Criteria to Determine Intervals of Treatment

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Eidesstattliche Erklärung

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Wien, 01.12.2008 Christina Halasz

Abstract

Christina Halasz: criteria to determine the interval of treatment in osteopathy

This study examines according to which criteria and on the basis of which concepts osteopaths decide when to make follow-up appointments for the patients' next treatments.

It is the aim to make transparent on which basis the decision about the interval until the follow-up treatment is taken. This should help the author in her daily work to make thorough decisions and to optimise intervals of treatment. With regard to the recognition of osteopathy as a profession in its own right in Austria this study should supply a basis for argumentation toward social insurance agencies.

To this aim, eight problem-centred interviews based on guidelines are conducted and evaluated on the basis of a qualitative content analysis (Mayring 1996). The interview partners' statements are assigned to categories and subsequently interpreted and put in relation with literature.

Results:

The point in time for a follow-up treatment has to be decided individually from patient to patient.

The follow-up treatment should only be applied when the reaction to the previous treatment has been completed and the patient has reached a state of homeostasis again.

To determine the interval of treatment osteopaths use their knowledge of sets of symptoms and diagnoses, constitution and psyche, palpatory information, the patients' verbal information, expertise as well as their therapeutic experiences, which they balance off individually.

The statements may be seen as the starting point for further research.

Choosing an approach of an explorative study makes it possible to have ample discussion on the subject, which has brought to light many aspects.

We may, however, criticise the fact that due to this variety of aspects a more thorough discussion and confrontation with literature has not really been conducted in some places.

Table of Content

1 Introduction

In the course of my personal osteopathic treatments as a patient I have made the experience that the intervals between two treatments varied between two weeks and three months, depending on the osteopath.
When I began actively working as an osteopath myself, the question of when to make follow-up appointments after first treatments arose for me as well.
In physiotherapy – my primary profession – the case is quite straightforward. Does my therapeutic approach consist of exercises in healing gymnastics the patient is supposed to come in at least twice a week in order to obtain successful treatment outcomes (Radlinger et al. 1998). Do I wish to mobilise a contracted joint I will make a follow-up appointment with the patient after two days as well (van den Berg 1999).
Knowledge from exercise physiology and tissue physiology is the basis of these decisions.
On which principles, however, do we make decisions in osteopathic treatment?

Krönke (2003) made a survey of what is current practice concerning osteopaths working in Austria.
It shows that 30 % of acute patients are mostly treated at intervals of one week, 23% at intervals of two weeks. Patients with chronic problems mostly come in again at intervals of two weeks (18%). These cases, however, show a much wider spreading between several treatments per week (13%) and six weeks (13%).

During my training a “tradition” of 2-3 weeks was communicated to me without, however, giving any good reason.
Neither does literature supply any study explicitly on this question.

Only in Dobler’s General Osteopathic Treatment do we find the recommendation to repeat treatment after 1-3 weeks, depending on the set of symptoms and examination results. (Dobler 2002)

Intervals of treatment have also varied in randomised controlled osteopathic studies of recent years – with Recknagel (2007) and Steffen (2007) , for example, they are two weeks, with Marx (2006) one week first, then, after three treatments, three weeks.
In the area of structural manual therapy Edwards (1994) refers to this subject in the context of the Maitland concept. However, he doesn't supply any basic principles either, but expresses an experience:

> *"A patient is treated over a period of 10 – 14 days without showing any perceptible changes concerning his symptoms and indications. A two week break in treatment would be advisable here as there are cases when recovery only begins in the third week. This happens quite often (….)." (Maitland 1994, S.155)*

Thus there are experiences as well as the recommendation to use sets of symptoms and examination results as guidance.

The objective of this study is to collect data about how osteopaths trained by the WSO and practising in Austria manage their intervals of treatment, which criteria they apply for it and which concepts serve as a background for these decisions. The results should make transparent the basic principles to make decisions about intervals for follow-up appointments.
In daily work this should help me – and eventually other osteopaths as well – to arrive at well-founded decisions and to optimise intervals of treatment.
With regard to the recognition of osteopathy as a profession in its own right in Austria it seems equally essential to me to clarify when and on the basis of which considerations patients are booked in for follow-up appointments. Currently Austrian health politics aims exclusively at reducing costs (Perndl 2007). In her master thesis Perndl (2007) considers it therefore essential for osteopathy to have to prove that it works "economically". Concerning intervals of treatment I regard it therefore as essential to supply a basis of clear argumentation toward our health system and also toward the patient. Each osteopath should be in a position to explain to her patient why she should come in again within a certain period of time.

The paper has been organised as follows:

- Chapter 2 puts the problem into more concrete terms.
- Chapter 3 describes the chosen qualitative examination method and the evaluation procedure.
- Chapter 4 describes and interprets results.
- Chapter 5 once again summarises the most relevant results.
- Chapter 6 gives an outlook, chapter 7 concludes the paper.

2 The Problem

The essential question of this paper is as follows:
According to which criteria do graduates from the WSO determine the point of time for their next treatment?

This is put into concrete terms by answering the following questions:
Which criteria are used?
On the basis of which theoretical concepts are decisions being taken?
How do we evaluate the intensity of a single treatment and a treatment stimulus respectively?
Which effect does this have on determining intervals of treatment?
What are the underlying experiences for the present intervals of treatment?

3 Methodology

3.1 Research perspective

I am assigning the method of problem-centred interviews and the qualitative content analysis to a constructivist perspective.

> *"Knowledge does not reflect an objective world but enables us to act in our world of experience and to pursuit goals. Knowledge must be appropriate but not be in accord with." (Glasersfeld 1991, 24)*

Building up knowledge is a constructive process of observers being anxious to construct things in a way which makes them useable for their survival (Förster 1999).

> *"The subjective is not a contrast to the objective, the real world, but represents a given moment in the construction of reality, the only one in which the individual disposes of a possibility to intervene (…). (Kaufmann 1999, 88)*

This paper describes and analyses from an observer's point of view what the interview partners report with regard to the problem. According to Förster (1999) this is an observation of second order. Analysis and interpretation are the constructive processes mentioned above.
In this paper an osteopath examines other osteopaths' perspectives (see also chapter 5).

3.2 The problem-centred interview (Mayring 1996)

For this study the method of the problem-centred interview was chosen which Mayring describes as follows:

> *"The interview lets the respondents speak as freely as possible in order to approach an open conversation. It focuses, however, on a certain problem brought up by the interviewer (…). The interviewer has already analysed the problem, he has developed certain aspects compiled in an interview guideline and addressed by him in the course of the conversation." (Mayring 1996, S.50)*

As literature is not very concrete on this subject, this method was chosen to collect the osteopaths' existing knowledge and experience.
The diversity of the therapeutic process, of the persons' individuality and of the cultural backgrounds was the reason to choose this qualitative approach in order to detect and discuss a maximum of these different criteria.

3.3 Design of the study

3.3.1 Interview guideline

In the course of a first debate on the problem, the discussion with colleagues and the study of literature a first draft of an interview guideline was developed. It was tested in a trial interview with a colleague in March 2008 and subsequently revised again.

At this point a short description follows. The whole content can be referred to in the appendix.
After some general questions on the person and occupation the real interview part starts by inviting the interview partner to describe her approach when deciding about follow-up appointments for a patient.
It is the objective to raise consciousness for the problem (Kaufmann 1999) and to come up with as many aspects of that decision as possible.
Subsequently, concrete questions are being formulated which I have assigned to the areas of

- treatment concepts (diagnoses, ...)
- person (patients' expectations,…)
- structure (available appointments, costs,…)
- general considerations.

These questions developed through my personal confrontation with the subject – a central point were the many informal personal conversations with colleagues and teaching staff.

3.3.2 Realisation

The interview partners were chosen according to the following criteria:

- Different federal states should be represented: in Austria “Health” matters are subject to state laws, i.e. osteopaths work under different basic conditions; effects on intervals of treatment were inquired about; 3 osteopaths from Vienna, 3 from Styria and 2 from Salzburg were interviewed; when it turned out after the first interviews that there is only a minor influence of state laws on the problem, the aim to cover all federal states was not taken into consideration any more.
- They should be graduates from the WSO: it was an underlying assumption that similar training implicates similar actions and therefore facilitates to derive a theoretical basis.
- At least 3 years of work experience following the final examination: interview partners should have enough practice for reflecting.
- At least 25% of the work should be done structurally: the reason was that, following my observations, osteopaths working mainly cranially or biodynamically manage their intervals of treatment in completely different ways; moreover, I found relevant literature on the subject only in the area of manual therapy and structural osteopathy respectively; in the course of one interview it turned out that one osteopath has switched to biodynamical work in the meantime; nevertheless, I have included her statements in my evaluation to find out if any differences would arise from this aspect with regard to the problem.
- The ratio physiotherapists/doctors among osteopaths in Austria should be reflected: Krönke (2003) shows in her study that 77% work in physiotherapy as their primary profession. 5 people working in physiotherapy as their primary profession and 3 doctors were interviewed.
- Availability: people I knew personally or were recommended to me were asked for an interview.
- Gender neutrality; 4 men and 4 women were being interviewed.

Contact was established through telephone or via e-mail.
The interviews were made in April 2008.
An MP3-player was used for digital recording.

3.3.3 Evaluation procedure

3.3.3.1 Transcription

The interviews were transcribed in two sessions by two persons. In the process the technique of “transcribing into normal written German” was employed (Mayring 1996), i.e. dialectal features were adjusted, mistakes in syntax were partially corrected, style was smoothened, filler words were eliminated. The interviews were made anonymous while gender was retained. The first person to transcribe the interviews had no medical training, nor did she have anything to do with osteopathy. I carried out the second session myself in the sense of a correction.

3.3.3.2 Qualitative content analysis according to Mayring (1996, 2000)

The evaluation of the transcribed interviews followed the method of qualitative content analysis according to Mayring.
For that purpose a system of categories, based on the interview guideline, was established and each of the statements assigned to those categories. After completing interviews 1 – 3 these categories were revised again and illustrated graphically. After that the final review of the material was done.
Subsequently the material was interpreted. The content is presented in chapter 4. Results are compared with literature and elaborated on in more detail where it seems appropriate.

4 Results

The table at the beginning gives an overview of interview partners and general information.
The graph gives a survey of the categories used for evaluation and their relationships.

In the following chapters the results referring to each of the categories are presented, analysed and interpreted with regard to the problem. At the end of each comprehensive category short summaries are given.

In Chapter 5 the most relevant statements have been summarised again.

4.1 Overview of interview partners

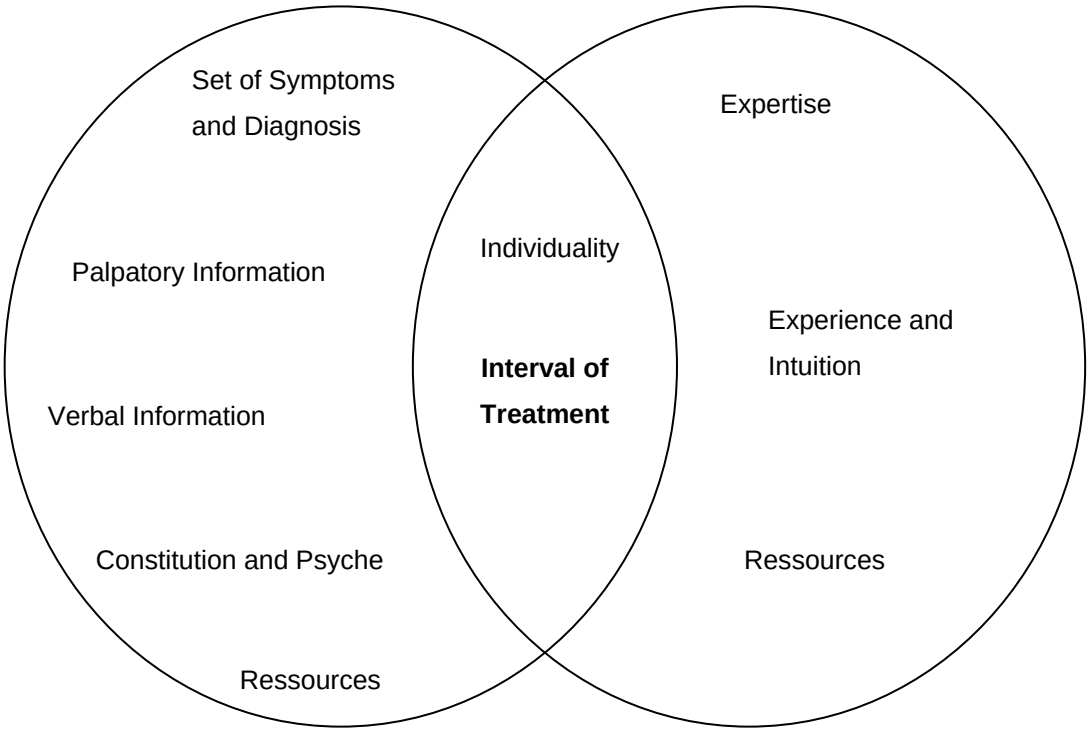
This table gives an overview of interview partners, their original profession and how long they have been working in it, further qualifications, to which degree they have worked structurally, viscerally, cranially and biodynamically respectively, gender and federal state. In the following text the interview partners are referred to by their abbreviations IP 1 to IP 8.

Table 1: Interview partners

IP	*Original profession*	*Duration of time working in original profession (in years)*	*Further qualifications, additional therapeutic offers*	*Ratio Structural: Visceral: Cranial/biodynamical*	*Sex*	*Federal State*
1	general practitioner	6	acupuncture, emergency doctor, TCM	40 : 35 : 25	M	Vienna
2	physiotherapist	10		balanced	M	Styria
3	specialist in physical medicine	3	Nowo Balance, acupuncture, Mc Kenzie, Brügger, Tilscher, electrotherapy	60 : 20 : 20	M	Salz-burg
4	physiotherapist	0	healing gymnastics	balanced	W	Styria
5	physiotherapist	0	trigger point, Sohier	35 : 35 : 30	M	Salz-burg
6	physiotherapist	7		25 : 25 : 50	W	Vienna
7	physiotherapist	1	healing gymnastics	30 : 30 : 40	W	Styria
8	specialist in physical medicine	3		20 : 0 : 80	W	Vienna

4.2 The categories

Figure 1: System of categories



All interview partners mention that decisions about follow-up treatments are taken in accordance with the patient. They are consequently the result of a dialogical construction of reality (Glasersfeld 1991). This means that a concordance between patient and osteopath is being established.

The intersection represents the contact, the relationship that serves as the background for decision-making.

The therapist then brings in her expertise and her experience and combines these with observations and information from the patient. Considering all resources the intervals of treatment are then being determined.

In the following chapters the statements concerning the single categories are presented. At the beginning I am describing the category and the statements referring to it, followed by the interpretation. There is a short summary at the end of major chapters.

4.2.1 Individuality of patient and therapist

The basic statement that intervals of treatment have to be determined individually from patient to patient turns up in all interviews.
Three aspects are addressed: the patient's individuality, the therapist's individuality and the individual evaluation of the categories still to follow (expertise, constitution, etc.).

4.2.1.1 Individuality of the patient

> *"Each patient who comes in is a different human being. Consequently, also the time intervals always differ. This has got to do (…) with the individual, with all his endogenous and exogenous factors."*
>
> *(IP 2, Z 166)*

I quote these lines, which represent many statements in the interviews, because they summarise the content best.
My interview partners have a holistic approach toward their patients and try to perceive all aspects of their personalities and to include them in their treatment. They don't simply search for anatomical and physiological disturbances of the body but are concerned with their patients' history and way of living.

> *„Each person is treated as a unique individual, not as a disease entity."*
>
> *(Seffinger et al. 2003, 7)*

Concerning the problem this means that it is not possible to determine a pattern of treatment, e.g. for a specific diagnosis like "Prolaps L5", or even decide how many treatments are required.

> *„Such (…) guidelines are often difficult to implement for osteopathically oriented physicians because they do not allow for the wide range of patient responses (...)." (Kuchera et al. 2003, 1150)*

An osteopathic context would not allow the possibility, a priori, to favour a certain medical theory (tissue physiology, bio-chemistry, psychology, …) as it is, for example, the case with physiotherapy. Healing gymnastics is prescribed at least twice a week, based on the knowledge of exercise

physiology (Radlinger et al. 1998), as exercise physiology states that else no stimulus that has an effect on training is possible (and some social insurance agencies only refund costs if there has been gymnastics with the physiotherapist twice a week). In osteopathy it is not possible to establish or derive such a rule as it tempts to take all levels of a person into consideration.

I would like to present a model from daily practice, used by IP 1 and IP3, as, in my view, it serves as a good example how to do justice to the individuality of a person even from the point of view of rising health costs. IP 1 and IP 3 ask patients with acute pains to call one or two days after their treatments and to report on their condition. It is only on the basis of this report that the follow-up appointment is being agreed upon. In these cases a lot of time and money, which an immediate follow-up appointment would cost, is saved and the patient's individual situation is still taken into account.

4.2.1.2 The individuality of the therapist

On the therapist's side my interview partners raise the aspects of expertise, experience and personality.

Expertise:

In Austria individuality on the therapist's side is also shaped by the structure of osteopathic training. Entry requirements are a degree in physiotherapy or an advanced stage of medical studies. So osteopaths already introduce a different job image, experience in medical work and further training (physiotherapy, Traditional Chinese Medicine, Bach's flower therapy, etc.) into their osteopathic activities. Krönke's study indicates that over 60% of Austrian osteopaths offer physiotherapy as well (Krönke 2003). Also my interview partners use additional therapies as can be seen in the overview in 4.1 (table 1).

I have been asking myself if this factor may have a decisive influence on intervals of treatment. I don't find any relevant reference in my interviews, the random sample being too low.

Using Krönke's data you might conduct a relevant statistical analysis in order to see if there is any relationship between (further) training and intervals of treatment. I would suppose, however, that the categories still to follow are too essential and therefore no significance should be detected here.
The still considerable spreading concerning intervals of treatment might partially also be attributed to the various forms of further training. We may well assume that a good deal of "mixed" work has been employed, e.g. osteopathy combined with healing gymnastics. Comparing countries with a different structure of osteopathic training may throw more light on the problem of intervals of treatment.

Personality

The therapist's personality affects the various ways therapeutic relationships are built up.
In the interviews this aspect becomes apparent in connection with patients who are demanding a shorter interval of treatment and wish to be treated more often, or who experience a high degree of suffering. IP 1, IP 2 and IP 6 yield to this demand. They introduce shorter intervals of treatment if they consider it necessary for the patient's mental situation. IP 4 and IP 5 don't let themselves get influenced by this aspect. They put more weight on other decision criteria and explain their proceedings to the patient.
There are obviously different approaches to build up therapeutic relationships. My interview partners have different ways to deal with the psychological situation of their patients within the context of treatment.
In order to act professionally and to be able to adapt to different situations I consider it essential for osteopaths to be aware of their options in building up those relationships.
The "Osteopathic Standards" of the General Osteopathic Council in Great Britain describe a basic knowledge of psychology and sociology as well as the ability of self-reflection and of being aware of personal peculiarities as competences of each osteopath (General Osteopathic Council 2000). Here great importance is attached to building up the therapeutic relationship since, among other things, close body contact requires adequate interaction.

In her master thesis Novy (2007) put the focus on the therapeutic relationship. She concludes that during training there is a profound discrepancy between developing palpatory abilities and the subject of relationship and interaction with patients.
In his paper Felder (2007) describes that empathy constitutes an important part of the palpatory process. He concludes that a mature personality and a highly developed ability to reflect will raise empathic competence significantly (Felder 2007, 143) and that this fact should also have its place in training.
During my osteopathic training only one day in six years was devoted to the subject of “Therapeutic Relationship”. The WSO probably assumes that within the framework of the compulsory basic education (to be a doctor and physiotherapist respectively) this aspect is thoroughly discussed. From my experience I can only report that this is definitely not the case. Basic theoretical knowledge is imparted but the training does not support an attempt to confront yourself with your own personality.
I would consider it appropriate to devote at least one seminar of 3 - 5 days to the subject of “Self-awareness in Relationships” in order to broaden one’s abilities of decision-making.

The area of experience is described in 4.2.7.

4.2.1.3 Individual evaluation of categories

The relation between and the importance given to the single categories is addressed in the interviews, particularly with regard to the training at the WSO.
IP 1 and IP 2 stress the need to put the various individual criteria in relation to each other. It is only through this combination that you get a “coarsely meshed net” (IP 2, Z 256), on which your decisions about intervals of treatment may be based.
This is an aspect where IP 2 and IP 5 observe a deficit in the area of expertise. They regard detailed lectures in classes on the scientific basis of osteopathy – particularly on clinical osteopathy and tissue physiology – as essential to enable the therapist to develop expert criteria for this decision. In this respect, they do not consider the current options as sufficient yet.

About classes IP 1 states,

> *"During classes, however, it is more important to stress, (….) to always discuss fully that the (interval of treatment) always has to be considered individually and that you are aware that there are no norms and that different circumstances may lead to different times." (IP 1, Z 285)*

I subscribe to this view. During my personal training the question of intervals of treatment was hardly discussed. Particularly during clinical classes and in supervisions do I consider it sensible to discuss intervals of treatment. This is where balancing off different factors could be taught in a model way. Using concrete examples the question of "When do I book in a patient again?" should be extensively discussed examining all kinds of aspects.
Furthermore it would make sense that patients are treated successively by the same student more often so that she may already notice in the course of her training which effects the chosen intervals of treatment could have.

4.2.1.4 Summary

The interview partners stress that the interval of treatment has to be decided individually from patient to patient.
They respect each patient's individual personality and consequently treat individually.
Kuchera (2003) believes that it is therefore not possible to establish patterns of treatment for certain diagnoses (e.g. Prolaps L5) as it wouldn't do any justice to this holistic approach.

On the therapist's side the interview partners raise the issue of the therapist's expertise, experience and personality in building up the relationship.

Concerning the area of expertise it is first of all the osteopaths' former and further training that determine their approach to work. We may suppose that this mixture, which is due to the structure of Austrian training at the WSO, favours the fact that intervals of treatment vary.

My interview partners deal differently with “demanding” patients. I attribute this aspect to the fact that therapeutic relationships are built up in different ways. These relationships themselves, on the other hand, are strongly influenced by the therapist’s personality. I would therefore suggest that during training more room should be given to the area of personality development.

The osteopath’s individual evaluation of the single categories is brought up with regard to the training at the WSO. Stronger support in evaluating and combining the single factors is being asked for.
Following these views, the question begs to be asked how to put more emphasis on this aspect during training. In my view, clinical classes would be particularly appropriate. Using concrete examples the question, “When do I book the patient in again” may be discussed and weighing up the importance of the single factors may be practised.

In spite of emphasising individuality the following categories present certain patterns concerning intervals of treatment.

4.2.2 Significance of sets of symptoms and diagnoses

"The more chronic the problem is the longer the intervals." (IP 3, Z 87)

For patients with acute ailments all interview partners establish shorter intervals for follow-up appointments compared to patients with chronic ailments.

Table 2: Intervals of treatment with acute ailments

Interview partner	**Interval**	**Reasons**
1	no signs of recovery : 2-3 days with signs of recovery: 2 weeks	still too little to set the patient in motion
2	2 weeks	only indirect work possible; check if it was sufficient
3	2 days	
4	1 week	more care when he feels bad; the body needs more support; periods of inflammation;
5	1 week	patients react very quickly; periods of inflammation;
6	2 – 3 days	you can work only indirectly, apply little input; check if it was enough
7	4 – 7 weeks	check; periods of inflammation;
8	1 week	check

Table 3: Intervals of treatment with chronic ailments:

Interview partner	**Interval**	**Reasons**
1	4 weeks	reaction to last treatment must be completed, a pattern should have been established
2	4 – 6 weeks	body has reduced ability to react (see somatic dysfunction);
3	3 – 4 weeks	homeostasis has been reached again;
4	3 – 4 weeks	during this time the body can work by itself;
5	3 weeks	experience figure; patients react more slowly;
6	4 – 6 weeks	reaction time must be over;
7	2 – 3 weeks	body needs more time to react;
8	3 – 5 weeks	from her own experience as a patient; this is the time your body needs to react

With acute ailments – they *"appear abruptly, progress rapidly and are intense"* (Pschyrembel 1998, 34) - the mentioned intervals of treatment range from 2 – 14 days.

With chronic ailments – they *“develop slowly and progress slowly”* (Pschyrembel 1998, 283) – the mentioned intervals of treatment are between 2 and 6 weeks. Classical chronic ailments include e.g. migraine caused by menstruation or chronic low-back pain.

Throughout the interviews all interview partners distinguish between acute and chronic. This distinction seems to have been of value in practice and to correspond best to the needs of the patients as well as those of the therapists.
In the area of acute ailments this survey corresponds to Krönke’s study (2003). She observed that the majority of patients (about 30%) with acute ailments are treated in weekly intervals.
Concerning chronic ailments her study shows that about 18% of the patients are treated in an interval of 2 weeks and about 13% each in an interval of one, three, four or five weeks. There is a considerably higher spreading rate here than in my interviews.
Supposedly, this is due to the fact that she interviewed a much higher number of persons and also job beginners and osteopaths having been trained at other schools. Some of my interview partners report that they introduced weekly intervals at the beginning of their osteopathic activities – out of their physiotherapeutic habits and also because they disposed of the necessary (time) resources. It was only after having had enough experience that they changed to longer intervals.
My surveys did not include to what extent other schools recommend other intervals of treatment. However, this could be another interesting aspect of the problem.

Concerning acute and chronic ailments there are manifold reasons for the chosen intervals. For the most part, they are discussed and described from various perspectives in the following chapters.

I would like to address two more aspects:
Osteopathy regards itself as a therapy which sets the patient and her body’s self healing process in motion (IP 1, Z 6).

According to IP 2 and IP 6 you can only employ few techniques and work only “indirectly” with acute ailments, i.e. you have to induce this motion very carefully. For this reason it is essential to check after a short time *“if what I did was also sufficient”.* (IP 2, Z 9)
With acute patients IP 5 observed that they react intensely to the applied stimuli. Later, however, they would achieve a new actual state much faster (see also homeostasis).
IP 2 adds that *“chronicity reduces the body’s ability to react”.* (IP 2, Z 25)
IP 5 has observed as well that patients with chronic ailments require more time to react to their treatment. (IP 5, Z 83)
Thus we have experience figures which obviously account for the different intervals of treatment concerning acute and chronic ailments.
I regard these statements as highly valuable, particularly for job novices. The simple distinction between acute and chronic may give - in case you are not that experienced - clear orientation in your daily practice.

Another important aspect concerning the distinction between acute and chronic is addressed by IP4, IP 5 and IP 7. Not only do they use this distinction for the general set of symptoms but also for local processes in the area of ailments. Tissue causing pains over many years may thus feel as if it were acute (IP 5, Z 47), i.e. it assumes a gelatinous consistency and shows signs of inflammation. For them this is just as well a reason to make a follow-up appointment with the patient within a week in order to observe the assumed progress of inflammation. By contrast chronic tissue feels brittle (IP 5, Z 70).

A survey of examples mentioned in the interviews is presented below:

Table 4: Intervals of treatment for selected examples

Interview Partner	**Diagnosis**	**Interval**	**Reasons**
1	dental braces for children	3 months	accompanying treatment
	patient with psychological regression	2 weeks	needs „guidance“ by therapist
	prophylaxis	3 months	
2	dysostosis enchondralis	1 week	

	„service“ fort the body	3 months	
3	migraine due to menstruation cronic lumbalgy shoulder contracture	1 month 1 month 2 – 3 days	 to mobilise the joint
4	children	2 – 3 months	intense reaction
5	contracture after cast removal prophylaxis	2 – 3 days 2 months	to mobilise the joint
6	ankle distorsion trauma	2 – 3 days	
7			
8			

4.2.2.1 Summary

All interview partners make sooner follow-up appointments for patients with acute ailments (2 -14 days) than for patients with chronic ailments (2 – 6 weeks).

There are manifold reasons to choose intervals of treatment for acute and chronic sets of symptoms. In the following chapters a majority of them is largely discussed and described from different angles.

From their experience, my interview partners report that patients with acute ailments usually react intensely to treatment stimuli. Therefore you have to be very cautious and work indirectly. A check after a short time (2 days) should indicate if a self healing process has been triggered off or if a follow-up treatment, another kick-off, is necessary.

Concerning chronic ailments the body usually has, from experience, a reduced ability to react. Patients require more time to react to a treatment. For this reason my interview partners make follow-up appointments after 2 weeks at the earliest.

The distinction between acute and chronic may also refer to tissue quality, irrespective of the patient’s pains.

Acute tissue has a gelatinous consistency and shows signs of inflammation. Patients with this type of tissue are booked in sooner even though their overall state might be one with chronic ailments. In contrast chronic tissue feels brittle (IP 5, Z 70).

4.2.3 Significance of Constitution and Psyche

Answering the question “Do you consider the patient’s constitution?” the aspects of type of connective tissue, mental constitution and age were addressed.

4.2.3.1 Types of connective tissue

In my practical work I have made the experience that patients with very loose connective tissue, i.e. hypermobile patients, react differently to treatment stimuli than patients with hard, dense and very inflexible connective tissue. In my interviews I therefore enquired if my colleagues shared this experience and if it influenced intervals of treatment.

IP 2 confirmed that hypermobile patients often react intensely to a treatment (IP 2, Z 123). This prompts him to allow longer time intervals for a follow-up treatment – 5 to 6 weeks in his case – until the reaction has dissipated.

He also confirms my experience that patients with very hard connective tissue require stimuli more often and faster in order to react. He then makes follow-up appointments after 3 weeks.

IP 4 is of the same opinion. She makes appointments with patients who have hard connective tissue after already one week.

> *“I treat several athletes with whom I have the feeling that I don’t get into them with my treatment. There is so much musculature and hard connective tissue over it that my fingers hurt that much that I cannot go on before I even get to the joint.” (IP 4, Z 198)*

With hard connective tissue IP 7 also employs a more intense stimulus –

> *“they usually tolerate more so that you can go really hard right into the tissue” (IP 7, Z 229).*

Her interval of treatment does not depend on this aspect, she decides according to the therapeutic success of a treatment.

So patients with hypermobile connective tissue react intensely to stimuli. Types of hard connective tissue, however, require a very intense stimulus. But this does not mean that my interview partners would change their

intervals of treatment substantially. You might interpret this aspect to the effect that the category “connective tissue” is accounted for in single treatments. It is no crucial factor, however, when deciding about intervals of treatment.

4.2.3.2 Psyche

Concerning psychological factors, the aspects of the degree of suffering and regression are addressed.

The question “*Does a patient’s degree of suffering play a role for you and, if yes, which one?”* is answered in different ways.

Their resources permitting, IP 1, IP 2 and IP 6 make sooner follow-up appointments for patients with a high degree of suffering - after about one week.

> *“With these patients you must often act fast and do a lot in a shorter time even though it may only be an exchange of information – advice about who they should turn to, clinical clarifications, discussing medical findings, etc.” (IP 6, Z 155)*

> *“There are situations when I would say, okay, come in again next week. This is rather an exception if I notice that the patient might need not so much the treatment but the discussion about it.” (IP 2, Z 207)*

Concerning these people IP 1 often observes the situation of psychological regression. He feels that people who are stuck in such a regression cannot cope with longer intervals of treatment as the illness or its symptoms imply too much strain to leave the patients on their own with it. He regards it therefore as essential to

> *“partially take over a guiding role which is then subsequently (…) reduced again.” (IP 1, Z 93)*

In such a case he fixes intervals of two weeks and extends them again later on.

Concerning their decisions IP 4 and IP 5 give less room to the aspect of degree of suffering. Other criteria are emphasised and the strain stays with the patient.

I attribute the different approaches regarding psychological aspects to the osteopaths' different ways of building up relationships. How osteopaths react to the requests and personality of each patient and how they let themselves be influenced when fixing follow-up appointments depends on their differing experiences, interests and personality dispositions.
IP 1 and IP 2 give much room to the mental situation of their patients. The question arises if this still belongs to the core of osteopathic treatment or if accompanying psychological support shouldn't rather be taken into consideration. IP 8, for example, works closely together with a psychologist. Concerning intervals of treatment she is therefore in a position to put this criterion last as her patients are well cared for.
See also 4.2.1.2.

4.2.3.3 Age

Regarding age some aspects concerning older patients – around 65 – and children are mentioned.

IP 1 is very cautious giving input to older people in the course of a treatment. He does very little and makes appointments in shorter intervals instead (2 weeks) (IP 1, Z 68).
Concerning children he often does not see any problems even with intervals of 6 weeks.
IP 4 attributes this to the fact that children react so intensely to a treatment that you may subsequently allow the system a long time to work independently (IP 4, Z 134).

That age plays a role in osteopathy is in itself reflected in the fact that there is specific training for pediatric osteopathy.
There is already intensive research done in geriatric medicine on the changes in tissues with age 50 +. This is the basis for recommendations to adjust OMT in order to do justice to these particular aspects. They concern first of all the choice of techniques employed (Cavalieri 2003).

Cavalieri recommends to work without HVLA- techniques. Instead he regards soft-tissue techniques, muscle energy techniques, breathing techniques and cranial techniques as appropriate for older patients.
In literature I did not discover any reference to a change in intervals of treatment as practised by IP 1. I would suppose that – similar to acute patients - IP 1 here wishes to accurately control and observe processes and is therefore simply very cautious. This may at least make you think that aging tissue reacts immediately and intensely to osteopathic techniques or that at least patients have this feeling. This corresponds to my personal experience from practice. I have consequently adjusted my treatment to the pattern described by IP 1 (low intensity, shorter intervals) and have made positive experiences.

In osteopathic literature constitutional factors are addressed by way of constitutional types (Parsons et al. 2006). They should give orientation to the therapist as to which techniques should be employed (structural, cranial, etc.) and which intensity of stimuli is required by a patient.
Examples for this aspect are Littlejohn's anterior and posterior posture types, Sheldon's classification into endomorph, ectomorph and mesomorph or L.Vannier's carbonic, phosphoric and fluoric type (Parson et al. 2005).
My interview partners themselves did not raise the issue of these constitution models, which are partially taught in osteopathic classes. They are obviously not or only marginally employed to determine intervals of treatment.
I would say that it is rather Littlejohn's model (Parsons et al. 2006) that lends itself to find the correct approach for setting the system in motion during a single treatment. In my view, the way the other models are taught in training is not professional enough to allow for easy employment.

4.2.3.4 Summary

When asked about the significance of constitution and psyche to determine intervals of treatment, my interview partners mention the areas of tissue type, psyche and age.
Concerning tissue types we observe that patients with loose tissue react more intensely to treatment stimuli than patients with hard and inflexible

tissue. The second also require a more intense treatment stimulus. This fact does not have, however, any significant influence on the intervals of treatment.

As far as psyche is concerned the question of how to deal with the patients' degree of suffering is raised. In this respect, the interview partners express different views. Some make sooner follow-up appointments in order to be able to accompany them, others do not let themselves get influenced by this aspect and keep to their usual intervals of treatment. I attribute this to the fact that osteopaths build up their therapeutic relationships in different ways. I have gone into more detail on this particular aspect in 4.2.1.2. .

As far as age is concerned differences are mentioned between children and older people.

It is my interview partners' experience that, after a treatment, children react for a long time and therefore can be booked in again in longer intervals (6 weeks).

According to IP 1 older people react very intensely, he consequently recommends a low dosage of stimuli with short intervals of treatment (2 weeks). From my experience, I can only agree.

In literature there are recommendations on the choice and application of osteopathic techniques concerning the treatment of older people (Cavalieri 2003), without, however, any concrete references as to how you determine intervals of treatment.

Classical constitutional concepts like e.g. Littlejohn's anterior and posterior posture type (Parsons et al 2006) are not mentioned by my interview partners – they obviously do not seem to influence intervals of treatment.

4.2.4 The significance of palpatory information

In the interviews I was asking, in a very concrete sense, which palpatory information osteopaths use with regard to intervals of treatment and dosage of stimuli during a treatment.

In the interview guideline the relevant question runs as follows, *"Concerning palpatory factors, can you observe something that tells you how much a patient may tolerate, how he will react?"*

I assign the answers to 2 areas.

On the one hand palpatory information in the course of a treatment is used for very specific purposes, in the following table they are summarised on the left.

The column on the right summarises the concrete information observed in palpation.

The additions following the table describe how these observations are interpreted in a very concrete sense.

This representation enables us to get a quick overview of each interview partner.

Table 6: Palpatory information

	Palpatory information is used		**Observed and interpreted are**	
IP 1 IP 5 IP 6	to find out at the beginning of a treatment how far the healing process has progressed		(1) tissue quality	IP 4 IP 5 IP 6
IP 3	to decide what to treat		(2) expression of cranial rhythm, „motion"	IP 1 IP 5 IP 6 IP 7
IP 5 IP 7	for dosage of treatment stimuli		(3) feedback, reactions of the tissue, tensions	IP 1 IP 2 IP 8
IP 4 IP 5 IP 6	to check the effects of the treatment at the end of a treatment		(4) flexibility in the sense of mobility	IP 6 IP 7
IP 5 IP 7 IP 8	to decide when to make follow-up appointments with the patient		(5) reactions on the surface (sweating, heat, discolouration)	IP 1 IP 7

(1)

IP 5 emphasises tissue quality. He distinguishes between acute and chronic tissue. His decision to treat a patient as acute or chronic patient is taken on the basis of tissue and not on the basis of the pain situation. He explains this approach through the physiological model of the stages of wound healing. (van den Berg 1999).

The resulting intervals of treatment are described in 4.2.2. .

IP 4 found defensive tensions with patients coming in at very short intervals (twice a week). She interprets this aspect through the fact that it was too early for a new treatment stimulus and she extended intervals accordingly.

(2)

IP 5 and IP 7 judge the vitality level of a patient by the expression of cranial rhythm (IP 5, Z 293, IP 7, Z 130). They evaluate intensity and frequency without giving any numeral data as to how these factors should be in order to speak of a good vitality level. The intensity of their treatment stimuli is based on this aspect, but not the interval of treatment.

Furthermore cranial rhythm is drawn on to decide about the progress of the patient's healing process. All interview partners mention that reaction to a treatment should be completed before the following one may take place (see also 4.2.7.1.). Some use cranial rhythm to verify this.

> *"You feel it when it's too early" (for another treatment). (IP 6, Z 33)*
>
> *"…you can (…) notice it if the system, on the whole, can express itself well and if it is in balance, if there is a nice middle line (…). If this reaction time has not been completed, the patient feels disturbed and uneasy and it would be a mistake to apply another treatment then." (IP 6, Z 38)*

IP 1 describes similar experiences when talking of "motion". When he touches a patient coming in to a follow-up appointment and feels *"that there is still a lot in motion*" (IP 1, Z 32), that still *"no pattern has been established"* (IP 1, Z 109), he knows that you have to be cautious with inputs. He is, however, noncommittal about whether this movement takes place on a

cranial level. In this context he is talking of “pattern recognition” as described by Mayr-Fally in his script “Clinical Osteopathy” (Mayr-Fally 2007).

> *“You have a gut feeling to recognize patterns, meaning, you say that somehow I have the feeling this person might need this or that now. So you recognize patterns and things repeating themselves within this pattern and you then have the feeling where to get the best start.” (IP 1, Z 138)*

How long, by experience, the patients’ reaction time lasts until a new homeostasis has been reached is illustrated in 4.2.7.1. . If the palpatory diagnosis tells you that it is still too early for a follow-up treatment, patients are not sent home without any treatment. Osteopaths then apply either supporting techniques or work over other body regions.

(3)

The direct feedback of tissues on therapeutic touching is used for the dosage of stimuli during a single treatment.

> *“(…) when I already notice during my first touches that each tissue reacts to my inputs in the same way, I will be more cautious. When I notice that nothing much happens during my input, I will get more intense and would then also often go deeper (with my treatment stimuli)” . (IP 1, Z 177)*

Here IP 1 describes a dialogue he is having with the tissue. In his statement he is noncommittal about the level where this feedback takes place.

IP 8 describes her experience in the following words,

> *“Yes, apart from the tension I feel exactly what I’m at. If I get drawn to a certain point, if I should stay longer somewhere.” (IP 8, Z 163)*

If this tension, however, gets very strong, *“where I just have the feeling that I really get drawn into it”* (IP 8, Z 33), she makes follow-up appointments with her patients in shorter intervals (2 – 3 weeks).

(4)
Flexibility in the sense of mobility is drawn on to verify the effect of a single treatment stimulus, like e.g. the successful treatment of adhering fascia (IP 7, Z 237; IP 6, Z 132).

(5)
Superficial phenomena like sweating, skin heating, and discolouring are equally taken into account to evaluate the intensity of a single treatment stimulus.

Tissue quality, the expression of cranial rhythm and a “motion” in the body as well as a “tissue feedback” which is not more accurately defined therefore lend themselves to answer the question of the best follow-up treatment date.

Studies about the reliability of palpation attribute an acceptable reliability to the palpation of tissue tension, pain provocation and to the locating of anatomical points (Fryer 2007).
The study on the reliability of the palpation of cranial rhythm by Sommerfeld et al. (Sommerfeld 2003) did not yield any results, nor did several other studies he mentions in his paper.
Considering this aspect, how do we have to interpret the statements made here?

The abundance of interview material on palpation shows that it is a fundamental part of osteopathic treatment as well as for dosage of stimuli and intervals of treatment.
Concerning tissue quality study results support my interview partners’ statements. In my view, it can therefore be drawn on as an important factor when considering intervals of treatment.
As the physiological existence of the PRM cannot be regarded as proven (Sommerfeld 2003, 27), Sommerfeld recommends not to draw on it to make clinical decisions.

I subscribe to this opinion. Osteopathy struggles for recognition in a scientifically-oriented medical science. I therefore consider it more sensible to put more emphasis on verifiable and comprehensible facts.
In daily practice I personally let myself also be guided mainly by concrete factors, e.g. distinguishing between acute and chronic ailments, when it comes to deciding about a follow-up treatment date.

In this respect, many readers are probably of a different opinion. Many osteopaths very successfully treat with the underlying concept of PRM. I work with PRM as well and have good results with it. Many patients come in for osteopathy particularly for this reason.
We must be aware, however, that in doing so we do not draw on scientific results.
"Who heals is right" (Meiners 2001, 2) is a common argument in the context of alternative medicine.

> *"The primary criterion for a successful medical method is its effectiveness" (Meiners 2001, 2).*

This does not prove, however, that the underlying explanatory models are correct (Meiners 2001).
Whenever we make clinical decisions, we must supply comprehensive argumentation for the outside world.

Palpation is a core feature of our osteopathic work. Its training requires the majority of time in our training. I personally often lacked the support when interpreting what I felt. This is where teaching methods should be further developed.
The term "Cognitive apprenticeship" describes a method to learn clinical reasoning, a method which I also think of as an appropriate means to pass on palpatory knowledge. This is a method where the expert plays the role of the model for the novice. By thinking out loud he visualises his thoughts (Klemme et al. 2006). This method could be used more intensively in clinical classes at the WSO.

4.2.4.1 Summary

Palpatory information is used by the interview partners

- to find out about the progress of the patient's healing process at the beginning of a treatment
- to decide what is being treated
- to employ correct dosage of treatment stimuli
- to verify the effectiveness of a treatment at the end of a single treatment
- to determine when to make a follow-up appointment with a patient.

Observed and interpreted are

- tissue quality
- the expression of cranial rhythm, "motion"
- feedback, tissue reactions, tensions
- flexibility in the sense of mobility
- reactions of the surface (sweating, heat, discolouring).

Concerning the question of treatment intervals tissue quality, the expression of cranial rhythm and a certain "motion" in the body as well as a "tissue feedback" which is not accurately defined is drawn on by the interview partners to make decisions.
The reliability of the palpation of tissue quality is confirmed in scientific studies (Fryer 2000), they support this approach.
The physiological existence of PRM has not been scientifically proven yet (Sommerfeld 2003, 27). Sommerfeld therefore recommends not to draw on it for clinical decisions. I subscribe to this opinion. I consider it essential for clinical decisions to argue them clearly and thoroughly.

In my view, interpreting palpatory information should be taught more thoroughly during our training. An appropriate method would be, e.g., "Cognitive Apprenticeship" (Klemme et al. 2006) which may be easily employed in clinical classes.

4.2.5 The significance of verbal information

There is no question in the interview guidelines that is specifically asked about verbal information from the patients' side.
This aspect was brought up by my interview partners themselves.
Relevant statements can be found in 5 interviews.

My interview partners ask their patients about reactions and progress after their first treatment with the intent to treat again only after the reaction to the first treatment has completely dissipated and the patients are in balance again (see also 4.2.6.1.).

> *"Patients report, for example, that they felt hardening, muscle soreness etc. more intensely after treatment. This was followed by a period during which they felt really good. In the last days before the treatment they had really been looking forward to the next treatment, they had the feeling everything was fine again. So it comes directly from the patient." (IP 4, Z 48)*
>
> *"I trust the patient's body awareness a lot." (IP 1, Z 214)*

4 interview partners let themselves (among other things) be guided by this information when it comes to the point to decide if the interval has fitted the last treatment and if reaction time is over.

If patients express themselves on the interval of treatment – they are mostly surprised about the long intervals – osteopaths listen and explain to the patient how it comes about and why it makes sense.

If shorter intervals are asked for, all osteopaths critically analyse if any other underlying needs – to get response, to communicate, to be accompanied – may be behind the wish to have shorter intervals. How they deal with this aspect is described in the chapter 'Individuality of the Therapist' in 4.2.1.2. .

The patients' statements are obviously seen as very important to manage treatment intervals. This aspect has considerable advantages. Patients feel taken seriously, they are encouraged to think about and reflect on their body

and the symptoms; it becomes apparent that a part of the responsibility to recover again stays with them as their statements are taken very seriously (Brandstetter-Halberstadt, 1996, Payton et al. 1998, Halasz 2001).

It is only through detailed inquiring that a process of self-reflection on one's own body and the symptoms is triggered off in many patients (Halasz 2001). In my view, this is a precondition to realize, for example, behaviours that are detrimental to your health and to change them.
If you take the patient seriously and let her actively participate – e.g. in making decisions about intervals of treatment – you assign a part of the responsibility to her. This has a positive effect on compliance (Halasz 2001).
Assumedly, this may also be an advantage for the sense of coherence (Antonovsky 1997).

These statements and considerations lead us to the conclusion that the patients' verbal information should be strongly taken into account when it comes to choosing and verifying intervals of treatment.

4.2.5.1 Summary

My interview partners themselves raise the issue of taking into account the patient's verbal information.
This aspect is used to verify the reactions to a treatment and the moment when the reaction time is over.
This has considerable advantages: patients feel taken seriously; they are encouraged to think about and reflect on their bodies and the symptoms; it becomes evident that part of the responsibility to recover stays with them as their statements are taken very seriously (Brandstetter-Halberstadt 1996, Payton et al.1998, Halasz 2001).
This has a very positive effect on compliance and health awareness of the patients (Halasz 2001).
The patients' verbal information should therefore be taken into consideration when choosing and verifying intervals of treatment.

4.2.6 The influence of expertise

This category tries to show in more detail on the basis of which scientific findings and professional concepts decisions about intervals of treatment and stimulus intensity are made. In this respect, it is difficult to exclude the area of experience and traditions completely because *“medical science actually lives on these traditions”* (IP 1, Z 348)

The professional concepts brought up and outlined in the interviews are presented below.

4.2.6.1 The concept of self-organisation – homeostasis

> *“…that I understand treatment or therapy in osteopathy as something that does not “repair” but should initiate something, can get things moving.” (IP 1, Z 6)*

For IP 1 this process starts through the treatment in the first therapy. The patient should be set in motion and find her balance again until the follow-up treatment (IP 1, Z 40). He checks this at the beginning of the follow-up treatment by ‘listening’ and palpation (see more details in 4.2.4.) and hereby estimates if the chosen interval has made sense.

> *“The patient comes in to you, you apply the stimulus, disturb (…) homeostasis and release him into a process of restructuring and only if this has been completed, you might apply the next stimulus.” (Halasz in interview 1, Z 241)*

All interview partners agree to this pattern and stress that it is necessary for a new homeostasis to be reached after a treatment before you treat again. IP 5 also terms this state “neutral” (IP 5, Z 24), however does not define this term more accurately.

Verbal and palpatory information tell the therapists if this state has been reached again (see 4.2.4., 4.2.5.).

IP 6 opts for basically doing as little as possible,

> *“really only the most essential things and always give the system only a kick-off, keep on doing, do something more.” (IP 6, Z 98)*

There are experience figures from practice about which intervals are necessary to resume homeostasis.

Table 6: Experience figures for reaction times after treating a “typical” patient

IP	***Time***
IP 1	3 weeks
IP 2	4 – 6 weeks
IP 3	3 – 4 weeks
IP 4	3 – 4 weeks
IP 5	3 weeks
IP 6	4 – 6 weeks
IP 7	2 – 3 weeks
IP 8	4 – 5 weeks

The figures vary between 2 and 6 weeks.
One reason for the spreading might be that I am, in fact, asking about intervals concerning “typical” patients without, however, defining this term more accurately. Each osteopath has probably a different idea of a “typical patient” in her mind.
The different figures might also be attributed to the different intensities of treatment. Each osteopath is probably of a different opinion about how much a patient requires and when it is enough.
The term homeostasis is not more accurately defined, either.

The concept of self-organisation, which is actually a concept of self-healing, is the core to osteopathic philosophy (Parsons et al. 2006). Still put it in a nutshell with his much-cited sentence, *“Find it, fix it and leave it alone.”*
Considering the problem of this paper we might ask Still: *”How long shall we leave the body alone?”*
Until homeostasis has been resumed again is not a very exact time definition but still an answer which may guide your thoughts. It would be interesting to hear from osteopaths what exactly they understand by homeostasis, what they observe on a patient which lets you draw conclusions about homeostasis, how a body feels in the state of homeostasis. There are some references in 4.2.4. .

The intervention model described here by my interview partners might be assigned to system theory (Kriz 1997).
Self-organisation is a central term of system theory. In system theory self-organisation mainly signifies a form of system development in which the shaping, formative and restrictive influences emanate from the elements of the self-organising system themselves (Birken 2008).
What does it mean to intervene into a self-organising system from outside? Considering a system-theoretical approach, an osteopathic treatment means a disturbance of the system. It cannot be predicted how the system copes with this disturbance, how it assimilates and integrates it. Outside observers can only interpret what they see.
From a system-theoretical point of view the statements above would mean: the appropriate moment for a follow-up treatment has arrived when the previous disturbance has been assimilated and integrated. This point is not predictable and can only be clarified through the exchange of information between the patient's and the therapist's systems.

4.2.6.2 The concept of somatic dysfunction

The American Osteopathic Association defines "somatic dysfunction" as follows:

> *„Impaired or altered function of related components of the somatic (body framework) system: Skeletal, arthroidal and myofascial structures, and their related vascular, lymphatic, and neural elements." (Educational Council on Osteopathic Principals 2002, Glossary, 21)*

Concerning the problem this concept is drawn on for explanation concerning its temporal significance.

> *"The longer it (the somatic dysfunction) lasts the more reduced the reaction time of the tissue is." (IP 2, Z 32)*

If you consider the area of expertise, the concept of somatic dysfunction might therefore be drawn on - on a scientific level - to account for the distinctions made concerning sets of symptoms and diagnoses with acute and chronic symptoms.

IP 2's statement is confirmed by osteopathic scholarly literature.

> *„The longer the dysfunction has been present the more marked the tissue changes will be, both locally and distally, resulting in progressively greater functional or even pathological tissue changes; and proportionately the longer the expected prognosis and duration of treatment." (Parsons et al. 2006: 28)*

4.2.6.3 The concept of primary lesion - the hierarchy of lesions

The original mechanical or functional change is termed primary lesion or key lesion which, so to speak, functions as a trigger of the patient's problems (Educational Council on Osteopathic Principles 2002).

> *"It manifests itself as the area of strongest tension in your body. It triggers off secondary dysfunctions which may be regarded as biological defence of the body to maintain corporal homeostasis." (Liem et al.2002, 104)*

By his own account, IP 3, who was one of the first aspirants at the WSO, learnt in his training that *"A good osteopath finds the primary problem, treats it and it's all right."* (IP 3, Z 191)
His daily experience as an osteopath is a different one. Long time feedback from patients tells him that it is only in the minority of cases enough to treat once.

> *"As you find a lot (of lesions) it is often difficult to seize the correct point." (IP 3, Z 260).*

This is reason enough to make a second appointment necessary in order to verify if the treatment was successful.
For Dummer it is even possible that the primary lesion is located outside the body, for example in the shape of psychological stress (Dummer 1999, 97).
Nevertheless IP 2 aims to

> *"find a very precise starting point in your body, that is, to diagnose exactly what the cause is – it is here that I have to intervene." (IP 2, Z 150)*

This means that applying as many stimuli as possible in a short time in order to disturb the system – as it is, for example, practised in reflex therapy (Tilscher 1999) – is disapproved of. IP 2 as well as IP 1 consider osteopathic treatment a “therapeutic act of healing” (IP 1, Z 234) in which it is a matter of the most possible precision as far as intervention or correction is concerned. This is then verified and continued respectively in subsequent treatments.
Secondary dysfunctions might right themselves by eliminating the primary lesion (Parsons at al. 2006). It is definitely possible, however, that due to chronic misloading they are not able to resume their normal function. With regard to our problem this would mean that after treating the primary lesion there should be enough time to determine if secondary dysfunctions are changing or if they still require treatment (Liem et al.2000).
If there is a mixture of different problems/dysfunctions on a structural, cranial and visceral level, IP3 makes follow-up appointments with patients after 2 weeks to verify if the primary problem has been detected. For him this interval is a compromise between giving the organism time and not leaving the patient to herself (IP 3, Z 77). This leads us to the next point.

4.2.6.4 The distinction between structural/cranial/visceral

The following questions are discussed here:
Do structural, cranial or visceral treatment stimuli have different effects and therefore also different durations of effects?
Does the type of lesion – structural, cranial or visceral – influence the duration of the interval of treatment?

Concerning the first question IP 6 adopts a clear point of view:

> *“Basically, cranial work (…) is, to a large extent, physiological and biochemical work and due to this high physiological proportion of course also has an intense effect. (…) Manipulations and direct techniques are felt very intensely by the system but also integrated very quickly. Instead of change it is rather local metabolic processes that take place. In cranial work, however, a very general systemic physiological change takes place.” (IP 6, Z 21)*

For this reason she chooses longer intervals of treatment of 4 - 8 weeks if the cranial proportion in treatment was very high.
For IP 2, however, it is of no importance whether he is treating cranially, structurally or viscerally. No matter which techniques are employed,

> *"it is the appropriate stimulus for the patient and his problem. If you apply the appropriate stimulus there should actually not be much difference to what will happen later." (IP 2, Z 163)*

Table 7: Reaction times and used concept

IP	*Time*	*Proportion of structural/visceral/cranial-biodynamical work*
IP 1	3 weeks	40 : 35 : 25
IP 2	4 – 6 weeks	33 : 33 : 33
IP 3	3 – 4 weeks	60 : 20 : 20
IP 4	3 – 4 weeks	33 : 33 : 33
IP 5	3 weeks	35 : 35 : 30
IP 6	4 – 6 weeks	25 : 25 : 50
IP 7	2 – 3 weeks	30 : 30 : 40
IP 8	4 – 5 weeks	20 : 00 : 80

This table compares experience figures for reaction times with the techniques applied – i.e. if the structural, visceral or cranial proportion is higher.
The figures reflect the different approaches mentioned above. IP 6 and IP 8 cite long intervals but also IP 3, whose work is well-balanced, lies within the same range with his experience figures. With 2 - 3 weeks IP 7, who also has a high proportion of cranial work, even has rather short intervals. Reaction times vary considerably, irrespective also of the techniques applied.

Summing up the different answers you can only establish a tendency to evaluate structural treatment stimuli – this does also include structural techniques in the area of the viscera – as very intense stimuli in the course of treatment (IP 1, IP 2, IP 3, IP 6).

It makes a difference if it is a matter of the type of lesion, the cause of the problem. *"As each structure reacts differently"*, (IP 2, Z 55) the osteopath has to account for the tissue's various abilities to react.

IP 3 sees it the same way. In a very concrete sense, he assumes that due to the histological reactions of organic tissue a visceral problem requires longer intervals of treatment than a structural one (see also 4.2.6.5.) (IP 3, Z 19).
IP 1 even makes a clear distinction between reaction times on these levels:

> *"(…) you may, for example, apply a good stimulus on a cranial level and notice the next time that it is still working (…) (IP 1, Z 248),*

and in spite of this fact you could still do something on a structural level then if it had a positive effect.
There is a tendency here towards the fact that the type of lesion makes a difference and that, in a temporal order, structural lesions require less time to reorganise after a treatment than visceral and finally cranial lesions. This hypothesis, however, still needs to be verified.

4.2.6.5 Tissue physiological concepts

I asked the interview partners if they drew on any physiological or biochemical principles to decide about intervals of treatment. Concerning this aspect 4 persons made statements which I would like to present below.

In a very concrete sense, IP 5's decisions are based on the stages of wound healing (van den Berg 1999). He considers his treatment stimuli to trigger off a biochemical cascade which then follows the pattern inflammation or irritation stage, proliferation stage, consolidation stage and organisation stage.
IP 7 works with the same underlying model.
They employ it when working with acute sets of symptoms and then adapt their intervals of treatment according to this model.

IP 3 also considers histological aspects. Based on the time organ cells need for renewal he allows long intervals of treatment as far as visceral manipulations are concerned (IP 3, Z 19). On a histological level the liver, for example, renews itself within a period of three months (IP 3, Z 43), meaning for him that after working on the liver - if it was the primary problem – a long

interval of treatment is required from a point of view of the tissue's physiology.

IP 6 assumes that structural techniques improve local cell metabolism, blood circulation and osmosis (IP 6, Z 142). She observes the biochemical effects of cranial techniques in the whole system (IP 6, Z 22).

Although, in my opinion, tissue physiology is actually a decisive factor for the interval of treatment, my interview partners make only few references to this aspect.
At the beginning of the discussion about this subject the relevant literature on tissue physiology was analysed first. It was the aim – similar to exercise physiology – to identify the connection between external pressure and internal strain. In a concrete sense, explanation models that describe what happens in your body when applying an osteopathic technique were looked for.
In the American-Canadian region a conference organised by the Canadian Institute of Health Research and the United States National Institute of Health took place in 2005 with the aim to collect and combine knowledge about the biology of manual therapies (the main representatives were chiropractic, massage and osteopathic manipulative theory) and to give recommendations for future research (Triano 2005). In my view, this report makes it evident that research only covers few aspects whereas, concerning many other aspects, it is still a long way off from practical work, and that the majority of osteopathic work is actually based on experience.
In osteopathic literature you find physiological models (Willard 2003, Sparks 2003, Portanova 2003) which cover some aspects of our work.
Given osteopathy's claim to work with a holistic approach it is probably not possible to reduce therapy to physiology (Seffinger et al. 2003, Parsons 2006).

4.2.6.6 Summary

Concerning expertise 5 concepts about intervals of treatment are addressed.

All interview partners consider the concept of homeostasis as a fundamental concept. It states that the next treatment should only start when homeostasis has been resumed again after a treatment (Parsons et al. 2006).
The interview partners' experience figures for reaction times after treating a typical patient range from 2 - 6 weeks. Assumedly, this may be attributed to different intensities of treatment or a different approach towards homeostasis. In this respect it could be interesting to hear from osteopaths what exactly they understand by homeostasis, what they observe on a patient to allow conclusions to be drawn about homeostasis, how a body feels in a state of homeostasis. There are some references in section 4.2.4. .
From a system-theoretical point of view (Kriz 1996) a follow-up treatment is appropriate at the moment when the previous disturbance has been assimilated and integrated. This point is not predictable and can only be clarified through exchanging information between the patients' and the therapists' systems (Kriz 1996).

In the interviews the concept of somatic dysfunction is drawn on for explanation concerning its temporal significance in connection with the decision about intervals of treatment.

> *"The longer the (somatic dysfunction) lasts the more reduced is the tissue's reaction time." (IP 2, Z 32)*

This could explain the differences in intervals of treatment concerning acute and chronic ailments (see 4.2.2.).

The concept of the hierarchy of lesions distinguishes between primary lesions and secondary lesions (Parsons et al. 2006). It states that after treating the primary lesion sufficient time should be left for the secondary lesion to dissipate (Liem et al. 2000).
The interviewees claim that it is the aim of a treatment to set an precise intervention or correction which is then verified or continued in follow-up treatments (IP 2 + IP 1).
IP 3 points to the difficulties of this concept. His daily experience tells him that only in the fewest cases is it sufficient to have only one treatment as you

will often find many lesions and the primary lesion may not be identified (IP 3, Z 260).

The distinction structural – cranial – visceral is discussed on two levels.
On the one hand there is discussion whether structural, cranial or visceral treatment stimuli have different effects and therefore different reaction times. In this respect my interview partners do not agree. There are no recognizable tendencies even when you juxtapose a preferred technique and the experience figures of reaction times.
On the other hand there is discussion whether the type of lesion – be it structural, cranial or visceral – changes the duration of the interval of treatment. This is an aspect where the interview partners largely agree.
There is a certain tendency in the statements that structural lesions require less time to reorganise after treatment than visceral and that cranial lesions require the most time (IP 6). However, this still needs to be verified.
My interview partners employ the concept of the stages of wound healing, which is taken from the area of tissue physiology, for acute sets of symptoms (van den Berg 1999). IP 5 and IP 7 consider their treatment stimuli to trigger off a biochemical cascade which then follows the pattern inflammation or irritation stage, proliferation stage, consolidation stage and organisation stage with the corresponding temporal biochemical processes.
Apart from this, individual histological aspects concerning visceral manipulations are also mentioned (IP 3) as well as IP 6's view that structural techniques improve local cell metabolism, blood circulation and osmosis (IP 6, Z 142) whereas cranial techniques have a biochemical effect on the whole system (IP 6, Z 22). These statements are not backed, however, by theoretical studies.
Although, in my view, tissue physiology is a decisive factor concerning intervals of treatment, my interview partners make only few references to it.
Assumedly, this is due to the fact that relevant research only covers few aspects while at the same time being a long way off from practical work with many other aspects. Actually, the majority of osteopathic work is still based on experience (Triano 2005, Willard 2003, Sparks 2003, Portanova 2003).

Given osteopathy's claim to work with a holistic approach it is probably not possible to reduce therapy to physiology (Seffinger et al. 2003, Parsons 2006).

4.2.7 Experience and Intuition

Experience as a category in its own right is introduced because all the experiences osteopaths have and reflect on will influence their following actions. (see "Lernen als bewusste Akkomodation" in Glasersfeld 1997).
My interview partners often answered, "It comes from experience" or "This is just a figure from experience".
Only through detailed inquiring did they express themselves in a more concrete sense and finally much information about the problem has been collected on the issue.
It should be part of the osteopath's daily practice to reflect on their experiences – possible options are conversations with colleagues, supervisions and quality circles.
In the previous chapters many of the osteopath's concrete experiences have been presented. I do not want to repeat them here again.

In the interviews intuition is raised as an issue in connection with appropriate dosage of stimuli during treatment.
Answering the question, *"How do you estimate how many treatment stimuli a patient may tolerate?"* intuition is – apart from palpatory information – always mentioned as being a basis for decision-making, similar to "gut feeling". Intuition draws on experience (IP 3, Z 248) and

> *"from what I saw when the patient came in, his posture, his language." (IP 2, Z 111)*
>
> *"Many osteopaths base their decision-making on intuition or "tactic knowledge", i.e. non-verbalisable knowledge acquired through experience. 'If nobody asks me I know it. If I want to explain it to somebody who asks I don't know it.' " (Augustinus, cited by IP 1, Z 10).*

Wikipedia defines intuition as follows:

> *"Intuition (…) is the ability to get insight into facts, perspectives, regularities or the subjective coherence of decisions through spontaneously emerging inspirations which have occurred unconsciously." (Wikipedia 2008)*

In connection with a follow-up appointment the aspect of intuition does not come up very often. We may interpret this to the effect that during treatment itself intuition guides your actions considerably. In order to take a decision about a follow-up appointment, however, there are other cognitive considerations which are emphasised.

4.2.8 Pragmatic aspects – resources, prescriptions

According to my interview partners the billing via prescriptions only plays a minor role.

Except for IP 2 all interview partners do the billing via prescriptions. In concrete terms, this means that for patients with prescriptions for physiotherapy costs are refunded by social insurance agencies. If they consult doctors they will be refunded through a "Wahlarztregelung", i.e. regulations covering doctors without contracts.

Physiotherapists among the interview partners specify (with the only exception of IP 2) that the number of prescribed treatments within a certain period is usually exploited (in Styria, for example, mostly 7, in Salzburg mostly 6).

All interview partners take pains to manage their appointments in order to be able to consider the – what they think - ideal intervals of treatment. In practice, however, this does not always work.

IP 1 states to be usually fully booked up for 4 weeks. Therefore he can often not make follow-up appointments as he would like to (IP 1, Z 21). IP 2 also extends the interval of treatment due to the abundance of appointments. (IP 2, Z 132).

At the beginning of their osteopathic work IP 4 and IP 5 had weekly intervals – out of physiotherapeutic habit and because there were enough available

appointment dates (IP 4, Z 41, IP 5, Z 240). When appointment schedules were filling up and consequently intervals got longer they realised that during these longer breaks there were much more effects concerning the patients. In these cases pragmatic circumstances changed intervals of treatment in a useful way.

All other interview partners did not mention any problems with regard to appointment schedules. They book in their patients on the basis of other criteria.

Concerning this particular aspect it would now be interesting to get the patients' point of view (see also chapter 6).

The influence of financial circumstances is not discussed in the interviews.

5 Summary

The essential question of this paper is:
What are the criteria on the basis of which graduates from the Vienna School of Osteopathy determine the point in time for a follow-up treatment?

The interview partners' statements present fundamental considerations how to determine intervals of treatment. These are evident throughout the interviews. In addition there are specific aspects concerning single criteria. Having made this distinction the most important statements are summarised again below.

5.1 Fundamentals:

- The point in time for a follow-up treatment has to be decided individually from patient to patient. The patient's individuality concerning her entire personality is a basic principle of osteopathy (Seffinger et al. 2003). It is not possible that a particular diagnosis determines a particular treatment pattern and consequently particular intervals of treatment.
- The follow-up treatment should only take place when the reaction to the previous treatment has been completed and the patient has reached a state of homeostasis again.
- To determine intervals of treatment osteopaths use their knowledge of sets of symptoms and diagnoses, constitution and psyche, palpatory information, verbal information of the patients, expertise as well as their therapeutic experience, which they weigh up individually.

5.2 Specific aspects of the single categories

- Appointments are made sooner for patients with acute ailments (2 – 14 days) than for patients with chronic ailments (2 – 6 weeks).

From experience, my interview partners report that patients with acute ailments usually react intensely to treatment stimuli. For this reason you should rather work very cautiously and indirectly. A check after a short time (2 days) should give a clue if the process of self healing has started or if a follow-up treatment is still necessary.
Concerning chronic ailments experience tells that the body's ability to react has been reduced. This is why my interview partners make follow-up appointments with patients after 2 weeks at the earliest.
The distinction between acute and chronic can also refer to tissue quality, irrespective of the patient's pains.

- Palpation tells osteopaths about the progress of the healing process and if the treatment interval was sufficient.

In concrete terms, tissue quality, the expression of cranial rhythm as well as a "tissue feedback" that is not more accurately defined is drawn on for decision-making by my interview partners.
The reliability of the palpation of tissue quality is confirmed in scientific studies (Fryer 2000), they support this approach.
The physiological existence of PRM has not been verified scientifically (Sommerfeld 2003, 27), thus Sommerfeld recommends not to draw on it to make clinical decisions. I subscribe to this view.
In my opinion, the interpretation of palpatory information should be taught more thoroughly during training. An appropriate method would be, e.g., "Cognitive Apprenticeship" (Klemme et al. 2006), which may be easily employed in clinical classes.

- Concerning expertise the concept of homeostasis, the concept of somatic dysfunction, the concept of the hierarchy of lesions, the concept of wound healing taken from tissue physiology and the type of lesion (structural, visceral, cranial) indicate when a patient should be treated again.

All interview partners address the concept of homeostasis as a fundamental concept. It states that a follow-up treatment should only start when homeostasis has been reached again after the previous treatment (Parsons et al. 2006)

The concept of somatic dysfunction states that the longer somatic dysfunction lasts, the more reduced the reaction time of the tissue is (Parsons 2006, Ward 2003).
This aspect may explain the differences in intervals of treatment between acute and chronic ailments (see 4.2.2.).

The concept of the hierarchy of lesions distinguishes between primary and secondary lesions (Parsons et al. 2006). It states that after treating the primary lesion enough time should be left until a follow-up treatment so that secondary lesions may dissipate (Liem et al. 2000).

The distinction between structural – cranial – visceral is discussed on two levels.
The assumption that structural, cranial and visceral treatment stimuli have different effects and therefore different reaction times is not confirmed. There are no recognizable tendencies even when you juxtapose a preferred technique and the experience figures of reaction times.
According to my interview partners the type of lesion – be it structural, cranial or visceral – changes the duration of the interval of treatment. We may interpret the statements to the extent that after a treatment structural lesions require less time to reorganise than visceral and that cranial lesions require the most time. However, this still needs to be verified.

My interview partners employ the concept of the stages of wound healing, which is taken from the area of tissue physiology, for acute sets of symptoms (van den Berg 1999).

Apart from this, individual histological aspects concerning visceral manipulations are mentioned (IP 3) as well as IP 6's view that structural techniques improve local cell metabolism, blood circulation and osmosis (IP 6, Z 142) whereas cranial techniques have a biochemical effect on the whole system (IP 6, Z 22). These statements are not backed, however, by theoretical studies.

Although, in my view, tissue physiology is a decisive factor concerning intervals of treatment, my interview partners make only few references to it.
Assumedly, this is due to the fact that relevant research only covers few aspects while at the same time being a long way off from practical work with many other aspects. The majority of osteopathic work is actually still based on experience (Triano 2005, Willard 2003, Sparks 2003, Portanova 2003).

- The patients' verbal information has a strong influence on determining intervals of treatment.

They are used to verify the reactions to the treatment and the moment when the reaction time is over.
This has a positive effect on compliance and the patient's health awareness (Brandstetter-Halberstatt 1995, Halasz 2001).

- Constitution and psyche are also relevant for managing intervals of treatment. However, they do not dominate.

Age, psyche and the osteopaths' personal impressions of the person influence intervals of treatment.
Classical constitution concepts (anterior/posterior posture type, etc.) are not drawn on to determine follow-up treatments.

6 Outlook

In research qualitative-explorative studies are often used to collect first fundamental statements on a certain subject (Mayring 1996). These statements may be the starting point for further research.
Quantitative and/or qualitative surveys may lead to a more intensive confrontation with the subject.
For example:

- A quantitative study may examine the correlation between the criteria developed here and the intervals of treatment.
- A qualitative survey may consider the patients' point of view, their opinions and satisfaction with intervals of treatment. In this respect, it would be interesting to ask how they feel when their osteopath is booked up.

In the course of the discussion with state institutions and social insurance agencies on the recognition of osteopathy some thoughts should be given to the question of how to organise the billing so that it meets the individual expectation of an osteopathic treatment.

Concerning basic research in osteopathy central models like, e.g., the concept of homeostasis, should be further developed in order to make them verifiable (e.g. with laboratory data).
Research and teaching should, to a greater extent, combine the basic principles of tissue physiology with practical osteopathic work.

7 Conclusion

From my point of view, the problem of this paper has been answered to my satisfaction.

The approach of using an explorative study made it possible to discuss the subject amply, which has brought to light many aspects.
We may, however, criticise the fact that due to this variety of aspects a more thorough discussion and confrontation with literature has not really been conducted in some places.

Personally, I could sharpen my perception for all the mentioned criteria through the work on this paper. In my daily practice I now decide much more consciously about appointments for follow-up treatments and I am in a position to articulate my arguments more clearly to patients.

Many thanks to all those who supported me!

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9 Appendix

9.1 List of abbreviations

IP	Interview partner
HVLA	High Velocity Low Amplitude Techniques
OMT	Osteopathic Manipulative Treatment
PRM	Primary Respiratory Mechanism
WSO	Vienna School of Osteopathy

9.2 Index of tables

9.3 Index of figures

Interviewleitfaden

1. Warming Up, Einstieg, Small Talk

2. Personbezogene Daten:

- Ursprungsberuf
- Berufslaufbahn im Überblick, seit wann als Osteopathin tätig
- Aufteilung der Arbeit: wie viel strukturell, cranial, viszeral?

3. Interviewteil

Meine Arbeit beschäftigt sich mit der Frage: „Wann ist der richtige / günstigste Zeitpunkt für die nächste Behandlung?“.

Zu Beginn bitte ich sie, an einen typischen Patienten zu denken. Schildern sie mir ihr vorgehen, wenn es darum geht, die weiteren Behandlungstermine festzulegen.

Worauf achten sie? Welche Überlegungen stellen sie an? Was beziehen sie alles in diese Entscheidung mit ein?

Ebene Behandlungskonzept:

Welche Beschwerdebilder bestellen sie schnell wieder, welche in längerem Abstand?

Wie schätzen sie ab, wie viel Behandlungsreize ein Patient verträgt? Welche Reaktionen können sie feststellen und welche Schlüsse ziehen sie daraus?

Können sie palpatorisch etwas wahrnehmen, dass ihnen verrät, wie viel ein Patient verträgt, wie er reagieren wird?

Verlangen unterschiedliche Techniken unterschiedliche Intervalle?

Gehen sie auf die Konstitution des Patienten ein?

Erwartete Wirkung der Behandlung – Homöostasekonzept

Ebene Person:

Welche Erwartungen haben Patienten in Bezug auf die zeitliche Anordnung von Behandlungsterminen?

Spielt der Leidensdruck des Patienten für sie eine Rolle und wenn ja welche?

Hat ihre Vorbildung als Physiotherapeut/Arzt eine Auswirkung auf diese Entscheidung?

Ebene Struktur:

Entscheiden sie nach Maßgabe freier Termine?

Sind Zeit- und Geldressourcen des Patienten von Bedeutung?

Rechnen sie über ärztliche Verordnung ab und hat das einen Einfluss auf das Behandlungsintervall?

Allgemeines zum Thema Behandlungsintervalle:

Es gibt seitens der Ausbildung ja keine Vorgaben für Behandlungsintervalle, eher eine „Tradition“ die gelehrt wird. Fehlen ihnen für die Praxis geeignete Richtlinien oder Informationen?

Wissen wie, wie andere Osteopathinnen die Intervalle handhaben?

Wie lange werden Patientinnen bei ihnen behandelt und welche Behandlungsintervalle wählen sie am häufigsten?

4. Allgemeine vertiefende Fragestellungen

Woran denken sie da genau?

Wie machen sie das genau?

Wie drückt sich das aus?

Können sie das näher ausführen?

Welche Gedanken stehen da im Hintergrund?