as soon as she got up from the treatment couch. Which forms of touch rank among pleasant touching, according to my interviewees, can be read and compared in question 4 – “Which proportion does touching have in these changes?”

5.2.3.4 I am liberated from pressure

All patients agreed unanimously with this item. As far as I am concerned I think that the respective statements of Mrs. Moosbauer and Mrs. Friedrich are particularly interesting.

…ich weiß nicht, ob`s das Wort überhaupt gibt, so eine Gelenkshygiene, die sie da so betreibt. (…) dass dann einfach alles wie`s in der Wohnung ist, einfach alles durchgeputzt ist und sauber ist und dieses Wohlbefinden spür ich dann und denk ich mir, aha, das geht jetzt wieder. (…) Es ist dann eigentlich doch ein Druck, ja. Vielleicht so der Druck mit der unordentlichen Wohnung. Das könnte man so vergleichen. (Fr. Moosbauer, 377-378, 380-381 und 385-386)
[… I don't know if this word exists, for me it's a kind of joint hygienics that she is carrying out. (…) that everything is, similar to an apartment, everything is so cleaned through and tidy and then I feel this kind of well-being on the inside, yes, now everything works again. (…) Actually it's pressure, yes. Like pressure caused by an untidy flat. One could compare that.]

…egal was drückt, das lass ich dort. Ich bewundere das oft, weil`s wirklich oft, der eine geht, der andere kommt. Und also dass man das selber so aushält, als Therapeut. (Fr. Friedmann, 318-319)
[…not matter what kind of pressure it is, I leave it there. I admire that very often, one patient leaves the next patient arrives, a continual coming and going, that therapists are able to take that all.]

5.2.3.5 I am content with my current bodily condition

Although in principal all patients more or less agreed with this statement, some patients expressed restrictions, such as Mrs. Friedrich:

Ja, bis auf das was sowieso nicht passt, aber das was er gemacht hat…(lacht). Wo er mithelfen kann, ja das ist richtig, das passt. (Fr. Friedrich, 321-322)
[Apart from what is wrong anyway, but what he has done… (laughs). I mean where he can help he does and that's alright.]

Generally it was hard for the patients to comment on this item, as it was formulated in a rather general way. What should they include into "current bodily condition"? The interviewees were not sure whether they should refer only to issues that concern therapy or to a rather global condition. This question required further explanations on the part of the interviewer.

5.2.4 Well-being in regard to the neurobiological model of Kirsch & Gruppe (2007)

To mention it again, Kirsch & Gruppe (2007) differentiate three essential functions, which are not independent from each that are crucial for the development of well-being caused by the neurotransmitters oxytocin and dopamine.

Construction of close social contacts
Reduction of fear
Moderation of stress reactions

5.2.4.1 Construction of close social contacts

Establishing close social contact to the therapist seems to be normal for every patient over the course of a long-term therapy. Age difference does not play any role for Mrs. Baumann for establishing social nearness and binding. On the contrary, there are common topics of conversation.

Ich schätze ihn menschlich so sehr und wir haben eine gute Gesprächsbasis und so, aber nein, das kann ich nicht so einfach beantworten. Es ist einfach angenehm hinzukommen, weil ich einfach mit ihm gerne spreche, weil ich eine gute Gefühlsebene, obwohl er mein Sohn sein könnte, es ist einfach angenehm und ich schätze ihn sehr. … Aber zufällig haben wir dasselbe „Kreuz und quer" gesehen oder dann ergibt sich da wieder ein Gespräch und ich empfinde ihn halt sehr, sehr wertvoll. (Fr. Baumann, 122-125 und 191-192)
[I respect him highly and we have a good conversational basis and so, but no, I can't answer that so easily. It's just pleasant to be there, because I enjoy talking to him, because of a good emotional basis, although he could be my son, it's just pleasant and I highly respect him… I mean, for example we have seen the same "Kreuz und quer" (N.B. television program) and we had a conversation about that and I really, really appreciate him.]

Conversation, but also nearness and confidence seem to play an important role thereby (cf. question 3).

5.2.4.2 Reduction of fear

Due to the absence of pain, which was achieved by means of osteopathic techniques, Mrs. Krumpler found a new lease of life. Her fears, especially her fear for existence, stayed away.

…weil ich weiß, dass es was gibt, dass es nicht so was Festgefahrenes ist, (…) ich hab jetzt nicht die Angst, die Ängste, die hab ich nicht mehr, die Existenzängste hab ich eigentlich nicht, dass ich nicht mehr meine Arbeit machen könnte. (Fr. Krumpler, 290 und 292-293)
[…because I know that there is something, that it's nothing deadlocked, (…) I haven't got these fears anymore, these fears for existence, that I could become unable to do my work.]

5.2.4.3 Moderation of stress reactions

In our society everyone seems to have feelings of stress and this was also the case for my interviewees, who talked about stress again and again. Luckily Mrs. Huemer managed to get rid of her stomach troubles with the aid of osteopathy.

…ich hab früher wenn ich Stress gehabt hab, Magenbeschwerden gehabt, das hat aufgehört,… (Fr. Huemer, 68-69)
[… in former times I always had stomach troubles when I was under stress, that terminated…]

For her the initial status is important for stress reduction in therapy and views herself as a "regulator".

…bei mir ist es schon eher, hab ich Stress gehabt an dem Tag, oder ist irgendwie, zwickt`s irgendwo besonders, dann dauert`s normalerweise länger und bin ich mal völlig stressfrei und ist ein freier Tag, dann ist es nach fünf Minuten, das ist rein von mir abhängig. (Fr. Huemer, 236-238)
[… in my case it's somehow, when I was under stress that day or something like that, it's especially pinching somewhere, it normally takes longer but when I'm stress-free and I have a day off it takes only five minutes, that totally depends on me.]

To come to the appointment punctually, the stress of the daily routine but also to look after the children and heavy work-load are important factors

concerning the patients‘ stress sensation. In one case it was also stress that caused visceral complaints.

5.3 Results Question 3

5.3.1 Model of health-related quality of life according to Patrick & Erickson (1988)

According to Patrick & Erickson (1988) health-related quality of life is partitioned in four contentwise areas (see chapter 3.2.1. Origin and definition of quality of life).
I adapted these areas as issues to assign them practically by examples of the interviews.
The issues are the following:

Disease-related bodily defects which are considered by many patients as the main cause for restrictions of quality of life.

Mental health in the sense of emotional state of mind, well being in general and life-satisfaction.

Disease-related functional restrictions in everyday life like job, household and spare time.

The configuration of interpersonal relations und social interactions as well as the disease-related restrictions in this area.

5.3.1.1 Disease-related bodily defects which are considered by many patients as the main cause for restrictions of quality of life.

Not only “structural” diseases or disturbances like for example at the spine restrain quality of life of my interviewees. Mrs. Baumann is definitely aware of her visceral problems:

Was ich schon auch weiß, weil ich TCM ausprobiert hab, und das glaub ich schon, dass ich eine Schwachstelle, wie wir alle gewisse Schwachstellen irgendwo haben, und ich glaube, das ist bei mir schon Niere und Blase und ich glaub, da hilft er mir auch irgendwie. (…) Naja, das mit dem Beckenboden war mir eigentlich schon bewusst…
(Fr. Baumann, 70-72 und 100) ["I already know that since I tried TCM, and I suppose I have a weak point, like everyone has such weak points somewhere, and I think mine are kidney and bladder and I think, he also helps me in this case. (...) Well, I was aware of the thing with the pelvic floor...."]

Mrs. Moosbauer reports about perceptions when she feels pain:

Hängt dann mit der Tagesverfassung zusammen, mit den Umständen und (Pause) wenn ich wirklich wieder mal recht Kreuzweh hab, dann wird schon alles mühsam. (Fr. Moosbauer, 396-397)
["It is connected to the daily constitution, the surrounding and (stops) when my back is hurting a lot, then everything gets very tiring."]

5.3.1.2 Mental health in the sense of emotional state of mind, well being in general and life-satisfaction.

A patient tries to describe well being in general this way.

Wohlbefinden…ja einfach in meiner Haut mich wohl fühlen, ich kann`s eigentlich eh nicht anders sagen. Und vielleicht auch einmal all die Dinge, die einem sonst so ein bissl sehr blockieren, einfach mehr Loslassen können. (…) Ja, Wohlbefinden in mir selber. (Fr. Baumann, 217-218 und 226)
["Well being...just to feel comfortable with myself, I cannot describe it any better. And also just to let things go, that normally block you. (...) Yes, well being within myself."]

Because of the pain, Mrs. Krumpler had a massive sleep deficit that in the end also affected her mind:

Das war bestimmt so, wo ich einfach nicht mehr so belastbar war durch diesen Schlafdefizit, den ich gehabt habe. (Fr. Krumpler, 123-124)
["It was surely like that, I was not so resilient anymore because of the sleep deficit I had."]

Which further restrictions affected everyday life, job and spare time because of disease, should be displayed within the following issue. Thus it

is quite obvious how tight-knit those partial aspects of well being, life-satisfaction and quality of life are.

5.3.1.3 Disease-related functional restrictions in everyday life like job, household and spare time.

Mrs. Krumpler was not only restrained within spare time.

Das der Schmerz sich so eindämmt, dass ich meinen Sport wieder machen kann. (Fr. Krumpler, 71-72)
["That pain is so far contained that I can do sports again."]

She also talks about fears and restrictions concerning everyday life and job.

…dass ich Angst gehabt habe, dass ich meine Arbeit nicht mehr machen kann, weil wenn man manuell arbeitet und man hat immer in dem Bereich Schmerzen, dass war schon für mich bedrohlich, sag ich mal. (…) Für den Alltag war`s so, dass ich mir gedacht habe, es hemmt natürlich, weilst ja ständig mit dem beschäftigt bist, oder ich hab ja nicht mehr schlafen können in der Nacht. Und das war einfach von dem her eine Beeinträchtigung, weil man schon überreizt wird. (Fr. Kreuzer, 110-112 und 116-118)
["...I feared that I could not do my job any longer because if you work manually and you have pain in this area, it was threatening for me, I would say. (...) In everyday life I thought it would hinder me since you deal with it all the time or I was not able to sleep during the night. And it was a restriction for me insofar as I became more and more petulant."]

Another patient could not follow her hobbies anymore like for example skiing.

5.3.1.4 The configuration of interpersonal relations und social interactions as well as the disease-related restrictions in this area.

The social closeness and interpersonal relations have already been discussed in the previous issues (see question 1 and 2). Finally I want to mention a statement of Mrs. Baumann, who can impact positively on her social surroundings because of the strength she got from the osteopathic treatment.

Aber ich glaub schon, weil ich dann doch die Kraft habe, dass ich anderen Menschen helfend zur Seite stehe und dass mir das dann doch auch gelingt. (Fr. Baumann, 231-232)
["But I do think, that I have the strength to help other people and that I can do so successfully."]

According to that, osteopathic treatments benefit that patient as well as their surroundings.

5.4 Results Question 4

5.4.1 Touch

As mentioned in the theoretical part of this paper (cf. Nathan (2001), Wyschogrod (1981), Adams (1997)) this aspect is not negligible as a "healing factor" in osteopathic therapy. Touch happens on many different levels of the human body, the physical as well as psychic level, whereby for Mrs. Rosenberger „*einfach jeder Griff eine Wohltat (ist)*" (188) ["just every grip is a blessing"]. Thereby for one thing the way of touch and for another thing the technique influences the patient's sensation.

…die Monika hat eine Gabe einen Menschen, (…) so langsam und sanft und doch kräftig gleichzeitig zu berühren und zu nehmen und zu halten, (…) das ist ein Gefühl und eine Geborgenheit und eine Sanftheit (…) Wie gesagt, die Langsamheit, das Sanfte und trotzdem das Feste. Und was mir körperlich besonders gut tut sind auch so Schieben von Gewebe, so Tauchen und Ziehen, oder auch das Gehaltensein am Kopf, im Nacken, es ist einfach so vielfältig.
(Fr. Rosenberger, 171-176)
[… Monika has a gift to touch someone (…) so slowly and softly but at the same time forcefully and to take and to hold, (…) that there is such a feeling of security and gentleness (…) As I said the slowness, the gentleness and also the fastness. And what does me really good is that kind of moving the tissue, a sort of shifting and dragging, or being held on the head, in the neck, it's just so manifold.]

Two patients state that they have no fears of contact at all. For Mrs. Friedrich osteopathic treatment and touch on a therapeutic level have become as important as brushing her teeth.

Also ich hab keine Berührungsängste, generell nicht und das ist eine therapeutische Berührung, das hätte ich noch nie anders gesehen. … war dankbar, dort gewesen zu sein und glücklich, also ich gehe gern, das ist wirklich wie Zähneputzen, oder wie ich meine Zähne putze, ja, 2 3 mal am Tag, so gehe ich alle paar Wochen zum Osteopathen.
(Fr. Friedrich, 260-261 und 270-272)
[Well, I have no fears of contact, generally not and this is purely therapeutic touch, I would never have regarded that as anything else… I was grateful to have been there and happy, I like to go there, really that is like brushing my teeth, in the same way I brush my teeth twice of three times a day, I go to see the osteopath every couple of weeks.]

Und ich glaub nicht, dass ich da ein Manko hab von Berührungen her oder auch Berührungsangst auch dann zu anderen Leuten. ... Das Berühren tut gut und das kann ich mitnehmen. Mit hinausnehmen von da weg. (Fr. Moosbauer, 357-358 und 344-345)
[And I don't think I have any shortcomings in this respect, any fears of contact or so, not with other people either… Touch is pleasant and I can take something with me. Take it with me from there.]

Two main aspects the patients mention, which can also be related to a theory that regards touch and being touched as deep and first touch, are the following ones:

Berührung, ja einfach ein Geborgenheitsgefühl, löst das auch aus, angenommen sein, fallen lassen können, ja ganz, ganz verschiedene Dinge. Ja, ich denke schon, dass das ein ganz wesentlicher Faktor der Heilung sein kann. Und sein wird. (Fr. Baumann, 356-357 und 354)
[Touch, yes that triggers such a feeling of security, to be accepted, to be able to let oneself go, yes many different things. Yes, I think that can be a crucial factor concerning healing. And it will be.]

Sich-fallen-lassen zu können, das bewirkt das bei mir, wenn wer den Kopf gut angenehm, nicht fest, aber gut angenehm hält, dann ist das, dann hat das mit Fallen-Lassen zu tun, auch Vertrauen… (Fr. Krumpler, 458-459)
[To let myself go, yes that happens if someone holds my head in a pleasant way, not too strong, but in a good and pleasant way, that has to do with letting myself go, also with confidence…]

Furthermore Mrs. Krumpler associates touch with an improved bodily perception.

…die körperliche Wahrnehmung wird besser durch Berührung, von dem gehe ich einfach aus, (…) dass sich auf der psychischen Ebene sehr viel lösen kann, durch körperlichen Kontakt, dass das einfach die Wahrnehmung schult, die körperliche Wahrnehmung. (Fr. Krumpler, 450-452)
[… bodily perception improves by touch, that's what I assume, (…) that on a mental level very much is released by means of bodily contact, that it trains perception, bodily perception.]

As a conclusion I would like to cite the quotation from Nathan (2001) once again:
„Sich selbst zu berühren, bedeutet auch berührt zu werden" (p. 121)
["Touching oneself also means being touched."]

Mrs. Moosbauer seems to be aware of the meaning of these words as well, however, uses them the other way round.

Ich glaube, ich kann es deswegen, weil ich Berührungen empfange, dass ich auch selber dann berühren kann, ich glaub das ist, das eine bedingt das andere, sonst glaub ich wenn das einseitig ist, dann geht`s nicht. (Fr. Moosbauer, 369-371)
[I think I can because, because I receive touch, also touch myself, I think that the one causes the other, otherwise, if that was one-sided that would not be possible.]

6 Discussion

“Osteopathy – the way from therapy to prevention“

From this heading, which is also the title of the study at hand, two essential terms can be read out, therapy and prevention. Two factors of the health care system which I, as a practicing therapist, regard as possibilities and chances for our profession.

Ulrich (1989) mentions three specifications of prevention, which are primary, secondary or tertiary prevention. „Die primäre Prävention soll dabei die Wahrscheinlichkeit vermindern, dass (psychische) Störungen überhaupt auftreten, Leidenszustände überhaupt entstehen können. Zur Senkung der Auftrittswahrscheinlichkeit muss man die potentiell schädlichen Lebensumstände bekämpfen oder verändern. Die sekundäre Prävention richtet sich auf die möglichst rasche Erkennung und möglichst frühe und wirksame Behandlung von bereits entstandenen (psychischen) Problemen, um dadurch die Dauer und Häufigkeit von (psychischen) Störungen zu vermindern. Sekundäre Prävention umfasst also auch Diagnostik und Therapie. Tertiäre Prävention soll helfen, die Folgeschäden von (psychischen) Störungen zu vermeiden oder zu verringern, also Therapieerfolge zu stabilisieren und Rückfälle zu vermindern“ (p. 206) [“Thereby primary prevention shall prevent the rise of (mental) disorders, states of sufferings in the first place. In order to lower the risk of arisal, potentially harmful circumstances of life have to be fought or altered. Secondary prevention aims at a preferably early and effective treatment of already existing (mental) problems in order to decrease duration and frequency of (mental) disorders. Thus secondary prevention also consists of diagnosis and therapy. Tertiary prevention shall be an aid in preventing or reducing consequential damages of (mental) disorders, i.e. to stabilize therapeutic success and prevent relapse.”]

Now, according to this, into which of these three categories falls osteopathy applied by osteopaths in freelance practice? Despite all obvious advantages of preventive measures, our (psychosocial) health

care system is primarily curative, i.e. oriented towards – sustaining – healing (Pfingsten, 1985, p. 140). This becomes obvious from my results as well. All patients that took part in this study consulted therapists because of complaints, most often this was pain. For me that means that all interviewees were treated by their therapists only concerning the second step of prevention, in terms of the definition developed by Ulrich (1989).

From a critical perspective the question arises where “health” has its place in this model. In the theoretical part of this paper (cf. chapter 2.3.) health is regarded as important aspect of life-satisfaction. Contradistinctive to the Asian world, in Europe people only consult a physician or therapist if disease has already appeared, i.e. if the first step of prevention has already been left. In contrast to that stands the “medicine“ that comes from China or Japan, which aims at preserving the patients’ “health“ before symptoms even appear. Thus this kind of “medicine” corresponds to primary prevention (Chen, 2005).

After these critical considerations concerning prevention, the main results from question 3, which asked: “Which significance has the quality of life and all its corresponding changes with regard to the osteopathic treatment?“ shall be presented.

For some interviewees disease meant a change of life situation, due to the osteopathic treatment certain further changes in different sensitivities came along as well. Does that allow the conclusion that osteopathy is not only a bodily therapy for patients, but has furthermore led them to an altered “concept of life”? This question can be backed by the following quotation from von Dunn (1984) very well: „Die Wirkung der physischen Handlung. Die Tatsache, dass der Osteopath am Körper des Patienten „etwas tut“, hat neben den rein physiologischen Reaktionen, die aus der manuellen Handlung heraus resultieren, auch einen psychologischen Effekt. Jeder von uns hat eine geistige Vorstellung von seinem physischen Körper. Psychiater sprechen hier vom „Körperschema“. Im Verlauf einer therapeutischen Behandlung sieht und fühlt der Patient eine Veränderung

in der Körperstruktur, was zu einer positiveren geistigen Vorstellung von sich selbst führt“ (196-199).

[The effect of the physical action. The fact that the osteopath “does something” on the body of the patient leads to, besides mere physiological reactions, which result from the manual action, also to a psychological effect. Every one of us has a mental imagination of his/her physical body. Psychiatrists call this the “body scheme”. In the course of a therapeutic treatment the patient sees and feels a change in the body structure, which leads to a more positive mental imagination of him-/herself.]

Life-concept in the sense that the interviewees deal more consciously with themselves and their own body and, as mentioned before, “allow themselves something” and certainly listen more carefully to their inner voice concerning overload, stress and possibilities of finding a balance. For all the interviewees the osteopathic treatment means a possibility of alleviating stress and to cope better with the strains of everyday life, job or leisure time. Statements such as to unload, to let go, or being held show that patients have incredible confidence in their therapists. This becomes apparent from the interviews as well. Thus social contact and nearness is a crucial factor for long-lasting, long-term therapy.

With regard to the three steps of prevention developed by Ulrich, the interviewees mainly class among the third step of tertiary prevention. In my opinion they could also be classified among the first step of primary prevention, as by means of long-term therapy also other levels of the body are treated and thus a “breeding ground” for a “healthier and more conscious lifestyle” is created.

At the beginning of my literature research I was not aware that my interviewees are already on the “second step of prevention”. In my mind the terms therapy and approach to therapy was closely related to “disease” and not so much to the term “health”. Thus with the wisdom of hindsight the title of this paper should be probably changed or at least critically questioned concerning its validity.

With regard to the choice of examination methodology every interviewer should bear in mind that planning and conducting a sequence of interviews might be a rather time-consuming examination procedure. However this method is very much oriented towards reality concerning the presentation of problems. Acquisition of interviewees might be complicated due to various reasons. It has to be stated that it requires a great deal of compliance on the part of the patients. Several problems concerning acquisition and forming an appropriate experimental group might be the enormous amount of time an interview takes, comfort or laziness or restraint when it comes to talking about personal things or experiences. In particular for this examination it was important to ask patients several questions about very personal experiences they made in therapy.

On the one hand it may be an advantage to personally know the interviewees, because the initial blockade to talk about personal things may not be there. On the other hand exactly this close contact could be an impediment because patients could be afraid that the interviewer might give away information they have revealed in private. This problem can be solved by ensuring anonymity again before the interview. In my perspective it is a useful tactic of introducing the topic to the patients, to let them fill in a personal data form before the interview which also serves for creating a conversational basis. During the interview itself test persons should first of all answer more general questions, e.g. in this study questions about their personal access to osteopathy or about their complaints. Subsequently by means of the actual interviews it was possible to gain insights into their personal experiences with and by the osteopathic treatment. In the interviews they not only revealed their bodily states and corresponding changes but also pointed out that in therapy also psychic components surface which are seized by the therapists and “treated” in accordance with their possibilities.

It has to be mentioned critically that for this examination only female interviewees could be acquired. Thus the question emerges whether male

test persons would have shown the same readiness to talk? In how far does gender play a role here? In a further examination this gender aspect could be taken up.

The most important results concerning question 1 “Which aspects are to be expected from the illness, the osteopathy, the therapist, the therapy and the environment of long-term therapies?” are the following ones.

The interviews indicate that all interviewees have a very conscious approach to their body in its wholeness. Evidence therefore seems to be that they all want to “allow themselves” something and also pursue this want. Furthermore this becomes apparent from the fact that they have all tried already several different therapies. All patients agree that currently osteopathy is the right treatment for them. This was confirmed in the interviewees by means of the answers to the questions concerning their contentment with the therapist and the therapy per se. These statements can be compared to the written thoughts of Nathan (2001) in the theoretical part of this paper. He states, and regards his statements as generally valid, that the therapist hopes to contribute to a better self-image and self-esteem, as well as to an improved well-being on the part of the patients by means of their positive experience of the therapists touching. Therefore it is essential that touching is carried out in an attentive, sensitive, trustful, competent and respectful way. The results from the interviews grant the osteopathic treatment, the therapist and the environment a significant influence concerning changes of the disease symptoms. However, it has to be remarked critically that all patients have undergone other treatments simultaneously or consecutively as well. Thus it can only be assumed, either by me or by the patients themselves, which therapy actually brought about change. Furthermore one has to bear in mind that this examination is in part a retrospective one. Not only “life” has influenced the patients in the course of these years, also the personal development seems to be an important factor that has contributed to changes concerning well-being and disease. Two patients that participated in this study started training in the field of life coaching and mediation.

Certainly this influence cannot be neglected in the discussion concerning additional influences.
For a further study it would be probably interesting to interview patients who have not undergone any other therapy or to additionally interview a “control group” of patients that have undergone another body therapy except for osteopathy. Based on my study it would be probably interesting to conduct further research in the form of a long-term study that could reveal possible differences of all factors of efficiency and changes, especially concerning well-being, caused by osteopathy over the course of several years. In such a study one question could address the changes patients experience after 2, 4, 6 or 8 years.

The most important results concerning the second question “Which significance has the feeling of well-being in this?” can be described on two levels because the definition of well-being according to Becker (1991) differentiates well-being into mental and physical well-being with all its corresponding subitems as well. On a mental level the interviewees experienced many different positive moods and feelings during, but also after the therapy. They mentioned a reduction of fear, joy as well as a feeling of happiness. Depending on the technique used by the therapist patients relax very quickly and partly even fall asleep. On a physical level therapy achieved a freedom from pain, a freedom from complaints and even a retardation of a big operation of the knee with an unchanged quality of life. Here as well the aspect of social nearness was an issue, which can be also read in the results of the third and fourth question.

In order to summarize the main results of the fourth question “Which proportion does touching have in these changes?” I would like to add a further question. Which factors make osteopathy so efficient? Is osteopathy, in contrast to Dunn’s opinion, only a placebo? According to Waddell (1987) improvement, or even healing, does not arise from procedural, but from expressive, healing touch, i.e. transferring healing.

Thus the therapist is experienced as somebody who is omniscient, competent and attentive.
Do we, as students, simply believe in the treatment models lecturers confront us with without critically questioning them? With regard to my scope of work I will try to be more attentive concerning the way I touch and treat patients on the one hand and concerning the conversations that emerge during therapeutic sessions sometimes more sometimes, less on the other hand. Critically questioning means in this respect also whether we, as osteopaths, receive the right training. To think over our classes is certainly necessary at this point. We, as osteopaths, can surely not replace the profession of psychotherapists; a claim I certainly do not want to rise. However, communication skills are definitely an issue that should be paid attention to during training as well as later in practice.

Throughout all my interviews only one patient talked about the “money” she had spent on therapy over the years. To talk about money in connection with health and therapies still seems to be tabooed. Personally I regard myself not only as a therapist but also as a business woman who aims at working as economically as possible. And this is the next topic that certainly still has to be investigated: the economic viability and cost-benefit-ratio of long-term therapies. Many osteopaths still invoice their therapies as medical gymnastics, i.e. the patient has the opportunity to charge back therapies from the health insurance. In how far do these long-term therapies contribute to a decrease of sick leaves, retard operations or prevent “bigger” diseases? An issue that could certainly be investigated in a further master thesis.
To come back to Ulrich’s thoughts on prevention, osteopathy should unite social, economical and ecological ideas in order to answer the expectations of primary prevention.
All in all I am grateful that my interviewees provided me an insight into their experiences with and changes due to osteopathy. My mind was broadened in so far, as seemingly irrelevant trivialities that are mentioned

only in passing very well play a role concerning therapy and its success. The human being behind the osteopath is certainly decisive during such a long-term accompaniment that very often develops into friendship.

The summary in the fourth and last chapter shall finally draw an arch between theoretical and practical dedication to the topic of well-being, quality of life, life-satisfaction and touch as well as the possible influences on these aspects due to long-term osteopathic treatment.

7 Summary

In the search of the “right” therapy for their diseases, my interviewees have a long way of suffering behind them. Diseases like tinnitus, pelvic floor complaints, spinal problems, headache or arthrosis surfaced (chapter 5.1.1). Depending on their openness towards holistic medicine, they undergo various forms of therapy, sometimes also at the same time to get relief or bettering of their complaints. Forms of therapy like tuina, shiatsu, acupuncture massage, singing bowl therapy have been tried by my interviewees as well as massages or classic physiotherapy (chapter 5.1.2.). The approach of the persons concerned to osteopathy is very different. From medical referral, to the physiotherapist to word-of-mouth recommendation or if it happened accidentally to start a therapy (chapter 5.1.2) that dates back between two and a half to eight years regarding the patients (chapter 5.1.4). The desire and expectation of my test persons towards therapy or the therapist are mainly “cure” or bettering. Most of them already knew the term osteopathy but not how we osteopaths create our therapy sessions. Some of the interviewees also mentioned that they did not really know what to expect before the first session (chapter 5.1.2). Further, they experienced the sessions very different, depending on the current complaints, the frequency of sessions or on the time of day when treatment was applied. The experienced perceptions often vary within intensity whereas the initial condition of the patients plays an important role (chapter 5.1.4). The comforting relaxation, tiredness, freedom of pain but also the energy within during and after the therapy are only a few of the physical and psychic expressions patients report of (chapter 5.2). The tenor for all the interviewees through the long-time company of the osteopath is primarily the topic “well being”.

The second question of my piece “Which status has the feeling of well being in long-time therapy?”, can be considered as an essential element.

The construct well being in its various peculiarities has been analysed in different areas of research, psychology, medicine but also social research

within the American as well as the German region. A clear definition for the various facets of well being is not yet existing. Nevertheless there are some important proponents within this area like for example Becker, Ryff, Frank or also Kirsch & Gruppe, just to name some of them. Models of this researchers have pointed out within the theoretical part and backed up with statements of the interviewees. Becker (1991) divides well being in mental and physical well being whereas he furthermore divides into current and habitual well being. The habitual mental and physical well being is again divided into a habitual life-satisfaction with mental and physical peculiarities. Both slip into the umbrella term of general and area-specific life-satisfaction.

Ryff (1989) belongs to a flow coming from the American region. He defines well being in six dimensions, self-acceptance, positive relation to others, autonomy, environmental mastery, purpose in life and personal growth. The personality of the human being with his interaction is expressed very good within this model (chapter 3.1.1).

Models of Frank (2007) about the current physical well being and the neurobiological model of Kirsch & Gruppe (2007) explain on a physical and neurobiological level the formation of well being (chapter 3.1.2 and 3.1.5.). Especially for the neurobiological model the existence of touch and its positive estimation already in the womb is essential. Later close social relations and the closeness to familiar people drastically form the perception of well being and life-satisfaction (chapter 3.1.3 and 3.1.5).

The factor of touch within the osteopathic treatment must not be disregarded. The close connection between touch and being touched is shown by Nathan (2001). As well as the different effectiveness of therapeutic touch whereas he sees on the one hand the expressive, healing touch and on the other hand the procedural touch (chapter 3.4). My interviewees enjoy the touch of the therapist, the warmth of the therapist's hands or the feeling of being hold at the head. Various techniques trigger different states. Pressing painful points within therapy is afflicted with the tolerance of the patient in this context (chapter 5.4).

To draw a range from the beginning to end of this piece is not easy. In my opinion the basic question “Why do patients attend therapy over the course of years although the primal problems ceased to exist?” could be answered by evaluating the interviews. The more difficult it is for experts to define well being, life-satisfaction or quality of life, the easier it seems for the interviewees to express this term but also the perceptions connected with them. That certainly argues for the settling of theoretical models near reality and that the actual peculiarities of well being are well recorded and represented.

Because of the various diseases of the interviewees restrictions of well being, life-satisfaction and quality of life appear. Restricted mobility, fears, sleep deprivation, restriction within everyday life, spare time or within the job, as well as decreased social contacts because of the disease are experienced by these patients. All of them report on pain, in most cases this led them to the osteopath (chapter 5.1.1 and 5.3). The surroundings of the interviewees has the lowest significance and influence on “cure” whereas light, friendly, clean, ample rooms have been remarked positively (chapter 5.1.5).

It is crucial that the osteopathic therapy con only have full efficiency in connection with the therapist (chapter 5.1.2). Concerning therapy pain reduction, improvement in mobility, in physical or psychic area or an obvious diminution of medication is cited (chapter 5.2).

Depending on the technique the therapist is carrying out, the interviewees report about relaxation up to sleep, a physical well being, warmth or floating, just to name physical indications. Because of therapy, operations could be retarded for years during the same level of quality of life. Concerning the psychic part, happiness, reduction of fear, joy of living or energy are named. Also tears of joy because of bettering or just out of a moment of happiness were experienced by the patient and also mentioned within the interviews (chapter 5.2).

Not only the techniques affect the success, also the personality of the person treated has to be regarded. Some people of my study talk about

that by mentioning their own mentality and reason their statement by saying that they like to stay at the therapy if they are content with the treatment or the therapist (chapter 5.1.3 and 5.2).

This leads to the second component of the osteopathic efficiency, the therapist him- or herself. All models of well being, life-satisfaction and quality of life that have already been mentioned refer to the importance of social contact as a factor of dimension. The interviewees consider the therapist as personality as the biggest possible influence within the “osteopathic trefoil”, osteopathic technique, surroundings and therapist. The sex of the therapist is experienced differently, depending on the complaints. Gentleness is mostly awarded to women. All interviewees agree in the fact, that they got support and understanding from the therapist, not only concerning the disease but also the whole life situation. Talking is the base for deep trust in the therapist, as it has already been displayed in chapter 5, the discussion. Trust and the feeling of social closeness let the patients feel sensations like emotional letting go, letting fall or feeling kept during the single treatments. Over the course of years a close friendship between patient and the therapist, which is rather concerned as furthering than hindering the therapy (chapter 5.1.3).

The long-term osteopathic accompany implicates a change within the personality of the majority of my interviewees. This paper tries to verify the claim that osteopathy not only influences on a physical level but also the psyche. During the recordings the patients report on a change in mind and self-acceptance for the own body. The increased energy of life, which before vanished during working up the disease, is used to reach personal aims and wants, to allow oneself a treat. Therefore Ryff (1989) uses the terms purpose in life and personal growth (chapter 3.1.1 and 5.2).

Due to the collected data there seems to be a distinct consensus why these patients still attend the osteopath although their primal problems ceased to exist. The change within state to a positive development. These states, that implicate well being and a physical, psychic and social level, quality of life and life-satisfaction, seem to be this effective that the

interviewees do not spare temporal expenditure nor expenses to prevent concerning prevention.

I want to finish this work with a statement of an interviewee which I consider as a very beautiful compliment to us as osteopaths:

> Ja, ich bin immer wieder erstaunt, von eurer Kunst, wie ihr doch immer wieder den richtigen Punkt findet, das ist für mich immer phänomenal. Das ist wirklich, dass ich mir denke, das dürfte es heute gerade wieder gewesen sein. Oder nicht nur heute, sondern vielleicht gerade im Moment. (Fr. Baumann, 257-259) ["I am again and again astounded by your skills, how you find the right point every time, that is really phenomenal. That's really, that is what I think, it might have been exactly like that today. But not only today, perhaps right now at this moment."]

8 List of literature

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11 Appendix

Informationsblatt für Interviewpartner/innen

Wie Sie ja mittlerweile wissen, interviewe ich im Zuge meiner Masterarbeit mit dem Titel „Osteopathie - der Weg von der Therapie zur Prävention“ für das Masterstudium Osteopathie Patienten, die nach „Heilung“ ihrer akuten Beschwerden uns, den Therapeuten, als langfristige Patienten erhalten bleiben.

Um ein umfassendes Bild über die Beweggründe und eventuelle Veränderungen der Befindlichkeiten (z.B. Wohlbefinden) für und durch die Therapie zu gewinnen, ist es für mich wichtig Ihren ganz persönlichen Eindruck davon zu erfahren. Ich möchte Sie deshalb auch bitten, mir möglichst offen von den positiven, aber genauso von den negativen Erfahrungen die Sie im Laufe Ihrer Behandlungen vor allem in Bezug auf die Osteopathie gemacht haben, zu berichten. Mit Ihrer Hilfe können wir als Therapeuten vielleicht noch Verbesserungen in unserer Therapie erreichen und diese an Sie weitergeben.

In diesem Gespräch möchte ich Ihnen zuerst einige Fragen über Ihre Krankheit im Allgemeinen und den Zugang zur Osteopathie stellen. Danach würde ich gerne genauer auf die Veränderungen der Befindlichkeiten und soziale Komponenten der osteopathischen Behandlung eingehen.

Wenn Ihnen während des Gesprächs gewisse Dinge einfallen, die Ihnen wichtig erscheinen, und ich nicht genauer nachfrage, so möchte ich Sie einladen, mir auch ohne ausdrückliche Aufforderung von meiner Seite mehr darüber zu erzählen.

Die Tonbandaufnahmen werde ich selbstverständlich vertraulich behandeln, das heißt, dass ich Namen, persönliche Daten und Ortsangaben verändern werde. Haben Sie vor Beginn des Interviews noch irgendwelche Fragen?

Sozialblatt

1. **Wie alt sind Sie?**_____

2. **Geschlecht** weiblich o
   männlich o

3. **Wie groß sind Sie?**_____

4. **Wie schwer sind Sie?**_____

5. **Welcher Religion gehören Sie an?**_____

6. **Haben Sie einen Beruf erlernt?** ja o
   nein o

   Wenn „ja“**, welchen Beruf haben Sie erlernt?**

   _____

7. **Welche Tätigkeit üben Sie derzeit aus?**
   _____

8. **Sind Sie verheiratet? (**Familienstand**)**
   Sie sind also ledig, verwitwet, geschieden?

   verheiratet o

   ledig o

   geschieden o

   verwitwet o

9. **Haben Sie Kinder?** ja o
   nein o

Wenn „ja“**, wie viele Kinder haben Sie?**_____

Wie alt sind Ihre Kinder?_____

Interviewleitfaden

Zugang/Allgemeines:

Wie sind Sie zur Osteopathie gekommen?

Ist Ihr Therapeut männlich oder weiblich?

Spielt das für Sie eine entscheidende Rolle für die Behandlung?

Haben Sie nur einen osteopathischen Therapeuten gehabt?

Wenn nein, warum haben Sie gewechselt?

Wie oft waren Sie beim ersten Therapeuten?

Wie oft waren Sie bei den anderen?

Haben Sie vorher schon andere Therapien, in welcher Form auch immer, bekommen oder konsumiert?

Wenn ja, welche?

Finden diese noch gleichzeitig statt oder sind Sie beendet?

Wenn noch immer stattfindend, in welcher Häufigkeit?

Wenn beendet, warum nur mehr Osteopathie?

Krankheitsbild:

Welche Art von Erkrankung haben Sie?

Warum sind Sie primär zur Therapie gekommen?

Können Sie mir einen kurzen Überblick über Ihren Krankheitsverlauf geben, bevor Sie zur ersten Osteopathie-Sitzung gekommen sind?

Häufigkeit:

Wann haben Sie die erste osteopathische Behandlung gehabt?

Wie viele osteopathische Sitzungen haben Sie schon gehabt? (Gesamtmenge?)

In welchen Abständen gehen Sie zur osteopathischen Behandlung?

Hat sich der Abstand von Beginn an der Therapiesitzungen zu jetzt verändert? (Häufigkeit?)

Wie lange dauert eine osteopathische Behandlung? (Dauer?)

Zu Beginn?

Jetzt?

Wünsche und Erwartungen:

Mit welchen Wünschen und Erwartungen sind Sie zur Osteopathie gekommen? Physisch, psychisch, sozial, an die Therapeutin, den Therapeuten?

Befindlichkeiten:

Wie geht es Ihnen während Sie eine osteopathische Behandlung bekommen? Körperlich, psychisch, sozial?

Wie fühlen Sie sich nach der osteopathischen Behandlung?

Haben bzw. fühlen Sie sich von der Therapeutin/dem Therapeuten verstanden und unterstützt?

Wenn nein, warum nicht?

Befindlichkeitsfragebogen

Können Sie sich in diesen Befindlichkeiten einordnen?

- Ich verspüre nachlassende Anspannung. (Nachlassende Anspannung)
- Ich habe das Gefühl durchstarten zu können. (Vitalität/Lebensfreude)
- Ich spüre, dass eine angenehme Berührung nachwirkt. (Genuss/Lebensfreude)
- Ich bin von Druck befreit. (Ruhe/Muße)
- Ich bin mit meinem gegenwärtigen Körperzustand einverstanden. (Zufriedenheit mit dem aktuellen Körperzustand)

Welchen Einfluss denken Sie hat dabei…

- die osteopathische Behandlung an sich?
- die Therapeutin/der Therapeut?
- das Umfeld (Praxis, Service,…)

Wie geht es Ihnen zurzeit mit Ihrer primären Krankheit?

Sind im Laufe der Therapiedauer noch andere Krankheiten aufgetreten?
Wie lange dauerte es bis hier eine „Veränderung“ der Symptome stattfand?
Sind diese Krankheitssymptome verschwunden?
Sind sie zurzeit schmerzfrei?

Soziale Komponente/Wünsche/Verbesserungen:

Erzählen Sie Familienmitgliedern, Freunden, Verwandten von Ihren Therapien?
Wenn ja, welche Details?
Wenn nein, warum nicht?
Was würden Sie sich von Ihrer Therapeutin/Ihrem Therapeuten/für die Therapiesitzung/das Umfeld sonst noch wünschen?
Gibt es Ihrer Meinung nach Verbesserungs-, Veränderungsvorschläge für die Therapiesituation oder sind Sie damit zufrieden?

Translation for the model of Becker (p. 14)

Wohlbefinden = well-being
Aktuelles Wohlbefinden = current well-being
Habituelles Wohlbefinden = habitual well-being
Psychisches Wohlbefinden = mental well-being
Physisches Wohlbefinden = physical well-being
Aktuelles psychisches Wohlbefinden = current mental well-being
Habituelles psychisches Wohlbefinden = habitual mental well-being
Aktuelles physisches Wohlbefinden = current physical well-being
Habituelles physisches Wohlbefinden = habitual physical well-being
Positive Gefühle = positive feelings
Positive Stimmung = positive mood
Aktuelle Beschwerdefreiheit = current freedom of symptoms
Seltenheit negativer Gefühle und Stimmungen = scarcity of negative moods and feelings Häufigkeit positiver Gefühle und Stimmungen = frequency of positive feelings and moods
Aktuelle positive körperliche Empfindungen = current positive bodily sensations
Habituelle Beschwerdefreiheit = habitual freedom of symptoms
Habituelle positive körperliche Empfindungen = habitual positive bodily sensation
Habituelle Lebenszufriedenheit incl. psychischer Verfassung = habitual life satisfaction including mental health
Habituelle Zufriedenheit incl. physischer Verfassung = life-satisfaction including physical health
Allgemeine und bereichsspezifische Lebenszufriedenheit = general and area specific life-satisfaction
Freude = pleasure
Kompetenzgefühl = competence
Wohlbehagen = complacency
Entspannung = relaxation

Gelassenheit = calmness

Begeisterung = enthusiasm

Positive Erregung = elatedness

Flow = flow

Glücklichsein = contentedness

Angenehme Müdigkeit = fatigue

Vitalität = vitality

Lustempfinden = lust for life

Frische = freshness

Sich-Fit-Fühlen = to feel fit