Therapist- Patient- Relationship in Osteopathy

How do osteopaths form their relationship to patients?
A qualitative study

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Content

I. Introduction

1. Personal background / motivation

The matter of the meaning of the relationship between patient and therapist has already occupied me since I have started my osteopathic education.

Osteopathy defines itself as a holistic concept that integrates many different human aspects, such as structure, psyche and function or body, spirit and soul into its view of human beings as well as into the osteopathic treatment. Thereby osteopathy refers to A.T. Still as the founder of a new, the entire person-meaning, view of bodily dysfunctions. This holism according to Still, however, does not include the aspect of relationship between osteopath and patient.

I have always experienced the intensity and fineness with which palpation was developed throughout the osteopathic education and how students were accompanied during their development as discrepant in contrast to the relatively little attention that was paid to the interaction with patients and the formation of these relationships.

During our education we were skilfully and very intensively instructed how to come in contact with the patients' tissue and how to learn to understand the language of the tissue, but we were sparsely trained how to come in contact with the patients and all their dimensions of body, spirit and psyche and how to shape this relationship consciously. This ability seems to be presumed as an intuitive ability.

Although the field of psyche is a prevalent subject of discussion during the education, it is not very differentiated and concretised. The relationship with patients shall be created professionally, but are there any clear parameters how a professional relationship should look like in the osteopathic treatment?

During our education we learned to understand the language of the tissues, but did we thereby necessarily learn to sense the mental states of our patients?

Does the ability to understand the human being in its entireness not require a reflection at a cognitive and verbal level?

Does professional therapeutic action not require a reflection from the outside, a reflection that does not only refer to the patient but also to the therapist and the relationship patient and osteopath are in?

If a human being looks for help from another one and admits 'treatment' on a bodily level, isn't that necessarily linked to regression and surrender on part of the patient? Isn't, therefore,

a critical reflection of the roles that are adopted during an osteopathic treatment needed? Shouldn't also the power relations, which necessarily arise in a body therapeutic setting, be reflected, in order to provide a responsible treatment?
All these thoughts induced me to dedicate my master thesis to the topic of therapist-patient relationship in osteopathy.

2. Question

Every therapeutic setting involves the encounter of two human beings.
In psychotherapy, for example, there are clear structural features of this therapeutic relationship such as empathy, compliance and transference/ countertransference. In osteopathy, however, there is no clear definition of the specific features of the therapeutic relationship but there are big individual differences in the shape of the therapist-patient-relationship, depending on the self-conception and the idea of man of osteopaths.
Based on depth psychological and developmental psychological considerations and considerations on the psychotherapeutic relationship, the therapist-patient-relationship is examined.
Osteopathy is a body-related treatment. The body experience of the osteopath and of the patient as well as dysfunctions of the body experience can influence the osteopathic treatment. That's why the aspect of body experience is incorporated into this paper.
It will be investigated in how far findings of depth psychology, neurobiology, developmental psychology and psychotherapy have found their way into osteopathy. By means of a qualitative study including guideline-oriented, problem-centred interviews with osteopaths it will be analysed how osteopaths create the therapeutic relationship during their practical work and in how far the findings from attachment theory, developmental psychology, neurobiology and psychotherapy are reflected in the practical work of osteopaths.

3. Osteopathic relevance

Research on this topic should contribute to a better interconnectedness of osteopathy with the findings from adjoining sciences and lead to alternatives of action in the education of osteopaths.

4. Content/ Structure of the paper

In the first chapter relationship in the context of depth psychology and developmental psychology is treated. Thereby attachment theory (Bowlby, Bion, Fonagy) and its relevance for a therapeutic treatment is highlighted. In the second chapter neurobiological findings coming from the research on mirror neurons (Bauer 2005) are included into the reflection on therapeutic relationships.

As osteopathy is a body-oriented method, in the third chapter body experience in connection with mental development and the development of the ability to relate to others is focussed.

Starting from sensomotoric development, research on body-image (Inhelder/Piaget, Schilder, Frostig, Du Bois) and from observations on corporeity in psychoanalysis (Ego-development as desomatisation) I will, by means of the concept of Ego dimension (Scharfetter), address the issue of interaction in the field of body experience and furthermore highlight the correlation between dysfunctions concerning body experience and dysfunctions of one's ability to relate to others. In connection with that I will then elaborate on particularities and constraints of osteopathy.

The fourth chapter attends the therapeutic relationship in psychotherapy.

Specific features of the psychotherapeutic relationship, such as empathy, compliance, transference/ countertransference and reciprocity shall be illustrated from the perspective of latest psychotherapeutic research.

Finally, in the fifth chapter the therapist-patient-relationship in osteopathic literature is examined.

Thereby the osteopathic literature is analysed under the aspect whether findings from attachment theory, neurobiology, developmental psychology and psychotherapeutic research were incorporated or not.

In part III of the paper way of working and self-conception of osteopaths concerning their therapist-patient relation will be analysed by means of a qualitative study consisting of problem-centred, guideline-supported interviews with five osteopaths.

5. Methodology

In order to illustrate how osteopaths concretely create the relationships to their patients I decided to conduct a qualitative study consisting of guideline-oriented, problem-centred interviews. Subsequently manifest and latent contents in the context of the interview are compiled by means of a qualitative content analysis. The most important aspects that emerge from the individual interviews are then related in a synopsis. Thereby several categories will be created. Relevant statements will be assigned to these categories, whereat it is important not to divorce these statements form their context in order to preserve the interview-immanent structure.

II. Theoretical approaches

1. Relationship in the context of depth psychology - attachment theory

In order to approximate the question which depth psychological concepts form the basis of the human ability to relate to others, the first chapter will deal with attachment theory, as well as with its forerunners (A. Freud) and its most important exponents such as Bowlby, Winnicott, Bion, Fonagy and Target. Subsequently I will work out the relevance of attachment theory for the osteopathic treatment.

1.1. J. Bowlby: Infantile attachment and the ability to relate to others

Attachment theory is a theoretical approach in the framework of depth psychology, which was developed by John Bowlby (1896-1972) in the middle of the twentieth century *(Fonagy, 2006, p. 11).*

It is based upon the assumption that the early bond between mother and child forms the basis for the ability to relate to others later in their life. Bowlby realised that the human suckling has the inborn tendency for social interactions. In the middle of the twentieth century he advanced the view *„dass der Säugling aufgrund einer biologisch vorgegebenen Bindungsneigung Interaktionen mit der Fürsorgeperson initiiere, aufrechterhalte oder abbreche und diese Person als sichere Basis für Welterkundung und Selbstentfaltung nutze“* (*Bowlby 1962, zitiert nach Fonagy,2004, S 12). [that due to a biologically predetermined attachment tendency the suckling initiates, maintains or abandons interactions with the caregiving person, and that the suckling uses this person as a secure basis for the exploration of the world and for his or her self-development (translated by A. Walchshofer)]*

Thus attachment theory holds the view that a person's attachment experience with the first attachment figure (in most cases the mother) affects his/her attachment behaviour throughout his/her whole life. This means that disorders in the early interaction might cause later attachment disorders.

One of the core messages of attachment theory according to Bowlby is the realisation that the security of the infantile attachment leads to a generalised feeling of competence and self-esteem and that one might proceed on the assumption that a secure attachment positively affects a number of cognitive and social abilities (*Fonagy, 2006, S 15).*

Due to developmental psychology this realization has become part of the general mindset, but at the time of its formation it was totally contradictory to Sigmund Freud`s drive theory, according to which the development of a child happens in the conflicting field of libidinous and aggressive drives and that environment, as well as attachment to the caregiving person only play a subordinate role.

1.2. Anna Freud: Ego and defence mechanisms

Researches on the bond between mother and child by Anna Freud (1895-1982) were forerunners for attachment theory. She was the first to realise that the infantile development is shaped by inner as well as by outer influences and that it might come to deviations in the personality structures if it comes to disturbances either at the constitutional level or at the level of environmental influences (*Fonagy,2006, S 77).*

In her work she proceeds on the assumption that the child develops defence mechanisms that should protect the Ego. These defence mechanisms answer the purposes of angst defence (Freud A., 1936).

If those defence mechanisms cannot sufficiently serve this purpose any longer, it comes to psychological disorders.

Hence pathology would be equivalent to malfunctioning defence mechanisms, which in turn are based upon deficient attachment strategies.

1.3. D.W. Winnicott: Holding and Handling

Attachment theory is closely connected to the realisations of D.W. Winnicott (1896-1971) for whom the self originates in the bond between mother and child.

In his opinion the child develops from a unity of mother and suckling. A healthy development can only happen if the mother is adequately capable of Holding and Handling. The ‘empathetic care’ of the attachment figure throughout the first months of life benefits these experiences of ‘being held’. By means of these sensomotor experiences the child learns to perceive him-/herself as an entity and also learns to differentiate between ‘Me’ and ‘Not-me’. Thus object relations become possible (Winnicott, 1984).

1.4. W.R. Bion: Containment

Wilfried Ruprecht Bion (1897-1979) completes this perspective according to which the primary attachment figure (mother) conveys, by means of the empathetic perception of the child, the feeling of being held to the child and coins the term 'Containment'(Container).

According to Bion (1962), successful Containment is based on the mother's ability to mentally hold the child. She reacts to the child in a bodily, caring way. She shows that she has noticed the child's mental state and at the same time demonstrates that she handles the situation.

Bion furthermore states that emotional experiences are the forerunners of thoughts. The comprehension, the allocation and the naming of one's own or another one's state of feelings are the precondition for the emergence and the development of thinking process ('presymbolic communication'). Thus, by 'container' we mean the psychological state of receptiveness for all emotions of the child. The feelings of the child are kept inside (in the mother) and answered with adequate reactions. Thereby feelings become nameable, are being understood and thoughts gain meaning and coherence. The suckling learns to distinguish between physical and psychical.

The boundary between inside and outside, between self and not-self is noticed by the baby for the first time (Bion, 1962).

Containment is an active process of intake, preserving, understanding, naming, transforming (Container: 'thinking breast'). It is not a passive understanding, not a mere holding, but a dynamic, processual relationship. The caring behaviour of the attachment figure is therefore crucial for the development of healthy attachment behaviour.

One has, however, to distinguish between emotional relationship and attachment relation.

The moment the person involved looks for security and comfort in the relationship an emotional relation transforms into an attachment relation. While emotional relations are either symmetric or asymmetric, attachment relations normally are deeply unbalanced (Fonagy, 2006). This means that the attachment figure (primary attachment figure/mother) should not look for protection by the child. If that is the case, this indicates a mental disorder of the mother and leads to mental disorders of the child. Shortcomings in the early attachment phase could subsequently lead to aggressive behaviour, mood swings and depressive moods.

Attachment theory assumes that every person develops attachments. However, these attachments can be either secure or insecure.

The security of the attachment system depends on the attachment figure's disposition to react. Furthermore it depends on how much the mother allows or rejects clinging or similar behaviour patterns (Bowlby, 2001).
The insecure attachment system is characterised by distrust, anger, angst and fear.

1.5. P. Fonagy und M. Target: Self-regulation

Peter Fonagy and Mary Target refined attachment theory and amplified it for the aspect of self- regulation.
By self-regulation we mean the ability to regulate one's own mental states and to relate to others adequately. This self-regulation system is partly genetically pre-programmed but is also strongly influenced by the infantile attachment experience. The ability of self regulation is the precondition for self-determined and responsible acting. Also neurobiological constituents, such as the function of the gyrus cinguli and its relation to the limbic system play, according to Fonagy and Target (2004), an important role for the development of emotional self-regulation.
„*Die Aktivität des Gyrus cinguli bildet unsere Fähigkeit ab, den Distress anderer zu teilen. Entsprechend sind manche Menschen vermutlich nicht in der Lage, Empathie zu zeigen, weil eine Dysfunktion auf subcortikaler Ebene vorliegt; bei anderen Menschen dagegen ist, vielleicht als Folge früher Erfahrungen mit der primären Bezugsperson, die Kontrolle der Aufmerksamkeit inadäquat und diese Dysfunktion kann auch in Reaktion auf andere psychosoziale Einwirkungen auftreten.“(Fonagy& Target, 2004, S 115)*
[The activity of the gyrus cinguli represents our ability, to share the distress of others. Accordingly some people are not able to show empathy, because there is a dysfunction at the subcortical level. Others may have an inadequate control of attention- maybe due to early experiences with the primary attachment figure- and this dysfunction can also occur in reaction to other psychosocial experience (translated by A. Walchshofer)]
Our ability to interpret emotionally exceptional situations is also closely connected to infantile attachment relations. The ability to regulate one's attention and to consciously concentrate it on certain stimuli develops from early attachment experiences. Hence the ability to consciously control our behaviour develops. That also implies the ability to put oneself into the position of others but at the same time not to let oneself be defeated by the distress of others.

„Bewusste Kontrolle ist die Fähigkeit, Aufmerksamkeit zu fokussieren, inadäquate Reaktionen zu unterdrücken und Wahrnehmungen sensibel aufzunehmen. Sie hängt mit den zahlreichen Folgeerscheinungen der sicheren Bindung zusammen, einschließlich sozialer Kompetenz, Empathie, Sympathie, niedrigem Aggressionsspiegel und Entwicklung des Gewissens. Sie korreliert mit Sympathie und der Fähigkeit, sich in andere hineinzuversetzen. Bewusste Kontrolliertheit ermöglicht es, sich vom Leiden des anderen, auch wenn man Sympathie für ihn empfinden kann, nicht überwältigen zu lassen.... Die Fähigkeit zur Selbstregulation , die mit Hilfe der bewussten Kontrolle erworben wird, hilft beim Aufbau des Gefühls von Eigenständigkeit, das es dem Individuum ermöglicht, psychische Nähe zuzulassen, eine Nähe, die es in Kontakt zum Denken und Fühlen des anderen bringt, ohne von dessen Leid überwältigt zu werden." (Fonagy &Target,2004, S 118)

[Conscious control is the ability to focus attention, to oppress inadequate reactions and to sensitively absorb apperceptions. It is closely connected to numerous after-effects of secure attachment, including social competence, empathy, sympathy, a low level of aggression and the development of conscience. It correlates with sympathy and the ability to put oneself into the position of others. Conscious control enables us, not to let us be defeated by the distress of others, even if we feel sympathy for them. ... The ability of self- regulation, which is learnt with the aid of conscious control, permits the development of self-reliance, which allows individuals to accept mental proximity, a sort of proximity that brings the individual person in contact with the other person's thoughts and feelings without being defeated by the other person's distress (translated by A. Walchshofer]

This means that the ability to adequately relate to others and to sense the feelings of others is closely linked to one's own infantile attachment experience and the successful development of self-regulation. In case self-regulation is not sufficiently developed, deficient empathy or the merging of one's own with the feelings of others might be the result.

In connection with self-regulation Fontagy und Target (2004) also deal with the function of mentalising.

Thereby we understand the growth of mental structures, which enable us to comprehend actions within an interpersonal context *(Fonagy& Target, 2004, S120).* One could interpret mentalising as the core aspect of human social functions. The coexistence of human beings is determined by this ability. Mentalising allows individuals to understand their feelings and communicate them to others.

The prototype of mentalising is language. Precondition, however, is that the individual understands his/her own mental states. These must have a meaning so as to be communicated. Understanding one's own mental states is closely linked to the ability of self-regulation.
The ability to think about one's own sensitivies is called reflexive function.
Thereby we understand the ability to become aware of one's own feelings and the feelings of others, to name one's emotional experiences and to be able to experience them expediently and to identify attitudes, plans and intentions of others (*Fonagy & Target,2004, S 120).*
Another important aspect concerning attachment is, according to Fonagy & Target (2004), mindfulness. Delicacy and empathy of the attachment figure foster the self-development of the child and thus enable the child to develop adequate attachment behaviour.

1.6. Summary

All in all one can say that a secure attachment during infancy is the precondition for the development of cognitive abilities, emotional self-regulation and the ability to communicate. A secure infantile attachment aids the development of an adequate attachment style that is characterized by empathy and self-esteem. Attachment security throughout the first year of one's life sets the stage for a quick and competent development of comprehension and interpretation of interpersonal processes. At best the human being is able to identify his/her own mental states as well as the states of others and to separate them from each other. Insecure attachment behaviour could lead to an avoiding attachment style that tries to protect the insecure self. In such a case the person is not able to distinguish between him-/herself and others and thus must try to avoid interpersonal encounters with the aid of avoiding strategies.
Insecure attachment behaviour may also lead to an involved attachment style that inflates others and negates the self.

1.7. Osteopathic relevance

The findings of attachment theory are the basis of each and every therapeutic relationship- and thus also of the relationship between patient and therapist during osteopathic treatments.
Thereby it is important to emphasise that it is a question of the attachment behaviour of the patient as well as about the attachment behaviour of the osteopath. Due to the findings from attachment theory, it is important that the osteopath has reflected his/her own attachment

behaviour and that he/she is able to distinguish between his/her own and the patient's attachment style during the therapeutic process.

Furthermore it is necessary to be able to distinguish between relationship and attachment. A therapeutic relationship might contain elements of attachment, as soon as it comes to regression on the part of the patient. (By regression we mean the return to infantile attachment behaviour.) An osteopathic treatment fosters, especially because of the therapeutic setting (the patient lies and is touched by the therapist) the regression of the patient. The responsibility of the therapist to show empathic, sensitive behaviour (holding) and to be a secure container for all the feelings of the patient (containment) is thus so much greater. It is in the responsibility of the osteopath to respect the psychical and physical limits of the patients and to reflect his/her own personal (attachment) share in the relationship.

The relationship between patient and therapist becomes problematic, if the therapist does not consciously reflect the regressive position of the patient and does not offer enough containment as well as if he/she does not conduct the patient out of the regressive situation, respectively. In this case the patient might experience an iteration of negative infantile attachment experiences.

A therapeutic relationship also becomes 'pathological', if it comes to attachment behaviour on part of the therapist. This means if the therapist looks for security and comfort in the relationship to the patient or if he/she looks for consolidation, thus for an infantile form of relationship.

The findings about mentalising and reflexive function are also relevant for the osteopathic treatment. Attachment theory assumes that reflexive function - the ability to think about one's own feelings - is the basis for relations and that language, as prototype of mentalising, permits interpersonal communication in the first place. As will be mentioned in the forthcoming chapters this is also significant for osteopathic treatments. Language can, because of its mentalising function, be very helpful during a body-oriented therapy, such as osteopathy, in order to communicate therapeutic processes and can thus act in an angst-regulating and self-regulating way for patients.

2. Neurobiological basis of interpersonal relationships – mirror neurons

In this chapter I will attend to the neurobiological basis of interpersonal relationships and its meaning for the osteopathic treatment. Recent research shows that one should also look at the ability to relate to other human beings from a neurobiological viewpoint. Since the discovery of mirror neurons (Rizzolatti, 1996) phenomena, such as empathy and intuition, are also

viewed under a neurobiological aspect (Bauer 2005). As empathy and intuition undoubtedly play an important role in osteopathy, these neurobiological findings are of great importance for osteopathy, too.

2.1. Mirror neurons

In the 1990s the researcher Giacomo Rizzolatti and his colleagues conducted several animal tests with monkeys and thereby discovered that it comes to an activation of specific areas of the brain not only when a certain action is performed or planned, respectively, but also when the monkey observes someone else performing the action. These particular action neurons are called mirror neurons *(Bauer, 2005, S 23).*

This means that this team of researchers discovered something like a neurobiological resonance for intuitive acting.

This discovery offers, on the one hand, an explanatory model for phenomena such as empathy or compassion and on the other hand an explanation for how we preconsciously adapt to our fellow men, how we sense and sympathise their emotional conditions. This definitely is another mechanism than understanding other persons in an intellectual way, as it leads to vibrations on an emotional level with the person concerned, as it sets resonance.

„Indem er [der Beobachter] das, was er beobachtet, unbewusst als inneres Simulationsprogramm erlebt, versteht er, und zwar spontan und ohne nachzudenken, was der andere tut. Weil dieses Verstehen die Innenperspektive des Handelnden mit einschließt, beinhaltet es eine ganz andere Dimension als das, was eine intellektuelle oder mathematische Analyse des beobachteten Handlungsablaufes leisten könnte. Was die Spiegelnervenzellen im Beobachter ablaufen lassen, ist das Spiegelbild dessen, was der andere tut." (Bauer, 2005, S 25)

[As the observer experiences what he/she observes as an inner simulation program, he/she understands- spontaneously and without thinking- what the other person is doing. Because this sort of comprehension includes the inner perspective of the agent, it implies a totally different dimension in comparison to how an intellectual or mathematical analysis of the actions observed looks like (translated by A. Walchshofer)]

Furthermore Bauer (2005) states that it is enough for the brain to observe only one sequence of the action so as to let the whole program run down. Mirror neurons are being activated, even if an action is only indicated. They can complete actions independently. Thereby the experience of the person concerned plays an important role. If a certain sequence has been

experienced frequently the brain learns to anticipate the probable ending of this action *(Bauer, 2005, S 31).* Thus Bauer assumes that these action neurons (mirror neurons) are the basis of unconscious human interaction and communication. *„Spiegelneurone benutzen das neurobiologische Inventar des Beobachters, um ihn in einer Art innerer Simulation spüren lassen, was in anderen, die er beobachtet, vorgeht." (Bauer, 2005, S 57)*

[Mirror neurons use the neurobiological inventory of the observer in order to let him/her sense what the person observed feels (translated by A. Walchshofer)]

Mirror neurons are the basis for spontaneous, intuitive behaviour, which is called the Theory of Mind (ToM).

Thereby we understand the interpersonal comprehension of mental states but also the ability to represent one's own as well as other's mental states in the own cognitive system. ToM describes the cognitive ability to understand that other people might have other opinions, desires or intentions. ToM also describes the ability to form theories about the mental states, conditions or intentions of others. It is also called the theory of mentalising *(see Fonagy 1.5)*.

„Die Fähigkeit, Mitgefühl und Empathie zu empfinden, beruht darauf, dass unsere eigenen neuronalen Systeme [...] spontan und unwillkürlich in uns jene Gefühle rekonstruieren, die wir bei einem Mitmenschen wahrnehmen". (Bauer,2005, S 51)

[The ability to feel compassion and empathy is based on the fact that our own neural systems […] spontaneously and mechanically reconstruct in us those feelings that we observe in others (translated by A. Walchshofer)]

This intuitive comprehension is a preconscious – pre-reflexive function. Due to its automatic and implicit mode of operation intuition permits extremely fast interpersonal processes of adjustment and coordination *(Bauer, 2005, S 147).* This stands in opposition to rational analyses. Thereby we understand the cognitive planning and reflection of an action.

Our actions are guided by intuition and by rational analyses at the same time. In the best case it comes to a balance of both of theses functions. If we rely on intuition only, we run the risk of drawing premature conclusions, of anticipating endings of actions that seem probable from our own experience, but might, however, not be true in this specific situation. Furthermore the system of mirror neurons works definitely worse under stress. Intuitive reactions become extremely irrational under emotional strain or in panic *(Bauer,2005, S 34).*

On the other hand only rational analysis works much slower and involves the risk to mislead if no relationship to one's own experiences is established.

In order to reach a well-balanced evaluation of a situation, language plays an important role as the conveyor of meaning as well as symbolisation.

„Die Wahrscheinlichkeit, dass wir eine Situation richtig bewertet haben, ist am größten, wenn Intuition und kritische Reflexion zu ähnlichen Ergebnissen kommen und einander ergänzen. Die Grenzen sowohl des intuitiven als auch des analytischen Urteils machen die überragende Rolle der Sprache bzw. des klärenden Gesprächs deutlich. Intuition ist ohne Sprache möglich, aber nur Sprache versetzt uns in die Lage, uns explizit über intuitive Wahrnehmungen zu verständigen." (Bauer, 2005,S 35)

[The probability of having evaluated a situation correctly is highest if intuition and critical reflection have come to similar results and complement one another. The limits of intuitive as well as of analytic judgements reveal the role of language or clarifying conversations, respectively. Intuition is possible without language, but it is language that enables us to explicitly communicate our intuitive apperceptions (translated by A. Walchshofer)]

The principle of mirror neurons is also transmittable to body sensation. Nerve cells in the area of the inferior parietal cerebral cortex, which are responsible for the imagination of sensation, *„erzeugen im Beobachter ein intuitives, unmittelbares Verstehen der Empfindungen der wahrgenommenen Person." (Bauer, 2005, S 44) [create an intuitive, immediate comprehension of the sensations of the person perceived in the observer (translated by A. Walchshofer)]* A short impression of the person observed might be enough to generate an intuitive idea of how the bodily sensations will look like in the near future.

Bauer calls this ability of intuitive comprehension on a neurobiological basis the mirror resonance. This also implies the changes of the observer's biological state of body *(Bauer, 2005, S 57).*

In order to develop and enhance these mirror systems adequate stimuli and an offer of relationship are necessary. As mentioned in the first chapter the infantile offer of relationship is of great importance for the development of adequate attachment behaviour. Bauer also attaches great importance to the aspect of attachment. *„...nirgendwo zeigt es sich so deutlich wie bei den Spiegelsystemen, welche Bedeutung zwischenmenschliche Beziehung für die Biologie unseres Körpers haben." (Bauer, 2005, S 59)*

[Nowhere else it becomes that clear what a great importance interpersonal relations have for the biology of our body as in the mirror systems (translated by A. Walchshofer)]

Interactions with reference persons help the child to develop an idea of his/her own self *(Bauer, 2005, S 65).*

Furthermore Bauer comments on therapeutic interactions and psychotherapy from the angle of mirror neurons. In each and every medical or therapeutic setting primarily two persons meet; two persons, *„deren Einstellungen und Erwartungen zu intuitiven Wahrnehmungs-, und*

Spieglungsabläufen führen, die den Behandlungserfolg stärker beeinflussen als manche therapeutische Maßnahme.“(Bauer, 2005, S 129)
[whose attitudes and expectations lead to intuitive perception sequences and mirroring processes, which have a much stronger influence on the success of the treatment than many other therapeutic measures (translated by A. Walchshofer)]
As will be mentioned in detail in chapter 4, certain inner programs run off on part of the therapist as soon as therapist and patient meet. These programs specify the further course of action and how sensations on part of the persons involved develop. They lead to a resonance on the part of the patient and activate intuitively corresponding attitudes, moods and expectations on part of the patient that usually comply with that of the therapist *(Bauer, 2005, S 131).*
Thus, according to Bauer, psychotherapy has made these resonance phenomena to its method. Thereby reciprocal mirroring phenomena are a central element of the method of treatment on the one hand, and on the other hand the subject of treatment at the same time *(Bauer,2005, S 134, see also chapter 4).*
Like Fonagy & Target (2004) *(see chapter 1)* Bauer, too, describes the self-regulation processes as important control mechanisms of human actions. These self-regulation processes have the human body as a basis. Every idea, every concept, every thought is preceded by a concrete experience on a bodily level. All mental operations are based on experiences we make as acting bodily beings. Thus these bodily experiences form the basis for intersubjective comprehension processes*(Bauer, 2005, S 163).*

2.2. Osteopathic relevance

To sum up, one can state that due to Rizzolatti’s (1996) findings a neurobiological substratum for interpersonal relationships and intuitive comprehension could be investigated – the mirror neurons. Rizzolatti could prove that on the basis of individual attachment experience neurobiological programs run off in the brain which enable us to sense the emotional state of our vis-à-vis. These programs run off preconsciously and correspond to the empathic intuitive comprehension of a person.
As in every other therapeutic situation, too, these mechanisms play an important role in osteopathic treatments as well. During the treatment osteopaths use their ability of intuitive comprehension, of preconsciously understanding a situation. As Bauer explains, it is also very important to incorporate the rational analysis into the evaluation of a situation as the mere

intuitive comprehension might be susceptible to disorders and unreliable, particularly in stressful situations. This emphasises the importance of language as a common conveyor of meaning. Osteopathy is a body-therapeutic method where the body with all its experiences and imprints is in the foreground. The osteopath communicates intuitively, primarily on a bodily level, with the patient. This is why the neurobiological findings mentioned above are of great importance for osteopathy in the sense that they should facilitate language as a mean of communication in the osteopathic treatment. *(„nur Sprache versetzt uns in die Lage, uns explizit über intuitive Wahrnehmungen zu verständigen", Bauer, 2005, S 35). [only language enables us to explicitly communicate intuitive perceptions (translated by A. Walchshofer)]* Language admits a conscious reflection of the interaction between osteopath and patient and may help the patient to communicate what he/she experiences on a bodily level. Language may connect the intuitive (pre-reflexive) level to the rational level.

3. Development of the body ego and development of the ability to relate to others

As the relationship of osteopaths to their patients takes place on a bodily level it is important to integrate body experience into my considerations. Starting from a view on the sensomotor development (Hoffer 1950, Inhelder/Piaget 1986) and body image research (Schilder 1923, Frostig 1975) I will then elaborate on the concept of body in the psychoanalytic context as well as on the modern concept of body (Du Bois 1990). Furthermore I will highlight the connection of body experience with the ability to relate to others as well as its susceptibility to disturbance (Scharfetter 1995). Finally I will once more address the osteopathic relevance of these findings.

3.1. Sensomotor development as the basis of body experience

The first months of a child's life are affected by the sensomotor development. The child's experience is characterised by the processing of sensations from the outside and signals from the inside *(Inhelder/Piaget, 1986, S 14ff)*. During the first phase of life body experience has to be equalled with self-experience. Bodily sensations such as hunger or pain affect the emotional state of the suckling. Only in the course of the mental development the baby learns to distinguish body sensations from feelings and to differentiate such sensations from emotional states. This step of development goes along with the ability to distinguish the inner world from the external world *(Hoffer, 1950, S 57ff)*. In the first months of life the child is not yet able to differentiate between him-/herself and the environment, he/she lives in a state of

being melt with the environment. The differentiation between ego and not-ego is successful only when the child has already developed a clear, coherent image of his/her own body and has learned to perceive the boundary of his/her body. The psychologist Paul Schilder firstly linked a profound body-schema research to the concept of body image (Schilder 1923). According to this, body experience is based on neurologically founded, central-nervously determined orientation structures. The body schema is a weighting function for sensible and sensorial stimuli. Schilder assumes that the body image does not only act out of unconsciousness but is also disposable in a state of being conscious. In his terminology Schilder does not clearly distinguish between body-schema and body image as other authors, like e.g. Frostig (1975), do. Frostig distinguishes between the neurologically stamped body-schema, which is stamped by the consciousness of the position of the own body in space, by depth sensibility and by the vestibular apparatus on the one hand and the emotionally stamped body image, which reflects positively or negatively influenced experiences regarding the own body (holding) on the other hand. *(see Holding, Containment, chapter 1)*.

The perception of the own body is thus determined by neurological and by mental factors.

Frostig (1975) as well as Du Bois (1990) use the overriding term 'body consciousness', which implies body-schema, body image and body conception (the cognitive knowledge of the body).

Du Bois defines the concept of body consciousness as *„ein auf den Körper gerichtetes Bewusstsein, das teilweise reflektiert und sprachlich kommuniziert wird. Körper-Erleben ist teilweises Bewusstsein von sich selbst und impliziert eine komplexe Wahrnehmung von sich selbst und die Wahrnehmung der Grenze zwischen Körper und Umwelt" (Du Bois,1990, S 3) [a consciousness focussing the body, which is partly reflected, partly linguistically communicated. Body experience is a partial consciousness of the self and implies a complex perception of oneself as well as the perception of the boundary between body and environment.(translated by A. Walchshofer)]*

At the age of about nine months the child learns to perceive the reference person as a separate object, having his/her own feelings and emotional states. The child begins to realise the dimension of relationship and consciously makes contact with the reference person, initiates the relationship. *(see chapter 1.1.)*

3.2.Body experience in the psychoanalytic context

Psychoanalytic literature primarily links body experience with ego-experience and self-experience.

According to psychoanalysis emotional development means that the ego concentrates on this body experience and thereby replaces bodily contents of expression and experience by not bodily contents. In psychoanalysis mental development is understood as de-somatization (Müller- Braunschweig, 1986). In a psychoanalytic sense the mental maturation process implies a disembodiment. This process presupposes the ability of abstraction, the ability to reflect bodily feelings, to think about the body. Language acquisition plays an important role here. *(see chapter 2)*

„Im Unbewussten und in neurotischen Symptomen bleiben allerdings Hinweise auf den körperlichen Ursprung des Erlebens in symbolischer Verdichtung erhalten. In funktioneller Regression werden die ursprünglichen Bezugspunkte des Erlebens wieder offengelegt.“ (Du Bois 1990, S 11)

[Hints for the bodily origin of experience remain, however, in a symbolic compression in the unconsciousness and in neurotic symptoms. By means of functional regression these original reference points of experience are being revealed again. (translated by A. Walchshofer)]

In a psychoanalytic sense persisting in bodily sensations - as for examples in hypochondria (thereby we understand a pathologically changed body experience)- is understood as defective ego-development. Ego-psychology also suggests that ego strength has something to do with the absence of body experience (*du Bois, 1990, S 14).*

3.3. The modern concept of body

The modern concept of body, however, stands for the relationship of the subject to the body. The body is experienced and lived at the same time (Du Bois,1990). Thus it comes to a permanent interaction between being and having a body. The development of this body *„beruht auf der Evolution und Integration der körperlichen Funktionssysteme und Wahrnehmungsapparate, die dabei auf immer höhere Stufen der Selbstvergegenwärtigung führen.“(Du Bois, 1990, S 9)*

[is based on the evolution and integration of bodily functional systems and perception devices that thereby lead to ever higher steps of the realization of the self. (translated by A. Walchshofer)]

Federn (1956) speaks of a bodily and an emotional ego sensation. Thereby he means that the ego boundaries have to be perceived libidinously and, at a higher step of conscious-organisation, contentually known. He defines the bodily ego sensation as a proprioceptive ego sensation and links it with ego boundary-cathexis. The proprioceptive ego sensation can be equalled with the body schema, the consciousness of the own body, which is composed of the integration and the processing of sensations that affect the body. Ego boundary-cathexis means the consciousness of the delimitation of the own body. *„Die Demarkierung der Grenze muss sowohl zum Körperinneren wie auch zur Außenwelt vollzogen werden.“(Du Bois, 1990 , S 14)*

[The demarcation of the boundary has to be made against the inner body as well as against the external world. (translated by A. Walchshofer)]

Suffering from psychosis means that the inner as well as the outer feeling of demarcation is disturbed. This leads to demarcation difficulties against the environment but also to difficulties in differentiating physical from mental feelings.

3.4. Body experience disorders and attachment disorders

Starting from ego psychology Scharfetter (1985) developed a concept of ego structures that vividly explains the meaning of body perception for mental processes and for the ability to relate to others. According to that intact ego structures- also on a bodily level- are necessary in order to be able to establish relationships. According to Scharfetter ego identity consists of many different, onionskin-like ordered ego-functions.

Sketch from inside outwards:

Ego-vitality

Ego- acitivity

Ego-consistence and Ego-coherence

Ego- demarcation

Ego- identity

The area of ego – demarcation, the ability to perceive oneself delimited from the environment, deserves particular attention within the field of osteopathic work. Especially people who

suffer from psychotic disorders, borderline or eating disorders have problems with ego-demarcation. Also victims of sexual assaults or sexual abuse experience their body as not clearly delimited from the environment.
But also without suffering from a manifest mental disorder, being touched and brought into regressive states – thereby we mean the immediate body experience without cognitive control *(see chapter 1)*- could lead to insecurities regarding one's own boundaries of body.
Body contact may generate the feeling that somebody tries to violate or penetrate into the boundaries of body. Mostly the reaction then is either angst or defence. Body contact may also lead to an activation of the infantile wish for affiliation which leads to unrealistic expectations and infantile attachment behaviour *(see chapter 1)* on the part of the patient if he/she is a rather unstable person.

3.5. Osteopathic relevance

Findings on the development and susceptibility for disorder of the body experience and on the connection between body experience and attachment behaviour are of great importance for the osteopathic treatment. During the treatment osteopaths establish contact to their patients on a bodily and mainly non-verbal level. Particularly the therapeutic setting, where patients are lying and the osteopaths are standing or sitting, encourages regressive states of body that might be even intensified by certain osteopathic methods such as craniosacral osteopathy or somatoemotional release. This may lead to threatening body sensations for labile or traumatised persons (even without a manifest mental disorder). The feeling of affiliation might release angst in the patient, especially if he/she stays in this body sensation after the therapy instead of being led out of this immediate experience by means of stabilizing measures and verbal accounting and being accompanied and supported by the osteopath *(see pre-lingual body experience 3.1.)*
Treatments on a bodily level might lead patients back to an infantile (pre-lingual) attachment level and reactivate infantile attachment behaviour. The special containment of an osteopathic treatment thus contains besides holding and handling *(see chapter 1)* on the bodily level also a sensitive switching to a 'protective' language that leads patients out of their immediate body experience in order to provide stability to the patients. *(see chapter 2)*
This should not mean that interaction on a bodily level, as it happens during the osteopathic treatment, cannot stand on its own. Verbalizing might also have negative effects and might

relativise or affect intensity and immediacy of the body experience. Too much verbalizing could lead to a stagnation in the therapeutic process and chronify avoidance strategies.

However, it is important to understand that defence might be a protective mechanism on the part of the patient in order to protect unstable ego-structures. During the treatment it is thus necessary to adjust the extent of support to the patient in a very sensitive way and to be aware of the susceptibility of disorders of the mental structures caused by the bodily proximity. Osteopaths have to be aware that the bodily proximity, which is established during the treatment, might a border violation for the patient, as it puts him/her into a defenceless situation. It is in the responsibility of the osteopath to accompany the patient out of this state after the treatment. Thereby it is not enough to trust in the intact mental structures or the self-healing forces of the patients. It is in the responsibility of the osteopaths to create the therapeutic framework in such a way that they are able to reliably catch their patients in case mental conflicts are being activated during the treatment.

The aspect of body perception plays an important role for the osteopath, too. If we understand the therapeutic situation as a dialogue, as the interaction between two human beings (as will be explained in detail in chapter 4) the osteopath's body perception gains in importance. Osteopaths bring in their personal ‚body-history' when coming in contact with their patients, as well. Their corporeity reflects their own personal history, their emotionally stamped body image, too. Osteopaths are able to switch between inner and outer perception. During the treatment the osteopath perceives the patients' body with his/her own body, but at the same time notices his/her own feelings bodily caused by this contact *(see transference/countertransference chapter 4.3).* In order to be able to separate these levels from each other it is important to be aware of the borders between oneself and the patient and to use the function of mentalising *(see chapter 2)*, for example by means of anatomic tables i.e. to use the outside perception. By means of centering, i.e. to focus one's attention to the own body, osteopaths can use inside perception to make the borders between them and their patients clear in order not to merge with them.

This brings up a very important question:

Which are the strategies that are available to patients in order to demarcate themselves in the therapeutic situation?

4. Relationship in a psychotherapeutic context

The psychotherapeutic relationship has clear structural features (Hain 2001, Bauer 2005). This chapter shall highlight whether these features are significant for the osteopathic treatment as well. Starting from reflections on empathy (Strozka 1982), compliance, transference/countertransference (Klussmann 2001) and the reciprocity during the therapeutic process (Bettighofer 2004) I will analyse the relevance of these phenomena for the osteopathic treatment.

4.1. Definition of psychotherapy

According to Hain (2001) *„Psychotherapie die Entdeckung der heilende Kraft zwischenmenschlicher Beziehung in der Neuzeit, einer von beruflichem Wissen und Können geformten Beziehung. Sie ermöglicht, stagnierte Entwicklung in Gang zu bringen, mobilisiert Bewältigungskräfte, stärkt den Selbstwert, die Autonomie und die Beziehungsfähigkeit, reduziert das Leiden, unterstützt die Klärung von innerseelischen und zwischenmenschlichen Konflikten und hilft, sich mit verletzenden Lebenserfahrungen sinnvoll auseinander zusetzen." (H. Herzka nach Hain, 2005,S 8)*

[psychotherapy is the discovery of the healing forces of interpersonal relationships in modern times, relationships formed by professional knowledge and competence. Psychotherapy makes it possible to revive stagnating developments, mobilises coping forces, strengthens self-esteem, autonomy and the ability to relate to others, reduces distress, helps to clear inner emotional and interpersonal conflicts as well as to deal with hurtful life experiences in a reasonable way. (translated by A. Walchshofer)]

Bauer (2005) describes psychotherapy in connection with mirror neurons *(see chapter 2)* and states:

„In der Psychotherapie sind beide Erfahrungen von Bedeutung: Einerseits geht es um die Entdeckung des gemeinsamen Gefühls, um konkordante Spiegelungserfahrungen, das heißt Erfahrungen des intuitiven Verstanden-Werdens und Verstehens. Andererseits geht es darum, das eigenen Gefühl zu entdecken das heißt den Unterschied zwischen eigenen und fremden Impulsen, Vorstellungen und Absichten zu reflektieren, also eine Identität zu entwickeln."(Bauer, 2005, S139)

[In psychotherapy both experiences are of great importance. On the one hand it is about discovering the shared feeling; it is about concordant mirroring experiences, i.e. the

experience of being intuitively understood and of intuitive comprehension. On the other hand it is about discovering one's own feeling, which means to reflect the difference between own and external impulses, ideas and intentions, i.e. to develop one's own identity. (translated by A.Walchshofer)]

4.2. Psychotherapeutic basics: empathy, neutrality, compliance

Empathy is the basis of every psychotherapeutic relationship, it is „*das Bemühen um eine sympathisierende Einfühlung" (Strozka ,1982, S 2)*.
[the effort for a sympathising empathy (translated by A. Walchshofer)]
„Die Spiegelungsfähigkeit des Patienten nachreifen zu lassen gelingt nur dann, wenn der Therapeut selbst über ausreichende Intuition verfügt, spontan sein kann, warmherzig ist, Geduld und möglichst auch Humor hat. Eine weitere, vielleicht die wichtigste Voraussetzung ist, dass er seinen Patienten - bei aller gebotenen professionellen Distanz- auch mag." (Bauer, 2005, S 139).
[To make the mirroring ability of the patient increase only succeeds if the therapist him-/herself possesses enough intuition, if he/she is able to be spontaneous, if he/she is warm-hearted, has patience and humour. A further, maybe the most important, precondition is, that he/she likes the patient despite all professional distance. (translated by A. Walchshofer)]
In 1921 Freud describes the psychoanalytic attitude as a benevolent neutrality and constant attention.
Klußmann (2001) states that it is an important precondition for a psychotherapeutic relationship that the therapist has got to know his/her own relationship motifs and interaction stereotypes by means of self-experience and is thus able to distinguish between his/her interests on those of his/her patients. Otherwise it comes to a personal relationship and subsequently to an abuse of the therapeutic situation. *(See attachment theory 1.1.)*

A further important factor for therapeutic relationships is the compliance of the patients. Thereby we mean the cooperation and collaboration of patients as well as their interest in the therapeutic process.

4.3. Transference – countertransference

Empathy and compliance are two central elements of psychotherapy, so to speak the basis on which a therapeutic relationship may develop. Basing on this ground specific features of the

psychotherapeutic relationship such as transference and countertransference develop. In a classic analytical sense transference means the re-production of an infantile conflict by the patient. *„…er[der Patient] inszeniert seine unbewussten frühen Beziehungskonflikte und seine bevorzugte Art ihrer Bewältigung.“ (Klußmann,2001, S 308)*

[the patient stages his unconscious early relationship conflicts and his/her preferred way of solving them. (translated by A. Walchshofer)]

This ‘transference offer’ on part of the patient depends on his/her personality structure. With a person having an immature personality structure it may come to tensions, distrust, diffuse needs and the feeling of not being understood on part of the patient. Persons with infantile disorders may claim direct need satisfaction from the therapist. *„…Er [der Patient] lässt sich entsprechend seiner Persönlichkeitsstruktur mehr oder weniger intensiv auf die therapeutische Beziehung ein, er öffnet seine inneren Schemata, indem er die Situation auf die ihnen entsprechende Art gestaltet und erfährt.[...]Je stärker die Regression wird und je ausgeprägter die Persönlichkeitsstörung ist, desto deutlicher übt der Patient für ihn unbewusst einen interaktiven Drang aus, der den Therapeuten zur Übernahme und zum Ausspielen spezifischer Rollen zu bewegen sucht. Es liegt nun ganz in der Hand des Analytikers, ob diese Situation letztlich in einer Re-Inszenierung einer traumatischen Beziehungskonstellation des Patienten endet, oder ob es möglich wird, hier Weichen neu zu stellen und ihm einen Neubeginn zu ermöglichen.“(Balint 1968 nach Bettinghofer 2004, S 97)*

[According to his/her personality structure the patient gets involved more or less in the therapeutic relationship, he/she opens inner schemata by generating and experiencing the situation in his/her personal way. […] The stronger regression gets and the more distinctive the personality disorder is, the more he/she unconsciously practices an interactive drive that tries to induce the therapist to overtake specific roles. It is now up to the analyst if this situation ends up in a reproduction of a traumatic relationship constellation or if it becomes possible to newly set the course and gives the patient the chance for a new beginning. (translated by A. Walchshofer)]

The therapist can read off this transference offer of the patient from his/her countertransference experience. This means that the patient activates feelings such as agitation, confusion, threat or anxiety in the therapist. *„Die Kunst des Therapeuten besteht darin, diesen Vorgang aufzuzeigen und ihn mit dem Patienten gemeinsam zu untersuchen.“ (Klussmann, 2001, S 309)*

[It is the therapist’s task to identify this process and examine it together with the patient. (translated by A. Walchshofer)]

This process requires tact and intuition on part of the therapist and the willingness to accept emotional strains and reflection and to cope with the insight gained on part of the patient.

Bauer *(2005)* also goes into the topic of specific features of a psychotherapeutic relationship. He calls the therapists' countertransference-reaction resonance. For him resonance is both – subject and method of treatment.

„Ein guter Psychotherapeut nimmt nicht nur das wahr, was der Patient vernünftigerweise sagen kann, sondern muss im Interesse des Patienten auch die intuitiven Signale und Botschaften berücksichtigen, die dieser aussendet. Dazu gehört nicht nur die Beachtung verschiedener körpersprachlicher Zeichen, sondern zusätzlich auch die Wahrnehmung von Resonanzen, die der Patient im Laufe der Behandlung im Therapeuten immer wieder aufs neue auslöst. Diese Resonanzen äußern sich beim Therapeuten in der Regel als spontan auftretende Gedanken, manchmal, wenngleich erheblich seltener, auch als körperliche Empfindungen."(Bauer,2005, S 137)

[A good therapist does not only perceive what the patient can reasonably say, but also has to – on behalf of the patient – consider the intuitive signals and messages the patient sends out. This does not only imply the consideration of the different signs of body language, but additionally the perception of resonances the patient activates always anew throughout the treatment. These resonances manifest themselves as spontaneous thoughts of the therapist, sometimes, although much less frequently, as bodily sensations. (translated by A. Walchshofer)]

Bauer describes two very important elements of the psychotherapeutic working method.

On the one hand there is intuitive comprehension of moods and thoughts the patient is aware of himself/ herself and which her /she is able to communicate and on the other hand there is a complementary comprehension of those sequences of actions and emotions the patient is, mostly because of a deep angst, not able to feel, think and express.

„ Sie (die Resonanz) kann weiterführende, ergänzende Gedanken und Gefühle in ihm [dem Therapeuten] hervorrufen, die sozusagen fortspinnen, wie die Geschichte des Patienten an jenen Stellen verlaufen sein könnte, wo dieser es bei einer Lücke oder einem Abbruch belassen musste."(Bauer, 2005, S 137)

[Resonance may evoke further complementary thoughts and feelings in the therapist that enable him/her to spin out how the story of the patient might have proceeded at those stations of life where the patient has got lapses of memory. (translated by A. Walchshofer)]

This means that intuition is the basis of countertransference phenomena. Mirror neurons, as described in chapter 1.2, form the neurobiological basis therefore.

4.4. Psychotherapy as an interaction process

In contrast to the classic analytical theory Bettighofer (2004) describes transference- and countertransference-phenomena as interaction between therapist and patient. While in classic psychoanalytic theory the patient is believed to be the object and the analyst to be the subject and the mutual interactional influence is not reflected, Bettighofer talks about an interactional field that has its influence on the therapist as well *(Bettighofer, 2004, S 22)*. Thus the analyst is not only observer, container and interpreter but also gets influenced by the interaction with the patient. So Bettighofer speaks for a reflection of the actual relationship between therapist and patient during the analysis. Thereby the therapist´s value systems as well his/her concepts play an important role. His/her own life situation and experiences stamp interventions and interpretations (*Bettighofer, 2004, S 28).*

Here again findings from attachment theory *(see attachment theory 1.1)* are of great importance. On the basis of his/her infantile attachment experiences every human being establishes cognitive working models. These working models define his/her expectations regarding other persons' reactions and at the same time determine his/her action plans. In this regard Bettighofer deals with the seemingly neutral attitude of the analyst.

„…Es wurde dabei jedoch übersehen, dass in keiner Interaktion zwischen zwei Personen – und eine solche ist auch die analytische wie jede andere therapeutische Situation - die Wahrung von Neutralität im Sinne einer Nicht- Beeinflussung auch durch die Person des Therapeuten möglich ist. Dies ist der Grundgedanke einer Zwei- Personen –Psychologie (Balint 1968, Bettighofer 2000) der sich während der letzten Jahre zunehmend durchzusetzen beginnt[...].In einer mitmenschlichen Kommunikation wie der analytischen Situation ist es nicht möglich, sich persönlich herauszuhalten und nicht zu kommunizieren (Wazlawik et al 1967) wie es bereits betont wurde. Auch Nicht – Kommunikation ist ein kommunikativer Akt, der vom anderen wahrgenommen und interpretiert wird. Die Negation einer Handlung , also ein Nicht- Handeln gibt es nicht, denn schon die reine Anwesenheit des Therapeuten ist eine kommunikative Handlung".(Bettighofer, 2004, S 53)

[Thereby it was, however, somehow overlooked that the preservation of neutrality in the sense of non-influence is not possible in any interaction between two persons – as is the analytic as well as every other therapeutic situation- not even for the therapist. This is the fundamental idea of a two person psychology (Balint 1968, Bettighofer 2000) that has started to win recognition within the last years. […] In an interpersonal communication such as the analytic situation it is not possible to keep oneself personally out or not to communicate (Wazlawik et

al 1967). Even non-communication is a communicative act, which is noticed and interpreted by the other person. The negation of an act does not exist; alone the therapist's presence is a communicative act. (translated by A. Walchshofer)]

Thus Bettighofer defines the therapeutic relationship as a symmetric interaction process between therapist and patient and centres the idea of the active role the analyst plays. He describes the therapeutic relationship as a circular process in which analysts can no longer be regarded as independent observers. With their personality and experience analysts are rather present in the therapeutic situation and their acting is influenced by the interaction with their patients. Bettighofer does not regard this as a lacking therapeutic abstinence but as a logical consequence of the insight that non-communication and not-acting is impossible.

Furthermore these insights also challenge the chronology of transference and countertransference phenomena. According to this view transference and countertransference are no longer chronologically successive processes whereby countertransference is understood as a reaction that follows transference, but simultaneous processes in patient and analyst (Bettighofer, 2004).

„Dadurch, dass der Therapeut als Beobachter mit dem Beobachteten in einer gemeinsamen Beziehung steht, beeinflusst er selbst den beobachteten und behandelten Patienten und ist wiederum selbst durch das Beobachtete in seiner Beobachtung beeinflußt." (Maturana, 1985 nach Bettighofer 2004, S 60)

[As the therapist as the observer is in relationship with the observed person, he/she influences the patient that he/she observes and treats and his/her observations are being influenced by what he/she observes in turn. (translated by A. Walchshofer)]

In modern psychotherapeutic research neutrality and abstinence of the analyst is being increasingly challenged in favour of an interactional view of the psychotherapeutic relationship. Thereby the actual relationship between patient and therapist is being reflected as well.

In this regard the significance of the therapist´s personal, ideological, religious and social backgrounds has to be considered. As mentioned above the therapist brings in his/her own history, worldview and idea of man whenever he/she comes in contact with the patient. If we assume that neutrality is only conditionally possible, it is necessary to consistently reflect one's own values and views when being in contact with patients.

4.5. Osteopathic relevance

The specific features of a psychotherapeutic relationship – empathy, compliance, transference and countertransference are also significant for the osteopathic treatment. An empathic approach to patients and the patients' compliance are the basis for a sustainable relationship during the treatment. But also phenomena such as transference and countertransference play an as important role for the osteopathic treatment as they do in every other therapeutic relationship, too. Especially resonances on a bodily level are of great importance for the osteopathic treatment.

Also the aspect of interaction between osteopath and patient – thus the reciprocity of transference and countertransference and the simultaneous existence of both phenomena – is a remarkable finding for osteopathy. Osteopaths try to approach their patients neutrally, try to absorb the signals, which are sent out by the patients' bodies, in a value-free way and try to act as neutral regulator. In osteopathy the importance of this neutral attitude towards patients is often emphasised. During the treatment oneself should withdraw and only absorb the impulses coming from patients. This attitude is comparable to the consistent attention and neutral attitude in a psychoanalytical sense. However, if we look at these intractions against the background of the component mentioned above, the osteopaths' neutrality and abstinence become a totally different meaning. Then we also have to reflect in osteopathy, that the perception of the patient is already a product of interaction with him/her and that the patient cannot be perceived isolated from the relationship that has developed between osteopath and patient in the treatment room. Interaction with the patient takes place on a verbal as well as on a bodily level in osteopathy. This makes the handling of transference and countertransference phenomena even more complicated and requires special mindfulness and cautiousness as well as a readiness for and ability of reflection of one's own motifs and interventions on part of the therapist. As transference and countertransference proceed in a body-oriented treatment such as osteopathy mainly on a bodily level, it is necessary to have ability for reflection on a bodily level as mentioned in chapter 1.3. Thereby we mean that that the body perception of the osteopathy plays an important role as an indicator of countertransference reactions. Osteopaths have to be able to perceive and reflect those feelings that are triggered off by patients and abstracted from the body such as anger, fury, grief on the one hand as well as the concrete bodily correlations such as tensions or tiredness on the other hand. The more differentiated the osteopath is able to perceive him-/herself in his/her corporeity, the better he/she is able to perceive those body sensations triggered off in the sense of

contertransference reactions and the better he/she can use them therapeutically. The osteopath must, however, be able to reflect these interaction processes on a cognitive level as well, i.e. to bring them to an abstract level and to communicate them to the patients.

5. The aspect of relationship in osteopathic research

In order to describe how the therapist-patient-relationship is positioned in the occupational image of osteopaths, in the following section essential competences of osteopaths and their liability towards patients will be discussed and analysed on the basis of Osteopathic Standards and the General Council of Osteopathy (2000).
Subsequently the osteopathic literature will be analysed with regard to the aspect of relationship between osteopath and patient and linked with those aspects of therapeutic relationship discussed in previous chapters**.**

5.1. Analysis of the Standards of the General Osteopathic Council 2000 with respect to therapist-patient relation

The Standards of the General Osteopathic Council clearly define the necessary wide competences of osteopaths.
An essential sociological and psychological knowledge of the patients is mentioned. *"A knowledge of human psychology and sociology, relevant to the acquisition and maintenance of health, sufficient to provide a context for clinical decision- making and patient manangement."(Osteopathic Standards, 2000, p 4)*
Also the professional therapeutic relationship is addressed and it is mentioned that such a relationship implies many ethic challenges. *„The therapeutic relationship in osteopathy is characterised by many ethical challenges for the osteopath and the patient. A key characteristic of osteopathy is the use of informed touch and this needs mutual trust and confidence between patient and osteopath. Therefore osteopaths must be able to establish and maintain an ethically sound, sincere, caring, concerned and appropriately empathic relationship with a patient […] The osteopath should be able to demonstrate a range of integrated skills and self-awareness sufficient to manage clinical challenges effectively in unfamiliar circumstances or situations."(Osteopathic Standards, 2000, p 6)*
Personal abilities of osteopaths must include the ability for self-reflection. "*Osteopaths must be self- aware and have a conscious, mature and realistic insight to their personal strengh*

and limitations. Critical self – reflection will be developed to a high level and used to guide the effective use of clinical reasoning skills."(Osteopathic Standards, 2000, p 7)

Concerning communication it is stressed that *"Effective and efficient communication is a key requirement for the delivery of high quality osteopathic care. It is primarily, but not entirely, confined to interactions between the patient and the osteopath. […] Osteopaths must have highly developed interpersonal skills […]Highly refined non- vebal skills including palpation, auditory and visual recogntion must complement good oral and written comunication skills. Such non- verbal communication is used to amplify, confirm or challenge data, information and insight from the case history." (Osteopathic Standards, 2000, p 8)*

Osteopaths should be able to identify and evaluate the needs of their patients: "A *recognition of the relative importance of the psychosocial context of the patient´s presenting complaint[…and…]an ability to recognise the characteristics and consequences of non-verbal communication and issues of ethnicity, gender, religious beliefs and socioeconomic states as they may impact on the patient´s health." (Osteopathic Standards, 2000, p 13)*

Furthermore it is highlighted that tactile palpation is one of the primary communication channels in osteopathy by means of which osteopaths come in contact with their patients.

"A defining character of osteopaths is their effective use of a highly developed and refined skill of palpation. Palption may be considered to be one of the primary communication channels for most osteopaths in undertaking their professional interactions with patients[…]The osteopath should be able to demonstrate a critical appreciation of the therapeutic value of touch and palption[…and]the ability to use palpation in conjunction with other evaluation methods before forming a diagnostic hypothesis." (Osteopathic Standards, 2000, p 15)

It is, thus, stressed that one of the most important quality criteria is that osteopaths are aware of their liability towards patients, that palpation is not the only criterion of diagnosis and that osteopaths are conscious of the consequences of bodily contact. Furthermore the importance of critical self-reflection and knowledge of sociological and psychological aspects of the therapist-patient-relationship for a responsible osteopathic work is emphasised.

5.2. Analysis of osteopathic literature with regard to therapist-patient relationship

In the following chapter I will analyse in how far osteopathic literature goes into the aspect of relationship between osteopath and patient during the treatment and how much of the aspects outlined in previous chapters can be found in osteopathic literature.

Especially those aspects of attachment theory will be addressed that are of a particular interest for osteopathy – namely the concept of containment, which is the ability of the therapist to hold and protect the patient. Furthermore it will be analysed in how far neurobiological findings concerning mirror neurons found their way into osteopathy. Particularly important here is the insight that an intuitive comprehension of sensitivities and emotional states of others is a product of the person's own experience and that intuition cannot be looked at isolated from the rational analysis of a situation, as intuition is a preconscious process and susceptible of error under stress. The significance of developmental psychological aspects, especially the development and susceptibility of body experience and the connection between body experience and the ability to relate to others, are highlighted here as well. Furthermore it will be analysed in how far the features of a psychotherapeutic relationship, such as empathy, compliance, transference and countertransference are incorporated into the reflections on the osteopathic relationship. Thereby I will go into detail whether the interactional aspect, thus the correlation between osteopath and patient, is of any importance in osteopathic literature or not.

Hereby I have to point out that inquiry of osteopathic literature was rather difficult. The ESO only provided introductions and conclusions of the relevant master theses, while the BSO did not react to repeated requests concerning the full texts of the relevant papers.

5.2.1. Attachment theory and osteopathy

In later osteopathic research several osteopaths have dealt with the therapist-patient-relationship in osteopathy.

Therese Harcourt (1989) writes about the topic 'Osteopathy and the Unconscious' and thereby already includes in her work the psychoanalytical concepts of Winnicott's 'Holding' and Bion's 'Containment'.

In his article „ The balance of practice: preparing for long-term work"(1997 b) Philip Latey deals with the aspect of relationship between osteopaths and patients in long-term therapies in a very differentiated way. The editor of the journal depicts him as clinical philosopher with osteopathic roots.

Latey highlights the relationship between patient and therapist and establishes connections to findings from psychology and psychotherapy. According to Latey patients react deeply to be in good hands during the therapy. He uses the term containment as it was coined in attachment theory by Bion *(see attachment theory, 1.1).* This feeling of being in good hands is

guaranteed by factors such as humour or integrity on part of the therapist, furthermore by the acceptance of a long-term therapy on both parts and the shared responsibility for content and progress of the therapy *(Latey, 1997, S 226).* If these factors are given, patients feel safe and supported and are able to admit changes in this secure situation. Latey admits that there is little experience with long-term therapy in the field of osteopathy and that there exists only little discussion and literature on this topic. For long-term therapies continuity, availability and reliability have to be guaranteed on the part of the therapist. A clinical setting has to be established, which enables the patient to bring in personal experiences and feelings into the therapy.

Latey emphasises that in a therapeutic setting a certain degree of dependence is necessary in order to make changes possible. This dependence is a mutual one. The patient depends on the abilities and the containment of the therapist and the therapist, on the other hand, depends on the compliance and participation of the patient. The longer the therapy lasts the more important become, according to Latey, the emotional and psychosocial influences on the therapist-patient relationship for the success of the therapy. The longer a therapy lasts the bigger problems of dependence and lacking compliance may grow. Latey assumes that dependence often occurs in therapeutic relationships if the patient is not assured of the therapist *(see attachment theory chapter 1.1.).* He analyses the different phases of an osteopathic therapy and especially highlights the therapists' liability towards their patients, in particular with regard to the patient's dependence, detachment and acceptance of autonomy. It becomes clear from the article that the osteopathic treatment implies a dependence of patients on their therapists (but also vice versa) which has to be handled with care.

Findings from attachment theory have already found their way into the osteopathic literature. Latey as well as Harcourt directly refer to Winnicott and Bion and Latey especially stresses the therapist's liability towards patients and the importance of containment as the basis of a therapeutic relationship.

5.2.2. Developmental psychological aspects in osteopathic research and the significance of body perception in the osteopathic treatment

In „Complexity and the changing individual" (1997a) Philip Latey also deals with developmental psychological aspects of body work. He deals with mental functions (*see 1.1.)* and refers to Piaget *(see chapter 3)* when he comes to describe the development of thinking.

Furthermore he states that during infancy it is impossible to distinguish between different sensorial (muscular and visceral) sensations and that the baby primarily tries to maintain a balanced state of energy at the different sensory channels. "*Two principles appear to govern the baby's behaviour: Keep the sum of energy entering all sensory channels within an optimal range* and *when the sum is at an appropriate level, attend to the familiar patterning of the energy regardless of the modality of origin until a schema is well formed, then search out a novel pattern of energy." (Latey, 1997, p 274 according to Barron-Cohen and Harrison 1997, p 227)* Out of this undifferentiated sensory processing a differentiated perception of the own body develops in the course of time *(see 3.1.).* Latey describes this as „*a sensory system that senses the senses"(Latey, 1997, p 274).* Furthermore he depicts in this regard the language as ability for abstraction, as a mentalising function (*see 1.1.). „the capacity of abstract hypothetic-deductive thought must arrive as a late addition somewhere within this complex layering"(Latey, 1997, p 274).* He emphasises that a complex body therapeutic (osteopathic) treatment also integrates language, whereby it is difficult to find the right balance. „*The introduction of talk to touch and movement can be marvellously integrative- but the balance can be hard to achieve."(Latey, 1997, p 270*)

To Latey it is particularly important to stress that touch, gesticulation, screaming and language belong together in the treatment. But there has to be a broad conceptual framework in order to integrate all these factors without losing track *(Latey, 1997, p 271).* He refers to A.T. Still and the importance of integrating different approaches when he states: *„The first osteopath, A.T.Still, had been a bonestetter and a magneitc healer (early form of hypnotherapy) before he joined them together in 1890s. In all of his writing and teaching he emphatizes that osteopathy had to be about ´mind, matter and motion´(Still 1897). This author aims to show how the purely mechanical bonesetter and the esoteric magnetic healer can modify their disconnected stance when they explore the middle ground."(Latey, 1997, p 271)*

Coralie Neville Smith (1999) deals with the significance of verbal communication as an important aspect of the therapists' holistic view of patients.

Thorsten Liem (2001) writes about the art of palpating and thereby integrates aspects of body perception. He quotes Ashley Motagnu: *"Das Gefühl der Identität erwächst aus einem Gefühl des Kontaktes mit dem Körper. Um zu wissen, wer ich bin, muss ich dessen gewahr sein, was ich fühle." (Montagnu in Liem, 2001, p 288)*

[The feeling of identity grows out of a feeling of contact with the body. In order to know who I am I have to be aware of what I feel. (translated by A. Walchshofer)]

Liem also integrates aspect of interaction between therapist and patient into his reflection: *„Es ist nützlich, sich erstens seiner emotionalen Verfassung und dieser Wechselwirkung immer bewusst zu werden und zweitens bestimmte Techniken und Rituale zu erlernen, um in das eigene Zentrum zu gelangen, wo immer diese auch sein mag, sich mit seinem weiseren Ich zu verbinden oder in einen Zustand der Leere zu gelangen."(Liem, 2001, S 290)*
[For one thing it is useful to be always aware of one's own emotional state and this interaction and for another thing it is helpful to learn certain techniques and rites to reach one's own centre- wherever this might be- and to affiliate with one's wiser ego or to reach a state of inner emptiness. (translated by A. Walchshofer)]
Viola Frymann (1968) highlights distinctiveness of osteopaths compared to conventional doctors, because they use parts of their own being as diagnostic and therapeutic instruments. „*He has merely begun to use parts of his own beeing as diagnostic and therapeutic instruments"(Frymann, 1968, p 65)* and emphasises the meaning of non-verbal interaction between osteopath and patient. „*The response of the one to whom we speak is profoundly influenced by the unspoken words that are uttered emotionally and mentally, and are heard in the same sphere."(Frymann, 1968, p 65)*

Developmental psychological aspects are reflected in osteopathic literature. By means of developmental psychological reflections Latey highlights the meaning of body perception for the ability to relate to others. In this regard he elaborates on the meaning of language as a way of abstraction of feelings. Latey, as well as Frymann and Liem mention the meaning of body perception in the osteopathic process as diagnostic criterion on the one hand, and on the other hand as demarcation strategy. Body perception of patients, however, is no subject of discussion.

5.2.3. Empathy, Compliance and Compassion in Osteopathy

Frymann (1968) complements the term empathy by the term compassion. To her, compassion is an important connection between patient and therapist. Only if a relationship is borne by compassion, the patient becomes able to open up to the therapist and on the other hand the therapist is only able to empathise if he/she is aware of him-/herself.
"Compassion is the bridge of rapport built by the physicians own inner awareness across which our patient can carry his burden to us and lay it at our feet. The physician sees his

patient with understanding that is proportionate to his own self- awareness[…]Compassion is the catalyst without which this interchange between patient and physician cannot occur." (Frymann, 1968, p 66)

To Frymann compassion means more than empathy, as it implies that the therapist recognises the patient's deepest needs, that he/she is able to deal with them in a sympathetic way and really takes care. "*But compassion means even more than this, for it implies that the individual recognizes, enters into the problem with understanding and deeply cares about the individual who has this deep need.*" (*Frymann,1968, p 67*) For her, this sort of compassion is as important as technical competence. *„The patient with the chronic upper thoracic strain pattern may need your compassion to enable her to unburden her load of responsabilities as much as she needs your skillful hands to release her back."(Frymann, 1968, p 69)*

Frymann also emphasises the high significance of the social competence of the osteopath and the interaction between patient and therapist. Precondition therefore is security, stability and demarcation against the patients' problems or sufferings. *„We must not become a part of his suffering, but we must have a vivid awareness of its nature and its intensity."(Frymann, 1968, p 67)*

Frymann stresses the importance that the patients themselves open up the door to their inner needs. Only after that help can become effective, help '*can help flow in'*. For her the interaction between patient and osteopath goes far beyond the material or verbal aspect. She describes a sort of *'vibratory envelope'*, which encloses each and every person. Frymann sees this '*energetic field'* as a further diagnostic perception that enables osteopaths to advance to the deepest needs of their patients. She then links the concept of compassion with this energetic field. *„What is the key to unlock this door to greater diagnostic perception ? It is compassion."(Frymann, 1968, p 67)*

She introduces the special technique of diagnostic attention, which implies nonverbal questions to the patient that shall enable the osteopath to advance to their patients' deepest needs. Thereby the osteopath asks the body nonverbal questions and tries to sense the answers in the tissues of the patients. Alone these nonverbal questions make a deeper connection to the patient possible and can achieve answers of the patients – on the level of tissues as well as on a verbal level. Thus old fears and feelings of guilt, which were repressed for a long time, can be reached and subsequently tissues can start to relax.

Frymann also talks about verbal communication. She confronts patients with questions, such as *: 'Why would you like to feel better?'* or *'If tomorrow you woke up totally healthy, what would you do?'* and thereby often provokes angry answers – especially of chronic patients.

But even this anger often has a clarifying function for patients and might initiate changes. Fryman refers to A.T. Still here and states that it is the osteopath's task to open doors and provide channels so that healing can happen. *(Frymann, 1968, p 69)*
In ‚Aspects of the Patient –Practitioner –Relationship'(1987) Charlie Shaw deals with the realtionship between patient and practitioner in the osteopathic treatment. He compares the therapeutic process to a dance and highlights aspects such as compassion and empathy.

Empathy and compliance are two concepts that are reflected in the osteopathic literature quoted above. Frymann adds the concept of compassion to these concepts. To her compassion means more than empathy as it allows access to the patients' real needs and repressed feelings.

5.2.4. Transference and countertransference in Osteopathy

In 'Preparing for a long-term work' (1997 b) Philip Latey additionally describes the phenomenon of transference in the body therapeutic process.
He analyses the osteopathic work (or manual therapeutic work, exercise therapy) following the analysis of the processes in psychotherapeutic work. He stresses the importance of distinguishing the different phases of a therapeutic process as well as the importance of being aware of the phenomenon of transference *(see 4.2.)* and of acting thereupon. Again and again he emphasises the significance of verbalizing, especially in order to make countertransference phenomena and resistances transparent. On the one hand he points out that relationship in a osteopathic - , manualtherapeutic therapy shows specific interaction patterns due to the body contact. On the other hand he stresses the importance of verbalizing and reflecting on the part of the therapist.
Transference phenomena, such as the idealization of a person of whom one expects help is, according to Latey, a quite natural reaction. Not to abuse this situation requires a strong personality. But transference can also be expressed by depreciation, anger or distrust. This, in turn, causes countertransference on part of practitioners. Latey assumes that is not necessary to go back to the roots of these transference phenomena. But what he thinks is necessary, though, is to be aware of these phenomena, to be prepared for their occurrence and to permit oneself to observe. *(„... be aware of their potential presence, expect them to arise, and allow ourselves to observe them." (Latey,1997, p 227))* At the start of a therapy it often comes, according to Latey, to overreactions on part of the patients, in the sense that symptoms

disappear immediately. These transference-healings rarely hold on for a long time. They do not lead to developments desired. When it comes to such spontaneous healings it is, according to Latey, in the therapists' responsibility to accept the recovery potential of the patient on the one hand but yet to offer support for profound, process-oriented work. *(Latey, 1997, 1(4), p 228)*

According to Latey psychoanalysis as well as psychotherapy has brought important knowledge to manual therapy and to movement therapy. But he stresses that conversation that develops in manual therapy, is totally different from that in psychotherapy. '*We differ in our awareness of the tangibility of change" […]* „*The idea of mind, motivation and the therapeutic process that come naturally to the manual therapist do not yet appear in contemporary psychology." (Bodywork and movement therapies 1997, 1(4), p 224)*

That's why in bodywork a separate frame of reference has to be developed in order to describe the core of the therapeutic process. As manual therapy means thinking, feeling, observing and treating at the same time, this type of work is very complex.

Fymann (1968) highlights that osteopathic work means to perceive the human being in his/her wholeness and to reach his/her real needs. Thereby she describes phenomena that are comparable to transference in psychotherapy as energetic phenomenon, as *„vibratory envelope"*, that surrounds every being and that permits access to the patients' wholeness (as mentioned above). She uses nonverbal communication in order to reach unconscious conflicts of patients. The technique of *'diagnostic touch*' might be compared to countertransference in a psychotherapeutic sense, where therapists expand to basic conflicts of the patients by means of their mental or physical reactions towards them. Thereby the therapist tries to understand those feelings the patient is not able to feel, think and communicate - mostly because of deep angst. *(see 4.2.)*

Liem (2001) also deals with phenomena of transference and countertransference on a bodily level, when he writes*: „Wenn diese Resonanz zwischen dem Körperteil des Patienten und der Hand oder eines anderen berührenden Körperteils des Therapeuten stattfindet, hat dieser nichts weiter zu tun, als wahrzunehmen, wie sich sein Körperteil verhält und was er in seinem Körperteil empfindet, um zu verstehen, wie der Körper des Patienten organisiert ist. Die Grenzen des Erspürens von Resonanzphänomenen scheinen insbesondere durch die Empfindsamkeit und Wahrhaftigkeit des Therapeuten sowie durch das Niveau seiner Kenntnisse der beteiligten anatomischen Strukturen, Physiologien, embryologischen Entwicklungen, „energetischen" Feldern und ähnlichen bestimmt zu sein." (Liem, 2001, p 296-297)*

[When this resonance between the body part of the patient and the hand (or any other body part) of the therapist takes place, the therapist has to do nothing else than perceiving how his/her body part reacts and what he senses in this part of the body in order to understand how the patient's body is organised. Limits of sensation seem to be determined by sensibility and truthfulness of the therapist as well as by his/her level of knowledge of the anatomic structures involved, of physiology, embryonic development,' energetic' fields and the like. (translated by A. Walchshofer)]

In this statement the definition of transference and countertransference (or resonance) in a psychotherapeutic sense *(see 4.2.)* are being reflected. For osteopaths this necessarily implies the ability for self-reflection and to a great extent the ability of perceiving the own bodily phenomena (thus the kind of differentiated body-perception, inner perception mentioned in chapter 3), but also the cognitive knowledge of anatomic structures, the exterior view. *(see chapter 3)*

In her work 'A study into how osteopaths understand emotions in body tissues' Emily Dux (1999) also establishes a connection between osteopathy and psychotherapy.

Transference and countertransference are thus verbalised by osteopathic authors.

Latey points out that it is important to be aware of these phenomena during the therapeutic process. In this regard he highlights the importance of verbalizing. Fryman describes the *„diagnostic touch"*- technique, which enables the osteopath to come in contact with the patients' conflicts, which is comparable to countertransference in psychotherapy. Liem describes resonance phenomena on a bodily level, which might be compared to countertransference phenomena. From that it becomes clear that differentiated body perception as well as the ability for self-reflection is of great importance in the osteopathic context.

5.2.5. Osteopathy as interaction process

Frymann (1968) emphasises the interaction during an osteopathic treatment, *'the two-way–flow between patient and physician'* and stresses that the osteopath's self-perception plays an important role during the treatment. The osteopath can only perceive the patient in connection with his/her own personal history and the sensation of his/her own body. The osteopath is stamped by the unconscious and only a small part is accessible to the conscious awareness.

"the wealth of accumulated experiences is like an iceberg- a small portion is visible, as it were, for it lies within the accessible conscious mind, but the greater part lies hidden within the unconscious mind, awaiting only our need to bring its lessons to our conscious awareness."(Frymann, 1968, p 66)

Latey, too, puts emphasise on the interaction between therapist and patient. *'The clinical working relationship depends on our understanding of this two-sidedness' (Latey, 1997, p 272)*. Therefore reflection and the awareness of his/her own patterns and blind spots. This means that on part of the osteopath the function of mentalising, the abstraction of immediate experiences, is necessary as well.

Latey speaks about rhythm and resonance *(see chapter 2)* that develop in a manual-, and movement therapeutic relationship between therapist and patient. Furthermore he stresses the significance of interaction in the therapeutic relationship and the necessity of self-reflection on part of the therapist as important measure of meeting the complexity in a body centered treatment.

In „Zen-Bewußtsein bei der Lehre der Palpation: Ein osteopathischer Ansatz" (‚Zen-awareness in the teachings of palpation. An osteopathic approach.') Comeaux (2006) integrates spiritual aspects into his considerations. He describes the meaning of mutual interaction in the therapeutic process: *„...Diese Entwicklung erhält tiefere Bedeutung, wenn der Beobachter und das Beobachtete bei der gegenseitigen Wahrnehmung in reziproker Beziehung zueinander stehen und beide ihre wechselseitige Beteiligung an der Einheit allen Seins erkennen." (Comeaux, 2006, S 13)*

[This development gains a deeper meaning if the observer and the observed stand in a reciprocal relationship when mutually perceiving each other and if both realise their mutual contribution to the oneness of all being. (translated by A. Walchshofer)]

He refers to R.Becker when he states: *„In dem Moment, in dem der Arzt seine Hände zur palpatorischen Diagnose und Behandlung auf den Patienten legt, ist er gemeinsam mit diesem Patienten ein Teilnehmer an einer großen gemeinsamen Erfahrung. Er ist für ihn gänzlich unmöglich, neutraler oder unbeteiligter Beobachter zu sein, während er mit dem lebenden Gewebe des Patienten arbeitet.(Becker 1997, S 138)*

[The moment the doctors puts his hands onto the patient to palpatorically diagnose, he/she is participates in a big conjoint experience. It is totally impossible for him/her to be a neutral or not involved observer, while he/she works with the living tissue of patients. (translated by A. Walchshofer)]

In the conclusion of his paper 'Inter and intraexaminer reliability in palpation of the PRM'(2000) Sommerfeld (2000) writes*: „Another aspect can be seen in the complex interaction between subject (patient) and examiner. Phenomena like transmission and couter-transmission, which are known from psychology and psychotherapy, can be regarded as relevant. As the observers are always humans (not machines), the subject´s influence on the examiner should be taken into account, too. So changes of methodological aspects, regarding the system subject- examiner as a constantly changing network of complex interaction should be considered […]For the future, methodological advice of psychologists and sociologists can be helpful." (Sommerfeld, 2000, S 143)*

Latey as well as Frymann emphasise *'the two- sidedness'* of a therapeutic process. Comeaux links osteopathy with Zen-Buddhism and stresses the reciprocity of the relationship between patient and osteopath. Becker highlights the impossibility of neutrality and abstinence of the practitioner. Sommerfeld calls the relationship between patient and osteopath as a permanently changing network of complex interactions and speaks for the integration of psychological and sociological findings into osteopathy. These statements reflect findings from later psychotherapy - research. Thereby the concepts of abstinence and neutrality in the psychotherapeutic process are increasingly challenged and interaction is increasingly centred. All authors quoted mention the necessity of critical self-reflection.

5.2.6. Critical reflections of religious-spiritual aspects in osteopathy with regard to the therapist-patient relationship

It is astonishing to find so many religious aspects in Frymann's article (1968) that is a scientific one and deals very differentiated with the therapist-patient-relationship.
In regard of her reflections on the wholeness of osteopathy Frymann establishes a connection to the divine, to the *'Great Physician'*. Thereby she refers to A.T. Still and thinks that:*„Dr. Still drew deeply from this river of Divine Intelligence to bring forth the improved system of medical practice known as osteopathy." (Frymann, 1968, p 64)*
W. Sutherland integrated cranial osteopathy in this osteopathic concept. *"Osteopathy in the cranial field was born out of William Sutherland´s drawing from the river of Divine Intelligence." (Frymann, 1968, p 64)*
And Frymann thinks the time has come to expand the osteopathic concept for a holistic view of human beings. '*The time has come when this profession must draw again from this great*

Intelligence in order to expand the osteopathic concept to encompass not the body below the occiput, not only the whole physical structure including the head, but the totality which is man.[...]I have come to you to talk with you that we may navigate together in deep humility this river of Intelligenc and draw from its depths some more answers to the needs of this sick being who comes to us seeking help.'(Frymann, 1968, p 65)

Frymann closes the article with the following words: *"Let us now go out into the stream of life once more to see and to serve the total being that is man, using every part of our being as diagnostic and therapeutic instruments that we may indeed become clear channels through which the Great Physician may minister to our patients." (Frymann, 1968, p 69).*

This statement implies a religiously motivated osteopathic self-image. The osteopath is thereby a sort of intermediary between divine and human. It becomes clear that as soon as the scientific field of osteopathy is left, a religious approach becomes effective. Even latest literature refers to 'the divine' (Jealous, 2006). Terms, such as wholeness seem to be an attempt to explain inexplicable phenomena and to do justice to the complexity of interpersonal interaction. Maybe this could be explained by the religiously determined history of osteopathy. A.T. Still was a deeply religious man. Even today it sometimes comes to a merging of scientific explanatory models and religious convictions – as in Still.

Latey (1997 b), however, analyses the terms structure and function, which are being centred in modern philosophy of osteopathy and expand these terms by saying that osteopathic treatment is also about *'being and acting'*, about *'system and process'* and about *,static and dynamics'*. This means, that according to his perspective osteopathy should imply process-oriented thinking and more complex views on the human being, which include, for example, developmental psychological aspects. If this synthesis does not take place, it comes to simplifying models that do not do justice to the complexity of a treatment. "*In manual therapies and movement therapies there is an instant regression to naive theories of mechanim or vitalism as soon as structure and function are split. Both are deaf to the rich biosocial ways of the world and the unique turbulence of personal existence." (Latey, 1997b, p 272).*

Latey stresses the speciality of the therapist-patient relationship in a body therapeutic setting and emphasises the difference from psychotherapy, however without explaining this difference in any detail. He talks about creating a reference frame in order to make the phenomena of body centered therapies transparent, although he does not really make clear how this reference system should look like. In one of his other articles, called 'Feelings , muscles and movements' (1996), he presents his own concept and interpretation of postures

and their related feelings. Thereby he refers to muscle tensions in different parts of the body which represent different mental conflicts *(Latey, 1996, 1(1) 44-52).*His assignation of feelings and the referring body parts seems to be a little simplified (as it seems to be found often in osteopathy) and thus does not do justice to his own demand for a complex frame of reference. For me exactly this is the key problem of osteopathy- that when it comes to transferring scientific findings onto the practical level of palpation it falls back to simplified models.

In 'Complexity and the changing individual' (1997 b) Latey made already an important step out of this dilemma, by dealing with developmental-phase-specific conflicts of man. With that he answered the question about the specific framework of a body-centered or osteopathic treatment at least partly. The integration of related disciplines, such as developmental psychology and psychotherapy, expands the reference frame and rather meets the complexity of individuals. He writes: *"But it is the clinician´s job to be looking behind the scenes and searching out the detail of ´what is happening to what´ when the patient is having problems." (Latey, 1996,1(1) p 44)*

"From this point of view our emphasis needs to shift away from the restoration of homeostasis and look carfully at the blocks and barriers preventing metamorphosis and transformation. It is typically human, that we oscillate quite widely in either direction in health; gradually broadening our maturation- but never to arrive!" (Latey, 1996, 1(1), p 47)

This point of view of not aiming at a defined goal in the therapeutic process but trying to accompany patients during processes of change, the outcome of which have to do with maturation, without a preconceived target means modesty on part of the osteopaths and retreating from a – as it can be found sometimes in osteopathy – religiously motivated claim to absoluteness, which proceeds from leading patients to wholeness. It is more a matter of accompanying patients on their personal way, with their personal blockades and obstacles to maturation.

5.3. Summary- prospects

In osteopathic literature the aspect of therapist-patient-relationship is highlighted rather marginally. The General Osteopathic Council (2000) clearly defines the expectations to osteopaths and stresses the importance of sociological and psychological knowledge on part of the osteopaths. Many different master theses deal with the aspect of therapist-patient-relationship. Frymann highlights this relationship under the aspect of the osteopaths' liability

towards patients and stresses the importance of empathy and compassion in the osteopathic treatment. She establishes a connection to religious aspects of interaction, which should be questioned by a therapy that commits itself to modern scientific standards. Liem describes processes during palpation that correspond to transference and countertransference in a psychotherapeutic sense. Becker and Comeaux emphasise interaction in therapeutic processes. Sommerfeld describes the relationship between patient and osteopath as a permanently changing network of complex interaction and speaks for the integration of sociological and psychological findings into osteopathy. Latey establishes differentiated connections between psychotherapy, developmental psychology and osteopathy and analyses the therapeutic process of an osteopathic treatment.

From all the literature it becomes clear that osteopathy has already dealt with the different aspects of therapist-patient relationship.

The question, with which form of self-image osteopaths should face their patients, remains, however, unanswered. In the older literature (Frymann 1968) but also in more recent works (Jealous 2006, Comeaux 2006), religious aspects seem to play a role in the background. Recent works, such as some of the master theses and Latey, however, link osteopathy with developmental psychology and psychotherapy and analyse the interaction with patients referring to this background. They do, however, not make clear how these insights should become reflected in the practical work of osteopaths. Furthermore the question is raised, how osteopaths should create their relationships to patients in concrete terms and how they define and perceive their liability towards patients.

I tried to investigate this question refering to guideline-oriented, problem-centred interviews about the therapist-patient-relationship with five osteopaths.

In Part III of this paper I will thus present the result of this qualitative study.

III. Qualitative study

1. Methodology

1.1. A qualitative study in the form of problem-centred, guideline-oriented interviews

In order to investigate the question how osteopaths create their relationships to patients and if findings from psychology and psychotherapy have found their way into the practical work of osteopaths, I decided to conduct a qualitative study in the form of problem-centred, guideline-oriented interviews.

In contrast to quantitative studies, qualitative studies construct hypotheses. This means, it is not a matter of verifying or falsifying of hypotheses, but a matter of constructing new hypotheses in a field that has been rather sparsely researched in order to form the basis for further research.

There are different forms of qualitative interviews. In this specific case the problem-oriented interview was chosen, as it most likely meets the problem. „*Beim narrativen Interview geht der Forscher völlig ohne wissenschaftliches Konzept über die Themenbereiche des Interviews (im Idealfall jedenfalls) in die Datenerhebung[...]Im problemzentrierten Interview hingegen steht die Konzeptgenerierung durch den Befragten zwar immer in Vordergrund, doch wird ein bereits bestehendes wissenschaftliches Konzept durch die Äußerungen des Erzählenden evt. modifiziert.“ (Lamnek, 1995, S 74)*

[When conducting a narrative interview the researcher starts the data collection ideally without a scientific concept about the subject area of the interview. […] In a problem-centred interview, however, concept generation by the interviewee is in the foreground, but the existing scientific concept might be modified by the statements and remarks of the talker. (translated by A. Walchshofer)]

As with quantitative studies, too, the researcher prepares the interview by means of studying literature. He/she filters out seemingly relevant aspects of the problem area. As with narrative interviews the narrative principle is applied. The questions are open - merely the problem area of interest is narrowed down. (*Lamnek, 1995, p 75)*. The difficulty of problem-centred interviews lies in the fact that the interviewer has already a theoretical concept in mind before starting the interview but should not reveal it to the interviewee, in order not to influence

him/her in the first place. The theoretical concept is quasi measured by the reality of interviewees. Thereby deductive (theoretical) and inductive (empirical) aspects are being combined.
Thereby the guideline makes a partial standardisation possible (see appendix).
For this study a guideline was created that should filter out how osteopaths create and reflect their relationship to patients and how they perceive their liability towards patients. As mentioned in the theoretical part, it is assumed that the relationship between therapist and patient is well reflected in osteopathy. This becomes clear from the osteopathic literature quoted. What remained open, however, is the question how osteopaths concretely shape this relationship, how they reflect the interaction with patients and what they understand by liability towards patients.

1.2. Implementation

The main point was to filter out how the interviewees concretely treat patients and not how they theoretically reflect their relationship to patients. In order to reach this concrete operating level, the interviewees had to be encouraged to talk about their therapeutic everyday life by means of as concrete examples as possible, in order to gain insight into their concrete acting instead of finding out about their theoretical ideas and concepts. The guideline served as orientation but was not always carried out in the same order and sometimes even not asked completely. I tried not to interrupt the narrative flow of the interviewees, so that sometimes questions were already answered during free telling. The order of questions was modified after the first interview as the asking biographical data turned out to somehow obstruct the narrative flow of free telling. Subsequently questions about personal background and self-conception as osteopath were asked at the end of the interview.
The interviews were literally transcribed and separately analysed. Thereby I tried to analyse not only manifest contents, i.e. what concretely was said, but also the latent contents, thus those messages that could be interpreted from the context of the interview, so to say could be read out between the lines. Then the interviews were paraphrased. Thus every interview was resumed, with the objective to reduce the material in such a way that only constitutive elements remained, in order to create a manageable corpus, which was, however, a reflection of the basic material. (Mayering 1999, according to Hain, 2001) Then every interview was analysed according to the qualitative content analysis. Several passages were also discussed with social scientists in order to avoid hasty, one-sided interpretations. Those most important

aspects that emerged from the single interviews were later on related in a synopsis. Therefore categories were built, but I refrained deliberately from a strict classification in order not to divorce single text passages from their context, in order to maintain the shape and structure of the single interviews. (Rosenthal 1995 according to Novy 2000).

1.3. Note

I tried to win over differently oriented osteopaths to an interview. I have to point out here that all the questions were aimed at bringing up difficult interactions and conflict situations. It was not my intention to 'unmask' the interviewees' weaknesses but to work out action varieties or similarities of different osteopaths. At this point I would like to thank all my interviewees for their willingness to talk, for their honesty and for their frankness.

The whole translation of the relevant parts of the interviews was made by Anna Walchshofer,

2. Interview analysis

2.1. Interviewee I

Interviewee 1 (in succession called Erika) is osteopath whose basic profession is physiotherapist.

It is important to her, to stress that she perceives osteopathy as a totally different profession than physiotherapy.

„Hab aber dann wirklich rasch erkannt, dass das doch ein wirklich neuer, ein neuer Berufszweig ist, den wir da lernen und nicht eine Zusatzausbildung und ja und bin jetzt eigentlich sehr froh, dass ich diesen Weg eingeschlagen hab."(IP1, S1/20 -22)

[I realised really quickly that it is a really new profession that we are learning there and not only a sort of further training and yes, now I'm really happy that I have decided to pursue this way. (translated by A. Walchshofer in succession:t.b.A.W.)]

In connection with the other interviewees this statement gets a special meaning, as in this regard there is a clearly observable difference between osteopaths whose basic profession is physiotherapist and those whose basic profession is physician, which will be discussed later on. She describes the work with children and elder patients with difficult and complex problems as her main therapeutic focus.

2.1.1. Relationship formation: 'Now-it's-okay-feeling'

„Manche Kinder sind sehr zappelig und unruhig, da gelingt´s mir nur zu erkennen, dass es gut läuft, das ist so ein Gefühl, das ist jetzt da und ruhig. Ich würd´s mal so beschreiben. Es ist fast wie so eine Glocke und wenn dieser Punkt erreicht ist, dann ist so eine eigenartige, jetzt- ist- es- richtig- Gefühle, dann kannst Du machen was du willst und die Therapie haut hin."(IP1, S 4/14-21).
[Some children are very fidgety and unsettled, in this case I can only tell that it's going nicely, that's such a feeling that's there and quiet. I would describe it like this: somehow it's like a bell and if this point is reached there are these strange 'now-it's-okay-feelings' and then you can do what you want and the therapy works. (t.b.A.W.)]
Erika describes this feeling of a well working relationship as something independent, as a spatial apperception of coherence, a feeling that arises, '*then you can do what you want and the therapy works.'* It sounds as if the appearance of this feeling is somehow outside her influence. It seems remarkable that this coherence in relationship arises all of a sudden, but is something firm and stable. At the same time this description shows the willingness of the child to get involved with therapy, to entrust to the therapist. It becomes clear that for Erika a good therapeutic relationship depends on the willingness of patients to absolutely get involved with therapy. This 'well working therapy' seems to imply strong symbiotic aspects, elements of affiliation between therapists and patients.
On the other hand she emphasises that a well working relationship is additionally related to the degree of her own centeredness as therapist: *„und ich bin auch ganz ruhig und in meiner Mitte und dann läuft's sicher gut".(IP1, S 13/17) [and I'm also completely quiet and in my own centre and then it certainly works well. (t.b.A.W.)]*
Concentrating on her own inner centre helps her to create a stable relationship during the osteopathic treatment.

2.1.2. Interaction problems

Lack of willingness on part of the patients – responsibility of the osteopaths?

She perceives interaction problems atmospherically and depicts situations with patients, who try to evade from the start, often even already during the anamnesis talk. She experiences this as camouflage, as an 'attempt to hush-up'.

Erika thinks that this lack of willingness to get involved with the therapy is sensible on a bodily as well as on a verbal level.

„Aber, dass jemand verwirrende Aussagen macht und ich dann eine klare Linie seh, wenn ich den Körper angreif', das habe ich noch nicht erlebt."(IP1, S 4/10-12) „…wenn der dann immer noch so ausweicht und so, so drüber hudelt und so ja eigentlich bin ich hier aber doch nicht hier und so, dann geht's ganz schlecht, ja."(IP1, S 4/ 33-5/2)

[But I have never experienced that someone makes confusing statements and then I can see a clear line, when I touch the body. […] if he still evades and so on, if he huddles and is so yes technically speaking I'm here but on the other hand I'm not, then it doesn't work well at all. (t.b.A.W.)]

It becomes clear that difficult situations, such as for example ambivalent behaviour of the patients towards the osteopathic treatment, are perceived as obstacles by Erika.

In this context it seems interesting to investigate the question about the osteopaths' responsibility. How much responsibility for the success of the treatment should osteopaths shoulder? As it becomes clear from the other interviews, too, osteopaths often escape liability towards patients and the therapeutic relationship rather quickly when it comes to interaction problems. As soon as it comes to such problems osteopaths often think about discontinuing therapy.

Erika, however, distinguishes between adults and children:

From adults she expects the willingness to get involved with therapy – with children, on the other hand it is different *„dann spiel ich mich deswegen länger, weil ich mir denk, die können es auch nicht so gut einschätzen, was es für Konsequenzen hat, wenn sie jetzt eben nicht behandelt werden." (IP1, S 6/6-10)*

[I try harder, as I think they are not really able to estimate the consequences, if they're not being treated now. (t.b.A.W.)]

This means she clearly differentiates between her responsibilities according to her judgement of the patients' ability for autonomy.

2.1.3. Demarcation

For Erika relationships are problematic if her patients cross the border between therapeutic relationship and friendship on the one hand and on the other hand if patients have too high expectations from her. She reflects that these problems could arise from her own attachment behaviour.

„Vielleicht sowohl von mir auch, das halte ich für möglich, aber ich sag natürlich jetzt, dass es eine falsche Erwartung vom Patienten ist und dass ich vielleicht was dazu beitrage, dass das entsteht, das ist möglich.“(IP1, S 7/5-8)

[Maybe from my part, too, I think that's possible, but of course now I say that it is a wrong expectation on the part of the patient and maybe I contribute to the occurrence, to make it possible. (t.b.A.W.)]

She says that this behaviour of patients causes aggression in her, which indicates that she reflects countertransference processes and interaction in the therapeutic process. When being asked about her strategies to solve such conflicts and about the significance of language, or verbalizing, she answers:

„Also sicher die Sprache, aber ich weiß nicht, ob ich nur die Sprache zu Hilfe nehm'. Ich glaub ich verändere auch meine Körperhaltung, die Gestik und ich werd' sicher klarer, wenn da was nicht stimmt, damit für den Anderen auch deutlich ist, wer ich bin und wer er ist, oder sie. Aber ich spreche es an, aber das ist etwas was ich noch viel üben muss.“(IP1,S 8/1-5)

[Oh, of course language, but I don't know if it's only language I use. I think I also change my posture, gestures and I definitely express myself clearer, if something is wrong, so that I make it clear to the other person who I am and who he is, or she. I address the topic, but that's definitely something I still have to practise. (t.b.A.W.)]

Concerning her non-verbal structures in demarcation she specifies above all the return to her own body perception in order to make the boundaries between herself and the patient more obvious. As already mentioned above this demarcation strategy of returning to the inner perception of the own body can be brought in connection with the importance of body perception for the ability to relate to others which is described in chapter 3. *„..Ich habe das Gefühl, dass ich vielmehr wieder in mich zurückgeh', ja, viel weniger auf denjenigen zugeh' und sehr sachlich werde, wenn irgend etwas in der Richtung eigenartig wird. Also im Prinzip kommt's einem wieder in die Mitte zurückgehen gleich oder so ähnlich ist es.“(IP1, S 8/14-18)*

[I have the feeling that I go back into myself instead of approaching the other person, if something develops in a strange way. In principle it's again something like centering or so. (t.b.A.W.)]

She seems to be more secure of her non-verbal demarcation strategies than of her verbal strategies *('that's definitely something I still have to practice.').* In the same way in that she primarily perceives a successful relationship atmospherically, i.e. intuitively, she also senses conflicts on the level of relationships in this intuitive, thus preconscious way *('if something develops in a strange way', see also chapter 2)* and uses certain strategies on a non-verbal

level. But she is aware of the fact that verbal strategies are important and necessary and that she is still insecure there.

It becomes clear that dealing with this 'boundary crossing' on part of the patient is a recurring topic for her. And she appears to be weary about the changeability of such a situation. Despite all her social competence she feels insecure in such difficult interactions.

„…wenn's mal so weit gekommen ist, dass diese Therapeuten-Patienten-Ebene so gestört ist, dass es entweder in eine Freundschaft oder in eine Herablassung vom Patienten mündet, das sind glaube ich dann Störungen, die nicht mehr so leicht aufzuholen sind. Also, wo's schon geht ist, wenn der Zugang noch nicht möglich war, dass der dann geschaffen ist und dass das dann gut läuft. Aber ich glaube, also das würde ich jetzt mal, jetzt hier und jetzt so behaupten, dass wenn's gröbere Störungen im Patienten-Therapeuten-Verhältnis gibt, wie schon vorher genannt, dass das nicht mehr auszubügeln ist."(IP1/S 33-9/6)

[… when the point is reached that the therapist-patient-level is that disturbed that it comes to either friendship with the patient or condescendence on part of the patient – I think these are the disturbances that cannot be made up for. I mean, where I think this works is if the approach was not yet possible, that it is then created and that it works well then. But I think, I mean that's what I would say now, is that if there are a great many of disturbances or difficulties in the therapist-patient-relationship, as mentioned above, it's not really possible anymore to smooth them away.(t.b.A.W.)]

From this description one could conclude that for her there is only little scope between an intact and a disturbed therapist-patient-relationship. As the functioning of the relationship is primarily perceived atmospherically, there are obviously only few tools or strategies for Erika to articulate conflicts and thus to initiate processes of change. So in this case problematic interactions, which occur because of the as insufficient experienced own verbal strategies, are perceived as obstacle for the osteopathic treatment.

2.1.4. Self-conception: Answering the needs of patients

On the other hand Erika envisions her empathic abilities as her strong point. She explains the fact that patients come to her after having seen other osteopaths like this:

„Ja, ich glaub, das ist einfach zuhören. Also es gibt viele Osteopathen, die so eng eingeteilt haben, dass sie, dass sie ehm keine Zeit mehr haben zuzuhören. Also, das ist schon was, was ich glaub, was ich trotzdem dass die Patienten sehr knapp hintereinander kommen, ich schon versuche wirklich gut zuzuhören, was der eigentlich will von mir. Also, sowohl der Sprache

zuzuhören, als auch der Gestik und zwischen den Zeilen und alle Sinne aufzumachen, dass ich genau erfahr, was wirklich sein Anliegen ist. Weil manchmal glaubt man, er wünscht sich die Schmerzfreiheit, aber der wünscht sich nur, dass wer zuhört."(IP1, S 10/17-21)
[Yeah, I think it's just listening. There are many osteopaths whose appointment books are so full that they simply don't have time to listen. I mean, I think that's something I really try to do, even if I have really many patients one after another, I try to listen carefully what they really want from me. I mean I try to listen to their words, as well as to gestures and I also try to read between the lines, to open up all my senses to find out about their real concerns. Because sometimes you think that somebody desires to become pain-free but in reality he only wishes for someone to listen. (t.b.A.W.)]
This attitude corresponds to what Viola Frymann *(chapter 5)* describes as 'perceiving the real needs of the patients'.
„.die nonverbale Kommunikation würde ich da genauso wichtig wie die Sprache, also ich kann nicht sagen, dass mir die sprachliche genauso wichtig ist, sondern jede Interaktion ist mir genauso wichtig wie die fachliche Behandlung. Ja, also schon. Ich bemüh mich zumindest drum." (IP1/ S 10/31-34)
[… non-verbal communication; I would say, is as important as language, I mean I can't say that only verbal communication is as important for me, but every other interaction is as important for me as the technical treatment. This means yes. I try to be after it. (t.b.A.W.)]
This shows that for Erika the interaction with patients and mutuality in the therapeutic process are of great importance, whereby there is obviously a certain gap between theoretical demand and the concrete action level. Her depictions of conflict situations demonstrate that she very well expects certain behaviour ('willingness for therapy') on part of the patients and that she sees only little scope for interaction processes and processes of change.

2.1.5. Summary

The most important subject areas Erika addresses in the interview are the formation of relationships as well as the osteopaths' responsibility.
From the depiction of an ideal therapist-patient-relationship hints at findings from attachment theories can be deduced. Thus one can compare the description of coherence to successful containment, the ability of the reference person to convey a feeling of being held to the child, by means of empathic conception, and at the same time be in a mental state of receptiveness towards the emotions of the child. *(see attachment theory 1.4)*

Furthermore it reflects the basic sensation of empathy as the basis of a therapeutic relationship as it was described in chapter 4.

It becomes apparent that Erika expects certain behaviour from her patients, called the 'willingness for therapy' and she experiences it as resistance on part of the patients if they are not able to absolutely engage get involved with therapy, but maintain certain control mechanisms and display ambivalent attitudes towards the treatment.

One could compare this behaviour of the patient to an avoiding attachment style. *(see chapter 1)* As mentioned in chapter 1 this avoiding attachment style is often caused by insecurity or fear of affiliation, as protective mechanism of the Ego.*(see chapter 1.5)* According to attachment theory this avoiding attachment style might be the result of insecure infantile attachment behaviour due to faulty containment of the reference person. *(see chapter 1.4)* Considering the bodily closeness between therapist and patient during an osteopathic treatment, it seems understandable that some patients unconsciously fall back upon infantile attachment patterns to deal with this maybe threatening situation. As much more responsibility has to be carried by the osteopath, as the therapeutic setting already fosters regressions of the patients and lets them fall back upon infantile patterns. However, from the description of conflict situations in the therapeutic relationship it becomes clear that according to Erika patients have to display certain behaviour ('willingness for therapy') and that according to her understanding the osteopath carries only a limited responsibility for the formation of a stable relationship.

The description of her self-conception as therapist, the return to the own body-perception can be linked with the meaning of body-perception for the ability to relate to others mentioned in chapter 3. According to that the perception of the own body's demarcation against the environment is the precondition for adequate attachment behaviour. It is the ability to perceive oneself as demarcated from the environment that makes relationships possible. This brings in an interesting aspect. Erika uses the strategy of inside perception so as not to affiliate with patients. But which strategies are available to patients in order to demarcate themselves during the therapeutic treatment?

In the same way in that Erika uses mainly intuitive, non-verbal strategies to create relationships she also uses primarily non-verbal strategies in conflict situations and calls this disability of verbalising conflicts her personal weakness. As mentioned in chapter 2 language can be conceived as an interpersonal conveyor of meaning *(„Intuition ist ohne Sprache möglich, aber nur Sprache versetzt uns in die Lage, uns explizit über intuitive Wahrnehmungen zu verständigen." – 'Intuition is possible without language, but it is only language that enables us*

to explicitly talk about our intuitive perceptions.'(t.b.A.W.)) (Bauer, 2005, p 35) and help patients to be accompanied out of regressive states.
Erika's self-conception makes clear that the interaction with patients is of great importance to her, that she tries, as Frymann puts it, to find out her patients' real needs and that she tries to achieve this by means of all - verbal and non-verbal - channels.

2.2. Interviewee II

Interviewee 2, in succession called Wolfgang, is osteopath with the basic profession physician who practises in his own surgery.

2.2.1. Relationship-formation

2.2.1.1. Human or therapeutic relationship?

From the beginning of the interview on Wolfgang distinguishes between human and therapeutic relationship.
„Wenn man es systematisch sieht, dann versuch ich einmal zu trennen. Es gibt eben Interaktion auf der rein menschlichen Ebene , wo sich zwei Menschen begegnen und wo´s ein Austausch ist, wo einfach einmal das Ganze beginnt und dann gibt es die therapeutische Ebene, die therapeutische Interaktion, wo ´s einfach mehr Austausch ist, dass ein Mensch eine Geschichte erzählt, also der Patient erzählt da seine Geschichte oder einen Ausschnitt seiner Geschichte, und meine Idee dahinter ist aus dieser Geschichte die Information rauszuholen, wo ich das Gefühl hab', sie umsetzbar in eine Therapie zu machen." (IP2, S1/13-21)
[If you see it systematically I first of all try to divide. There are interactions on a sheer human level, when two persons meet and when there is exchange, when everything starts and then there is the therapeutic level, the therapeutic interaction where there is more that sort of exchange when one of the two, in this case the patient, tells his story or one section of it and my idea behind is to get information out of the story which I can use in the therapy. (t.b.A.W.)]
On a human level other aspects take effect:
„Auf der anderen Seite rennt natürlich dann auch eine Interaktion, dass der Patient sehr viele Wünsche hat, Hoffnungen hat, Sehnsüchte hat, ah und die halt auch erfüllt bekommen möchte und ja, dann beginnen so, so Geschichten wie Reflexionen, Übertragungen, ich mache mir auch Notizen zum Patienten, ich mach mir nicht nur ein Bild im therapeutischen Sinn vom

Patienten, sondern dann kommen dann so Dinge wie, der ist mir sympathisch, der ist mir weniger sympathisch, da gibt's eine Offenheit auch von mir, nicht nur vom Patienten. Oder es gibt auch eine Verschlossenheit vom Patienten und ich frage, warum verschließt er sich, welche Dinge verschließt er." (IP2, S1, 23-30)

[On the other hand there is this interaction that the patient has got many wishes, hopes and desires that he would like to be fulfilled and yes then all these things such as reflections, transferences come up, I take notes about the patient, I try to get not only an idea of the patient in a therapeutic sense, but there are also these things like this one is likable or I like that one less, there is also openness from my side, not only on the part of the patient. Or there is taciturnity on part of the patient and I ask why he is that closed and which things does he lock up. (t.b.A.W.)]

He clarifies this perception of *'taciturnity'* by means of perception on the level of tissues, which is a therapeutic level to him. *„Also, jetzt fällt mir konkretes Beispiel ein, von einer 50-jährigen Dame, wo ich einfach einmal so beginnend mit einem „lokal listening" auf den Bauch gegriffen habe und wo[...] ich einfach Bilder gesehen hab', alle möglichen von der Kindheit, und so diese Richtung. Ah, also das ist einmal so diese eine Möglichkeit, das ist nicht so oft bei mir. Und das Zweite ist einfach meine Hand hinzulegen, einfach einmal eine Art Grußbotschaft loszulassen indem ich etwas mehr Druck auf das Gewebe mache und dann schau wie reagiert dieses Gewebe bei dieser Patientin, weil es eher die Tür zugemacht hat und es einfach fester geworden ist, ja, obwohl ich das Gefühl hab' auch wenn ich dann ein bisserl an dieser Tür rüttle tut sich um Beispiel nichts. Oder es kann eben bei einem anderen Patienten nehmen wir den Vorletzten, wo ich dann einfach an der Tür gerüttelt habe, also sprich vielleicht den Druck verändert hab oder meine Intention verändert hab, also von direkt oder indirekt oder umgekehrt, dass dann auf einmal das Gewebe so fast den Aggregatzustand verändert hat, beginnend also von fest, von einer Art kristalliner Struktur in eine amorphe oder vielleicht sogar flüssige Masse." (IP2, S 8, 15-31)*

[Now a concrete example of a woman of about 50 years comes to my mind, where I started with local listening and therefore touched her belly and […] where I saw pictures, from the childhood and the like. That's one possibility but that doesn't happen too often to me. The second thing is to simply place my hand, to simply send a greeting by putting more pressure on the tissue and then I have a look how the tissue of this patient reacts, because it rather closed the door, simply got tighter, yes, and although I have the feeling to rattle at the door a little bit nothing happens. Or some other patients, lets say the last one, where I rattled at the door, which means I changed the pressure or my intention from direct to indirect or the other

way round so that all of a sudden the tissue nearly changed its aggregate state, starting from really tight, from a sort of crystalline structure to an amorphous or maybe even liquid mass. (t.b.A.W.)]

From this description it becomes clear that the level of tissues also notices 'permission' or 'closure'.

It would be interesting to further analyse the interactional aspects of this form of perception in connection with the aspects mentioned in chapter 4, which means to analyse the mutuality between patient and therapist to that effect in how far the osteopath unconsciously reacts already in this situation to the signals of the patient and thus changes pressure or if the patient reacts to a certain pressure of the therapist and thus consciously or unconsciously admits the contact, hence engages with the relationship or closes up. Thus this implies an active role on part of the patients. Thereby transference phenomena on a bodily level can play an important role. Here again the interactional aspects of the therapeutic relationship, as described in chapter 4.4. take effect. So the idea of therapeutic neutrality has to be questioned, as it comes to a permanent mutuality between patients and therapists in the therapeutic situation. Thereby I would like to refer to Sommerfeld (2000), who points out that the system between therapist and patient is a permanently changing network of complex interactions.

Wolfgang depicts a balance of give and receive on the human level, too. *„Ah, im menschlichen Sinne, da möchte ich jetzt keine Wertung machen was mehr oder weniger wert ist, es ist einfach a gute Aktion wenn man das Gefühl hat, es ist ein gegenseitiges Geben und Nehmen vorhanden. Der Patient fühlt sicht gut aufgehoben, der Patient hat das Gefühl ernst genommen zu werden und, und auch ich habe dann das Gefühl, als Therapeut ernst genommen zu werden und nicht benützt, sondern gebraucht zu werden."(IP2, S5/21-30)*

[Ah, in the human sense I don't want to judge what is more important and what less, it is simply a good thing, if you have the feeling that there is mutual giving and receiving. The patient feels that he is in good hands, has the feeling of being taken seriously and then I have the feeling of being taken seriously as a therapist, too, and I don't feel like being used but like being needed. (t.b.A.W.)]

He describes – similar to Erika – an atmospheric feeling of vibrancies:

„Wir haben oft das Gefühl, dass einfach diese Schwingung zwischen uns, zwischen mir und dem Patienten, einfach so gut ist, dass sie, dass wenn der Patient den Raum verlässt, beide das Gefühl haben, es hat nichts gefehlt jetzt. Und das war in einem klaren Rahmen, der für beide vertretbar war, dann habe ich das Gefühl, dann läuft's sehr gut." (IP2, S 6/10-14)

[We often have the feeling of such a good vibration between the two of us, me and the patient, that when the patient leaves the room both of us have the feeling that nothing was missing. And that was in a clear framework that was reasonable for both of us, then I have the feeling, then it's going nicely. (t.b.A.W.)]

The division between therapeutic and human relationship that crosses his description is remarkable.

2.2.1.2. Long-term therapies: Demarcation of therapeutic relationship and amical relationship

According to Wolfgang in long-term therapies more intensive human relations develop, which can, in his opinion, be in fact prejudicial to the therapeutic process.

He describes situations with long-term patients, in which friendly contact develops and in which the division between therapeutic relationship and human relation apparently is not given any longer.

„Ich glaub da spiel ich, da ist meine Rolle einfach die, eine Person zu sein, wo sie regelmäßig hingeht, wo es eine gewisse Stabilität gibt, wo es eine Sicherheit gibt, auch die Sicherheit, dass ich da bin für sie." (IP2, S2/31-S3/1)

[I think in these situations my role is to be someone whom she sees regularly, where there is stability and also the security that I'm there for her. (t.b.A.W.)]

It becomes apparent that in these situations he perceives his liability towards patients as one that goes far beyond therapeutic intervention, he often sees himself as companion of his patients, whereby it is made clear that this role is quite susceptible to disturbances and affected by the patients' expectations from him.

Apparently the subject of demarcation against patients is an important topic for him and is associated with demarcating the therapeutic relationship against amical relationships. In his eyes friendship and therapeutic relationship are incompatible, but he also makes clear that it is difficult for him to preserve this boundary. He says that friendships 'happen', as if it was outside his influence:

„Also, meistens war's mir klar, wenn dann eine, eine Freundschaft passiert, dann ist die therapeutische Rolle einfach verlassen und es geht aber auch nur, wenn's auch nicht mehr notwendig ist, diese therapeutische Rolle zu behalten. Also ich glaub' beides funktioniert einfach nicht miteinander." (IP2, S 3/ 17-20)

[Most often it was clear for me that if a friendship happens I left the therapeutic role, but that only works if it's not necessary any longer to keep the therapeutic role. I think both at the same time, that doesn't work. (t.b.A.W.)]

2.2.2.Interaction, conflict management

The subject of demarcation against patients obviously bothers Wolfgang. He depicts the conflict with a patient who felt offended by his remark *„dass sie sich in gewissen Dingen in den Vordergrund spielen möchte" – 'that on some occasions she wants to put herself in the fore' (t.b.A.W.)* and addressed this later during a telephone conversation.

„sie hat das auf eine Art und Weise interpretiert, so wie ich es überhaupt nicht gemeint habe und sie hat mir das nicht gesagt, wie sie gegangen ist".... „Und da habe ich gemerkt, dass ich etwas nicht verstanden hab scheinbar und sie mich auch nicht verstanden hat, also das war überhaupt ein Beispiel einer schlechten Kommunikation." (IP2, S 6/25-7/2)

[…she interpreted this in a way in which I absolutely didn't mean it and didn't tell me when she left. … And then I realised that I obviously didn't get it right and that she in turn didn't understand me, so that was an example of really poor communication. (t.b.A.W.)]

In this example the patient might have felt very offended by a casual remark and experienced it as border violation. The therapist, on the other hand, feels affected by the feedback. For one thing he might have had the feeling that he has gone too far with his remark '*that on some occasions she wants to put herself in the fore'* and for another thing he depicts it as *'example of really poor communication',* as a misunderstanding and not as border violation on his part. He reacts with wihtdrawal from the therapeutic situation.

...„Das war so, dass dann die therapeutische Zusammenarbeit eigentlich von meiner Seite problematisch war, weil ich gemerkt hab, ich kann, ich werde von ihr in vielen Dingen missverstanden und da tu ich mir schwer mich zu artikulieren und da habe ich mir auch schwer getan, sie anzugreifen, weil ich glaub, dass das Angreifen oft sehr missverstanden wird." (IP2, S 7/5- 9)

[… for me the therapeutic collaboration was problematic from that moment on, because I realised that I was being misunderstood by her on many occasions and then I have difficulties to express myself and then I also had difficulties to touch her, because I think that touch is often misunderstood. (t.b.A.W.)]

This situation of *'misunderstandings'*, *'poor communication'* could also reflect a transference and countertransference situation, as described in chapter 4. Projections of the patient into the

osteopath which are probably associated with disenchanted expectations or projections of the osteopath into the patient which lead him to the percipience *'that on some occasions she wants to put herself in the fore'*. In this situation the discontinuation of therapy obviously was the only possible solution for Wolfgang. He seems to feel hurt by the feedback of the patient and withdraws from the therapeutic situation *'I also had difficulties to touch her, because I think that touch is often misunderstood.'*

2.2.3. Demarcation

2.2.3.1.Border violation by bodily proximity

Furthermore Wolfgang brings examples of interaction problems caused by the bodily proximity during the osteopathic treatment.

„Was vielleicht auch ein Beispiel ist für misslungene Intervention, dass sie, dass nachdem zum Beispiel ja die Osteopathie eigentlich sich dem Körper manchmal sehr tabulos nähert, was allerdings mit viel Scham einhergeht, ah, aber für manche Patienten bestimmte Körperregionen einfach ganz anders behaftet sind, also wenn ich am Bauch greif dann sehe ich schon den Menschen dahinter, aber ich sehe genauso die Leber und die Blase, usw. dahinter und für den Patienten, waren solche Kontakte manchmal zu intim, ein Kontakt am Sacrum zum Beispiel. Und da habe ich das Gefühl, dass vielleicht auch von meiner Seite die Kommunikation manchmal zu schlecht war um dem Patienten die Möglichkeit zu geben, das gleich zu artikulieren. Sonst baut sich einfach irgendwas auf, was fast wie ein undurchdringlicher Nebel erscheint und dann funktioniert's therapeutisch nicht." (IP2,S 7/9-18)

[Maybe another example for miscarried intervention is that osteopathy approaches the body without any taboos which is associated with shame by some patients, as certain parts of the body are afflicted differently for some patients. For example when I touch their belly, of course I see the person behind, but at the same time I see the liver and the bladder and so on. For some patients this contact was too intimate, the contact with the sacrum, for example. And then I have the feeling that maybe communication was not good enough on my part to give those patients the possibility to say that. And then something appears, something like impenetrable mist and then the therapy doesn't work at all. (t.b.A.W.)]

Thus the bodily proximity that develops during the treatment seems to additionally complicate dealing with interaction problems. As mentioned in chapter 3, interaction that develops during an osteopathic treatment is very complex alone because of the bodily proximity. So much

more important is the reflection of one's own behaviour. Wolfgang is aware of the fact that intensive bodily proximity during the treatment can lead to misunderstandings which have to be expressed. He reflects on this fact and admits that maybe sometimes he does not take care enough of the personal boundaries of his patients.

By means of the depiction of a female patient who did not accept him to touch her pubic bone in order to treat her bladder, the meaning of language in the osteopathic treatment is made clear.*(see chapter 2)*

„Also ich hab gesagt, das tut mir leid, das hätte ich vorher besser artikulieren sollen und ich tu's auch nicht. Also ich hab ihr erklärt, warum ich's tun würde und warum es in meinen Augen notwendig wäre, aber wenn sie es nicht will, dann heißt das nicht, dass ich jetzt die Therapie abbrechen muss, weil ich andere Möglichkeiten hab, jetzt auch da weiter zu arbeiten." (IP2, S 7/30-S 8/2)

[Well, I said that I was sorry and that I should have said that before and that I wouldn't do it. So I explained her why I would have to do it and why it was necessary from my point of view, but if she wouldn't want that, that wouldn't mean we couldn't continue with the therapy, because there was another possibility how I could continue. (t.b.A.W.)]

The interaction with another patient shows how delicate bodily proximity has to be handled in osteopathy and which expectations could be raised in patients if the osteopathic framework is not clearly defined.

„. Also ganz konkret war, dass sie gesagt hat, das macht sie irrsinnig an, was ich da tu und ich hab halt versucht zu reflektieren, warum dem so ist, warum sie das jetzt empfindet. Und da habe ich ihr halt dann klar gemacht, dass ich mich auf meine therapeutische Position zurückziehe." (IP2, S 8/5-8)

[Well, she concretely said that what I was doing was turning her on and I tried to reflect why she felt that now. And then I made clear that I was retracting to my therapeutic position. (t.b.A.W.)]

These conflicts described are clearly related to border violation on a bodily or verbal level. But Wolfgang tries to clear those interaction problems verbally, together with his patients. His approach to solution is seemingly the return to his therapeutic position, which, as he mentioned at the start of the interview, he clearly separates from the human relationship. This return obviously corresponds to a relatively abrupt withdrawal from personal interaction after too close proximity. His need for separation of human relations and therapeutic relationship evidently has to do with this demarcation problem. But here the question arises whether the

relationship on a human level is to be understood as an 'untherapeutic' one or if it is more a matter of developing a professional intercourse on a human level.

2.2.3.2. The significance of language in osteopathy

When being asked whether information given by patients on a bodily level is received by him in the same way as verbal information, he answers:

„Also für mich bedeutet es überhaupt nichts, dass wenn man verbal gut zugänglich ist, dass das Gewebe auch gut zugänglich ist. Ich hab' eher das Gefühl auch von meiner Erklärung her jemand der verbal sehr offen ist und vielleicht zu ungeschützt ist dadurch, dass fast sein Körper, nachdem er das Gefühl hat, alles was er reinlässt, wird schon gefährlich, möglichst zumacht. Also das ist meine Erfahrung." (IP2, S 9/4-8)

[I think that if someone is verbally open it doesn't necessarily mean that also the tissue is easily approachable. I've got the feeling, also from my explanation, that if someone is verbally very open his body feels the need to close up because it feels endangered by all this things it lets in. I mean, that's my experience.(t.b.A.W.)]

This statement asserts the active role of patients mentioned above, namely the closure on a bodily level as protection from threat and border violation on part of the therapist. It might be linked with aspects of body perception and demarcation on a bodily level, as described in chapter 3. According to that, bodily contact may be perceived as threat by persons who are not sure of their ego-borders and thus has to be fight off. To Wolfgang it therefore seems to be very important to deal with this subject as he perceives and reflects these ostensive inconsistencies on part of his patients.

(This statement contradicts Erika's impression according to which openness or taciturnity on a verbal level correlate with the level of the tissues.)

When being asked about the significance of language in his therapies, Wolfgang says:

„Naja, das ist schon eine Strategie von Anfang an, mir zu überlegen wie, welchen Zugang kriege überhaupt zum Patienten, ich versteh' mich ja nicht nur als Osteopath, sonder einfach als Arzt für Allgemeinmedizin und da kann sogar mein Zugang sein, dass ich sag' ich geb' dem jetzt ein Antibiotikum... ich mein ich bin jetzt kein Psychotherapeut, aber ich hab sehr viel Ausbildung in diese Richtung, ah, wenn ich jetzt merk' dass da auch eine Thematik ist die auch besprochen werden muss, dann besprech' ich's auch, dann ist das auch ein Zugang. Oder es kann sein, dass ich eben jetzt nicht übers Gewebe direkt hinkomm' dann, also nicht über Bindegewebe, dann geh ich halt mehr über die Organe oder über craniosacrale

Rhythmen oder ich werde, das ist das schöne an der Osteopathie oder mein Beruf als Arzt überhaupt, dass ich viele Wege oder viele Türen öffnen kann, die mir der Patient, bei manchen Patienten ist halt die Tür größer und bei manchen kleiner, man muss halt nur wissen, wo man reinkommt." (IP2, S 9,12-25)

[Well yes that's a strategy I pursue, to consider which approach to the patient I shall take, I mean, I don't see myself as osteopath only but simply as a general practitioner and that's why my approach could be to prescribe antibiotics… I mean, I'm not a psychotherapist but I have much education in this regard and when I feel that there is a topic that should be talked about I just talk about it and that's another approach then. Or if I can't reach it directly over the tissue, I try over the organs or craniosacral rhythms or I will… that's the good thing about osteopathy or my profession as physician in general, that I can go many ways and open many doors, I mean sometimes the door is bigger, sometimes smaller, you just have to now where to enter. (t.b.A.W.)]

This shows that he uses many approaches to patients. And thereby also the verbal approach plays an important role.

2.2.4. Self-conception: physician and osteopath

Thus Wolfgang integrates many different therapeutic approaches, depending on his patients' needs.

(It is remarkable that he does not feel the need to dissociate his profession as osteopath from his basic profession as physician, which stands in contrast to Erika's perception according to which osteopathy is a totally different profession than physiotherapy. Wolfgang, however, integrates all these different approaches. Generally one could say that it seems to be more important to those osteopaths whose basic profession is physiotherapist, to distinguish between their two professions. Maybe this has to do with the higher social image of doctors as compared to physiotherapists and with the apparent image improvement that comes along with the osteopathic education – which is obviously not perceived to the same extent by physicians.)

Wolfgang sees himself as companion of his patients, especially of his long-term patients.

When being asked how he has acquired his competences concerning his acquaintance with patients, he names, along with further training in the field of psychotherapy and his professional experience, childhood experiences as the most important basis. *„aber*

wahrscheinlich das, wo man am meisten lernt ist in der eigenen Kindheit und in der eigenen Sozialkompetenz, die man sich dort aneignet." (IP2, S 11, 12-14)
[… but I think it's your own childhood where you learn most and from your own social competence which you acquire during your own childhood. (t.b.A.W.)]
This complies with the findings from attachment theory *(see chapter 1)*, which state that secure infantile attachment significantly shapes attachment behaviour.

2.2.5. Summary

Wolfgang's main topic is apparently the subject of demarcation. On the one hand demarcation between therapeutic and human relationship and on the other hand demarcation or border violation between osteopath and patient.
He distinguishes between human relations that are, from his point of view, a matter of sympathies, transference and sometimes of friendship and the therapeutic relationship, which he describes as coming in contact with the patients' tissues.
This description highlights mutuality in the therapeutic process as described in chapter 4. 'Yielding' and 'closure' of the tissue may be comprehended as an interaction process between therapist and patient which implies a certain 'active' role of the patient. Closure might be understood as a protective mechanism of the body against too close proximity and the associated fear of border violations. *(see chapter 3)*
Wolfgang depicts interaction problems that are caused by the intensive bodily proximity during the osteopathic treatment. Thereby language has a clarifying function. As mentioned in chapter 2 and 3 language can have a protective function and help patients to get out of regressive states and threatening body sensations.
Apparently Wolfgang has certain difficulties to keep distance on the human level during the treatment. His approach to solution is to retreat to the therapeutic level, which could be understood as withdrawal from the human relationship. In this regard his need to separate the therapeutic relationship from the human relationship may be comprehended as demarcation strategy, as sometimes he is not able to maintain contact on the human level without exceeding the limits. In this context it is important to stress that a professional therapist-patient-relationship should be characterised by adequate distance behaviour on part of the therapist. In my opinion this aspect is not emphasised enough in the osteopathic education.
According to his own self-conception Wolfgang sees himself as physician and as osteopath. The way he approaches patients varies according to their needs. He approaches them either on

a verbal level, on the level of tissues or a medicinal level. Thus he obviously approaches them primarily as a physician who uses osteopathy as one of several therapeutic measures.

2. 3. Interviewee III

Intweviewee 3, in succession called Maria, is osteopath and practices in her own office. Her basic profession is physiotherpist. She calls her decision for osteopathy a random decision. As she wanted to give up her profession as physiotherapist her then-boss motivated her to start the osteopathic education.

„…Und hab sobald ich konnte mein Berufsbild zum Osteopathen hin gewechselt und arbeite seit Jahren überhaupt nicht mehr physiotherapeutisch." (IP3, S 13/9-115)

[As soon as I could I changed my occupational image to that of an osteopath. I haven't worked physiotherapeutically for years now. (t.b.A.W.)]

As Erika did, Maria, too, demarcates the profession 'osteopath' strictly from physiotherapy. The osteopathic education offered her an opportunity to stay in the social occupation field. Apparently because of this she stresses that she has not *worked physiotherapeutically for years now.*

2.3.1.Relationship formation: Demarcation on various levels

According to Maria's approach to patients it is very important to clarify their expectations and to explain them what osteopathy is. Furthermore it is important for her to demarcate osteopathy from other manual methods and to make clear that the main concern of osteopathy is to activate health and to improve vitality. By means of an example of a patient who suffered from burn-out syndrome she describes that for her it is important to explain patients that as an osteopath she occupies herself not only with the musculoskeletal system but attempts for a holistic recovery of patients.

Being asked how she realises that a relationship works well she, too, firstly mentions atmospheric aspects.

„Das merk ich einmal primär an der Atmosphäre, an der Spannung oder Entspannung zwischen uns beiden natürlich auch, ob mir der Patient zuhört ob er sich quasi dem hingeben kann, an der Wortwahl , oder auch an der Neugier, Neugier, die Dinge zu hinterfragen . Also das ist so der primäre Eindruck , dann kommen später so die persönlichen Geschichten ,

Probleme mit denen sie sich dann öffnen, was dann manchmal gar nicht so sehr notwendig ist.“ (IP3, S 1/29-2/2)

[I recognise that primarily by the atmosphere, by tension and relaxation between us, if he listens to what I say, if he is able to give himself over to that, by the choice of words or by the curiosity to question certain things. So it's the first impression and then later the personal histories and problems by which they open, which is sometimes not that necessary.(t.b.A.W.)]

This statement raises the question what she means by *which is sometimes not that necessary*. Does she think that the personal level between patient and therapist is irrelevant for the therapeutic process? In the course of the interview it emerges that she is rather ambivalent regarding the relationship formation and the question of how much personal should be facilitated during the therapy. She addresses aspects on a concrete level of relationship but does not clarify whether she thinks that opening up on a personal level is a sign of good therapeutic interaction or not. In the course of the interview it turns out that she has serious reservations against patients who bring in their personal history too much according to her opinion, who, as she puts it, are grouching.

„Ja , in der Regel ist es schon so, dass Leute, die so in der Endlosschleife sind , die sich zum Beispiel drei Wochen lang über ihren Mann auskotzen, das kann ich wirklich auf den Tod nicht leiden. ....aber also ich leg auch meine Grenzen, ich zieh auch meine Grenzen. Abdrehen ist ein ziemlich brutales Wort (lacht) aber es ist so, wenn ich merke, es ist so endlos und es ist nur ein Ausspeiben dann möchte ich das nicht.“ (IP3, S 2/27-3/3)

[Yes, normally I can't stand it when people are in this infinite loop, when they are grouching about their husbands for three weeks. … but I draw my boundaries. To turn it off is a quite hard word (laughs) but it's like that, when I realise it's so infinite and it's just grouching, then I really don't want that. (t.b.A.W.)]

Maria describes here very drastically that she finds it very embarrassing when people bring in their personal conflicts too much into the osteopathic treatment and is apparently very emotional about this topic *(I can't stand it; grouching; turn it off).*

On the other hand she describes the offer for relationship as her personal strength, „.... *weil ich irgendwie auch bereit bin, dass sie sich mir anzuvertrauen.“ (IP3, S 2/17) – because I'm somehow ready that they commit to me. (t.b.A.W.)*

It is apparent that she is very ambivalent concerning the demarcation from patients.

„Also sie [die Patientinnen] wissen zum Beispiel schon, dass ich nett und höflich zu ihnen bin, ihnen auch viel erkläre, eher sehr strukturiert vorgehe, denke, arbeite, eben nichts unausgesprochen lasse und ich warte halt, bis , bis was kommt vom Patienten also, ich würde

nie nachbohren, wenn ich merke, das ist ein Bereich, der nicht für mich bestimmt ist, das bemerke ich zwar, aber das lass ich dann so sein. Also vielleicht deswegen kommen die so gern, weil ich irgend wie auch bereit bin, dass sie sich mir anzuvertrauen." (IP3, S 2/10-17)
[I mean, patients know that I'm nice and polite and that I explain them a lot, that I precede well structured, think, work, that I leave nothing unexpressed and then I wait until something comes from the patient. I wouldn't pester them with questions when I realise that' s a part that's not meant for me, I mean I realise that but I leave it like that. Maybe that's why they like to come, because I'm somehow ready that they commit to me. (t.b.A.W.)]
One could compare this attitude of waiting and being open for feelings with the basic attitude of containment. But here again Maria's ambivalence becomes clear. On the one hand she stresses that she is *somehow ready that they commit to me* but on the other hand draws her boundaries in this regard, as she makes clear by means of an example. She depicts the situation with a patient who permanently complained about her husband and whom she advised to see a psychotherapist.
„und die war dann bös auf mich und ist dann weggeblieben. Also das nehme ich aber gerne in Kauf, das ist vielleicht für die Patientin, ja sie ist vielleicht dann nicht weitergekommen aber sie wäre auch mit mir nicht weitergekommen." (IP3,S 3/7-9)
[and then she was angry with me and didn't come anymore. But I gladly take this loss, I mean, okay, she didn't come anymore but she wouldn't have made any progress with me anyway. (t.b.A.W.)]
As Maria reacts that emotional to this topic one could assume that her offer to *leave nothing unexpressed* raises certain expectations in the patients with which she is overchallenged as osteopath and which she cannot or doesn't want to fulfil in her role as osteopath. It is obvious that Maria is ambivalent towards the fact that patients confide their personal problems during their treatment. On the one hand she emphasises her ability to leave nothing unexpressed and that she is ready that patients confide in her and on the other hand she reacts in a repulsing way to the fact that patients strongly bring in their personal aspects and seems to have demarcation problems in this regard.

2.3.2. Interaction, conflict management

Maria depicts the situation with a patient who fell in love with her and where she tried to reflect her contribution to this situation as an example for a conflict situation. *„Der hat aber irgendwie, der hat mir permanent irgendwelche Avancen gemacht und er war zwar ein Kavalier der alten Schule, aber trotzdem war es unangenehm, ja. Ich hab ihm das auch ganz,*

ganz, ganz konkret gesagt, er hat's rational hat er's schon verstanden, dumm ist er ja nicht, aber emotional hat er's nicht kapiert, ja." (IP 3, S 6/18-21)

[He permanently made advances to me and although he was a gentleman of the old school, it was still embarrassing, yes. And I told him really, really, really clearly, rationally he understood it, I mean he is certainly not dull, but emotionally he didn't get it.(t.b.A.W.)]

This incident clarifies the statement of leaving nothing unexpressed she made in the beginning. Obviously she is able to address even difficult situations, although the emphasis of *I told him really, really, really clearly* could also be interpreted as a certain insecurity.

Another example shows again that she apparently has no difficulties to address conflicts during therapy.

„Ah, also schwierig wird es für mich dann, wenn jemand ah, zum Beispiel im Gespräch in der Anamnese ahm nicht wirklich was erzählen will, sondern man hat so das Gefühl man muss ihm die Würmer aus der Nase ziehen und bei jeder zweiten, dritten Frage von meiner Seite fragt sie dann, also ist eine Frau konkret, ja, mit der das passiert ist, war dann nach jeder zweiten, dritten Frage von mir, eine Frage von ihr, warum müssen sie das wissen? Ah, bis ich dann nach ein paar Minuten gesagt hab:,Wissen Sie, jetzt machen wir folgendes, entweder sie sind bereit, ihre Geschichte, ihre Krankengeschichte mir so zu erzählen, dass ich da was damit anfangen kann und damit arbeiten kann, wenn sie das nicht möchten, dann kann ich nicht arbeiten, dann müssen's wieder gehen." (IP3, S6/31-7/7)

[I mean, it gets really difficult for me if someone doesn't want to speak during the anamnesis talk and if you have this feeling that you have to worm everything out of him and after every second or third question she asks, yes it was a woman where that happened, why do you have to know that. After a few minutes I said that she either had to tell me her clinical history in a way that I was able to make use of it or if she didn't want that I couldn't work like that, in this case she would have to leave. (t.b.A.W.)]

In such cases Maria then reflects her feelings - aggressions - that this patient caused in her and is able to perceive the aggressive comportment of the patient on a reflectional level as insecurity. This seems to be an example of transference and countertransference situations during an osteopathic treatment.

As described in chapter 3, the therapist realises which feelings the patient causes in herself, reflects them and is then able to perceive those feelings the patient is not able to feel, which are fear and insecurity hidden behind the aggressive comportment.

Thus the patient felt accepted and wanted to continue the therapy.

2.3.3. Demarcation

2.3.3.1. The divide between theory and praxis

When being directly asked about border violation during the treatment Maria's ambivalence is again apparent:

„Ahm, also Grenzen können nur dann verletzt werden von meiner Seite, also meine Grenzen können nur dann verletzt werden, wenn ich bereit bin, das zuzulassen. Das ist einmal grundsätzlich so[...]Mit einer Patientin ist es mir einmal passiert, die hat irgendwie sich permanent beklagt, also dass nach der zweiten Behandlung da nichts weitergegangen ist und hat mich angegriffen, dass ich eine schlechte Therapeutin bin und da ziehe ich also auch ganz, ganz klar meine Grenzen und sag' also ich bin ein absoluter Profi und das bin ich auch und das muss ich mir nicht sagen lassen und es gibt immer wieder die Situation, dass es Patienten nicht hilft, das kann vorkommen aus welchen Gründen auch immer. Ein Teil wird sicher bei mir liegen aber auch ein Teil beim Patienten, aber deswegen stell ich mich nicht in Frage. Das wäre zum Beispiel so eine Grenzüberschreitung. Ansonsten ist es so: je strukturierter und klarer man die Dinge vorgibt umso weniger hat der Patient überhaupt die Chance oder die Möglichkeit oder kommt auf den Gedanken irgendeine, eine Grenze zu überschreiten. Das ist meine Erfahrung." (IP3, S 3/12-29)

[Well, my borders can be only violated if I permit that. In principle it's like that. ... But there was one case, a patient who permanently complained about me, said already after the second session that she sees no progress and assaulted me that I was a bad therapist and in such cases I draw my boundaries really, really clearly and say that I'm an absolute professional, because that's what I am and I don't have to listen to that and that there are sometimes situations when the treatment doesn't help patients for whatever reason. Maybe it's partly because of me, but definitely also because of the patient, but therefore I don't call me into question. This would be an example for border violation. But normally it's like that: the better the structure and the clearer you specify things the less possibilities patients have to exceed the limits. That's my experience. (t.b.A.W.)]

This depiction shows that Maria alternates between the levels of theoretic demand '*my borders can be only violated if I permit that'* and personal concernment. In the situation in which she experiences devaluation on part of the patient as border violation she retreats to a level of justification: *I'm an absolute professional and I don't have to listen to that. Maybe it's partly because of me, but definitely also because of the patient, but therefore I don't call me into question.* It is apparent that she feels offended because she reacts with the

discontinuation of therapy and because she passes the patient to another osteopath but emphasises that the original problem was a strong attachment to a former therapist. *„Also, sie war einfach fixiert auf diese andere Person und deswegen bin aber ich keine schlechte Therapeutin. Ja.“ (IP3, S 4/10-11)*

[I mean she was totally fixated on this other person but that doesn't mean that I'm a bad therapist. Yes.(t.b.A.W.)]

Aspects of power seem to play a role, too, when she says: „ *Je strukturierter und klarer man die Dinge vorgibt umso weniger hat der Patient überhaupt die Chance oder die Möglichkeit oder kommt auf den Gedanken irgendeine Grenze zu überschreiten.“*

[the better the structure and the clearer you specify things the less possibilities patients have to exceed the limits. (t.b.A.W.)]

This makes clear again that according to her therapeutic understanding there should be clear terms of reference on part of the therapist which patients have to adjust to in the therapeutic relationship.

Again she is ambivalent when she says:

„*Ich hab' kein Problem damit, von mir Dinge preis zu geben, die jeder wissen kann, na, also es ist auch ganz, ganz wurscht oder das ist auch o.k., oder es schafft vielleicht auch eine gewisse Atmosphäre, wenn die Leute wissen, ja, ich bin verheiratet, hab Kinder und wenn's mich einfach fragen, das sind Dinge, die bin ich gerne bereit bin auch zu erzählen. Ja, oder, oder wo ich wohn, oder so, ja, also ich hab da keine Probleme damit.“* (*IP3, S4/ 26-30)*

[I'm fine with revealing some things about me, things that everybody may know. I really, really don't care. I mean that's really okay, or maybe that even creates a certain atmosphere if people know that I'm married, that I've got children and if they ask I'm really willing to talk about these things. Yes, or when they ask where I live. I'm really fine with that. (t.b.A.W.)]

If one connects this statement with the statement about boundaries which *can be only violated if I permit that'* it becomes apparent that on the action level she departs from her theoretic demand.

Thus there might be a certain contradiction between the theoretic demand of absolute demarcation and the concrete action level which admits personal aspects. This contradiction might lead to some conflicts.

When being asked about border violation on her part, Maria says she tries to articulate it and to apologise when she realises that she crossed her patient's boundaries.

When being asked for a concrete example she depicts the situation with a '*very high-ranking person of the state of Austria'* who got confused when she said*, 'I will now try to manipulate*

your backbone' because he felt like a guinea pig. She interprets this situation as a verbal misunderstanding and draws the conclusion that one should not show patients any insecurity *„weil der Patient ist selber unsicher genug, ja, wenn er daher kommt und als Therapeut darf man sich dann da keine Schwächen zeigen-, also erlauben eigentlich, oder keine Schwäche zeigen. Auch wenn man genug hat, aber man darf's nicht herzeigen, zu mindestens, ja." (IP3, S 5/25-28)*

['because the patient is insecure himself, when he comes to see me and as a therapist you are not allowed to show any weaknesses or insecurities . Even if you have some you are at least not allowed to show them, yes.' (t.b.A.W.)]

At a first glance this depiction has not much to do with the topic of 'border violation'. But on closer inspection one could interpret this aspect of showing no weaknesses and insecurities as a form of demarcation.

Again she interprets the appearance of a conflict as lack of demarcation on her part in the sense that she admits weaknesses. This corresponds to the example given above where border violation on part of the patient is described as questioning the therapist's competence. In fact this depiction is again about the therapist's boundary and not about that of the patient.

2.3.3.2. Interaction and demarcation on a bodily level

In connection with the description of an interaction with a patient who suffers from borderline personality disorder, Maria brings in the term 'mind-zone'. *„Das Interessante ist, diese Borderliner, so was hab ich schon ein, zweimal gehabt, da muss man eigentlich die Hände davon lassen, die sind, die fühlt man auch anders, ja. Die haben einen, ahm, einen anderen Rhythmus, eine andere Vitalität, eine andere Ausstrahlung, ja. Ich mach jetzt diese Biodynamik beim Tom Shaver und die fühlen sich einfach anders an. Ich kann's jetzt viel konkreter einordnen. Die sind einfach in ihrer Mind-Zone, ja, in dieser erweiterten Zone, sind sie einfach anders. Und die ist auch anders, ja." (IP3, S8/25-28)*

[I've had one or two borderliners, it's interesting, in fact you should keep your hands off them, you feel them differently, yes. And they have another rhythm, another vitality, another vibrancy, yes. I'm doing this biodynamics with Tom Shaver and they simply feel differently to the touch. I can classify that much better now. They are really different in their mind-zone, yes, in this expanded zone, I mean they are really different in any case. (t.b.A.W.)]

On the level of interaction with patients she then describes concrete strategies to deal with the non-demarcation that comes along with borderline personality disorder (clear timeframe, clear therapeutic setting,…).

She explains the altered perception of borderline disorder with the aid of the biodynamic model and cites the altered mind-zone as the reason why borderline patients are not apt for osteopathic treatments.

When being asked about these terms she specifies them as follows:

*„…Und wenn man es schafft von dieser C-Zone auf D zu kommen, ja, das ist die Zone von Mind, sagt Jim Jealous oder „Divine, die Göttlichkeit", dann ist es so ein umgebendes Gefühl der Ruhe aber der dynamischen Ruhe. Das ist ganz interessant. Da wird der Raum, du als Therapeut, die Person, still. Also, als ob die Zeit angehalten werden würde. Das ist die Zone von Mind, ja.***"** *(IP3, S10/20-26)*

[…And if you manage to come from the C-zone to D, yes, that's the zone of mind, as Jim Jealous puts it, or the divine, that's such a surrounding feeling of calmness, but it's a sort of dynamic calmness. That's very interesting. The room, you as the therapist and the patient become really calm. As if time has stopped. That's the zone of mind, yes. (t.b.A.W.)]

This description of the mind-zone resembles Erika's description of a well working therapy. As Erika and Wolfgang do, Maria, too, perceives coherence in a well working therapy; she describes it as mind-zone and thereby refers to the biodynamic model.

When she says that borderliners are different in their mind-zone, one may assume that with them this feeling of coherence does not appear. „*..muss man eigentlich die Hände davon lassen, die sind, die fühlt man auch anders, ja. Die haben einen, ahm, einen anderen Rhythmus, eine andere Vitalität, eine andere Ausstrahlung."*

[in fact you should keep your hands off them, you feel them differently, yes. And they have another rhythm, another vitality, another vibrancy.]

Maybe this perception is frightening and threatening for her and she feels her demarcation to be endangered.

It is interesting that on the one hand Maria describes a very clear strategy in dealing with borderline patients which might lead to the assumption that she is familiar with the psychopathology of borderline disorders but on the other hand uses the intuitive explanatory model of biodynamics for the description of borderline disorder on a bodily level. In the description of mind-zone references of certain osteopathic concepts, such as biodynamics, to religion and spirituality *(see chapter 5)* become apparent (*'the Divine').* This indicates that in the description of mental processes one tends to resort to transcendental instead of psychopathological explanatory models. As mentioned in chapter 5, I think these explanatory models do not do justice to the complexity of mental states. From my point of view hereby the level of interaction between therapist and patient is neglected. As it was already described in

connection with Wolfgang's case this perception of 'otherness' has to be understood in the context of interaction that is established between patient and therapist during the osteopathic treatment, as well. This means that the perception of the patient is already a product of this interaction which could in turn mean that the disorder on the level of relationship that is part of the psychopathology of borderline personality disorder is expressed already during the bodily contact approach with the patient. As mentioned in chapter 3 specific mental disorders, such as e.g. the borderline disorder, go along with a deficient ability for demarcation against environment (ego-demarcation disorder).

Thus the example given can be interpreted in that way that Maria perceives this patient as borderline personality because of her psychopathological knowledge and on a concrete action level acts in accordance with psychopathology (clear timeframe, clear therapeutic setting). She perceives the ego-demarcation disorder that accompanies borderline disorder intuitively *('in fact you should keep your hands off them, you feel them differently'*). As explanatory model, however, she does not bring psychopathology but the model of biodynamics, which is settled on a spiritual level. As mentioned in chapter 2, intuition is a precognitive function that is susceptible to disturbance in stress situations. This is the reason why in therapeutic situations one should combine intuition and rational analysis instead of relying on one's feelings only.

2.3.3.3. Self-awareness, self-perception as a way of demarcation

For Maria biodynamics seems to be a new territory and an important enrichment for her personal development.

„*...ich versuche, diese neue Sichtweise .... diese neue Möglichkeit auch auszuschöpfen, ich merk schon, dass ich ruhiger geworden bin, strukturierter, noch strukturierter geworden bin, interessanter Weise. Nämlich in der Cranio strukturierter geworden bin. Ich kenn mich jetzt einfach in diesem ganzen plastischen Veränderungen, Wellen, Bildern, Gefühlen bissl besser aus. Ich kann's besser einordnen. Das ist für mich wahnsinnig wichtig, weil ich nicht verloren gehen möchte, ja. Ah, das passiert aber immer wieder, dass ich dann in der Cranio irgendwann einmal .... weg bin und nimmer weiß, was ich tu, wer ich - , also was ich, wer ich bin schon, aber was ich tu und was konkret passiert und kann's dann auch nicht vermitteln.*" *(IP3, S11/3-11)*

[I try to exploit this new opportunity, this new view, and I feel already much calmer, even more structured, interestingly enough. Because I have become more structured in Cranio. I

know all these plastic changes, waves, images, feelings a bit better now. I can classify it better now. That's really important for me, because I don't want to get lost, yes. But that happens to me from time to time, that I'm away during cranio… I'm away and I don't know any longer what I'm doing and who… - I mean, yes I know who I am, but I don't know what I'm doing and what's happening and then I'm not able to get it across. (t.b.A.W.)]

The biodynamic approach seems to give her security in dealing with subtle processes of an osteopathic treatment. Additionally this approach seems to offer an opportunity of demarcation to her, to prevent that she does not *'any longer know what I'm [she's] doing and who…[I am]'*, that she does not affiliate with the patient during the treatment.

Self-awareness of the biodynamic therapy of a biodynamic osteopath seems to give her security in dealing with patients *„Also ich bin viel gesünder geworden, stabiler geworden, ruhiger geworden und sicher noch authentischer geworden. Das heißt, ich hab auch überhaupt keine Scheu mehr negative Dinge auszusprechen, wenn sie so sind, wie sie sind. Ohne dass ich mich schlecht dabei fühle."(IP3, S 11/15-17)*

[I mean I definitely got much healthier, more stable, calmer and definitely even more authentic. That implies that I'm not afraid of articulating negative things anymore, if they are like that. Without feeling guilty or bad about it. (t.b.A.W.)]

Also on the level of bodily demarcation her ambivalence becomes apparent. Again there is this contradiction between theoretic demand and practical action level.

„Ansonst ist es das, was wir quasi auch immer gelehrt bekommen haben, also jetzt auch in der Biodynamik. Du versuchst dich mit dem Patienten zu synchronisieren, bringst dich aber eigentlich nicht ein. Das heißt, dieses Wort Verschmelzen gibt's für mich so nicht. Es ist ein Synchronisieren mit ihm, mit seinen, mit seiner Welle, also mit seiner Ebene, auf der er sich befindet, auf der man dann arbeiten kann, aber verschmelzen, na verschmelzen eher nicht." (IP3, S12/3-8)

[In biodynamics it's the same thing that we were taught. You try to synchronise with your patient, but you don't bring in yourself. In fact this concept of affiliation doesn't exist for me. It's synchronising with the patient, with his wave, with this level he is on and with which you can work, but affiliating? No rather not. (t.b.A.W.)]

When being asked what she meant by 'not bringing in herself ', she answered:

„Ah, du bringst dich nicht ein, was bedeutet das für mich....Ja, also es ist nicht notwendig, ah, sich einzubringen, oder man soll es nicht tun, weil es hat ja die Therapiesituation als solches hat ja mit mir als Person ah wahrscheinlich nichts zu tun. Es stimmt nicht so, aber für eine konkrete Therapiesituation ist es nicht erforderlich. Sich nicht einbringen heißt, ich versuche

nicht da in diesen Körper hineinzutauchen und zu schauen, was da drinnen los ist und mich hineinziehen zu lassen, sondern ich bleib außerhalb, stelle mich und meine Möglichkeiten zur Verfügung und, und, und versuche ein neutrales empathisches Verhältnis, Therapieverhältnis herzustellen, obwohl ich aufmerksam bleibe, ja, aber diese eigene Zentrierung, Verbundenheit mit dem eigenen Hier und Jetzt, ja, ah ist wichtig um, um auch Prozesse die auf dem Therapiebett dann ablaufen, ja, die vor einem ablaufen sozusagen, ahm, dass die, dass dieser Prozess ungehindert ablaufen kann und nicht durch mich auch gestört wird. Das ist glaub ich auch noch ein Punkt, weil es hat überhaupt keinen Sinn, ich will ja jetzt nicht behandelt werden, sondern der kommt ja zu mir, weil er was von mir erwartet oder braucht." (IP3, S 12/23-13/4)

[I don't bring in myself, what does that mean for me.. well, it's not really necessary to bring in yourself, or you shouldn't do that, as the therapeutic situation presumably doesn't really have much to do with me as a person. Well that's not true like that, but for the concrete therapeutic situation it's not necessary. Not to bring in myself means that I don't try to plunge into this body and to look what's happening inside and to let me be dragged in, but I stay outside, I provide myself with my possibilities and I aim at a neutral empathic therapeutic relationship although I remain attentive, but my own centring, the connectedness with the here and now, yes that's important for the processes that run off before you on the therapy bed, it's important that these processes can run off unopposedly without being disturbed by me. I think that's an important point. Because that has really no sense, I don't want to be treated at this moment, but it's the patient who comes to see me because he expects or need help or something from me. (t.b.A.W.)]

According to her understanding described above it is hindering if the osteopath brings in him-/herself concretely as a person, because that could disturb processes that should run off autonomously. Maria emphasises that the therapeutic situation doesn't have really much to do with herself as a person and equates *'to bring in oneself'* with *'to plunge into the patient, to be dragged in'*, which are words that imply a lack of demarcation of the osteopath against patients. This makes clear that the personal level is hindering for the therapeutic process, that it is important to establish a neutral empathic therapeutic relationship, to provide oneself as therapist for the therapeutic process without being personally involved. '*The therapeutic situation presumably doesn't really have much to do with me as a person'* might be again interpreted as an attempt for demarcation.

This statement, however, contradicts these situations described during the interview in which she concretely interacts with patients on a communicative level and in which she brings in herself concretely into the therapy.
In this connection it appears interesting to me to defer to findings from psychotherapy, which are described in chapter 4. In recent psychotherapy research the idea of an interactive view is increasingly promoted as against the traditional therapeutic abstinence. According to this idea the therapeutic relationship is characterised by a permanent mutual interaction between patient and therapist while the concept of therapeutic neutrality is increasingly challenged.

2.3.4. Self-conception: Companion

According to her self-conception Maria describes herself as
„..ein Wegbegleiter, zeig ihm auch Möglichkeiten auf, was er tun kann, um diesen Zustand zu erhalten und weiterzuverbessern. Gebe ihm immer die Option, dass ich jeder Zeit da bin, zu mindestens telefonisch oder irgendwie, ja, aber dass man mich immer anrufen kann und lege die Verantwortung von Anfang an in seine Hände und sag das dem Patienten auch ganz konkret...die Patienten müssen schon wissen, dass das eine, eine Arbeit ist, die letztlich ihnen nicht erspart bleibt, dass es ihre eigene Körperarbeit ist." (IP3, S 14/5-19)
[…a companion, I also show him possibilities, what he can do to maintain this state or to improve it. I give him the option that I'm there for him at any time, at least by telephone or somehow, that he can call me any time and right from the start I delegate responsibility to him and tell him clearly… I mean patients have to know that this is work, that I can't save them the trouble, that it's their own bodywork. (t.b.A.W.)]
Again she is being ambivalent here: '*that I'm there for him at any time'* and '*right from the start I delegate responsibility to him'*.
When being asked how she acquired her competences concerning her acquaintance with patients, she refers, as Wolfgang, to the social competences she acquired during childhood and to knowledge from psychotherapeutic self-experience.
„…der Umgang mit den Patienten kann nur dann ein guter sein, wenn du als Therapeut so echt und authentisch wie möglich bist. Das ist die Quintessenz aus der ganzen Geschichte. Das ist ein langer Prozess gewesen, der sicher auch noch weiter geht, aber also ich glaub da bin ich schon ein großes Stück ah zusätzlich noch vorangekommen, ja." (IP3, S13/ 23-29)
[… the acquaintance with patients can only work well, if you, as the therapist, are as authentic as possible. That's the quintessence. It was a long process, which is definitely not finished yet, but I think I've already made a big step. (t.b.A.W.)]

This image of authenticity again contradicts the therapeutic abstinence she posits and also the statement '*as a therapist you are not allowed to show any weaknesses or insecurities. Even if you have some.'*

2.3.5. Summary

To sum up one could say that Maria's main topic throughout this interview is the subject of demarcation during the therapeutic process. Thereby her ambivalence becomes obvious.
For one thing she is ambivalent concerning the significance of personal interaction with patients during the osteopathic treatment. On the one hand she defines herself as someone whom you can recommend to, who does not leave anything unexpressed but at the same time expresses insecurity and excessive demand regarding too much personal involvement on part of the patients.
And for another thing there is an apparent discrepancy between her theoretical demand concerning demarcation and the concrete action level. In theory she proceeds from an ideal of total demarcation against patients which is absolutely not reflected on the concrete action level.
This raises the question whether theoretical demands should approximate praxis or praxis should approximate theoretical demands.
As I tried to show Maria emphasises the theoretical demands in this manner in order to compensate insecurities on the concrete action level.
In dealing with interaction problems Maria uses her communicative abilities and clearly addresses conflicts. Obviously on a verbal level she manages to form a foundation of trust and to work on conflicts with patients.
In dealing with demarcation on the bodily level there is notably a connection to biodynamics. The biodynamic thought model seems to give her security concerning bodily demarcation against her patients and helps her not to affiliate with them. But the question is whether this model can do justice to the complexity of interactive processes in a therapeutic situation. Again it should be questioned if there are any possibilities of demarcation that are available to patients in a body-therapeutic process such as osteopathy and if this aspect is emphasised sufficiently in osteopathy. From this interview, as well as from the interviews with Erika, Wolfgang and Thomas it becomes apparent that primarily demarcation on part of the osteopaths is reflected and hardly any room is given to the patients' need for demarcation.

The therapeutic abstinence postulated by Maria can be found only partly on the concrete action level, in fact she seems to be an osteopath who really gets involved personally but then in this respect sometimes feels overchallenged by her patients.
On the basis of the insights gained by this interview it seems to be necessary to critically question and attentively consider theoretic postulations of osteopathy as, for example, demarcation and to better train critical self-reflection already during the osteopathic education. Therefore a certain change of thinking in respect of therapeutic abstinence and dealings with interaction processes and mutuality in the therapeutic process seems to be important.
As mentioned in chapter 4, therapeutic abstinence is evermore questioned in the field of psychotherapy. The perspective of the therapists' neutrality is called into question and increasingly replaced by an interactional view of the therapeutic process. Sommerfeld (2000) claims for this view in osteopathy, too. It appears to me that this discussion is necessary in osteopathy as well, not at least because of the insights gained from this interview.

2.4. Interviewee IV

Interviewee 4, in succession called Thomas is osteopath with a long experience. His basic profession is physiotherapist, as osteopath he works biodynamic-oriented.

2.4.1.Relationship-formation

2.4.1.1. To reach the patient's centre

When being asked about a good therapist-patient-relationship Thomas makes out different aspects. He emphasises that a good human interaction cannot be equated with good therapeutic interaction.
„also wenn der Patient jetzt gern zu mir kommt, ja, dann bedeutet das noch nicht, dass ich mit dem in Beziehung bin, was ich behandeln will." (IP4, S1/18-20)
[I mean if the patient likes to come to me, well, that doesn't automatically mean that I'm in relation with what I want to treat. (t.b.A.W.)]
He cites the statement of a child, who does not only see him as a medical person, but also as a friend as an example for good human interaction. In his opinion that is a good basis for the therapeutic work.
„Aber, ich mein, es gibt Patienten, die kommen gerne her, das weiß ich, ja, oft auch Patienten, die länger kommen oder die regelmäßig kommen, und grad bei denen hab ich aber oft das Gefühl,

also manchmal das Gefühl, dass ich nicht genau dort hinkomm', wo ich hinkommen will, ja. Und dann gibt es vielleicht Patienten, die, die nicht so gern-, die halt neutraler sind im Kommen, ja, wo man das Gefühl hat nicht unbedingt von einer Sympathie, aber die kommen da her und im Behandlungskontext aber, da erlebt man was, wo man sagt, ah, da bin ich jetzt in Beziehung mit dem Menschen ganz, ganz tief und das war's dann auch wieder, ja. Und manchmal kommen die, trifft man die Jahre später und die sagen einem dann, ah, da ist wirklich irgendwas passiert, ja, was Tiefes. Und das ist eine andere, tiefere Beziehung, vielleicht ist das bei den Anderen auch da, ja, aber das ist das, das was ich am Wichtigsten find, eigentlich, dass etwas passiert, wo der Patient spürt, es ist etwas ganz, ganz Persönliches und, und Betreffendes auch für ihn." (IP4, S1/33-2/13)

[I mean there are patients who really like to come, I know that, often long-term patients or patients who come regularly but especially with those I often have the feeling I can't reach what I want to reach. And then there are patients who don't like to come that much or are simply more neutral, where you don't really have the feeling of sympathy, but they come and in the context of treatment you experience something that feels like now I'm in relationship with them, really deep, and that was about it. And sometimes you meet them after many years and they tell you that something has changed, something really deep. And that's another, a deeper relationship, maybe that's there with the other one's as well, but that's what I think is most important, that something happens… and the patient feels... it's something really, really personal and touching, also for him. (t.b.A.W.)]

Similar to Wolfgang, Thomas distinguishes between a good human basis and a deep meeting between patient and osteopath, that is, according to his view, something beyond all thinking processes and independent from intensive human relations between him and the patients. He defines the meeting, the relationship, only from the perspective that '*I [he] can't reach what I [he] want[s] to reach'*, mutual interaction doesn't seem to play a role for him in the therapeutic process. He explains the deep level of meeting by means of the term midline and thereby refers to A.T. Still.

Thomas distinguishes between three levels; a conscious, arbitrary level, a level of control of autonomous processes and a deep level of causality which is not accessible to thinking. He describes the relationship on this level as meeting, as affiliation on a very deep level.

„… Und das wäre eben die Ebene der Kausalität. Und die würd sich dann auch wieder mit der Mittellinie decken. Und die Ebene, die die Prozesse im Patienten steuert, ist mit großer Wahrscheinlichkeit auch die Ebene, die in mir meine Prozesse steuert. Und ist wahrscheinlich mit diesen Prozessen identisch eben, ja. Und ist nicht ähnlich, sondern ist wirklich identisch. Und deshalb hab ich das Gefühl, wenn ich zur Mitte des Patienten komm, dann komm ich gleichzeitig

auch zu meiner Mitte. Das heißt, seine Mitte ist meine Mitte und das ist nicht ähnlich sondern es ist das Selbe. Untrennbar das Selbe, ja. Und das ist etwas Schönes und wenn ich das Gefühl hab, der Patient löst auf dieser Ebene ein Problem, dann ist das was ganz, ganz Tiefes, was sehr Intimes, wo man dann auch gar nicht so viel nachfragen kann, oder soll, unter Umständen, das heißt, ja, wenn er will, dann kann er's mir selbst sagen, ja. Das meiste kann er eigentlich eh nicht beschreiben, gell. Aber das ist etwas sehr Authentisches und das ist das, womit ich in Beziehung kommen will, ja." (IP 4,S 2/17-3/17)

[And this would be the level of causality. And this level would correspond to the midline. And the level that controls the processes in the patient is in all probability also the level that controls my processes in me. And is presumably identical with these processes. And is not similar but really identical. And that's why I have the feeling when I reach the patient's centre I reach my own centre at the same time. This means his centre is my centre and that's not similar, it's really the same. Inseparably the same. And it's great when I have the feeling the patient solves a problem on this level, that's something really, really deep, something intimate, where you really shouldn't ask too much, I mean perhaps, if he wants that he can tell me himself. But most of it he wouldn't be able to describe anyway. But that's something really authentic, something I want to come in contact with. (t.b.A.W.)]

This means he aims for a relationship with his patients, an affiliation which is not accessible to consciousness and is thus on a precognitive, non-verbal level. He explains this affiliation by means of the term midline, which is for him a spiritual level of meeting. It is remarkable that verbalising obviously does not play a role for him; he absolutely relies on his feeling of coherence, but if patients really share this level of experience remains open. The relationship he creates with his patients claims a sort of absolute commitment and thus massive confidence on part of the patients.

This becomes apparent again, when he stresses that for him the osteopathic treatment is also a matter of leaving the level of thinking, he describes it as *'the level of thinking and wanting, the do-tension'* in order to reach the level of *'flowage'*, the level of autonomous processes. He says that when patients come for the treatment of only one specific symptom he is better able to let him sink into depth than when patients come regularly, as these patients '*include* [the osteopathic treatment] *into their concept of life'*. He explains that with a different 'treatment intention' on part of the patients, namely that it is up to the patients if they activate their self-healing forces. *„.. ‚und ich [der Patient] schau mir das ganz genau an, wie das funktioniert, dass ich dann selbst alleine damit zurecht komme' Und das machen die anderen glaub ich nicht in der Form, dass sie sich auf dieses ganz allein, selbst damit zurechtkommen einlassen."(IP4, S 4/31- S5/2)*

['and I [the patient] look exactly how that works so that I can handle it on my own' And I think that's what the others don't do, that they don't want to handle it on their own. (t.b.A.W.)]

It seems interesting to question why it is easier for those patients who go to therapy only once to absolutely '*let themselves sink into depth'* than for those who go to therapy regularly and '*have taken [the therapy] into their concept of life'*. For this could also mean that these patients link therapy with their lives and thus due to regularity a real relationship between them and the therapist comes into being and that absolute commitment and personal nearness become incompatible in the course of time. For Thomas real relationships seem to be prejudicial to the success of therapy. According to his understanding healing takes place on a level that is not accessible to consciousness.

2.4.1.2. Therapeutic relationship requires absolute commitment on part of the patient.

Thomas emphasises that he aims at activating the patients' self-healing forces and depicts the example of a patient who came to see him because of massive pain in her shoulder. He particularly sensed tensions in the liver, which for Thomas was a hint for relationship problems and indeed the patient named problems with her child. When being asked how he dealt with this situation, he said that he explained her the causal relations. *„In der Regel ist es so, dass man einfach mal bewusst macht, dass diese Nabelspannung auf der Ebene des Nabels, also auf der Ebene der Denkenden und Wollenden, Spannungen nicht gelöst werden können." (IP4, S 8/5-8)*

[Usually it's like that that you make clear that this navel tension cannot be resolved on the level of the navel, which means the level of the reasoners and the wishing. (t.b.A.W.)]

When I asked what function this 'making the problem clear' for the patient has got, he said:

„ Man muss da vorsichtig sein, es gibt eben verschiedene Bewusstseinsebenen, ja. Und der Akt des Denken ist noch keine Bewusstseinsebene. Der Akt des Denkens ist eine Tu-aktivität, ja. Aber es hängt davon ab, ja, worauf dieses Bewusstsein abzielt. Das heißt, die Intention des Denkens ist jetzt wichtig. Es ist ein Anstoß, der natürlich über das Denken und übers Erkennen geht.. Da versuch ich dann einfach Beispiele zu bringen, die der Patient verstehen kann, aber die ihn eigentlich dazu bringen soll, eben das Denken eigentlich während der Behandlung einzustellen." (IP4, S 11/17-26)

[You have to be careful, because there are different levels of consciousness. And the act of thinking is no level of consciousness. The act of thinking is a do-activity. But it depends where this consciousness aims at. This means the intention of thinking is important now. It's an impulse that

definitely goes via thinking and recognition. I try to bring examples the patient is able to understand, but which should actually make him stop thinking. (t.b.A.W.)]

This statement makes clear that for Thomas the level of consciousness has nothing to do with the cognitive level, but on the other hand he states: '*It's an impulse that definitely goes via thinking and recognition*.' That contains a certain contradiction.

(In this situation I experience Thomas as being instructive because of my question about the conscious level. It seems to me that he does not want to let questions about his concept of 'consciousness' arise.)

When being asked what is to be understood by *'impulse via thinking that should switch off thinking'* he tells me about his changeover to the biodynamic method that some patients couldn't or didn't want to follow. *„Die erwartet immer dass ich was mach und blockiert mit dem, mit dem Machen, also mit der Erwartung, dass ich was mach, eigentlich den gesamten Behandlungsprozess... und bestimmte Patienten sind dann eben weggegangen. Aber das ist eben etwas, das versteh ich jetzt darunter, dass jetzt jemand daliegt zum Bespiel und durch Denken eben auch das blockiert, was in der Tiefe passiert. Drum sag ich am Anfang, denken bringt da nichts, weil es geht um die autonomen Tiefenprozesse und versuch eben etwas zu sagen, das darauf abzielt, dass sich die Patienten wirklich frei hinlegen können.." (IP4, S 12/ 9-20)*

[She always expects me to do something and obstructs with this expectation that I should do something the whole therapeutic process and some patients discontinued therapy for this reason. But that's what I understand by it now, that someone is lying there and only by thinking blocks what happens in depth. That's why I tell them right from the start, that thinking is no use there, because it's all about autonomous in-depth processes and then I try to say something that makes them able to lie down really freely. (t.b.A.W.)]

When being asked how he can be sure that the patient is together with him on this level of in-depth processes, he stresses again that it's important for him that patients can engage with his mode of practice.

He says that he would ask during the treatment what patients feel, *„wenn ich sag, ich sitz an den Füßen und ich spür, dass sich im Kiefergelenk was tut oder im Schilddrüsenbereich, dann frag ich ob die Patienten was spüren und dann sagen sie mir das und manchmal deckt sich das und manchmal deckt sich das halt nicht und manchmal spür ich was und er Patient spürt das noch nicht."(IP4, S 13/ 18-22)* Er sagt aber dann, dass *„der Behandlungserfolg nicht davon abhängig ist, ob man jetzt was spürt oder nicht spürt... Und das ist mir einfach wichtig, dass die Leute , dass so wenig wie möglich Erwartungshaltung da ist." (IP4, S 13/ 25-28)*

[when I say that I'm sitting at the feet and that I feel that something's happening in the jaw joint or around the collar-bone I ask if the patients feel something and they tell me what they feel and sometimes it's in accord with what I feel and sometimes it's not and sometimes I feel something the patient does not yet feel. (t.b.A.W.)]

But then he says that: *the therapeutic outcome is not determined by what you feel or don't feel. And that's important to me, that people have as little expectations as possible. (t.b.A.W.)]*

Again it becomes apparent that Thomas expects his patients to switch off all cognitive control mechanisms, only in this way an osteopathic treatment appears useful to him. The relationship he establishes to his patients is an unilateral one, as was made clear already at the start of the interview (*that I'm in relation with what I want to treat).* From patients he claims willingness for therapy which means to absolutely let loose their cognitive processes and thus the patient has no other possibility for participating in therapy than having unbounded confidence in his/her therapist. This means for Thomas' mode of practice self-perception on part of the patients and interaction in the therapeutic process play no role.

2.4.1.3. Self-healing forces of patients – responsibility of osteopaths?

It seems important to me to point out in this connection that such an unilateral shape of relationship implies an enormous liability on part of the osteopath towards his patients and a danger for the abuse of power. We have to bear in mind that such an asymmetric situation very much fosters regression on part of the patients and make them dependent on the osteopath, because they have abandoned their cognitive control mechanisms and have surrendered themselves to the osteopath. This means that the osteopath takes over great liability towards his patients and that it is in his responsibility to accompany patients out of a regressive situation.

In his self-conception Thomas obviously does not carry this responsibility, because from his point of view, the therapeutic outcome can be traced back only to the unconscious self-healing forces of patients. Activating these self-healing forces, however, is not in his responsibility.

„Ja ich mein, wenn diese Selbstheilungskräfte funktionieren, wenn das anspringt, dann ist das ja auch etwas, wo ich mich dann nicht mehr wirklich verantwortlich fühle....wenn er es nicht macht, dann kann ich auch nichts machen.... und es gibt halt Grenzen und Gott sei Dank werden die Leute auch gesund, ohne dass sie oft Therapien überhaupt in Anspruch nehmen. Einfach weil das so ausgerichtet ist." (IP4, S 14/ 9-20)

[I mean when these self-healing forces work, when they start up it's something I don't really feel responsible about any longer, and if he doesn't do it I can't change it, I mean there are limits and

thank goodness patients often get better without making use of therapies. Simply because that's arranged like that. (t.b.a.W.)]

From my point of view this seems to be a striking statement concerning Thomas' self-conception as osteopath. According to his self-conception the osteopath carries very little liability towards patients, as in-depth processes and self-healing forces ultimately work autonomously.

Elsewhere he defines his liability towards patients as follows:

„Ja, in einer gewissen Weise Gesundheit spürbar zu machen und einfach diese Dimension die Gesundheit erfahrbar zu machen. Und ja und da kann man einen kleinen Mittler spielen, ja der halt einen bestimmten Beitrag leistet, ja. Einen unter vielen, vielen. Denn die Leute sind eingebettet in ein riesiges Leben und die Haupterlebnisse haben sie woanders, aber es kann sein, dass man hier einfach das eine oder andere ein bisschen ordnet, klärt und dass einfach etwas bewusst gemacht wird, was eben die Gesundheit ausmacht." (IP4, S 20/22-28)

[Well, it's making them feel health and make them able to experience this dimension of health. And yes, you can act as a small mediator who makes a certain contribution, yes. But it's only one of many. Because people are embedded in a huge life and they have their main experiences somewhere else, but you might adjust or clear one or two things so that you make them aware of what health is. (t.b.A.W.)]

The question that consequentially arises for me is an ethic moral question, as in this self-conception the osteopath eludes all verifiability of his actions and in the end always can retreat to an unassailable position. According to his understanding it is due to malfunctioning self-healing forces if the success desired does not arrive and he does not carry any responsibility therefore.

2.4.2. Interaction, conflict management

By means of the depiction of a difficult patient who was very sceptical at the beginning of the therapy Thomas' way of dealing with interaction problems is made clear.

„und dann hab ich einfach versucht, das auf vielen Ebenen zu erfassen, wie sie ist. Das hilft dann eben auch wegzukommen von dem, was man sieht und von dem was man spürt und die Ablehnung, die man spürt, die spürt man manchmal, ja Und wenn´s dann momentan aber rausgeht in diese Mitte, dann spürt man nichts mehr, in der Mitte spürt man nichts mehr, in der Mitte spürt man nichts, das ist freier Raum.. Und in diesem Raum ist dann eigentlich auch ja so etwas auch wie Sympathie entstanden, und dann haben wir eigentlich sehr gute Behandlungen gehabt." (IP4, S 17/ 22-33)

[and then I tried to comprehend on many different levels how she is. That helps to get away from what you see and feel and also from the rejection you feel, yes you feel that sometimes. And when it's going to the centre you don't feel it anymore, in the centre you feel nothing, that's clear space. And in this space something like sympathy developed and in fact we had a really good treatment. (t.b.A.W.)]

In dealing with conflicts he apparently tries to get away from the level of sympathy and antipathy and, as he puts it '*And when it's going to the centre you don't feel it anymore, in the centre you feel nothing, that's clear space.'* This attitude enables him to go away from the concrete level of meeting where maybe conflicts are perceptible to another level on which he is able to perceive the patient in an unconditional way. He also uses the perception of the own body as demarcation strategy during the treatment.

„ wenn ich das Gefühl habe, ich spür hier den Nabel bei mir, dass das nicht offen ist, dann muss ich schauen, was da nicht stimmt. Also ich muss mich, das ist meine wirkliche Voraussetzung, beim Arbeiten wohl fühlen." (IP4, S 18/28-31)

[… if I have the feeling that I feel the navel, that it's not open I have to find out what's wrong. I have to feel well during the treatment, that's my real precondition. (t.b.A.W)]

This means he uses the perception of own bodily tensions as parameter for interaction problems with patients. This perception might be linked to the countertransference reaction of therapists in therapeutic situations described in chapter 4.

When being asked how he deals with tensions he feels in his own body and which are caused by interaction problems Thomas answers:

„Also, ich muss mal schauen, ob ich überhaupt weiter mache, gell das kann sein, dass man sagt, OK unter diesen Umständen kann ich nicht mehr weiter behandeln, und wenn nicht, dann muss ich einfach, dann schaue ich, ja dann versuche ich einfach auf diesen Grund zu schauen, einfach auf das zu schauen, auf die Probleme des Patienten zu schauen, versuch ob ich die verstehen kann, und, und jedes Problem ist verständlich, jede Angst ist verständlich, und jede Verletzung ist verständlich und das dahinter ist immer die Gesundheit wieder und dann versuch ich, das ist etwas wo es bei mir um die Hauptbeziehungsrichtung geht, ich versuche mit der Gesundheit des Patienten Kontakt aufzunehmen und das ist das Ganze. Das ist der Patient auch dort wo er unverletzt ist, wo er seine Ressourcen hat, eben zur Heilung, wo er schön ist, wo er frei ist, wo er authentisch ist, wo er selbst ist und mit dem versuch ich in Beziehung zu treten. Und das, das ist eigentlich, das versuche ich eben jetzt zu befragen, seit vielen Jahren, ja." (IP4, S 19/6-19)

[Well first of all I have to find out if I continue at all, I mean it can happen that you say, okay, under these circumstances I cannot continue the treatment, in such cases I have to look for the

reasons, the problems of the patient, try to understand them and, and every problem is comprehensible, every fear is comprehensible, every violation is comprehensible and what's behind that all is health and then I try- that's my main way of relationship- to come in contact with the patient's health and all that. That's where the patient is unharmed, where he has his capabilities for healing, where he is beautiful and free, where he is himself and with that all I try to come in contact. Yes that's what I try to consult, since many years, yes. (t.b.A.W)]

Thomas tries to '*look at the reasons*', tries to look behind the superficial comportment of his patients in order to recognise the conflicts that lie behind. He tries to accept all patients with all their fears and violations hoping to thereby reach their health and self-healing forces. This attitude can be compared to containment described in chapter 1, which is the acceptance of patients with all their feelings in order to make change possible. One could also see it as strengthening the healthy parts of patients.

But again this statement makes clear that for Thomas conflicts during the therapeutic process are primarily conflicts of the patient and not so much interaction problems between him and the patient. Reflecting his own contribution to conflicts does not seem to be important for him.

As it is for Erika, Wolfgang and, as we will see later on, for Gerhard, too, the discontinuation of therapy on part of the osteopath is an important option for Thomas, when it comes to interaction problems: *'I have to find out if I continue at all.'* The same applies to children who are not ready for therapy, who *„kreischen und um sich schlagen"* and *„wenn ich das Gefühl habe , die Mutter drängt das Kind rein"... „dann sag ich bitte, das ist eine Grenze, da gibt es keine Behandlung. "(IP4, S15/33)*

['scream and lash out' and '*when I have the feeling the mother pressures the child into coming… then I say this is a limit, in such a case there is no treatment' (t.b.A.W)]*

2.4.3. Demarcation

As Erika and Maria Thomas also uses body perception as demarcation strategy. The return to the own body perception permits a dissociation of transference on part of the patient and helps to identify countertransference reactions. Again I have to mention here that these demarcation strategies are not available for patients as they should, according to Thomas' understanding, dedicate themselves absolutely free from any cognitive strategies to the treatment.

In this context it is important for me to point out again that Thomas expects clearly defined behaviour from his patients: absolute commitment to his method and '*adapted behaviour'* of, for example, children. Using the example of children it becomes apparent that according to his self-

conception, establishing a therapeutic relationship is no negotiation process between him and patients, which would be definitely imaginable especially with children (who rarely ever go unresistingly into a an alien situation) by means of offering games or confidence-building measures. On the contrary, he expects certain behaviour from his patients which reconfirms the fact that in Thomas self-conception there is only little room for mutual interaction during the therapeutic process. And he clearly sets the frame for the treatment and thereby demarcates himself a priori: '*then I say this is a limit, in such a case there is no treatment'*.

When being asked about border violation on his part again he primarily reports about a border violation on part of a patient and then talks about another patient who seriously offended him because he thought Thomas made unrealistic promises concerning the therapeutic outcome. Thomas appears to be hurt by this incident and says '*he hurt me pretty much then and he stressed me out as well'* and that he had tried to put himself in the patient's place and to '*reflect my contribution to the conflict'*. *„Er ist dann wiedergekommen, ja. Und hat sich dann, hat dann gefragt , ob er Termine haben kann, das ist, das war einfach eine ganz schwierige Person auch unheimlich viel Nabelspannungen, unheimlich misstrauisch und ja, ich mein, wir können nicht alles, wir können nicht alles leisten. Was ich gelernt hab von ihm, dass man auch nicht zu viel versprechen darf." (IP4,S15/11-19) „..Der hat Recht gehabt. Dann war´s eine Grenzüberschreitung von mir, ja und in dem Fall habe ich wahrscheinlich einen Fehler gemacht. Da bei Tausend anderen nicht, ja die hätten das vielleicht gar nicht so empfunden. Aber in seinem Fall bin ich einfach zu weit gegangen, ja. Und er hat mir das dann signalisiert und er hat Recht. Und ich bin froh, denn nur so kann man lernen."(IP4, S 16/22-28)*

[He returned, yes. And asked if he could have appointments and yes that was a really difficult person, great navel tension and extremely suspicious, yes, I mean we are not able to do everything, to solve every problem. What I've learned from that is that I shouldn't promise too much. ... He was right. So it was border violation on my part and yes, in this case I probably made a mistake. With thousands of others I didn't and maybe they wouldn't have conceived it as such. But in his case I've simply gone too far, yes. And he signalised that and he is right. And I'm glad about it, because it's only like that I can learn. (t.b.A.W.)]

It is remarkable that when talking about the issue of border violation Thomas primarily thinks of border violations on part of the patients and only after being asked again he can think of border violations on his part. Apparently the patient's reproach that Thomas made unrealistic promises concerning the therapeutic outcome made him feel afflicted and reflective. But at the same time he indicates that other patients wouldn't have conceived that as border violation, wherewith he relativises the fact of border violation.

2.4.4. Self-conception: mediator

Thomas envisions himself as a '*small mediator'*, who helps patients to make health sensible. He sees himself as one of many who makes a small contribution to health although he stresses that many people convalesce also without therapy, *because that's arranged like that*. In the end he bears on the patients' self-healing forces and envisions the responsibility the osteopath carries in this respect as very limited (see above).

2.4.5. Summary

The main topic that emerges from this interview is Thomas' self-conception and the question of responsibility in the osteopathic treatment.

It becomes apparent that in his understanding the relationship relevant for an osteopathic treatment proceeds on an unconscious level, a level of in-depth processes. Thereby thinking processes on part of the patients are hindering. In fact it is absolute commitment and letting lose all cognitive control mechanisms on part of the patients that is necessary for successful osteopathic treatment. *(see regression chapter 3.6.)*

According to Thomas the therapist-patient-relationship is an unilateral one. Interaction during the therapeutic process *(see chapter 4.4)* does not play any role for him. He proceeds on the assumption that he comes in contact with the patients' centre, the patients, on the other hand, do not have any possibility for participation in his understanding, and thus their self-conception has no significance for the therapeutic process.

In his self-conception osteopathic treatment is a matter of activating the patients' self-healing forces whereby he envisions his liability in this respect as a very small one. For me the question that arises here is an ethic-moral one, as, according to this self-conception, the osteopath eludes all verifiability of his actions and is thus able to retreat to an unassailable position whenever he wants to.

In dealing with conflicts and interaction problems Thomas apparently very well tries to accept his patients with all their fears and violations, but conflicts are primarily perceived as the patients' conflicts, reflecting the interaction between osteopath and patient seems to play a minor part. (*see therapy as interaction process chapter 4.4.)*

Furthermore he always leaves the door open for the discontinuation of therapy. As Thomas has got very clear defaults of the patients' behaviour, the formation of a stable therapeutic relationship by means of a negotiation process does not play a role in his self-conception.
Thomas also describes the return to his own body-perception *(see chapter 3.6.)* as his demarcation strategy. Again it is important to point out that this demarcation strategy is not available to his patients as they should let loose all cognitive strategies. Thus osteopaths hold a position of power which they have to handle with responsibility. As already mentioned in chapter 3, the situation of an osteopathic treatment fosters the patients' regression, especially if the verbal level is blanked out. It is therefore in the osteopath's responsibility to accompany patients out of this regressive situation. However, Thomas does not seem to accept this responsibility as he ultimately appeals to the patients' self-healing forces and envisions himself '*only as a small mediator'* who should bring patients in contact with their healthy parts.
This self-conception of being a '*mediator'* reflects the spiritual character of his mode of practice. He proceeds from an idea of man that is characterised by 'beauty' and 'pureness'. According to his self-conception the real human relationship with the patient plays a minor part. In this context it seems to be necessary to reflect the idea of man of osteopaths as well as the question of power in osteopathy.

2.5. Interviewee V

Interviewee 5, in succession called Gerhard, is an osteopath with long experience whose basic profession is physiotherapist and who practices in his own office.
He calls his decision for osteopathy a random decision. He says that he heard from a friend about the osteopathic education which then took place for the first time in Vienna and 'took a look', just out of curiosity.

2.5.1. Relationship formation:Trust, Interhumanity and Language

The interview makes clear that for Gerhard trust, interhumanity and language are the relevant aspects for the formation of the relationship between him and his patients.
„Also Vertrauen ist für mich so eine wesentliche Sache, wo ich halt versuch irgendwie den Patienten, auch als Person zu sehen... Für mich ist sozusagen ein wesentlicher Punkt, wenn man merkt, da gibt's also eine gewisse Vertrauensbasis, die steht und fällt nicht unbedingt mit dem Behandlungserfolg." (IP5, S1/13-22)

[Well, trust is an important thing for me, where I try to see the patient as a person. For me it's important to know that there is a certain foundation of trust that doesn't necessarily depend on the therapeutic outcome. (t.b.A.W.)]

According to Gerhard this foundation of trust is an important basis for the treatment upon which a professional relationship is built. But at this he mentions to have certain problems with the term 'professional relationship'.

„Aber ich hab das für mich noch nicht so wirklich geklärt, aber ich hab ein bisserl ein Problem sozusagen, mit dieser totalen Abschottung... dass man ...sich nicht nur hinter der Professionalität verbirgt, sondern dass eine gewisse Art von Zwischenmenschlichkeit da ist. Die nicht nur in einem sterilen Raum sozusagen stattfindet, ja. Ich mein, ich weiß, dass das ein heißes Eisen ist, vor allem bei den Psychoanalytikern, oder so, aber das Problem ist glaub ich, dass wir in der Osteopathie - das ist mein Eindruck,- diese Art von Beziehung auch sehr wenig thematisieren, es wird immer mehr darüber gesprochen, wie man sich abschotten kann, oder was man machen kann, um böse Energien oder was auch immer rauszukriegen. Aber sonst ist eigentlich wenig da. Aber für mich wie gesagt, ist das ein wesentlicher Punkt – Vertrauen, ja. [Würd ich schon sagen, ja]." (IP5, S 1/30 –2/9)

[But I haven't really clarified that for myself yet. I have certain problems with this shielding... that you hide behind professionalism. I think a sort of interhumanity should be given. That doesn't only happen in a sterile room. I mean I know that it's a sort of hot potato, especially for psychoanalysts and the like. I think the problem is – I mean that's my impression –that we don't really broach this issue in osteopathy, I mean we talk a lot about how to seal ourselves from negative energies, how to get them out. But that's it. But as I said that's an important point for me – trust, yes [I would say so]. (t.b.A.W.)]

From this statement it becomes clear that Gerhard obviously differs in his self-conception from Thomas who emphasises that human relations are no precondition for a good therapeutic relationship. Gerhard also distances himself from the therapeutic abstinence postulated in osteopathy and criticises the lack of discussion of interhuman relationship in osteopathy.

He becomes aware of this lacking foundation of trust, *„... wenn Patienten zum Beispiel bei jedem Untersuchungsschritt immer wieder hinten nachfragen, „was machen Sie jetzt, warum machen Sie das jetzt, warum haben Sie das jetzt, was haben Sie alles gefunden oder so weiter'. Ja also dieses 'auf Schritt und Tritt sozusagen auf der Hut zu sein', ja, also das ist für mich ein Zeichen, wo irgendwie eine Vertrauensbasis nicht da ist." (IP5, S 2/18-22)*

[when patients ask after every step of examination' what are you doing now and why are you doing that, why did you do that, what did you find' and so on. I mean this being on guard at every turn, well yes, that's a sign for a lack of trust. (t.b.A.W.)]

This depiction shows the need for control on part of the patients and Gerhard links it with a lack of trust. As mentioned in chapter 3, this strong need for control on part of the patients might signify a protective mechanism and a fear of affiliation. Thereby language can act as fear reduction.

For Gerhard language is necessary to establish a foundation of trust.

„ Also für mich ist irgendwie schon die Gesprächsebene , für mich persönlich, was ganz was Wesentliches. Ich könnte nicht, wie es manche Osteopathen tun, nur auf dieser rein sensorischen Ebene arbeiten. Das wäre mir zu wenig...Also für mich hat Vertrauen auch damit zu tun, dass man mit Patienten spricht." (IP5, S 7/18-23)

[Well for me the level of communication is something really important. I couldn't work on this only sensorial level as some other osteopaths do. That wouldn't be enough for me. For me trust has to do with talking to patients. (t.b.A.W.)]

Apparently for Gerhard establishing a trustful relationship is the basis of the osteopathic work. For him this trustful relationship implies a certain human closeness to his patients, *that a sort of interhumanity should be given.* For him the conversational level is necessary and thus he distances himself from working on a 'sensorial' level only as other osteopaths do.

By means of an example he describes the importance of the verbal level during the treatment. Gerhard tells me about a female patient who came to see him because of lumbal complaints. He did not succeed in the treatment until he initiated a conversation from which it became clear that the patient had a strong desire to have children but was afraid of getting serious problems throughout pregnancy because of her complaints of the lumbar spine. During the conversation he managed to ease her fear and soon after that she got pregnant.

As mentioned in chapter 3, language can be understood as the common ground of meaning and it is only language that makes unambiguous understanding between two people possible.

2.5.2. Interaction, conflict management

2.5.2.1. The body in the osteopathic treatment

On the basis of the example of a patient who seemed to be confused already during the examination and who reacted to intensive bodily proximity in a refusing way, Gerhard brings

up conflicts that can arise from the intensive bodily proximity during the osteopathic treatment.

„..also das war nicht so, wie wenn manche Patienten nicht locker lassen können, das ist was anderes, also da war wirklich, uah, da war wirklich die Panik teilweise.. Und ich habe dann einfach, ja ich hab dann gesagt, ich glaub, dass das wenig Sinn macht, wenn wir da weitermachen und ich kann Sie gerne an eine Kollegin verweisen, wenn Sie wollen.... und sie hat dann eigentlich nicht viel gesagt. Ich glaub auch, sie wäre überfordert gewesen, die Patientin jetzt, das zum Ausdruck zu bringen, was ihr Problem war." (IP5, S6/ 4-10)

[I mean there are patients who can't relax, but that wasn't the same, in part there was really panic. And I told her that it was pointless if we continued and that I could relegate her to a female colleague if she wanted that... and then she didn't say much. I think she would have been overchallenged if she had to bring forward her problem then. (t.b.A.W.)]

He says that he terminated the therapeutic situation as fast as possible, that the patient did not have to pay anything and that he relegated her to a female colleague. But he stresses that this situation was a really exceptional case. He continues:

„aber es gibt Patienten die haben einfach Angst oft mit dieser Nähe die man da hat und ich , ich arbeite schon kranial auch, aber ich arbeite sehr viel über den Körper und habe schon sehr viel Nähe zum Patienten, also körperliche Nähe und also damals war das extrem und da hab ich einfach abgebrochen, hab dann momentan muss ich sagen, auch ein bisserl die Panik gehabt, hab mir gedacht, uh, wenn die da jetzt irgendwas draus konstruiert und mir was vorwirft, weil ich das so noch nie erlebt hab." (IP5, S 4/11-18)

[but then there are patients who are simply afraid of this proximity and then I continue with cranial work, but I work a lot with the body, too, and then there is this proximity to the patient. But then it was extreme and I simply discontinued, and I have to admit that at first I panicked a little, because I thought that she might construct something out of that and that she might accuse me of something because I've never ever experienced a situation like that. (t.b.A.W.)]

This statement can be linked with transference and countertransference situations during the treatment and with the particularly necessary reflections of the interaction on part of the therapist during a body-therapeutic treatment as mentioned in chapter 3. Gerhard articulates and reflects the strong bodily proximity that develops during the osteopathic treatment and connects it to interaction problems. Again this makes clear that according to his self-conception interhumanity plays a major role in the osteopathic treatment. He perceives the patient's fear and also reflects the sexual component of the intensive bodily proximity during

the treatment although without addressing the topic in a concrete way. One notices that Gerhard was obviously overchallenged in this situation as he says that he '*I panicked a little'* and discontinued therapy. This could be linked to the subject of mutual interaction during the therapeutic process described in chapter 4 and raises the question whose panic it was and if it maybe was a product of the interaction between patient and therapist, respectively. It is remarkable that Gerhard could not verbalise the conflict in this situation although communication normally ranks high for him. He appears to be overchallenged himself but mainly perceives the patient's overstrain: '*I think she would have been overchallenged if she had to bring forward her problem.'*

Another important aspect is that Gerhard incorporates the patients' body perception into the treatment.

He describes his approach to mentally labile patients as work on the entire body perception. *„einfach um den Patienten irgendwie so ein Gefühl zu geben, wieder in seinen Körper zu kommen. Wobei wir das jetzt auch nicht wirklich gelernt haben." (IP5, S 13/ 11-14)*

[simply give patients the feeling to return into his body. Although we didn't really learn how to do that. (t.b.A.W.)]

Thereby he brings the example of a patient who initially seemed to be difficult in contact but whom he could approach by means of techniques that stimulate body perception, such as GOT. *„ und ab dem Punkt waren dann plötzlich so ganz konkrete Themen da, na ja, da gibt's mit der Hüfte was. Also wo man auch ganz konkrete Dinge dann plötzlich behandeln kann." (IP5, S 13 / 20-22)*

[and from that moment on there were concrete topics, well, there's something wrong with the hip. And suddenly you can treat concrete things. (t.b.A.W.)]

It seems remarkable that he incorporates the concretion of the body perception of the patient into the treatment. As mentioned in chapter 3, the concrete perception of the own body is the precondition for the ability to relate to others. It becomes clear from the example given that the concrete body perception helped the patient to better articulate her needs. For me this is a significant aspect which has not been brought up so far and which is no issue in the osteopathic education, as Gerhard puts it '*Although we didn't really learn how to do that.'*

2.5.2.2. Manipulation , instrumentalisation and power

Gerhard reflects the situation of patients who had to go through a long history of suffering and who see osteopathy as '*last resort',* as an '*exotic device'* and talks about the in many osteopaths inherent '*nimbus of a faith healer'* which he is not really able to deal with.

„Mit solchen Patienten kann ich ganz schlecht. Also die diesen unglaublichen Druck haben, ja, die auch mir diesen Druck hinschmeißen .....Auf diese versteckte Aufforderung jetzt sozusagen das Unmögliche zu tun, also da schaue ich auch, dass ich irgendwie die Beziehung, wenn es irgendwo geht, beende." (IP5, S 5/ 8-15)

[With these patients I can't really work. Who have this enormous pressure, who also throw that pressure at me. And when it comes to this hidden demand that I should manage the impossible, well in this case I also try to terminate that relationship if that's somehow possible. (t.b.A.W.)]

This indicates that for Gerhard also the discontinuation of therapy is a possible option when it comes to difficult interactions. It is apparent that he has big problems with pocketing patients.

„*Und in dem Sinn, wenn ich mich instrumentalisiert fühle, also das ist für mich ein ganz wichtiger Punkt, das betrifft aber jetzt nicht nur Patientenbeziehungen, auch sonst, ja, dann werde, da werd' ich sehr, also, das macht mich krank und da schaue ich dass ich das mehr oder minder so schnell wie möglich beende. Also ich lass mich nicht instrumentalisieren, ja. Also das ist ein Punkt , wo ich dann sehr, relativ schnell sag, nein, so nicht. "(IP 5, S 11/27-32)*

[And in the sense when I feel instrumentalised, well, that's a really important point for me, not only concerning patient-relationships, but in others as well, that makes me really sick and I try to terminate that as soon as possible. I don't let others instrumentalise me, yes. That's a point where I say really quickly, no, not like that. (t.b.A.W.)]

This topic seems to occupy Gerhard very much and he reacts very emotionally to it. *„....Eben auch mit dieser Instrumentalisierung, dann. Also dass ich instrumentalisiert werde vom Patienten irgendwie, wo ich manchmal ein Problem habe, damit umzugehen, das gebe ich ganz offen zu." (IP5, S 12/28-30)*

[Well yes it's this instrumentalisation I have a problem with. When I'm being instrumentalised by the patient, well yes I admit I can't really handle that. (t.b.A.W.)]

Obviously those patients who put him under pressure because of their high expectations are difficult patients for him. He reacts very emotionally to the topic of manipulation and instrumentalisation on part of the patients and is only able to handle such a situation by

discontinuing therapy. His defence can be understood as fear of affiliation or boundary crossing. This might be connected to his aversion to manipulation on part of the osteopaths, he describes that as '*acting'*.

„diese Ebene, da müsste ich jetzt anfangen schauzuspielen, ja, und das kann ich ganz schlecht, also ich kann nicht schauspielen. Das war auch immer mein Problem, das sag ich auch ganz offen, also im Kranialbereich. Also ich hab immer das Gefühl ich muss jetzt schauspielen, dass ich da jetzt irgendwie – ah ja also ich spür da jetzt, also das – irgendwann habe ich gemerkt das kann ich nicht. Und ich frag mich auch, ob das ethisch vertretbar ist, dass man sozusagen mit dem Patienten schauspielen tut. Also das ist vielleicht ein wichtiger Punkt. Ja. Also so Patienten, wo ich das Gefühl hab, ich muss jetzt schauspielen, damit die irgendwie sozusagen das Gefühl haben, sie werden auf ihrer Ebene, also dort abgeholt wo sie stehen." (IP5, S 14/ 4-11)

[this level, I would have to start acting and I'm really bad at that. To put it bluntly that has always been my problem in the field of cranio. I always have the feeling that I have to play act – ah yes, now I feel something – and sometime I realised that I'm not able to do that. And I also ask myself if that's ethical, to play act with patients. I think that's maybe an important point. I mean when I have the feeling that I have to play act so that patients have the feeling I collect them from the level they are standing on. (t.b.A.W.)]

Gerhard' approach to patients is obviously rationally oriented and he clearly distances himself from a purely 'energetic' methods of osteopathy. He calls this level 'acting' and brings it in connection with the manipulation of patients. This statement may be linked to his reflection of power relations that inevitably occur during an osteopathic treatment.

„*Also ich behandle, also die Leute wirklich als, eigentlich so eher als Mitmenschen, und nicht jetzt als einen Patienten, wo ich sozusagen der Machtmensch gegenüber bin. Also für mich ist das Thema Macht einfach ein ganz ein wichtiges Thema in der Auseinandersetzung und ich bin mir dessen bewusst, dass es immer eine Machtrelation ist, in der man da steht. Aber ich versuche trotzdem diese Machtrelation so, diese Differenz so klein wie möglich zu halten, die da drinnen ist. ...Also weil manche Patienten immer sagen, mein Gott, was Sie alles spüren und hin und her. Da hab ich manchmal schon ein Problem, weil das manchmal ein Vertrauen ist, das mir schon fast zu viel ist....." (IP5, S 9/21-31)*

[I really treat people as fellow humans and not that much as a patient whom I encounter as a sort of power-seeker. For me the topic of power is a very important topic in dealing with human beings and I'm aware of the fact that it is a power position you are in. But I try to keep it the difference as small as possible... I mean because some patients say, it's so impressive

what I can feel and so on. And then I get the feeling that that's a sort of trust that's too much for me. (t.b.A.W.)]

Interestingly enough Gerhard is the only interviewee who mentions the topic of power of osteopaths towards patients. He brings that in conjunction with his mode of practice, that is, according to Gerhard, characterised by interhumanity. This reflection can be linked to the patient's regression, which occurs because of the asymmetric relation that develops in the osteopathic setting (see chapter 3). Osteopaths have to be aware of the patients' regression and of the power on their part that is associated with it.

2.5.3. Demarcation: To respect the patients' boundaries

Already at the start of the interview Gerhard criticises the tendency for 'shielding' from patients as well as the lack of discussion concerning interaction processes in osteopathy.

When being asked about the topic boundaries and border violations in osteopathy, he answers spontaneously:

„Eine ganz wesentliche Grenze ist, nie zu tun, was der Patient nicht will. Das ist für mich also das oberste Gebot in der Behandlung. Es gibt für mich also kein, keines was darüber stehen würde." (IP5, S7/27-29)

[a really elementary border is to do nothing the patient does not want. For me that's the prime principle. There is not one that would rank higher. (t.b.A.W.)] and gives an example of patients who are afraid of manipulations [NB cervical spine manipulation].

„Also, die zweite Sache ist für mich, also da habe ich teilweise auch schon sehr viel diskutiert, sind also Grenzüberschreitungen, die einfach mit bestimmten Körperregionen zu tun haben. Also ich bin nicht der Meinung wie zum Beispiel Jean-Pierre Barral, der sagt, ok, die Beckenregion ist eine Region wie jede andere, und die müssen wir halt auch behandeln, na, also der Meinung bin ich nicht." (IP5, S 8/ 4-8)

[And the second thing is, I've already discussed that a lot, are border violations that have to do with certain regions of the body. I don't agree here with Jean-Pierre Barral who says that the pelvis region is a region as any other body region and so we have to treat it. I'm not of this opinion. (t.b.A.W.)]

In this connection he criticises the osteopathic profession that from his point of view does not reflect such ethic-moral questions sufficiently.

„Das in meinen Augen auch im Berufsstand selbst von seinen ethisch-moralischen Komponenten ja überhaupt nicht diskutiert wird, das ist für mich ein Riesenproblem, also

auch in der Didaktik, ja. Dass darüber nicht gesprochen wird. Das man's beschränkt auf einen Biologismus, dass man sagt ok, na da haben wir halt den Uterus und die Vagina und hin und her – Punkt. Ja. Und das ist für mich also ein schwerer Fehler. Also das wären für mich so die wesentlichen Dinge. Nicht zu tun, was der Patient nicht will." (IP5, S 9/4-9)

[In my eyes these ethic-moral components are not discussed sufficiently by the osteopathic profession, for me that's a huge problem, also in didactics. That it's not talked about that. That it's all restricted to biologism, that you say, okay, there is the uterus and the vagina and that's it. For me that's a big mistake. That's an elementary thing for me. To do nothing the patient doesn't want. (t.b.A.W.)]

He brings up the topic of confrontation with ethic-moral questions within osteopathy, which is, according to him, insufficient and calls the in osteopathy predominant approach to corporeity biologism. It is interesting that Gerhard is the only interviewee who brings the human body and bodily proximity during the osteopathic treatment in conjunction with ethic-moral questions.

For Gerhard another sort of border violation is the use of painful techniques, such as fascial techniques.

„Also wenn das Vertrauen da ist, dann halten die Leute den Schmerz auch aus, aber es ist nicht so, dass ich sozusagen jetzt da in die Katharsis gehen würde, also wie. Ich mein, ich hab das ein bisserl erfahren so in meiner Selbsterfahrungszeit, ja, dass man halt dann einfach sozusagen, dass man jemanden von der Klippe stößt, sozusagen. Also das würde ich nicht machen." (IP5, S 10/19-23)

[I mean if there is trust people can bear pain. But I wouldn't go into catharsis as... I mean I experienced that during my time of self-experience, that you knock someone down the cliff. I mean that's something I wouldn't do. (t.b.A.W.)]

Again he reflects the level of interaction with patients. In this statement he expresses that he is aware of the fact that he exercises power over his patients by means of painful techniques and that he perceives it as his responsibility that patients can handle them.

It becomes apparent that his understanding of boundaries and demarcation is characterised by a symmetric view of the therapist-patient-relationship in osteopathy and that the aspect of 'interhumanity' plays an important role for him. In contrast to the other interviewees he defines the topic of demarcation mainly by the patients' boundaries and not primarily by the osteopaths' boundaries.

2.5.4. Self-conception: Demarcation against other osteopaths

Obviously Gerhard finds it hard to identify himself with the osteopathic profession. *(IP5, S 15/28-16/2)*

He says that the acquaintance with a famous 'osteopathy-theorist' was crucial for his self-conception as osteopath.

„Ein wesentlicher Punkt war sicher auch, dass ich den XY kennen gelernt habe, also das war für mich schon ein Turningpoint, also. Wo für mich dann diese Reflexionen eingesetzt haben." (IP5, S15/18-21)

[That was a crucial point for me when I got to know XY, I mean that was a turning point for me. That was the moment when I started to reflect. (t.b.A.W.)]

He says that this theoretic discussion was important for him when he realised that he did not succeed with the *'naive approach'* (thereby he means physioenergetics and other complementary methods).

Moreover he says that his philosophy studies additionally gave him important impulses for the practical work.

„Und für mich war schon dann das Philosophiestudium, also das klingt zwar jetzt paradox ja, aber das war für mich für die Praxis, war diese Art von theoretischer Auseinandersetzung und ist es nach wie vor, also unglaublich wichtig, also das ist für mich eines der wesentlichsten Sachen. Gewesen." (IP5, S 17/1-5)

[Well, for me my philosophy studies, I know that sounds ironic, yes but for my philosophy studies was praxis, it was this sort of theoretic analysis and that's till very important for me, for me that's one of the most essential things. It was. (t.b.A.W.)]

He describes his liability towards patients as being a companion*, 'not an educator, a companion that has competences in certain fields'* and stresses that '*I don't have omnipotence, that I'm not omniscient'*.

He envisions himself as someone who has '*certain mechanical skills, who can sort certain things cognitively and possibly, establish a relationship to where the problem might be'* but does not feel '*like being a guru'*.

„Ich hab auch kein Problem damit, symptomorientiert zu arbeiten... Also diese Hybris hab ich mir irgendwie abgeschminkt, dass ich glaub, ich kann Ursachen behandeln...Also ich vergleich dann immer mit mir, wenn ich Beschwerden hab, das macht das Leben schon sehr mühsam manchmal und man ist schon sehr froh, wenn´s dann zumindest besser ist und man

kann mit dem wieder besser leben. Ob man das jetzt als Lebensqualität bezeichnet, sei dahingestellt, aber so was ähnliches wie Lebensqualität. " (IP5, S 16/31-S 17/25)
[I haven't got a problem to work symptom-oriented... I think I kissed this hubris thing goodbye, that I think I can cure the roots. I always compare that to me then, when I've got pain, well that really makes life very tedious and you are really relieved when it gets at least better and then you can live better with it again. I don't know if you can call that quality of life, but it's at least something like quality of life .(t.b.A.W.)]
And again he emphasises the importance of the theoretic analysis.
„*Das wären für mich so die obersten Prinzipien, nichts zu tun, was der Patient nicht will und so weiter, muss ich ganz ehrlich gestehen, das sind Sachen, die ich eigentlich aus meinem Philosophiestudium gewonnen hab. Also die hätte ich sonst nicht gewonnen, aus der Osteopathie garantiert nicht." (IP5, S16/24-28)*
[I guess these would be my main principles, to do nothing patients don't want and so on. I have to admit that I got my principles from philosophy studies. Otherwise I wouldn't have gained these insights. From osteopathy certainly not. (t.b.A.W.)]
Gerhard describes himself almost as an outsider and stresses that he does not identify with the osteopathic profession. Apparently he feels the need to distance himself from energetic-oriented currents in osteopathy, as, for example, biodynamics. He rather seems to draw his self-conception from sciences such as philosophy and medicine.

2.5.5. Summary

Gerhard's self-conception is characterised by interhumanity and mutual interaction in the osteopathic treatment. For him establishing a foundation of trust is the central element of an osteopathic treatment. In his understanding language plays a significant role during the treatment. In this respect he clearly distances himself from those osteopaths who work on a 'sensorial level only'.
He reflects conflicts that might be caused by the bodily proximity during an osteopathic treatment whereby it is apparent that despite his theoretical reflection on the concrete action level there are insecurities referring to this.
Corporeity is an important issue, in theoretical reflections as well as on the concrete action level. Gerhard incorporates body-perception on part of his patients into the treatment and establishes a relation between the improvement of body-perception and an improved therapeutic relationship. This reflection might be linked to the connections between body-perception and the ability to relate to others mentioned in chapter 3.

He is the only interviewee who reflects on the power situation that develops during the osteopathic treatment and concerns himself with manipulation and instrumentalisation whereby it becomes clear that these are extremely problematic topics for him, especially when he feels being instrumentalised or suspected of manipulating patients. In this context it becomes apparent that his approach to osteopathy is a very rational-oriented one. He distances himself from osteopaths who work energetically.

Particularily remarkable is the fact that he is the only interviewee who defines the topic demarcation by the patients' boundaries instead of the osteopaths' boundaries. Again this illustrates that this mode of practice is characterised by interhuman aspects as well as by the concrete interaction between patient and osteopath. He envisions himself as his patients' 'companion' who knows a certain 'trade' and not as their 'educator'. Apparently he has problems with the occupational image of osteopaths as he draws his self-conception from other sciences such as philosophy. Only there he is able to find the right impulses for his mode of practice and the theoretic analysis of ethic-moral questions: '*Otherwise I wouldn't have gained these insights. From osteopathy certainly not'*.

This interview permits the conclusion that impulses from other sciences are useful for osteopathy in order to reflect central ethic-moral questions.

3. Synopsis of the interviews - prospect

In the following chapter I will categorise the main topics that emerged from the interviews and subsequently I will relate the statements from the different interviews to each other.

The following categories were built:

1. Relationship-formation
2. Interaction and conflict management
3. Demarcation
4. Self-conception

3.1. Relationship-formation

3.1.1. Definition of relationships: human or therapeutic?

The relationship between patient and osteopath is defined differently by the single interviewees.

Wolfgang differentiates between a human and a therapeutic relationship whereby it becomes apparent that permitting the human relationship can lead to conflicts and demarcation problems. While Gerhard places special emphasis on interhumanity, mutual interaction and establishing a foundation, Thomas stresses that a good human relation does not necessarily have to mean that he is *automatically [...]'in relation with what I want to treat'*. For him it is important to come in contact with the '*patient's centre'* and he thinks that a too close '*human'* relationship is rather hindering the therapeutic success.

Maria stresses the significance of neutrality and abstinence on part of the osteopath, '*neutral empathic therapeutic relationship [...] that the processes that run off before you on the therapy bed, it's important that these processes can run off unopposedly without being disturbed by me'* but at the same time emphasises that patients like about her that they can confide in her and that she '*leaves nothing unexpressed'*. On the other hand she apparently has problems with patients who personally bring in themselves too much. Erika describes her personal strength insofar as she tries '*to listen carefully what they really want from me. I mean I try to listen to their words, as well as to gestures and I also try to read between the lines, to open up all my senses to find out about their real concerns. ... every other interaction is as important for me as the technical treatment. I means yes. I try to be after it.'*

Thus it becomes apparent that there is a wide spectrum concerning relationship-formation in osteopathy. The significance of the 'human' relationship is estimated very differently by the interviewees whereby it becomes clear that this aspect seems to be less important for those osteopaths whose method is biodynamic-oriented. The question that arises is to what extent the human relationship should be separated from the therapeutic relationship or if a professional therapeutic relationship implies a human relationship. As emerged from the interviews the interviewees obviously feel a strong need for separating these different levels.

May it be the case that the education does not focus the integration of the human level sufficiently?

Apparently in this respect there is a need for action in the osteopathic education.

3.1.2. The patients' task: 'willingness for therapy'

It is made clear that all interviewees expect certain behaviour on part of the patients, namely the 'willingness for therapy'. This willingness for therapy is defined as the ability 'to get involved' with therapy by all interviewees.

For Thomas it means letting loose all cognitive control mechanisms, the '*do-activities'* and the absolute and unconditional commitment on part of the patients for the osteopath can reach their centre and the patients' self-healing forces can come into operation. Erika also calls it the ability to get involved with the therapy, letting loose and in the best case a feeling of coherence, a '*surrounding feeling of calmness'* and the feeling of *'you can do what you want and the therapy works'.* Similar to Thomas description her depiction of a good relationship can be equated with the affiliation between osteopath and patient. Maria uses a similar picture as Erika in order to describe a 'well working therapy'. It appears that both refer in their description of coherence to Jim Jealous' biodynamic model. Erika, as well as Maria, calls patients' ambivalent behaviour a sign for a lack of willingness for therapy, '*technically speaking I'm here but on the other hand I'm not', 'you have this feeling that you have to worm everything out of him and after every second or third question [...] she asks, why do you have to know that?'* and see only limited possibilities for change. Wolfgang perceives the patients' ability for commitment on a verbal as well as on the level of tissues, he describes an '*easing'* or a '*closure'* of tissues. Gerhard also describe permanent controlling asking on part of the patients as a sign for a lacking foundation of trust. He is the only one to reflect on strategies that should enable patients to more actively participate during the therapy. He uses treatment techniques such as GOT that contribute to the concretion of the patients' body-perception and give them the opportunity to feel more secure and enables them to better articulate their needs.

3.1.3. Personal responsibility on part of the patients – responsibility of osteopaths

The patients' personal responsibility and the responsibility of osteopaths is perceived differently by the interviewees. While Thomas eludes responsibility to a large extent, as according to his self-conception, he tries to activate the patients' self-healing forces on the level of on-depth processes '*when they start up it's something I don't really feel responsible about any longer, and if he doesn't do it I can't change it'* Gerhard vehemently articulates his reservations against 'shielding' and a lack of 'interhumanity' in the self-conception of many osteopaths. Maria is very ambivalent in this respect. On the one hand she says that she is always there for her patients but on the other hand delegates responsibility to the patient right from the start. Wolfgang primarily defines his responsibility by his profession as physician, which means that he offers different medical treatments, according to his personal estimation, and thus tries to do justice to the respective needs of his patients. This return to his function as

physician obviously gives him the possibility to demarcate himself against his patients. Erika clearly differentiates in her liability between adults and children.
In this context it is important to stress again that regression, which necessarily comes along with an osteopathic treatment, inevitably determines the osteopaths' liability. This leads to the ethic-moral question if osteopaths are aware of this liability and to what extent they are ready to accept this responsibility.

3.1.4. Summary

The analysis of the interviews shows that there are significant differences between the osteopaths concerning relationship-formation. All interviewees assume that certain behaviour, namely the 'willingness for therapy', can be expected from patients. This willingness for therapy is primarily defined as the ability to get involved with therapy by all interviewees. Biodynamic-oriented osteopaths thereby understand the ability to let loose all cognitive control mechanisms, whereas osteopaths, for whom the interhuman relationship ranks high, envision the ability to let loose as the product of a successful interpersonal relationship. From this, one could derive the meaning of concrete relationship-formation for the osteopaths. While osteopaths, for whom the interaction on a human level rates high, feel accountable for their patients, do osteopaths, who define relationship rather on the level of tissues, see their liability towards patients as much more limited, as they mainly refer to the activation of their patients' self-healing forces. Language also seems to have a different significance for the individual interviewees. While language rates high in connection with interhuman relationship-formation, it is perceived as obstacle on the level of in-depth processes. This implies the question about the osteopaths' liability towards patients and it is pointed out several times that a body-oriented treatment, such as osteopathy, fosters, because of its therapeutic setting, the patients' regression which has to be handled professionally and responsibly on part of the osteopaths. Therefore it is necessary to incorporate depth-psychological findings from attachment theory and developmental psychological findings concerning ego-development and the ability for demarcation into osteopathic education, in order to do justice to the complex demands of this therapeutic situation.

3.2. Interaction and conflict management

3.2.1. Interaction in the therapeutic process

On a cognitive level all interviewees reflect their potential contributions to interaction problems in the osteopathic treatment. Also transference problems are addressed, for example by Wolfgang and Erika. On the action level, however, it becomes apparent that in this respect certain insecurities and personal overloads exist *(*Gerhard: *'I have to admit that at first I panicked a little'*) to which the osteopaths often react with personal offence and defence. (Wolfgang: '*I realised that I was being misunderstood by her on many occasions and then I have difficulties to express myself and then I also had difficulties to touch her'*, Erika: '*if he still evades and so on, if he huddles and is so yes technically speaking I'm here but on the other hand I'm not, then it doesn't work well at all.'*, Maria: '*she assaulted me that I was a bad therapist and in such cases I draw my boundaries really, really clearly and say that I'm an absolute professional, because that's what I am and I don't have to listen to that [...] Maybe it's partly because of me, but definitely also because of the patient, but therefore I don't call me into question',* Thomas: '*in this case I probably made a mistake. With thousands of others I didn't and maybe they wouldn't have conceived it as such*.'*)*
Mutual interaction during the therapeutic process is perceived only partly. Phenomena such as tensions, fear, ambivalence are mainly reflected as the problems of patients, but are rarely brought in connection with interaction processes during the treatment. The ideal of therapeutic neutrality and abstinence serves as protection from personal concernment and insecurity. Therefore it is important to point out again that in adjoining sciences, such as psychotherapy research, neutrality and abstinence increasingly take a backseat in favour of an interactional perspective. It would be interesting to examine interactional processes in osteopathy carefully and in connection with other sciences.

3.2.2. Discontinuation of Therapy

The discontinuation of therapy is for all interviewees a possible option when it comes to conflicts and interaction problems. In this respect only little scope or possibility for change of the therapeutic process is perceived. Thereby boundaries are interpreted differently by the interviewees. While Thomas draws this boundary relatively early regarding children who are not willing for therapy *'then I say this is a limit, in such a case there is no treatment'*, Erika,

draws a more ample boundary in such cases, '*I try harder, as I think they are not really able to estimate the consequences, if they're not being treated now'*.

3.2.3. Summary

When it comes to interaction problems all interviewees reflect their own potential contributions. Transference and countertransference phenomena are perceived and described on the level of tissues by some of the interviewees as well, whereby the interactional perspective, i.e. the perspective that is based on mutuality between therapist and patient in the therapeutic process and which is postulated by recent psychotherapy research, plays only a minor role. It is more a matter of perceiving the patient's as being open or close. Similar to classic psychoanalysis one's own role is defined as being as abstinent and neutral as possible. This abstinence may be comprehended as protective mechanism on pert of the osteopaths when it comes to demarcation problems. Thereby those interviewees, who actively come in contact with patients on a human level, apparently promote the concept of therapeutic abstinence less than those interviewees who define the relationship to patients primarily on the level of tissues.

In dealing with conflicts all interviewees keep the possibility for the discontinuation of therapy open, although their opinions concerning border violations that should lead to the discontinuation of therapy are rather different. It becomes obvious that the option for the discontinuation of therapy has to do with personal overloads caused by conflicts and a lack of perspective regarding the possibilities for change in the therapeutic process.

In this respect alternatives of action during the education, which aim at more professional handling of conflicts, seem to be necessary.

3.3. Demarcation

3.3.1. Demarcation on part of the osteopaths

The topic of demarcation against patients occupies all interviewees. In this respect bodily proximity during the osteopathic treatment apparently is a big challenge and entails strong conflict potential. Thereby demarcation strategies on a bodily as well as on a verbal level are mentioned.

For Erika the return to her own body-perception, to her own centre is one way of demarcating herself from patients *'and I'm also completely quiet and in my own centre.'* And Thomas says: '*if I have the feeling that I feel the navel, that it's not open I have to find out what's wrong.'* Maria describes it as '*my own centring, the connectedness with the here and now'*.
Another possibility for demarcation is language. Maria gives examples of situations in which she tries to demarcate herself verbally from assaults of patients. And also Wolfgang describes situations in which he tries defuse conflicts caused by bodily proximity by means of conversation. However, it is obvious that often osteopaths fall back upon the option of discontinuing therapy when it comes to such conflicts, as they apparently cannot handle offences on part of the patients in any other way.

3.3.2. Demarcation on part of the patients

Interestingly enough the need for demarcation on part of the patients is hardly verbalised. When it comes to the topic of border violation only Gerhard spontaneously talks about the patients' boundaries and not about the osteopaths'. Above all he cites the autonomy of patients, '*a really elementary border is to do nothing the patient does not want'* and names the treatment of intimate regions of the body as border violation, which is not discussed sufficiently as an ethic-moral question in osteopathy. In this context Wolfgang gives the example of a woman who experienced his contact with her pubic bone as assault, '*as certain parts of the body are afflicted differently for some patients.'* The question that arises is, if this taboo-free approach to the body, which definitely exits in osteopathy, should not be scrutinised more critically and reflected during the education.
In this context it is important to point out again that the strategy of self-perception as demarcation strategy, which is applied by many osteopaths, is not available to patients to the same extent, as they can rarely ever participate actively in the treatment. As mentioned above only Gerhard names treatment techniques, which improve self-perception on part of the patients and thus bring about their active participation.

3.3.3. Summary

The topic of demarcation plays an important role in the interviews. When being asked about this topic most interviewees primarily think of their own demarcation against patients. Only one interviewee spontaneously addresses the boundaries of patients. Primarily bodily

demarcation is mentioned as demarcation strategy. The most frequent demarcation strategy is the return to one's own body perception. Demarcation on a verbal level is mainly applied when it comes to conflicts caused by the intensive bodily proximity during the treatment. Thereby insecurities on part of the osteopaths become apparent that often lead to the strategy of relationship-termination.

Demarcation on part of the patients is hardly a subject of discussion for the interviewees. As emerged from the interviews, the demarcation strategy of returning to one's own body-perception is not available to patients because of the expected willingness for therapy, which, especially in the biodynamic method, implies letting loose all cognitive strategies.

Theoretical findings from developmental psychology and body-schema research suggest a more differentiated dealing with the patient's boundaries and should lead to alternatives of action in the osteopathic education as well as to critical questions of the osteopathic self-conception concerning therapy style.

3.4. Self-conception of the osteopaths

3.4.1. Companion, mediator

Maria, Wolfgang and Gerhard define themselves as their patients' companions. Especially Maria and Wolfgang bring this sort of companionship in conjunction with long-term therapies, in which, according to them, a specific form of relationship develops, that does not develop during short-term therapies. Maria, as well as Wolfgang, expresses that these long-term therapies challenge her in a specific way and that the topic of demarcation thereby particularly comes to the fore. In this context I would like to refer to Latey in chapter 5, who states that there is only little discussion of long-term therapies in the osteopathic literature. Thus it would be interesting to further research this topic as well.

Thomas on the other hand envisions himself as mediator, who wants to bring patients in contact with the healthy parts of their personality. For him a human relationship is rather hindering the therapeutic success. He proceeds from the assumption that he establishes a sort of relationship with his patients that is close to affiliation on a spiritual level. '*And that's why I have the feeling when I reach the patient's centre I reach my own centre at the same time.'*

This means that his self-conception is stamped by spirituality. This approach, which proceeds from the assumption that the osteopaths solves problems on a level that is not consciously

accessible for patients, implies a certain power towards patients on part of the osteopath, which he has to handle with care and responsibility.

3.4.2. Is power a topic in osteopathy?

Gerhard is the only interviewee who articulates the issue of power. '*For me the topic of power is a very important topic in dealing with human beings and I'm aware of the fact that it is a power position you are in.'* Furthermore he stresses that in his understanding these ethic-moral questions are not discussed sufficiently in osteopathy. He says the he gets his impulses for the theoretical analysis of elementary questions of osteopathy from other sciences, above all from philosophy. As explained in the theoretical part of this paper, it is important to integrate adjoining sciences, in particular psychology and psychotherapy, in order to be able to discuss fundamental ethic-moral questions of osteopathy and the self-conception of osteopaths on a wider base.

3.4.3. Summary

Those interviewees, for whom the human relationship in the osteopathic treatment rates high, see themselves as companions while biodynamic-oriented osteopaths, who mainly communicate on the level of in-depth processes with their patients, rather envision themselves as mediator between patients and their healthy parts. This self-conception implies only little responsibility for patients and therefore permits personal abstinence to a large extent.
In this context it is repeatedly pointed to the question of power and manipulation that may come along with the asymmetric relationship between patient and osteopath. It is made clear that these fundamental ethic-moral questions should be discussed on a wider basis in osteopathy, in connection with adjoining sciences, such as philosophy, psychology and psychotherapy.

IV: Discussion

This paper tries to work out the interconnectedness of osteopathy with adjoining sciences, such as psychology and psychotherapy. Thereby the emphasis in the literary research was put on psychological and psychotherapeutic technical literature. I aimed at highlighting the single sections as comprehensively as possible. It was not possible to conduct a profound discussion of the current state of research in every section, though. This would have gone beyond the scope of this paper. I rather tried to work out those aspects that are relevant for osteopathy. As the attended topic is highlighted rather marginally in the osteopathic literature, the extent of literature is relatively small. Furthermore it has to be said that the literary research was difficult insofar as certain osteopathic training centres only provided introductions and conclusions of relevant master theses or did not react to requests for literature at all.

The qualitative study was conducted with the aid of osteopaths. I tried to win over differently oriented osteopaths to an interview. The number of interviewees is indeed small but enough for a qualitative study as the aim was not a quantification of results (how many osteopaths do act in this or in that way etc.) but a content analysis of the individual interviews (manifest and latent contents), the synopsis of the different interviews and to work on relevant aspects (categories). That the conduction of the interviews could sometimes not work out specifically enough the relevant aspects, which is due to the little experience of the interviewer, made the content analysis more difficult. This might be critically remarked.

V: Conclusion

The paper at hand highlighted the therapist-patient relationship in osteopathy. Thereby findings from depth psychology, neurobiology, developmental psychology and psychotherapy were examined to that effect whether they are relevant for the therapist-patient-relationship in osteopathy and whether they are reflected in the practical work of osteopaths.

1. The relevance of attachment theory to Osteopathy

Aspects of attachment theory (Winnicott´s Handling and Holding, Bion´s Containment) have found their way into osteopathic literature (Harcourt 1986, Latey 1997). They can be also found in the relationship-formation of the osteopaths interviewed. Establishing a trustful relationship plays an important role for the interviewees. They distinguish, however, clearly between human and therapeutic relationship. The therapeutic relationship is mainly defined on the level of tissues. Apparently biodynamic-oriented osteopaths, who envision themselves as mediator between patients and their healthy parts, attribute less importance to the relationship on a human level than those who see themselves as their patients' companions. Generally the interviewed osteopaths expect a certain willingness for therapy from their patients, which is characterised by letting loose all cognitive strategies. Thereby the interviewees attach different degrees of importance to the necessity of containment in connection with the resulting regression and the consequent responsibility of osteopaths towards their patients. Therefore the osteopaths' self-conception plays an important role. (Mediator or companion.)

In the osteopathic education more emphasis could be put on these findings by going into more detail concerning relationship-formation in the osteopathic treatment and critically reflect it against the background of depth psychological findings.

2. The balance between intuitive and rational acting in Osteopathy

The neurobiological findings of mirror neurons (Bauer 2005) are reflected in osteopathy. The insight that a responsible treatment of patients should be characterised by a balance between intuitive and rational acting can be also found in the osteopathic literature. (Latey 1997) On the contrary other authors (Comeaux 2006, Jealous 2006) promote a rather intuitive approach.

This discrepancy is affirmed by the results from the interviews. It is also reflected in the significance of language in the osteopathic treatment. Thereby it becomes apparent that osteopaths attribute a different meaning to language, depending on their self-conception. Osteopaths who envision themselves as mediator between patients and their healthy parts attribute less meaning to language than those who see themselves as their patients' companions.

As emerges from the analysis of the interviews a certain insecurity and uncertainty exists concerning the integration of intuitive and rational acting. This insight should be focussed on during the education. Furthermore attention should be paid to the development of adequate communication between patient and osteopath.

3. The reflection of developmental psychological findings in Osteopathy

Developmental psychological findings, especially from body-schema research about development (Schilder 1923, Frostig 1975, Du Bois 1990) and the susceptibility for disturbances (Scharfetter 1982) of body-experience are hardly reflected in the osteopathic literature.(Latey 1997 b) As the analysis of the interviews shows, osteopaths are hardly aware of the susceptibility for disturbances of body-experience on part of the patients and the resulting necessity for demarcation on part of the patients. In fact, they rather expect willingness for therapy from their patients in the sense that patients should let loose all their cognitive strategies. The osteopaths mainly reflect their own strategies for demarcation. These largely consist of a return to their own body-perception. These demarcation strategies, however, are not available to patients, as the willingness for therapy includes letting loose cognitive control mechanisms. Osteopaths often fall back upon the option of discontinuing therapy when it comes to demarcation problems.

The theoretical findings from developmental psychology and body-schema research suggest a more differentiated analysis of the subject of demarcation having regard to the patients' boundaries and should lead to alternatives of action in the osteopathic education as well as to scrutinising the osteopathic self-conception in respect of therapy style.

4. The relevance of psychotherapeutic findings to Osteopathy

The therapist-patient relationship in osteopathy is analysed, too, starting from the therapeutic relationship in psychotherapy (Strotzka 1982, Bettighofer 2004, Hain 2005). Thereby it becomes apparent that this issue is treated in the osteopathic literature rather marginally. Frymann (1968) reflects concepts such as empathy and compassion. Latey (1997) and Liem (2001) deal with transference and countertransference and highlight special aspects of transference in the osteopathic treatment. Transference and countertransference phenomena are reflected in the interviews but it shows that there is only little awareness for mutual interaction during the therapeutic process.

The phenomena of transference and coutertransference as well as the mutual interaction in the therapeutic process should be more regarded in education of osteopaths.

5. The reflection of power and responsibility in Osteopathy

By the inspection of the therapist-patient relationship, the spiritual/religious relatedness of some osteopathic authors (Frymann 1968, Jealous 2006, Comeaux 2006) becomes apparent and is critically reflected.
Some interviewees also display a spiritual self-conception which is associated with the function of a mediator between patients and their healthy parts and implies only little liability towards patients on part of the therapist. Connected ethic-moral questions about responsibilty and power are reflected by only one interviewee.

That implies the necessity to reflect power relations, which inevitably develop during an osteopathic treatment, already in the osteopathic education but also in the scientific discourse as well as to critically scrutinise the osteopaths' self-conception and idea of man.

6. Summary

In the paper at hand a need for a wider reference frame and the integration of adjoining sciences, such as psychology, psychotherapy or philosophy into osteopathy becomes apparent. The osteopathic treatment is based on an encounter of two human beings. It is necessary to

regard and reflect this relationship against a wider background in order to do justice to resulting ethic-moral questions.

Above all during the education the relationship between osteopath and patient could be emphasised more comprehensively and students could be coached better concerning this matter by means of lectures and supervisions. In this respect theoretic psychological and philosophical basics as well as supervisions, that integrate mainly interactional aspects, would be useful.

But also practising osteopaths could broach the issue of therapist-patient-relationship implying adjoining sciences in intervision groups. In addition self-experience and advanced training in the field psychology would be useful.

Only in this way it seems possible to do justice to the demand for holism postulated in osteopathy.

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VIII. Appendix

Interview guideline:

1. I'm sure you know this feeling that a good relationship has developed between you and the patient. How does that feel? Could you explain that by means of an example?

2. I'm sure you also know the situation that it doesn't work really well between you and the patient: How does that feel? Could you describe that by means of an example?

3. When it comes to long-term therapies, it surely happened that the relationship changed – either for the better or for the worse. Could you think of an example? What happened? How did you experience that?

4. I'm sure sometimes you realise that you don't really have a way with this or that patient. Is there any example that crosses your mind? What happened?

5. You surely experienced border violations during the therapy. Can you think of a concrete example?

6. I'm sure you experienced patients who seemed to be difficult or even mentally conspicuous in his/her contact behaviour. Can you remember a relevant example?

7. Could you tell me about your professional development? What motivated you to become an osteopath?

8. How did you acquire your skills in dealing with patients?

9. How would you define yourself as osteopath? How do you understand your liability, your duty towards your patients?